Health News & Notes

A Publication of the
Northwest Portland Area Indian Health Board

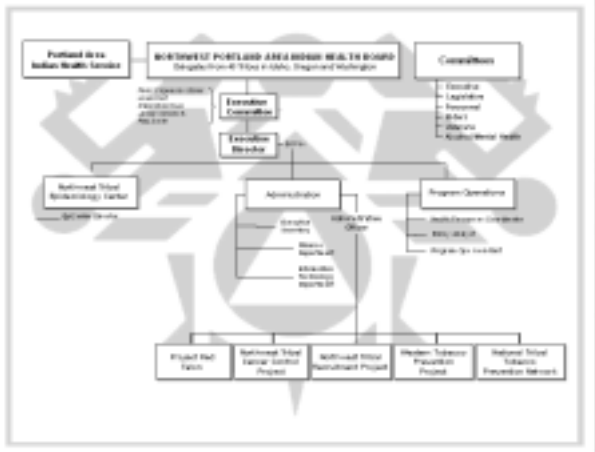
January, 2005

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 Engages in Strategic Planning

See page 4 for Strategic Planning article

Burns Paiute Tribe • Chehalis Tribe • Coeur d'Alene Tribe • Colville Tribe • Coos, Lower Umpqua & SiuslawTribes • Coquille Tribe • Cow Creek Tribe • Cowlitz Tribe • Grand Ronde Tribe • Hoh Tribe



Jamestown S'Klallam Tribe • Kalispel Tribe • Klamath Tribe
Kootenai Tribe • Lower Elwha S'Klallam Tribe
Lummi Nation • Makah Tribe
Muckleshoot Tribe • Nez Perce Nation
Nisqually Tribe • Nooksack Tribe
NW Band of Shoshone Indians • Port Gamble S'Klallam Tribe
Puyallup Tribe • Quileute Tribe • Quinault Nation • SamishTribe
Sauk-Suiattle Tribe • Shoalwater Bay Tribe
Shoshone-Bannock Tribes • Siletz Tribe • Skokomish Tribe
Spokane Tribe • Snoqualamie Tribe
Squaxin Island Tribe • Stillaguamish Tribe • Suquamish Tribe • Swinomish Tribe • Tulalip Tribe • Umatilla Tribe • Upper Skagit Tribe • Warm Springs Tribe • Yakama Nation

In This Issue

From the Chair:

Pearl Capoeman-Baller

Slow Moving Tsunami Fails to Evoke Effective Action

This past quarter has been a time of reflection for me. Our October Quarterly Board Meeting, hosted by the Spokane Tribe, was a great success. It seemed to have the right mix of useful information, camaraderie, and tribal hospitality. Thank you very much, Spokane Tribe. It was nice to publicly thank Bob Brisbois, our former Vice Chair, who said good-bye, for now, to our delegates at the meeting. I did attend the National Congress of American Indians meeting in Ft. Lauderdale, Florida where we heard from the various candidates and their representatives. I was also busy working on the presidential election and the never-ending governor's race in Washington. It was a busy time and it felt good to stay home with family and grandkids in Quinault in December. It also gave me much needed time to reflect on our own challenges and to absorb the terrible tragedy in South Asia.

The Quinault Tribe has undoubtedly suffered from tsunamis over our 10,000-year history on the west coast of Washington. In fact, the evidence that we were here longer may have been wiped out by tsunamis (or avalanches caused by earthquakes). I wonder what warning signs we have forgotten over the years. We do have a warning system in place now and practice drills that direct us to higher ground if ocean buoys detect rising seas. I want to explore the idea that we may not have a sufficient detection system for recognizing a looming crisis in Indian health funding.

I first want to convey the deep sadness we all feel for the people of South Asia as they mourn their lost loved ones and take stock of what they have left and then search for the strength to rebuild their communities after this terrible disaster. My heart is also heavy for our own challenges this year and the years ahead as we try to meet the health care needs of our people.

