# Health News & Notes

A Publication of the
Northwest Portland Area Indian Health Board

**April, 2005**


***Our Mission is to assist Northwest tribes to improve the health status and quality of life of member tribes and Indian people in their delivery of culturally appropriate and holistic health care.***

## NPAIHB Expands Office Space

*LtoR: Roselyn Tso, Julia Davis Wheeler, and Doni Wilder enjoying the new NPAIHB Northwest Conference Room during the Open House. NW Tribal Logos are framed and hanging on the wall.*
*See page 4-5 for related story.*

### In This Issue

*From the Chair:*

# Pearl Capoeman-Baller

## Northwest Portland Area Indian Health Board

### Executive Committee Members

**Pearl Capoeman-Baller,** *Chair*
Quinault Nation
**Andy Joseph**, *Vice Chair*
ColvilleTribe
**Janice Clements,** *Treasurer*
Warm Springs Tribe
**Rod Smith,** *Sergeant-At-Arms*
Puyallup Tribe
**Stella Washines,** *Secretary*
Yakama Nation

### Delegates

**Barbara Sam**, Burns Paiute Tribe
**Dan Gleason**, Chehalis Tribe
**Leta Campbell**, Coeur d'Alene Tribe
**Andy Joseph**, Colville Tribe
**Mark Johnston**, Coos, Lower Umpqua & Siuslaw Tribes
**Kelle Little,** Coquille Tribe
**Sharon Stanphill**, Cow Creek Tribe
**Carolee Morris**, Cowlitz Tribe
**Cheryle Kennedy,** Grand Ronde Tribe
**Vacant,** Hoh Tribe
**Bill Riley,** Jamestown S'Klallam Tribe
**Darren Holmes**, Kalispel Tribe
**Nadine Hatcher**, Klamath Tribe
**Velma Bahe**, Kootenai Tribe
**Rosi Francis**, Lower Elwha S'Klallam Tribe
**LaVerne Lane-Oreiro**, Lummi Nation
**Debbie Wachendorf**, Makah Tribe
**John Daniels,** Muckleshoot Tribe
**Rebecca Miles**, Nez Perce Nation
**Midred Frazier**, Nisqually Tribe
**Rick George,** Nooksack Tribe
**Shane Warner,** NW Band of Shoshone Indians
**Rose Purser,** Port Gamble S'Klallam Tribe
**Rod Smith**, Puyallup Tribe
**Bert Black**, Quileute Tribe
**Pearl Capoeman-Baller**, Quinault Nation
**Billie Jo Settle,** Samish Tribe
**Norma Joseph,** Sauk-Suiattle Tribe
**Marsha Crane**, Shoalwater Bay Tribe
**Belma Colter**, Shoshone-Bannock Tribes
**Judy Muschamp,** Siletz Tribe
**Marie Gouley,** Skokomish Tribe
**Robert Brisbois**, Spokane Tribe
**Katherine Barker**, Snoqualamie Tribe
**Whitney Jones**, Squaxin Island Tribe
**Tom Ashley**, Stillaguamish Tribe
**Linda Hol**t, Suquamish Tribe
**Leon John**, Swinomish Tribe
**Marie Zacouse,** Tulalip Tribe
**Sandra Sampson,** Umatilla Tribe
**Marilyn Scott,** Upper Skagit Tribe
**Janice Clements,** Warm Springs Tribe
**Stella Washines,** Yakama Nation

The past three months have seen a flurry of activity as Tribes get ready for the upcoming budget season and prepare legislative agendas for the 109th Congress. The President released his FY 2006 budget in February and it did not hold good things for Indian Country. Although the Indian Health Service (IHS) did receive a slight increase of 2%, other programs in the Department of Health and Human Services (HHS) did not fare as well, averaging less than a 1% increase. The programs in the Bureau of Indian Affairs (BIA) saw a 4.7% cut! We all understand the current budget realities of this country and given the BIA budget cut and lack of increases for HHS programs only means that we have a lot of work to do to advocate and keep the current increase for the IHS budget.

The Board conducted its 16th Annual All Tribes meeting on March 8-9, with those Tribes in attendance estimating that it will take $371 million to maintain current services. Northwest Tribes also estimated $228 million in program increases to restore lost services from past years. While the President's request is far short of these amounts, it does provide a better increase for the IHS when compared to other HHS agencies. So Tribes will need to be prepared to support and defend the current increase for the IHS. Given the current fiscal environment it will be very difficult to receive sizable increases and very easy for Congress to take back badly needed funding. In the President's budget submission, we also saw the effects of the Performance Assessment Rating Tool (PART) on three Indian programs. PART is a diagnostic and budget based performance tool used to assess Federal programs. PART results are used to reduce or reward federal programs in the budget process.

This year, the Office of Management and Budget (OMB) has informed the IHS that tribally operated health programs will be the subject of a PART Review. Agencies are held accountable for implementing PART follow-up actions and working toward continual improvements in performance. Those agencies performing successfully are supposedly rewarded in the budget process. Although there does not seem like much to gain, there is so much to lose in the PART process and the Board will work hard to ensure that the Agency's submission is representative of the positive performance of Self-Determination programs in order to be scored effectively.

January and February were very busy months for all of us. I want to convey a special thanks to the Squaxin Island Tribe for hosting our January quarterly board meeting. The Squaxin Island Tribe was a very gracious host and provided wonderful accommodations for us all to conduct the Board's strategic planning activities. The Board staff is in the process of finalizing the plan and a draft will be provided at the upcoming quarterly meeting to be held at Quinault. Janice Clements attended the National Indian Health Board's (NIHB) quarterly board meeting on my behalf as I stayed home to take care of important Tribal council matters. The NIHB agenda included information on the work of the

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*From the Executive Director:*

# Ed Fox

I have worked for tribes for 10 years, during which I mostly sat on the sidelines watching tribal leaders, our delegates, and the many volunteers to the committees and workgroups staffed by the Board. We have worked on a lot of issues. Some of those issues were hotly contested. Some involved dividing money between our tribes. Some issues were marathon struggles lasting for years, some just a couple weeks of intense activity. For the past four and half years as Executive Director, I have had to step up to the role usually reserved for a tribal leader or someone with much more experience than I in providing leadership appropriate to an Indian organization.

I would like to present some of the differences I have noted between non-Indian leadership aphorisms and Indian stories of leadership. I would also like to argue for the superior guidance that I think flows from the Indian way of management.

### "A wise man knows at first what a fool learns at last."

This non-Indian aphorism has many other incarnations that imply that the prize goes to the quick. The archetype would be the too bright student who shouts out the answer before anyone else can speak. The Indian way encourages discussion, probably led by a tribal elder or a leader followed by comments from all others who want to speak. It is clear that the Indian way is not the 'quick' way on several counts. First, you have to believe that the 'right answer' is not so apparent that it can be shouted out, that it might take time to discover the best answer. Secondly, the respect for the views of others clearly means the decision will take longer to complete.

### "Reward success, not best effort"

E for effort is the Indian way, not the way of non-Indian managers. Credit taking and plagiarism are common in organizations where only success is rewarded. I often say our tribes appreciate me despite the fact that our 'success rate is probably 20%." That's right, we lose 80% of the time. We often take risks that are not rewarded with success, but they are rewarded with the appreciation of our tribes for the hard work expended in our (temporarily) losing battle. Think about the struggle to retain Indian culture and you can understand why Indian people reward those who try against overwhelming odds. Think too about our most common adversary—the most powerful nation in the world.