You may have heard the story of how one frog saved itself from being boiled alive and another did not. The first frog took strong and immediate action in the face of danger and leaped from the water and went on to live a long and happy life. The second frog not only died in boiling water, but to add insult to his mortal injury, was also vilified for not taking steps to save himself. This vilification was unfair. You see, the first frog was thrown into boiling water and immediately reacted with all his

Continued on page 5

From the Executive Director:
Ed Fox

I hope everyone had a joyous holiday and wish a great and happy New Year to all. I know Tribes have both great challenges and tremendous successes awaiting us in 2005. I think the Board is better prepared than we have ever been to make the most of any opportunities that we all can identify for action in the next year (success equals preparation plus opportunity). Although our staffing has been reduced from a high of 62 three years ago to just 38 (full, part-time and temporary) employees, I firmly believe we are in a better place now than we were three years ago. Our staff is much more experienced and the newer staff are well-positioned in terms of education and commitment to grow and produce great things for our tribes. We do not have any lingering personnel issues as we close the New Year and we have submitted grant proposals for some great projects that will address needs identified in our strategic plan.

If I only had a permanent finance officer on board, I would be able to say the Board could operate without me for an extended period without my close supervision. We do have a very competent set of consultants assisting us as we complete this year's audit (field work in January) and get our projects the necessary grant management support they need to meet newer and more stringent federal requirements and enforcement. We will re-advertise the Finance Office position and we hope to fill it this spring (or sooner).

I was directed several years ago to delegate responsibilities to others and I believe I have done so by sharing executive responsibilities and mentoring our management team and other staff. Our management team of Verne Boerner, Joe Finkbonner, Sonciray Bonnell continues to grow and work together cooperatively. Eric Metcalf (Coquille) joins us as our Human Resources Director and together with Jim Roberts will add additional management expertise to the Board's operations. We are very excited to be implementing a new electronic personnel recordkeeping system. We have also contracted with HR Professionals for HR consulting services. The Jamestown S'Klallam Tribe owns HR Professionals and we are very pleased to be one of their first tribal customers.

Finally, the continued involvement of our Delegates in active Quarterly Board Meetings insures the Board serves our tribes in a way that is truly guided by their wishes. Our one and a half day strategic planning session (during the January QBM) will provide even closer guidance on the work we will do over the next three years.

Continued on page 19

Northwest Portland Area Indian Health Board

Projects & Staff

Administration
Ed Fox, Executive Director
Verné Boerner, Administrative Officer
Vacant, 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 Coordinator
Chris Sanford, Network Administrator
Ginger Clapp, Administrative Assistant

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

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

Show Me
Why Strategic Planning Is Important

by Verné Boerner, Administrative Officer

I am so very enthused about the Board's strategic planning process. The reason can be best described in Pearl Capoeman-Baller's (NPAIHB Chair) description of our strategic plan, "this is the Board's Bible." It reflects NPAIHB identity and guides the activities and efforts of this organization in every aspect, from internal operation decisions, to advocacy on the local, state, regional and national levels. NPAIHB uses our strategic plan in numerous ways; however, I want to share with you seven key ways that we have used our plan.

The first is how it reflects NPAIHB identity. Our strategic planning embraces tribal sovereignty and honors our most important partners, our member tribes. The tribes, via tribal resolution, appoint their representatives as Delegates and their Alternates to our Board. These tribally designated Delegates are the key individuals in the development of NPAIHB Strategic Plan and as such, our member tribes take ownership of the mission, vision, values, and priorities of this organization. Sovereignty, like the foundation and cedars of a longhouse, is the very basis on which we build NPAIHB's Strategic Plan.

The Strategic Plan also reflects NPAIHB's identity beyond its mission, vision, values, and priorities, by identifying our strengths, weaknesses, opportunities, and threats (SWOT). This exercise and the conscious recognition of these four items facilitate our ability to identify how to best chart our efforts. The SWOT analysis is the second key way in which we have used our plan: it provides guidance in our activities and efforts. Whenever management or the Delegates consider a new opportunity, such as a request for proposals (RFP) or a new partnership, we first consider how it fits within our Strategic Plan. For instance, when a Sexually Transmitted Disease Screening RFP was announced, management was able to identify it as a priority of our tribes in our Strategic Plan. As such, we sought a NPAIHB resolution to submit our application and included our Strategic Plan with the resolution to the grantors.