### "Short-term gain trumps long-term goals"

The concept of the seventh generation compared to this quarter's results captures neatly the difference between non-Indian time perspective and that of tribes. While fighting for the long term view may at times seem to concede a battle or two along the way, it is the war, not the battles that we must win in health care, economic growth, and preservation of culture and tribal sovereignty. Our tribes our forever and our tribal

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## Northwest Portland Area Indian Health Board

## Projects & Staff

***Administration***
*Ed Fox, Executive Director*
*Verné Boerner, Administrative Officer*
*Sue Lara, Finance Officer*
*Bobbie Treat, G/L & Contracts Accountant*
*Mike Feroglia, A/P & Payroll Accountant*
*Erin Moran, Executive Administrative Assistant*
*Elaine Cleaver, Office Manager*

***Program Operations***
*Jim Roberts, Policy Analyst*
*Sonciray Bonnell, Health Resource Coordinator*
*James Fry, Information Technology Director*
*Chris Sanford, Network Administrator*
*Chandra Wilson, Human Resource/Special Projects Assistant*

***Northwest Tribal Epidemiology Center***
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*Joshua Jones, Medical Epidemiologist*
*Emily Puukka, NW Tribal Registry Director*
*Ticey Casey, EpiCenter Project Assistant*
*Katrina Ramsey, Navigator Project Coordinator*
*Tam Lutz, TOT's and ICHPP Project Director*
*Julia Putman, TOT's Project Coordinator*
*Clarice Hudson, IRB & Immunization Project Coordinator*
*Luella Azule, NTRC Project Coordinator*
*Kerri Lopez, Western Tribal Diabetes Director*
*Rachel Plummer, WTD Project Assistant*
*Don Head, WTD Project Specialist*
*Crystal Gust, WTD and National Project Specialist*

***Tobacco Projects***
*Gerry RainingBird, NTTPN Project Director*
*Terresa White, NTTPN Project Specialist*
*Nichole Hildebrandt, WTPP Project Director*
*Karen Schmidt, WTPP Project Specialist*
*Doug White, WTPP Project Specialist*

***Northwest Tribal Recruitment Project***
*Gary Small, ProjectDirector*

***Northwest Tribal Cancer Control Project***
*Liling Sherry, Project Director*
*Cicelly Gabriel, Project Assistant*
*Eric Vinson, Survivor & Caregiver Coordinator*

***Project Red Talon***
*Stephanie Craig, Project Coordinator*
*Lisa Griggs, Project Assistant*

# NPAIHB Expands

*by Sonciray Bonnell, Health Resource Coordinator*

The Northwest Portland Area Indian Health Board is proud to announce the expansion of our offices. Our renewed eight-year lease with Portland State University (PSU) added the office space that had formerly divided our two suites. Prior to the expansion, the Board's offices were at opposite ends of the University Center Building and divided by the PSU Waseda University of Japan office. Our office space went from 13,300 square feet to 15,500 square feet and we now occupy the entire west side of the University Center Building. The best news is that a continuous hallway running the length of our office space now connects our two suites. Our renewed eight-year lease (5 years with a 3 year option) with Portland State University includes $50,000 in construction costs paid by the university to connect the two suites, but we did more than that. The construction consisted of connecting our two suites, expanding one conference room, building a larger conference/training room, and fixing our HVAC system. The Board has financed the balance of the $121,000 remodeling costs.

*NPAIHB Northwest Conference room*

Our conference and training rooms vary in seating capacity, ranging from 10-50 seats. We've tentatively named the conference rooms: Northwest Room (50 person classroom style), Oregon Conference Room (35 person), Idaho Conference Room (25 person ), and the Washington State Training/Library Room (24-computer training center). For our tribal Delegates and Board partners, we encourage you to consider using our facilities for trainings and meetings. NPAIHB is able to provide and an in-focus projector, wireless connection, a laptop, projection screen, and friendly technical support. We are very serious about extending an invitation to use our facilities and had this in mind when expanding our office space. And if you've ever been to the Board, you know our staff is friendly, we enjoy occasional bursts of loud laughter, we are accustomed to receiving guests, and we welcome visitors. NPAIHB staff also plan to increase the number of trainings we offer on-site, so visit our website www.npaihb.org for upcoming trainings at the Board.

Last year we were able to collect 42 of our 43 tribes' logos. We recently had most of the tribal logos framed, and they are on display in our new Northwest Room. If by chance the tribal logo that we have display is not your most current or there is a higher quality logo available, please contact Sonciray Bonnell (503) 228-4185 or sbonnell@npaihb.org to make arrangements for an exchange. We are very proud to display the Northwest tribal logos and they have already received much attention from our visitors and staff.

The Board hosted a two-day Open House on April 5-6, 2005 for our Delegates and partners to tour our new office space. Carl Sampson (Umatilla) blessed our entire office, the new space and old, inside and out, and gave the opening prayer for the formal Open House ceremony. The Board would like to thank Mr. Sampson for his prayers and blessings – an essential part of introducing our new space to the public.

# Office Space

*LtoR: Ed Fox (NPAIHB Executive Director) and Pearl Capoeman Baller (NPAIHB Chair)*

We were very excited to invite our Delegates and partners to our office and planned an afternoon of presentations that would tell the story of the Northwest Portland Area Indian Health Board (the hard working employees you saw was not scripted, but a genuine view into how we remain so successful). The lineup of speakers included:

- Pearl Capoeman Baller (Quinault), President of the Quinault Nation, Chair of NPAIHB, and Portland Area Representative to the National Indian Health Board
- Julia Davis-Wheeler (Nez Perce), former Chair of NPAIHB
- Doni Wilder (Rosebud Sioux), Portland Area Indian Health Service Direc tor and former Executive Director of NPAIHB
- Ed Fox, NPAIHB Executive Director
- Verne Boerner (Inupiaq), NPAIHB Administrative Office
- Jim Roberts (Hopi and Sioux), NPAIHB Policy Analyst

*LtoT: Pearl Capoeman Baller (NPAIHB Chair) thanking Carl Sampson (Umatilla) for his blessing*

The Open House was a great success that included NPAIHB Delegates, the construction crew who worked on the new office and conference space, staff of the Board, our current and most recent chairs (only 3 chairs in 33 years!), the Portland Area Office IHS Director, and a Northwest Indian spiritual leader who consecrated our space in a good way. Please do come by for a visit if you missed our open house.

Our next step is to solicit donations for art for our new conference rooms. We have already sent a letter to our 43 tribes soliciting donations of art or money to purchase art. If you are interested in donating art or donating money to purchase art for our office, please make checks payable to NPAIHB and send to:

NPAIHB
527 SW Hall, Suite 300
Portland, OR 97201

*Guests at NPAIHB Open House*

Also, if you have suggestions of artists you'd like to see represented, please contact Sonciray Bonnell. We are very serious about hearing from our Delegates and Northwest tribal leaders on how they want our offices to look. I will say that we are on a budget, but still promote the conversation on the selection of, primarily, Northwest Indian Art. As most of you know, we are focused on our work in providing services to our tribes, so the idea of soliciting donations for Indian art in our offices is new to us. Regardless of how our office looks, we will continue to fulfill the mission of the Northwest Portland Area Indian Health Board: "To assist Northwest Tribes to improve the health status and quality of life of Northwest tribes and Indian people in their delivery."