Having a Strategic Plan is a real strength when applying for funds. This is the third key use of our strategic plan. Grantors are assured of community interest and organizational commitment when a strategic plan supports efforts that are in line with the purpose of the grant announcement. This, along with the capacity, skills, proposed scope of work, and budget create a well-rounded application. The strategic plan also affords NPAIHB an opportunity to orientate the grantors to NPAIHB, giving them a greater understanding of our organization as well as the opportunity to learn about issues pertinent to health in Indian Country. I am happy to say that we were awarded the grant mentioned in the previous paragraph and it now supports our efforts with our long-standing program, Project Red Talon.

Orientation is the fourth key use of our strategic plan. We share our strategic plan with more than our employees, all of whom receive the strategic plan in their orientation packets, but also with new Delegates, new partners, and new funders. It is comprehensive enough to give a clear picture of NPAIHB, but succinct enough to be easily disseminated and actually reviewed. It goes over the building blocks of the organization, mission, vision, etc. but also outlines the main functional areas of NPAIHB. This gives those new to NPAIHB a quick study as to what we do and who we are.

We also use the strategic plan in developing our internal policies and procedures. This fifth key use has allowed us to make informed decisions that reflect a tribal organization. Tribal communities strongly value family. As such, the Delegates have stipulated that NPAIHB supports a balanced lifestyle (work/family) for its staff through policy and practice. It is on this basis that NPAIHB has incorporated, with the approval of the Delegates, that parents may bring in their infant children up to the age of six-months into the office to support family bonding and nursing. It is the strategic plan as designed by the Delegates that provides the basis for instituting such family-friendly policies.

The sixth key use of our strategic plan is to support other organizations with similar missions and to build coalitions. The strategic plan can be shared with other organizations as a model where aspects can be integrated into their plans, or even as a starting point for their organization if they don't currently

Continued on page 5

Pearl's Report Continued

Continued from page 2

strength to leap to safety. The second frog did not notice more subtle signs of danger because the heat was only applied to the water after he had entered it. In fact, the warmth felt good at first. Indeed, added heat not only felt soothing, but it also relaxed and made the frog somewhat sleepy. Imagine the terror when the frog realized that in a now-relaxed state he was in boiling water.

I believe Indian Health Service-funded health programs are arguably in 'hot water.' Have you ever noticed how we sometimes seem 'too relaxed' in the face of some pretty clear signs of danger? It is almost as if we understand too well the reasons why we are facing a 'disaster' in health care funding.

We have seen just a few 'good years' of 10% funding increases (FY 2001), a significant new funding stream like the Special Program for Diabetes, or the approval of the encounter rate for Medicaid payments, or increased grant funding for our health promotion and health research projects. Perhaps these promising events made the warming water feel good, maybe we became relaxed. For our most important 'program' IHS funding, however, most years were like last year; a funding increase of 1/3 or less the rate of inflation. In the past three weeks I have had a number of health directors tell me stories of shortfalls in their budgets of hundreds of thousands of dollars and, in one case, a health program more than a million dollars short of projected expenditures.

Maybe not everyone will say IHS funding is a disaster: that call will be made by the tribes and their members who depend on the health programs that will be told this month or next that their program will only receive a 1% to 2% increase in funding this year. It is certainly the case that we as individuals react with understanding and generosity when we see the tragedy of a disaster, but only disasters that move quickly like a tsunami. Slow-moving disasters like the IHS-funding crisis do not evoke understanding and certainly not generosity. Like the frog in the slowly warming water, IHS programs are likely to be 'blamed' for their inefficiency or tribes are going to be blamed for not acting to change their fate by finding solutions.

Continued from page 4

have a strategic plan. We also use it to build coalitions by using it as a support document when we engage in mutual activities or support their efforts. If we submit an application in conjunction with another organization, our strategic plan supports those efforts and again makes the overall partnership and therefore the overall application stronger.