# Pearl's Report continued

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Medicare Medicaid Policy Committee, the Tribal Technical Advisory Committee, agenda items for the upcoming Direct Service Tribes conference, and developing their upcoming agenda for the 109th Congress.

We conducted the Board's strategic planning session in January with the document currently being prepared and will available at our April meeting in Quinault. The strategic planning session allowed Board members and staff to interact in working sessions - something we don't always get an opportunity to do. The mission and vision statements of our organization were considered as we defined the priority areas for the Board to work on over the next five years. The preliminary plan revealed that the Board is focused and should continue to work in the priority areas of legislative and policy analysis, technical assistance and training, health promotion and disease prevention, and data surveillance and research. We are looking forward to the draft document in April.

The Board and I continue to be very active in the work of the Tribal Technical Advisory Committee (TTAG) to the Centers for Medicare and Medicaid Services (CMS). Our Executive Director and Policy Analyst also support the NIHB's Medicare and Medicaid Policy Committee (MMPC). Together the TTAG and MMPC have been working hard on CMS issues. The two groups met in Washington, DC in early February. There are a number of Medicare and Medicaid issues that continue to be unresolved and I understand the frustrations of Tribes to reach conclusion on these issues. The two groups are relentless and continue to forge ahead even when it seems impossible to reach consensus with CMS on issues. On a positive note, CMS has agreed to fund an American Indian and Alaska Native Strategic Plan that will hopefully guide how it works with tribes. The plan, developed by the TTAG for CMS, is intended to provide Dr. Mark McClellan, CMS Administrator, and top level people at CMS with a strategy to strengthen and better understand how it responds to Indian health needs. Ed Fox, Executive Director, and Jim Roberts, Policy Analyst, have been involved in the development of the plan and in conducting interviews in Baltimore with CMS personnel. It is expected that the plan will be available shortly after the April TTAG meeting.

I did attend the National Congress of American Indians winter session held in Washington, DC over February. Stella Washines (Yakama Nation) and Andy Joseph (Colville Tribes) from the Executive Committee along with Board member Linda Holt made hill visits to discuss the Board's legislative plan, IHS budget priorities, and other important Indian heath matters. Capital Hill visits included meeting with staffers of Senators Gordon Smith, Ron Wyden, Patty Murray, and Maria Cantwell. The group also met with Greg Knadle from the House Interior Subcommittee and members from the Senate Committee on Indian Affairs. The NIHB also hosted a briefing on the reauthorization of the Indian Health Care Improvement Act (IHCIA). Tribal leaders and the IHCIA National Steering Committee have been working at least four years on this very important legislation. The briefing provided an update on what happened to the two bills in the waning moments of the 108th Congress and an unofficial overview on some of the provisions that the Administration objected to. The short story is that Tribes still have a lot of work to do on the reauthorization process and the Portland Area did offer to convene a national work session if needed. A meeting of the National Steering committee is scheduled for April 28th in Albuquerque and it is hoped to have an official response from the Administration on their objections to the bills.

Finally, our Direct Service Tribe representatives Stella Washines (Yakama Nation) and Janice Clements (Warm Springs Tribe) continue their important work in planning the Direct Services Tribes conference scheduled for April 25-28, in Albuquerque. The conference agenda includes general assembly and plenary sessions on the legal and historical responsibility of the United States to provide health care, health disparities, budget information, CHS program overview, and many other worthwhile workshops. The Board does plan to participate in this very important conference by providing briefing papers on health issues and staff workshops if needed. I hope that your tribes will be able to support the important work of this group.

# Adult Tobacco Survey

*by Nichole Hildebrandt, Western Tobacco Prevention Project Director*

Commercial tobacco use is the single most preventable cause of disease and death in the United States, killing more than 430,000 people per year. Smoking results in more deaths each year than AIDS, alcohol, cocaine, heroin, homicide, suicide, motor vehicle crashes, and fires combined, and costs the Indian Health Service over $200 million per year in medical services. Further, smoking contributes to the development and exacerbation of numerous diseases, including heart disease, stroke, lung cancer, and chronic lung diseases—all of which are leading causes of death for the American Indian and Alaska Native population.[1] While we have some national, regional, and state-level tobacco related data broken down by age, gender, and urban or rural populations, factors affecting tobacco use on reservation communities is still largely unknown.

The Northwest Portland Area Indian Health Board, through the Western Tobacco Prevention Project, is conducting the American Indian Adult Tobacco Survey (AIATS) in an effort to better understand the effects of smoking use present among the tribal people of Oregon, Idaho, and Washington. The Nez Perce and Klamath tribal communities are participating in the current AIATS. Seven regional Tribal Tobacco Support Centers (including the Western Tobacco Prevention Project) and the Center for Disease Control collaborated to design the AIATS over a two-year period. The AIATS specifically distinguishes between commercial and traditional tobacco use, and has undergone extensive focus group and cognitive testing to assure cultural appropriateness. The AIATS will be carried out using face-to-face interviews by native interviewers.

The goals of the survey are to (1) provide tribes with a better understanding of their adult population's knowledge and practices regarding tobacco use, (2) raise awareness about the dangers of abusing commercial tobacco, and (3) provide tribes with data they can use. The results of this survey will give participating tribes current information about adult tobacco use, community knowledge and attitudes, and aid in the development of culturally appropriate prevention policies. This information is useful for monitoring tribal health, prioritizing health promotion activities, evaluating the efficacy of current programs, developing strategic plans, and substantiating the need for new or existing funding sources in tribal communities.

*Current activities*

The AIATS is in the initial stages of participant recruitment and Interviewer training. Ms. Janis Weber, Senior Research Scientist at RTI International (contracted with the CDC) joined the Western Tobacco Prevention Project in conducting a 2-day training on Interviewing skills and techniques to selected Nez Perce and Klamath tribal interviewers. The trainings took place from March 7-12, 2005 and included instruction on the guidelines for survey implementation provided by the CDC, but focused primarily on providing the Interviewers with an opportunity to work with the survey instrument and practice interviewing with others. Both the NiMiiPuu Clinic in Nez Perce and Klamath Tribal Health & Family Services were gracious in providing conference rooms and "participant actors" by staff members.

The project goal is to collect a total of 200 surveys in each if of our 43 tribes. It is intended for all surveys to be collected by August 1, 2005 and the final reports made available to participating tribes by September 31, 2005. At the completion of this project, a culturally appropriate survey instrument will be available for all tribes to use in their communities. For more information on the Adult Tobacco Survey or the Western Tobacco Prevention Project, please contact Nichole Hildebrandt, Director WTPP nhildebrandt@npaihb.org or Karen Schmidt, ATS Project Specialist kschmidt@npaihb.org at (503) 228-4185.

**(Footnotes)**

[1] Trends in Indian Health 1998-99. Indian Health Service publication. Retrieved on 9/2/2004 from: www.ihs.gov/PublicInfo/Publications/index.asp

# 16th Annual

*by Jim Roberts, Policy Analyst*

Tribal leaders, health directors, and other Indian health advocates met at the Portland Embassy Suites on March 8-9, 2005 to continue a long-standing tradition analyzing the President's budget request for the Indian Health Service (IHS) and developing consensus recommendations. This year marked the 16th year that Northwest Tribes have met in their annual budget workshop held in conjunction with the Area Office's All-Tribes meeting. This year's meeting included representatives from 20 different Portland Area Tribes as well as individuals representing Tribes from the California and Billings Areas. The individuals from other Areas came to Portland to observe the process that the Northwest uses to develop consensus recommendations on the IHS budget. They are hopeful to adopt some of the strategies that the Portland Area uses in their respective Areas.

On February 7, 2005, the President released his FY 2006 budget request for the IHS. The Administration's request for the IHS is $3.05 billion, an increase of $62.9 million (2.1%) over last year's final enacted budget. NPAIHB estimates that it will take at least $371 million in FY 2006 just to maintain current services. Thus, the President's request will fall short by $308 million. The expenses associated with pay act increases and staffing for new facilities of $27.4 million and proposed program increases of $35.4 will quickly exhaust the President's proposed increase of $62.9 million.

Despite the small increase for the IHS budget, the health services accounts did receive comparatively larger increases than the overall budget. This was achieved by reducing new facilities construction by $85 million and redirecting these savings to the health services accounts. For example, both the Public Health Nursing and Health Education line items received over a 10% increase. Other accounts receiving significant increases include the Dental (9.6%), and Mental Health (7.8%) line items. The largest activity, with over $1 billion in spending, was the Hospitals and Clinics programs' 5.4% increase (Please see FY 2006 Budget Table for additional details).

Although, the FY 2006 request does not include enough money to address the true health care needs of Indian people, it is quite possibly the best IHS budget of the Bush Administration. Does this mean it is a good budget for Indian people? The answer to this question is a categorical "NO"! The budget falls short by over $308 million and should be supplemented with an additional $228 million for program increases to fund Contract Health Service (CHS) deferrals and denials, facility and sanitation needs, and past year shortfalls for Contract Support Costs. Northwest Tribes recommended $371 million to fund current services and $228 for program increases. This brings the total to $599 million to address the true health care needs of Indian people in FY 2006.

Many people in the Administration will challenge that Tribes have fared well during this budget season arguing that IHS programs have averaged a 5% increase in FY 2006, while many of the Operating Divisions within the Department of Health and Human Services (HHS) have seen less than a one percent increase. The fact is that IHS and Tribes deserve this increase given their record of strong performance. Moreover, when the health care needs and health disparities of Indian people are taken into consideration, Indian programs should be provided adequate funding to elevate their health status.

Although some might concede that the President's request is a reasonable one and reflects priorities identified in the budget formulation process, Tribes continue to have serious concerns about the budget process. Because the IHS has what may be considered a good budget right now, does not mean that's the way it will end up. Tribes fear that the Congress will once again take the President's request and make changes to suit the priorities of their own constituencies and secondly, that they will once again apply an across the board reduction to meet artificial budget targets that have nothing to do with health care priorities. Tribes want money added to the budget and they are alert to the danger of Congressional cuts hiding behind the word "rescission".

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# IHS Budget Analysis

**Table 1: INDIAN HEALTH SERVICE BUDGET (000s)**
**Comparison of FY 2004, FY 2005, and President's FY 2006 Request**

| | Final | Final Change Over | | Pres. Budget | Change over FY 2005 | |
|---|---|---|---|---|---|---|
| | FY 2004 | FY 2005 | FY 2004 | FY 2006 | Amount | Percent |
| **Services:** | | | | | | |
| Hospitals & Health Clinics | $1,249,781 | $1,289,418 | $39,637 | $1,359,541 | 70,123 | 5.4% |
| Dental Health | 104,513 | 109,023 | 4,510 | 119,489 | 10,466 | 9.6% |
| Mental Health | 53,294 | 55,060 | 1,766 | 59,328 | 4,268 | 7.8% |
| Alcohol & Substance Abuse | 138,250 | 139,073 | 823 | 145,336 | 6,263 | 4.5% |
| Contract Health Services | 479,070 | 498,068 | 18,998 | 525,021 | 26,953 | 5.4% |
| *Sub-total, Clincial Services:* | *2,024,908* | *2,090,642* | *65,734* | *2,208,715* | *118,073* | 5.6% |
| **Prevention Health, Services** | | | | | - | |
| Public Health Nursing | 42,581 | 45,015 | 2,434 | 49,690 | 4,675 | 10.4% |
| Health Education | 11,793 | 12,429 | 636 | 13,787 | 1,358 | 10.9% |
| CHRs | 50,996 | 51,364 | 368 | 53,737 | 2,373 | 4.6% |
| AK Immunization | 1,561 | 1,573 | 12 | 1,645 | 72 | 4.6% |
| *Sub-total, Prevention Health* | *106,931* | *110,381* | *3,450* | *118,859* | *8,478* | 7.7% |
| | | | | | - | |
| Urban Health | 31,619 | 31,816 | 197 | 33,233 | 1,417 | 4.5% |
| Indian Health Professions | 30,774 | 30,392 | (382) | 31,503 | 1,111 | 3.7% |
| Tribal Management | 2,376 | 2,343 | (33) | 2,430 | 87 | 3.7% |
| Direct Operations | 60,714 | 61,648 | 934 | 63,123 | 1,475 | 2.4% |
| Self Governance | 5,644 | 5,586 | (58) | 5,752 | 166 | 3.0% |
| Contract Support Costs | 267,398 | 263,683 | (3,715) | 268,683 | 5,000 | 1.9% |
| *Total, Services:* | *2,530,364* | *2,596,491* | *66,127* | *2,732,298* | *135,807* | 5.2% |
| **Facilities:** | | | | | - | |
| Maintenance & Improvement | 48,897 | 49,204 | 307 | 49,904 | 700 | 1.4% |
| Sanitation Facilities Const. | 93,015 | 91,767 | (1,248) | 93,519 | 1,752 | 1.9% |
| Health Care Facilities Const. | 94,554 | 88,597 | (5,957) | 3,326 | (85,271) | -96.2% |
| Facil & Env Hlth Support | 137,803 | 141,669 | 3,866 | 150,959 | 9,290 | 6.6% |
| Equipment | 17,081 | 17,337 | 256 | 17,960 | 623 | 3.6% |
| *Total, Facilities:* | *391,350* | *388,574* | (2,776) | *315,668* | *(72,906)* | -18.8% |
| **TOTAL, IHS** | $2,921,714 | $2,985,065 | $63,351 | $3,047,966 | 62,901 | 2.1% |