Finally, the seventh key use of our strategic plan is supporting our efforts to increase the health status and quality of life of member tribes and Indian people in their delivery of culturally appropriate and holistic health care. We advocate and provide technical assistance based on the priorities set by our member tribes on all levels from local to national. Our projects range from activities at the various tribes we serve to national activities fully supported by this organization. The priorities set forth in the strategic plan justify our involvement in tribal workshops to participation in national workgroups.

I am grateful to all NPAIHB Delegates, staff, and partners for putting such a high value on this process. Those efforts contribute to a living document that is well utilized and highly valued.

FY 2005 Omnibus

By Jim Roberts, Policy Analyst

On December 8, 2004, the President signed into law H.R. 4818 the Consolidated Appropriations Act of 2005. The bill wrapped up nine different spending bills totaling $388.4 billion in discretionary spending. The bill provides $3.027 billion for the Indian Health Service (IHS), however, there are two rescissions that will need to be applied to the final IHS budget.

Section 122 of the Omnibus requires an Across-the-Board cut of .80%, while Section 501 (Division E: Department Of The Interior And Related Agencies Appropriations Act, 2005) requires an Across-the-Board Rescission of .594%. The Section 122 cut equates to $24.1 million, while the Section 501 rescission equates to $18 million, a net loss of $42.1 million. This means that **the net increase for the IHS budget is only $63.3 million**. This represents an increase of only 2.1% over last year's enacted level.

While it might be some compromise to realize that the Omnibus bill freezes non-defense discretionary spending at zero percent over FY 2004 levels, and the IHS received a 2.1% increase, it does not provide much reassurance for Indian health programs that currently operate at less than 50 percent level of need. Lack of funding for Indian health programs is further compounded by the state fiscal crisis that continues to loom. At the end of 2004, there were at least 22 states across the country that projected funding shortfalls averaging from 6 percent to 7.5 percent of their general fund spending. Over half of these states have American Indian tribes in them. The state deficit projections will threaten many public services that include Medicaid programs and the ability for Tribes to seek Medicaid third party collections. This will further reduce the available resources for Indian health programs. The result is that some Indian health programs will begin the year at Priority One status or move to Priority One sometime in the spring.

The House and Senate conference agreement provides $2.59 billion for the hospital and clinic programs, while providing $388.6 million for the facilities accounts. The final approved budget will provide an increase of $18.9 million for contract health services. Interestingly, the Contract Support Cost (CSC) line item will once again lose money in the appropriations process. Congress has not authorized an increase in CSC funding for two years. Since no increase was authorized by Congress in FY 2004, and after two across the board rescissions were applied, the CSC line item lost $3.2 million in FY 2004. Once again, in FY 2005 Congress did not authorize an increase for CSC. After the two rescissions are applied for FY 2005, the CSC line item will lose an additional $3.7 million. This represents a net loss $ 6.9 million of CSC funding and is contrary to the principles of government outsourcing by this Administration. Moreover, the Self-Governance line item will also have its base budget eroded by $51,000 after this year's rescissions are factored. At its face, $51,000 might not seem like much, however during the FY 2003, the Self-Governance programs lost over $4.3 million in base funding. This flies in the face of supporting Indian self-determination programs.

The Board's annual budget analysis estimated that it would take at least $380 million just to maintain current services. Again, the President and this Congress have failed to adequately fund Indian health programs. In light of the growing deficit and the war in Iraq, it is anticipated that flat line budgeting will be the pattern of this Administration and Tribes will have to be very strategic to protect our basic health programs.