# IHS Budget Analysis continued

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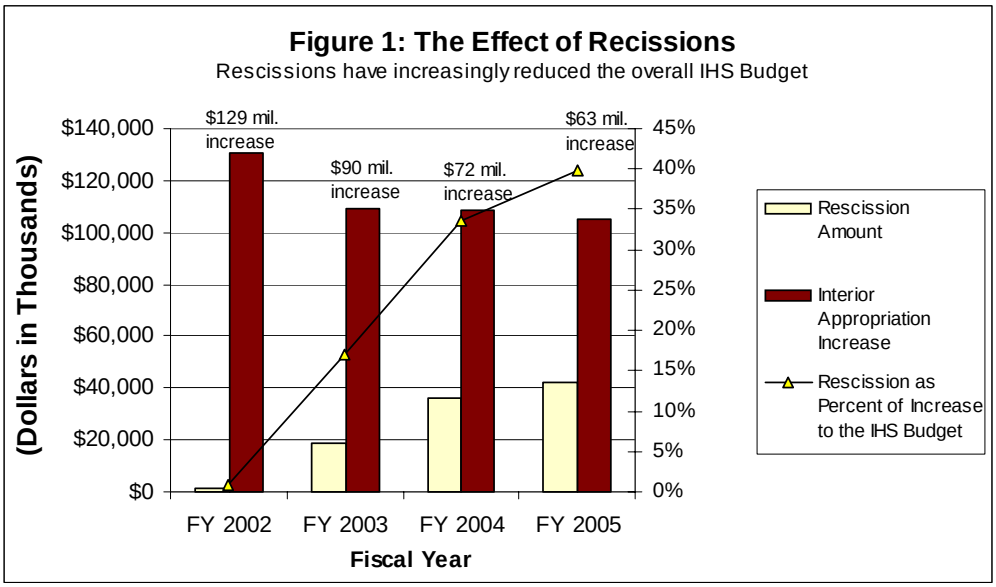
Rescissions over the last four years have had a significant effect on the IHS budget. In FY 2002, the rescission ($1 million) was approximately 1% of the approved increase ($130 million) for the IHS budget. In FY 2003, the effect of the rescission ($18 million) grew to 17% of the approved increase ($109 million) for the IHS budget. In FY 2005, the rescissions ($42 million) escalated to become 40% of the approved increase ($105 million) for the IHS budget. Members of Congress can now have it both ways; they can first say they supported increases and then go on to say (after elections) that they supported fiscal responsibility by cutting funding. No one has engaged the Congress in a discussion about how unfair and illogical across the board cuts are to IHS funded programs.




Unfortunately, the FY 2006 IHS budget request falls far short of preserving the existing IHS programs. Indian Health programs cannot afford to absorb such a large portion of mandatory cost increases year after year. The health and very lives of American Indian and Alaskan Natives are being put at risk by this chronic under-funding of the Indian Health Service budget. The most obvious effect of these lost revenues is fewer services and ultimately lower health status for American Indians and Alaska Natives. If tribes received mandatory cost increases there would be a decrease in the health disparities between the general population and American Indians and Alaska Natives. If the Administration is serious about addressing health disparities for Indian people, it needs to consider funding the $371 million to fund current services and some of the estimated additional $228 million in identified need for program increases. Ignoring the funding need in Indian Country sends a clear and resounding message to tribes; that the Administration does not care about the health needs of Indian people and they do not care about upholding the federal trust responsibility.

Shortly following the All Tribes meeting, the Board staff worked to send the "FY 2006 Indian Health Service Budget: Analysis and Recommendations" to the Congressional delegation from Washington, Oregon, and Idaho and to members of Appropriations Committees that have jurisdiction over the IHS budget. The report has also been published at the Board's website and is available at www.npaihb.org.

# The Heat is On!

*by Crystal Gust, Western Tribal Diabetes Project Specialist*

The Northwest Portland Area Indian Health Board and Portland Area Indian Health Service (IHS) are engaged in a competition to walk the most steps in a ten-week period. The competition began March 1 and is based on the number of steps taken daily by participating employees in NPAIHB and IHS offices. Updates on the number of steps taken are completed every two weeks. The competition has heated as both organizations rack in the steps.

NPAIHB staff had 24 staff members participating the first two weeks and four staff members joined the third week, bringing the total to 28 staff participants! NPAIHB employees logged approximately 2.67 million steps in the first two weeks. NPAIHB and IHS employees and their families also took part in the Portland Shamrock Run held on March 13 as an activity for the STEPS Challenge.

The goal for the STEPS Challenge is to increase daily activity and overall health and well-being. STEPS programs are based on a Japanese program to counteract sedentary lifestyles. The Japanese have used electronic pedometers for more than a decade, and the 10,000 steps per day goal comes from the nickname "manpo-kei," which means "10,000 steps meter" in Japanese. The US Surgeon General also recommends 10,000 steps in a day and says this activity is roughly equivalent to 30 minutes of activity most days of the week. The US Surgeon General states that this should be enough activity to reduce your risk for disease and help you lead a longer, healthier life.

**For long term health and reduced chronic disease risk:**
10,000 steps a day

**For successful, sustained weight loss:**
12,000 - 15,000 steps a day

**To build aerobic fitness:**
Make 3,000 or more of your daily steps fast

*US Surgeon General Recommendations*

*NPAIHB Staff in front LtoR: Clarice Hudson and Crystal Gust before the Shamrock Run in Portland, OR*

*Runners after the Portland Shamrock Run*

# January 2005 QBM Pictures

*Now that's one happy Executive Committee. LtoR: Janice Clements (Warm Springs), Pearl Capoeman Baller (Quinault), Rod Smith (Puyallup), Stella Washines (Yakama), and Andy Joseph (Colville)*

*Inter Tribal Warrior's Society posting colors for the NPAIHB QBM*

*LtoR: Jillene Joseph - Native Wellness Institute and Verne Boerner - NPAIHB's Administrative Officer*

*This activity was part of an ice breaker during our Strategic Planning Session. Josh Jones (NPAIHB's Epidemioligist) as a warrior shooting Debbie Wachendorf (Makah Delegate) as an Indian princess.*

*LtoR: Julia Davis Wheeler and Doni Wilder participate in an ice breaker activity.*

*Northwest Delegates hard at work*

# January 2005 QBM - Squaxin Island Tour

*Whitney Jones the Health Director at Squaxin Island Tribal Center with her daughters.*

*Ray Peters Executive Director of Squaxin Island Tribe with Ed Fox Exective Director of NPAIHB*

*NPAIHB QBM attendees enjoying dinner at Squaxin Island Museum*

*Whitney Jones, Squaxin Island hostess, serving dinner to guests at the Squaxin Island Museum*

*Squaxin Island Museum Curator and Director, Charlene Krise*

# TTAG Develops AI/AN Strategic Plan for CMS

*by Jim Roberts, Policy Analyst*

It has been 18 months since the Tribal Technical Advisory Group (TTAG) was adopted by the Centers for Medicare and Medicaid Services (CMS) as a Federal advisory committee. The purpose of the TTAG is to serve as an advisory body to CMS by providing expertise on policies, regulations and guidelines, and other programmatic issues affecting the delivery of health care to American Indian people served under the Medicare, Medicaid, and State Health Insurance Programs. The TTAG has met three times over the last year and presented CMS with a number of issues that impact IHS and tribally operated health programs. However, the results in addressing these issues have not been very successful for tribes and can best be described as "bitter-sweet."

Bitter represents the frustrations of the TTAG and the lack of success in getting appropriate CMS representatives to the table in order to discuss the issues. The sweet represents some of the successes that the TTAG and Medicaid Medicare Policy Committee (MMPC) have had on the issues. There have been some positive outcomes, however given the scope of the issues, not enough to deem the process a success. The TTAG and CMS meetings have been very frustrating at times for both sides. TTAG representatives feel that CMS is not willing to send representatives on issues that have been lingering for many years. CMS feels that they have rendered their decision on certain issues and consider those matters closed. In the course of Tribal Consultation, tribes wish to continue to dialogue on the issues challenging CMS rationale behind the decisions; which are often flawed and do not consider the legal distinction of tribes as governments when deciding issues on Medicare and Medicaid. CMS does not feel it has a legal or moral obligation to uphold its federal responsibility to provide health care services to American Indian and Alaska Natives. It feels that more contemporary laws, rules, and regulations trump the treaty and executive order obligations of the United States.

The TTAG realized very early when it began to organize itself that CMS did not understand very much about Indian tribes, responsibilities under the federal trust relationship, and the impact its decisions have on the Indian health system. In light of this, the TTAG's first recommendation to CMS is to develop an American Indian and Alaska Native (AI/AN) strategic plan. Fortunately, the agency has agreed to provide funding to complete this plan, and work has begun to develop the report. NPAIHB's Executive Director and Policy Analyst have both been involved in three different site visits to Baltimore to meet and interview CMS personnel. This process has been an invaluable experience as it has provided an inside look at the structure and organization of CMS. Board staff decided to participate in this process because they wanted to understand more about CMS and develop relationships with key people at the agency. It is hoped that these contacts can be cultivated in order to accentuate better outcomes on Medicare and Medicaid decisions that impact Northwest tribes.

The purpose of the plan will be to provide Dr. Mark McClellan, CMS Administrator, and top level people at the agency a strategy to strengthen their capacity and better understand Indian health needs. The plan will outline strategies for CMS to improve their ability to identify and analyze Medicare and Medicaid policy issues that impact the IHS and Tribal health programs. It will also provide recommendations on how to improve AI/AN access and participation in the Medicare and Medicaid programs. Finally, the plan proposes for the TTAG to work with CMS to develop a formal tribal consultation policy pursuant to Presidential Executive Order 13175. CMS does not have a formal tribal consultation policy similar to the IHS; rather CMS has a Consultation Strategy for dealing with tribes (See www.cms.hhs.gov/aian/conpl2.asp). The CMS Consultation Strategy outlines a process for on-going communication and identifies when consultation should happen, however it lacks the formal structure of the new HHS consultation policy and that of the IHS. It is hoped that the development of a new CMS tribal consultation policy will allow tribes a better opportunity to share their challenges with CMS and allow greater participation for AI/AN in Medicare and Medicaid programs.

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The TTAG will be meeting in Washington, DC on April 20th to finalize the draft of the "CMS American Indian and Alaska Native Strategic Plan." Once the TTAG has an opportunity to review and make recommendations on the draft plan, it will be sent out for tribal comment. This will provide Tribes with an opportunity for input into the development of the AI/AN strategic plan for CMS. A copy of the report will be posted on the Board's website shortly after the April 20th TTAG meeting at www.npaihb.org.

Continued from page 3

organizations must endure as long as the fight continues. We can't manage for short-term success at the risk of losing the seventh generation. My own staff should chuckle at my required quarterly reports; but rest assured it our long-term gains that interest me most.

### "Individual rights and responsibility are basis of a good society"

The needs and concerns of the community are clearly ahead of the concerns of individuals in Indian culture. Indian tribes unite in their struggle with the United States government for recognition of sovereignty and to honor commitments contained in treaties and laws. Our own organization sometimes struggles when individuals put their own needs above those of the organization or our communities. How many times have I heard complaints about policies that clearly helped the organization with just minimal loss to an individual? Perhaps assimilation has made some of us forget that our commitment is to Indian values and the community's needs over that of individuals. Of course, I acknowledge that our management operates under the laws of federal and state governments that enshrine these individualistic values and we have to follow those laws.

In summary, I have learned a lot from the Indian cultures that have aided our success at the Northwest Portland Area Indian Health Board. I have only been the director for 4 ½ years, but the Board has enjoyed 33 years of progress, 33 years of unity, 33 years of growing as a tribal and identifiably Indian organization. I don't believe the degree of this record of success, year after year, would have been as great if we had not incorporated Indian values into our daily management decisions. Ours is a solid organization with a solid foundation that is not measured in dollars or numbers of employees or programs, but on the commitment of our tribes to support us as long as we remain true to the values of Indian tribes. The support remains strong and we thank our tribes for your recognition of our success in becoming the nation's most professional Indian health organization.

# Northwest Tribes Meet

*by Kerri Lopez, Western Tribal Diabetes Project Director*

The Tiger Woods Center at Nike World Headquarters in Beaverton, OR, was abuzz with over 110 Native participants gathered for the Second Native Fitness: Pride in Movement Training on February 8th and 9th, 2005. Representatives from 35 Northwest tribal programs, Oklahoma, Minnesota, Montana and California were present. Portions of the training were revamped this year based on ideas and suggestions from last year's event participant evaluations. The training had an intricate balance between establishing and tracking data on community fitness events in tribal communities, and a practical training manual and workbook from Nike. The opening featured a host drum from Grand Ronde, and inspirational welcomes from Doni Wilder, Director of Portland Area Indian Health Service and Julia Davis, previous chair of the Northwest Portland Area Indian Health Board. Charlotte Harkshan, a Warm Springs elder, did the opening blessing incorporating the importance of working with our youth to promote healthy lifestyles.

***NPAIHB staff with Notah Begay. LtoR: Ticey Casey, Joe Finkbonner, Kerri Lopez, Notah Begay, Crystal Gust, Clarice Hudson, Don Head, and Rachel Plummer.***

The presenters invited by the Western Tribal Diabetes Project included experts speaking on different aspects of diabetes in Indian Country. Daryl Tonemah, the case management counselor for the Native participants in the Diabetes Prevention Program presented on motivational counseling focusing on small steps and big rewards in lifestyle intervention and changes. DeAnn DeRoin, a Native medical doctor, MPH and consultant for the National Indian Women's Health Resource Center, presented on exercise and knowing your numbers; weight, blood pressure, blood sugar, cholesterol, and how they are tied to exercise. Chris Frankle, personal trainer for Notah Begay and co-designer for Notah's youth curriculum for the girls and boys clubs "Walk with Notah Campaign," was scheduled to present on the curriculum. However, much to everyone's surprise, Chris introduced Notah Begay instead. The introduction and appearance of Notah was a total bombshell and quite exciting for all participants. The room was stunned at first and then erupted in applause and a standing ovation for the well-known Navajo PGA Golfer.

"I am proud to be here today, both as an athlete and as a member of the Native community," said Notah Begay, who also was recently renewed his Nike athlete sponsorship – [explain ]. "I have always been a strong proponent of feeding the mind, body, and spirit. The Native Fitness; Pride in Movement Project is an opportunity for all of us to address the issue of diabetes in our cultures and guide our communities to a whole body concept that gets to the heart of confronting issues of obesity and physical inactivity. We can make a difference. There are things within our reach—information and education—that I encourage all of you to go after and bring home with you to spread within your community."

The Nike components provided hands on training in four basic areas, all

# the Fitness Challenge

focusing on how to set up a fitness program upon returning to your tribal community. The first topic was a walking or running program based on the 10,000 steps program model. The second topic focused on fitness fundamentals and collecting baseline data measures. Another, very popular topic was chair aerobics. The final topic that Nike focused on featured a choice between basic anatomy for those participants interested in pursuing aerobic certification, or practical skills - the challenges of designing training, and content of a fitness program.