Signed into Law

Indian Health Service Budget
Comparing the FY 2005 Omnibus with FY 2004 and President's Request

(Dollars in Thousands)
Numbers may not add up exactly due to rounding

	FY 2004 Omnibus Conf. Mark	FY 2005 President Request	FY 2005 Conf. Rpt. H. Rpt. 108-792	Difference Versus FY 2004	Interior Sec. 501 Cut	Omnibus Sec. 122 Rescission	FY 2005 Conference Final	Net Difference vs. FY 2004	Percent over FY 2004
Clinical Health Services:									
Hospitals & Clinics	$1,249,781	$1,295,353	$1,307,103	$57,322	$7,764	$10,395	$1,288,944	$39,163	3.0%
Dental Health	104,513	110,255	$110,255	$5,742	$655	$877	$108,723	$4,210	3.9%
Mental Health	53,294	55,801	$55,801	$2,507	$331	$444	$55,026	$1,732	3.1%
Alcohol & Substance Abuse	138,250	141,680	$141,680	$3,430	$842	$1,127	$139,712	$1,462	1.0%
Contract Health Services	479,070	497,085	$505,085	$26,015	$3,000	$4,017	$498,068	$18,998	3.8%
Total, Clinical Services	$2,024,908	$2,100,174	$2,119,924	$95,016	$12,592	$16,859	$2,090,473	$65,565	3.1%
Preventive Health Services:									
Public Health Nursing	42,581	45,576	$45,576	$2,995	$271	$362	$44,943	$2,362	5.3%
Health Education	11,793	12,633	$12,633	$840	$75	$100	$12,457	$664	5.3%
Community Health Reps.	50,997	52,383	$52,383	$1,386	$311	$417	$51,655	$658	1.3%
Immunization AK	1,561	1604	$1,604	$43	$10	$13	$1,582	$21	1.3%
Total, Preventive Health Programs	$106,932	$112,196	$112,196	$5,264	$666	$892	$110,637	$3,705	3.3%
Other Services:									
Urban Health	31,619	32,410	$32,410	$791	$193	$258	$31,960	$341	1.1%
Health Professions	30,774	30,803	$30,803	$29	$183	$245	$30,375	-$399	-1.3%
Tribal Management	2,376	2,376	$2,376	$0	$14	$19	$2,343	-$33	-1.4%
Direct Operations	60,714	61,795	$62,293	$1,579	$370	$495	$61,428	$714	1.2%
Self-Governance/	5,644	5,672	$5,672	$28	$34	$45	$5,593	-$51	-0.9%
Contract Support Costs	267,398	267,398	$267,398	$0	$1,588	$2,126	$263,683	-$3,715	-1.4%
Total, Health Services Programs	$2,530,365	$2,612,824	$2,633,072	$102,707	$15,640	$20,939	$2,596,492	$66,127	2.5%
Indian Health Facilities:									
Maintenance & Improvement	48,897	48,897	$49,897	$1,000	$296	$397	$49,204	$307	0.6%
Sanitation Facilities	93,015	103,158	$93,158	$143	$553	$741	$91,864	-$1,151	-1.3%
Health Care Facilities Const.	94,554	41,745	$89,845	-$4,709	$534	$714	$88,597	-$5,957	-6.7%
Facilities & Envir. Hlth Support	137,803	143,567	$143,567	$5,764	$853	$1,142	$141,572	$3,769	2.7%
Medical Equipment	17,080	17,081	$17,581	$501	$104	$140	$17,337	$257	1.5%
Total, Facilities Programs	$391,349	$354,448	$394,048	$2,699	$2,341	$3,134	$388,574	-$2,775	-0.7%
TOTAL BUDGET AUTHORITY	$2,921,714	$2,967,272	$3,027,120	$105,406	$17,981	$24,073	$2,985,066	$63,352	2.1%

Klamath Tribal Health Center

by Taylor David, Klamath Editor and Ginger Clapp, NPAIHB Assistant

New Klamath Tribal Clinic

The Klamath Tribes new health facility dream breaks ground. The Klamath Tribes have reached a milestone in the quest to construct a new health facility. The journey began in 2001 with the submission and award of the Indian Health Service Small Ambulatory Grant. Plans were set to construct a building that would house medical and dental service providers using grant and tribal funds. After critical analogy the Tribal Health management came to the awareness that the tribal health needs far surpassed the capacity that a 7,000 square foot building could afford.

Through coordinated meetings with tribal council, tribal health staff met with consultants to predict the building needs of the Tribes over the next ten years. Based on those meetings, it was discovered that service delivery of health care for tribal members required a much larger building. Furthermore, the continuity of health care could be better achieved by placing all of the health care service providers in a central location. Klamath Tribal staff pulled together resources, and through innovative financing and funding opportunities, were able to get enough funding to construct a 16,112 square foot health center.