WTDP emphasized the importance of tracking community health and fitness programs and provided a compact disc with resource materials, and a guide to community fitness standards of care. Tools provided by WTDP and Nike included:

Western Tribal Diabetes Project

- Fitness activity flow sheet
- PCC overlay
- PAR-Q
- Participant Consent
- Modified Par Q
- Activity tracker
- Community standards for fitness
- BRFSS
- Diabetes and Exercise
- Benefits of Walking
- Be Fit - Be Healthy
- Lifestyle changes – increasing physical activity
- Balancing your life
- Compact disc with numerous resource articles

**Nike** – Training Manual

- Coaching
- Chair Aerobics
- 10,000 Steps
- Fitness Fundamentals
- Putting it together
- Anatomy

# Looking Back (from Massachusetts) at my Northwest Tribal Experience

*by Claire Fox, Phillips Academy Andover 2006*

"Claire, I'm not judging you or anything, but I really just view Oregon as a great big void." In general, this is the assessment I get from East Coast students about our beautiful state. Whenever I ask someone what they think of Oregon, their usual reply is, "I don't." I try to explain to them what they are missing. We have the great outdoors at our fingertips: a beautiful coastline and gorgeous mountains, breathtaking gorges, and amazing lakes and rivers. Urban life also exists in the quirky city of Portland, as well as smaller cites in the south and eastern parts of the state. Throughout Oregon, many different cultures exist and thrive. Among them is a group of cultures that adds much depth to Oregon's already stellar character: Native American cultures.

Since moving to Portland at the age of seven, I've been given the opportunity to experience Native American lifestyles up close. My memory is chock full of so many trips to reservations and conventions that I often lose track of what happened when or where. Among the tribes I have been able to visit in the Northwest are the Yakama (WA), Nez Perce(ID), Makah(WA), and several visits to Grand Ronde, Warm Springs, and Klamath Tribes of Oregon.. I've also had the opportunity to compare Oregon Native cultures to that of Idaho, Washington, New Mexico, California, and even the East Coast (when I visited Mohegan Sun this past summer). On top of tribal culture, I've been able to meet some great leaders, two of them being Pearl Capoeman-Baller of the Quinault Nation and Ron Allen of the Jamestown S'Klallam tribe.

What I remember over the years of my Native American cultural experiences are related to the senses. I admit that I wasn't often sure of what a certain convention was for or what was happening at the reservation I was visiting, but I do remember the foods, the art, the clothing, the dances, and the rituals. It's been interesting to see how so many tribes have preserved their cultures while adding aspects of modern times, like when ornate beaded leather would be made up into a Nike swoosh rather than something more traditional. This is much like the exhibit currently at the Portland Art Museum, where they have art by early 20th century Natives who lived by the Columbia river, whose beaded designs depicted scenes of a white man camping with rifles, frying pans, and sleeping bags. The incorporation or more the reflections on the influence of Non-native culture is not a new phenomenon. Now that I have reflected on Native culture I plan to take a more studied look when I next visit one of our NW tribes.

# Help Discover the Causes of Breast Cancer!

The Sister Study is a national breast cancer research study conducted by theNational Institute of Environmental Health Sciences (NIEHS), and is aimed at learning about how the environment and genes affect the chances of getting the disease. 50,000 sisters of women diagnosed with breast cancer are needed over the next three years. To date, over 17,000 women are already enrolled, yet most of the women are Caucasian, 35-64, and with college degrees or higher in education. Efforts to recruit a more diverse group of women are underway so that the study can truly represent all US women. Women are not equal in breast cancer risk! For example, the 5-year breast cancer survival rate for American Indian women is lower than that of other ethnic and racial groups in the US, and there has been an increase in breast cancer mortality rates among these women since the 1970s. Within your sphere of influence, please consider helping us recruit one woman, just one woman, who is African American, Asian, Latina, Native American, or age 65-74. We cannot learn what we need to know about breast cancer unless the women in the study reflect the diversity of US women in race, ethnicity, age, education and occupations. For more information, please call 1-877-4SISTER (1-877-474-7837) or visit the website at www.sisterstudy.org.

# A Comparison of Indian Health Boards

*by Ed Fox, Executive Director*

Northwest Tribes are rightfully proud of the Northwest Portland Area Indian Health Board and its accomplishments. NPAIHB is a recognized leader in health promotion and education, health care research (with strict protections for the rights of tribes and individuals) policy analysis, advocacy, and professionalism in providing these services. I think it is important to recognize our achievements as an organization that provides a broad range of non-clinical health services to our tribes. A bit of humility is also in order as we recognize also that there is much more that could be accomplished in partnership with our tribes. One way to identify where gains are possible is to look at how tribes have provided non-clinical health services in other parts of the country. In this short essay I draw a sketch of other organizations similar to the Board in an attempt to seek lessons for learning how we could do more or improve existing services. What this brief sketch will demonstrate is that there are many ways to provide the basic functions that the Board has identified as our core competencies: 1. Advocacy, 2. Health Promotion and Disease Prevention, 3. Technical Assistance and Training, and 4. Health Care Research. Some areas have chosen to establish comprehensive health organizations like the NPAIHB that do all four activities while others provide only one or two of these functions. The brief review will highlight the fact that the twelve areas of the Indian Health Service vary greatly in how they provide these services.

The Northwest Portland Area Indian Health Board is not the oldest organization of its type in the United States. The Alaska Native Health Board was founded in 1968. The California Rural Indian Health Board and the United South and Eastern Tribes were founded in 1969, the Northwest Portland Area Indian Health Board in 1972. The Northwest Portland Area Indian Health Board is not the largest Area Health Board, CRIHB is larger as measured by annual budget and number of employees. The Division of Health of the Navajo Nation may be the largest non-clinical health organization in the country. NPAIHB has a FY 2005 $6 million budget and about 45-50 FTEs on average over the period 2002-2005. NPAIHB is organized for health only, whereas USET, CRIHB, and the Intertribal Council of Arizona (ITCA) engage in many non-health activities. USET and ITCA also work, on behalf of their member tribes, with the Bureau of Indian Affairs, the NPAIHB does not. NPAIHB very strictly defines health care and does not even engage in non-health social service activities such as welfare or child-care services. Some area health boards play a large role in their tribes non-health care social services.

However, within non-Clinical health care, NPAIHB provides very comprehensive health care services that touch on all of the functional areas described above. Some organizations, like ANHB (Alaska) have restricted themselves to analysis and advocacy only. ANHB has now ceded its EpiCenter and health promotion disease prevention activities to the Alaska Native Tribal Health Consortium. A close partnership between these two organizations is likely to produce a high level of services similar to those produced by the NPAIHB. ANHB has been a leader in advocacy for the past several years with great connections in the United States Congress.

The connection between health research and area health boards varies across the country. Some areas have set up health research organizations (most notably the tribal EpiCenters) as free standing centers without a strong association with an area-wide organization (Great Lakes EpiCenter). One of the fastest growing organizations of the past two years is the Aberdeen Area Tribal Chairman's Association. It is more similar to the NPAIHB than any other Area Health Board, yet it combines a strong elected tribal leadership organization with a health care organization, the Great Plains Tribal Epidemiology Center. Contrast this to NPAIHB's close, but very separate affiliation with the Portland's area's political organization known as the Affiliated Tribes of Northwest Indians.

It appears that only the Aberdeen Area Health Board, the Navajo Nation's Health Division, and the Alaska Native Health Board share the NPAIHB's distinction of serving all the federally recognized tribes of their respective area of the Indian Health Services. This means that an all-encompassing Area Health Board or its equivalent does not exist in 8 of the 12 IHS areas. This is

**Continued on page 22**

# Upcoming Events

## APRIL 2005

**2005 Direct Service Tribes Conference**, Albuquerque, NM
April 25 - 28, 2005
http://directservicetribes.org/

**Cross-Cultural Medicine Workgroup**, Sante Fe, NM
April 28 – May 1, 2005
http://www.ihs.gov/index.asp

**International Meeting on Inuit and Native American Child Health: Innovations in Clinical Care and Research** combined with the **17th Annual IHS Research Conference**
April 29 - May 1, 2005
Seattle, WA (Info: www.aap.org/nach.)

## MAY 2005

**Tribal Self-Governance Spring Conference**, San Diego, CA
May 2 - 6, 2005
http://www.ihs.gov/index.asp

**7th Annual IHS Partnership Conference**, Scottsdale, AZ
May 3 - 5, 2005
http://www.ihs.gov/index.asp

**Prevention of Cardiovascular Disease & Diabetes Among AI/AN 2005 Conference**, Denver, CO
May 16-19, 2005
www.ProfessionalEd.Joslin.org

**HHS Annual Tribal Budget Consultation**, Washington, DC
May 17 - 18, 2005
http://www.ihs.gov/index.asp

**Coordinating Center for SPDI Competitive Grants**, Denver, CO
May 23 - 27, 2005
http://www.ihs.gov/index.asp

**HHS Tribal Consultation: Region X**, Ocean Shores, WA
May 25 - 26, 2005
http://www.ihs.gov/index.asp

# Upcoming Events

## JUNE 2005

**Surgeon General Convenes Global Health Summit**, Philadelphia, PA
June 5, 2005
http://www.globalhealthsummit.org/index.html

**COA Public Health Professional Conference**, Philadelphia, PA
June 6 - 10,
http://www.coausphsconference.org/

**Phoenix Area IHS/SAMHSA Health Summit**, Phoenix, AZ
June 13 - 15,
http://www.ihs.gov/index.asp

**NCAI Mid-Year Session**, Oneida, WI
June 13 - 16,
http://www.ncai.org

**Leadership for Change Conference: Native American Women's Health,** Denver, CO
May 20, 2005
www.kauffmaninc.com/

**National IHS/SAMHSA and Behavioral Health Conference,** San Diego, CA
June 28 - 30, 2005
http://www.kauffmaninc.com/ihssandiego.cfm

## JULY 2005

**Tribal Self-Governance Advisory Committee Quarterly Meeting**, Seldovia, AK
July 12 - 13, 2005
http://www.ihs.gov/index.asp

**Coordinating Center for SPDI Competitive Grants**, Denver, CO
July 18 - 22, 2005
http://www.ihs.gov/index.asp

**5th Bi-Annual CRIHB-NPAIHB Joint Meeting,** Lincoln City, OR
**July 19 – 21, 2005**
http://www.npaihb.org/

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highly significant in terms of developing area-wide political positions, conducting area-wide consultation and even in providing a guarantee of area-wide coverage in health promotion and disease prevention activities. However, it is likely that each area has its own mechanism for area-wide activities. In California, the IHS Area Director convenes an area wide meeting annually and as the need arises. In Oklahoma, tribes themselves coordinate area-wide activities. The Oklahoma City Area Inter-Tribal Health Board may follow the path of a more comprehensive organization similar to AATCA and NPAIHB. It is currently establishing the newest EpiCenter under its auspices. This will allow it to conduct area-wide health promotion and health research activities. The Albuquerque Health Board provides health research and health promotion activities, but has not engaged in much political advocacy or policy analysis perhaps because it represents a small share of the Area's tribes.

A lot more can be learned by analyzing the evolution of the area health boards. The Boards have gotten together to discuss their organizations on their own and in meetings facilitated by the National Indian Health Board to discuss what it is they are doing in their own words with an eye toward sharing successful strategies to improve the health of their member tribes.

## NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
## &
## CALIFORNIA RURAL INDIAN HEALTH BOARD

### 10th Annual Joint Meeting
### July 19-21, 2005

***1501 NW 40th Place***
***Lincoln City, OR 97367***
***1-877-423-2241***

Room blocks for this event at Chinook Winds are sold out. We are using Surftides Inn (1-800-452-2159) as our overflow hotel. Rates at this hotel range from $85.50 to $103.55 depending on room preference.

# New NPAIHB Staff

Doug White is the new Project Specialist for the Western Tobacco Prevention Project and he looks forward to working with the Northwest Tribes and Board staff. Doug is Yup'ik (Alaska Native) and his family is from Bethel, Alaska. He was raised in Rainier, Oregon (about one hour northwest of Portland) and attended college at Portland State University, majoring in Philosophy and Mathematics and receiving a minor in Geography. After completing his M.S. in Logic and Computation at Carnegie Mellon University (Pittsburgh, Pennsylvania,) he began work at the California Rural Indian Health Board in Sacramento, California. There, Doug acted as the American Indian Adult Tobacco Survey Project Coordinator. In this role, he served the tribes in their efforts to collect tribal specific information on their populations' beliefs, attitudes, and knowledge of tobacco. His duties also included development and presentation of culturally sensitive tobacco education materials. Additionally, much of Doug's prior work experience is related to education, having taught Mathematics at the middle school level and Philosophy at the college level. These experiences will help him to provide excellent service to Northwest Tribes.

Doug's enthusiasm for tobacco education and providing technical assistance to American Indian populations is not only professional, but also very personal. Most of his extended family members have suffered from smoking related illnesses and many of them have lost their lives from diseases caused by commercial tobacco.

Hello, My name is Chandra Wilson, (Klamath-Modoc) an enrolled member of the Klamath Tribes. I'm the new HR/Special Projects Assistant.

For the past five and half years I have worked as the EpiCenter Project Assistant, providing administrative support to the project staff. Prior to joining the board, I worked for both the Portland Area Indian Health Service, and the Confederated Tribes of Warm Springs.

When I'm not working, you'll find me hanging out with my two-daughters, M'kya and Chiarra Bettega. We enjoy playing dress-up, reading children's books, playing soccer and basketball and traveling with family to pow-wows and other fun places.

I'm very excited to be back on staff with NPAIHB and providing services to both the office staff and the Northwest Tribes. I look forward to this exciting opportunity to gain new experiences working in this area of business.

***Health News and Notes*** is published by the Northwest Portland Area Indian Health Board (NPAIHB). NPAIHB is a nonprofit advisory board established in 1972 to advocate for tribes of Washington, Oregon, and Idaho to address health issues. Previous issues of *Health News and Notes* can be found on the NPAIHB webpage www.npaihb.org.

Contact Sonciray Bonnell (503) 228-4185 or sbonnell@npaihb.org., *Health News and Notes* Editor, to submit articles, comments, letters, and requests to receive our newsletter via mail.

# January 2005 QBM Resolutions

**RESOLUTION # 05-02-01**
Supporting Washington State Division of Alcohol and Substance Abuse Funding for Encounter Rate Payments

**RESOLUTION #05-02-02**
Support for the distribution of funding for Public Health Emergency Preparedness via the Washington State Department of Health to the Tribes using existing funding formula

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