Cobby Shadley

Groundbreaking ceremony

The Klamath Tribal Health Center will house the pharmacy, medical, dental, health educator providers, and administrative support staff. This health center will also be equipped with X-Ray capabilities and a laboratory.

The groundbreaking was held on October 8, 2004 and over 100 dignitaries from tribal, local, and federal governments attended to celebrate this milestone with the Klamath Tribal members. Some guests included; Tribal Chairman Allen Foreman, Tribal Elder Bill Tupper, General Manager Leroy Jackson, Dr. Hanst, Klamath County Commissioner John Elliot, Commissioner Steve West, Klamath News Editor Taylor David, Portland Area Indian Health Director Doni Wilder, and Klamath Tribal member and Northwest Portland Area Indian Health Board representative Ginger Clapp.

The ceremony opened with a beautiful divine prayer from tribal Elder, Bill Tupper. Cobby Shadley then danced with his eagle feathers during the ground breaking to help bless the ground and give thanks to the creator. Next, Destiny Summers and the 2004 - 2005 Queen Jalisa Nunez and Princess, Shaylee Totten gracefully performed the Lord's Prayer. Guest Speaker Doni Wilder spoke about her ties and commitment to the Klamath Tribes. In closing, I would like to recognize the late Corrine Hicks, council member and former NPAIHB Executive Committee member and Delegate. During her years of dedication for the tribe, she was a fierce supporter of tribal health and dedicated her efforts to projects like this one. General Manager, Leroy Jackson asked for a moment of silence during the ceremonies in her honor. Her spirit was definitely present at the ceremony and many felt as if she was smiling down on us from *blaydal* (upward; Heaven in Klamath language).

Corrine Hicks in April 2000

Partnerships Produce Productivity

by Ed Fox, Executive Director

It is hard to quantify the gains made from successful partnerships, but we all know they are great. The Northwest Portland Area Indian Health Board is the envy of other area health boards because our membership includes every federally recognized Tribe of the Northwest. The partnership with our member tribes is long standing (33 years) and with familiarity comes additional benefits. We all know that we can withstand a misunderstanding about specific actions because we consider our relationship a permanent one. At this January Quarterly Board Meeting we will once again make explicit what our tribes expect from the Board. Our roles and responsibilities will be described in a written document – our Strategic Plan. Our mission and our goals will also be ratified. It is too bad all our partners can't participate in strategic planning with the Board so we can have equally clear guidance on roles and responsibilities with our various partners.

Other Areas are also envious of the good partnership the NPAIHB has with its Area Office of the Indian Health Service. Over the past ten years the Board and the Portland Area Office (PAO) have worked seamlessly in establishing new programs in the Northwest. Diabetes programs and other health promotion and disease prevention programs including the EpiCenter would not have achieved their great success without this partnership. Less noticed is the success in convening effective meetings to provide guidance to the Indian Health Service. Consultation is a high art in the Northwest and the Board and the PAO have worked hard to make consultation effective for health policymaking.

The Board does have some long-standing relationships with partners other than our member tribes. Importantly, we interact with other tribal organizations who count our tribes as members. The Affiliated Tribes of Northwest Indians (ATNI) is the Board's closest tribal organization in terms of longevity and collaboration. Our Chair is automatically the chair of the ATNI health Committee. Through the relationship with ATNI, we are also connected to the health committee of the National Congress of American Indians because the ATNI president is the Portland Area's representative to NCAI. Our Chair is automatically the Portland Area's delegate to the National Indian Health Board. This relationship to NIHB is also long lasting and continues to be a productive one. We support NIHB and its initiatives with our delegate (our chair) and our technical experts, such as our Policy Analyst and Executive Director.

Over the past ten years, the partnership with the executive agencies of the three states of Idaho, Washington, and Oregon have grown into very productive ones. Medicaid agencies, departments of health, and state universities are the most active state agencies in terms of working relationships with the Board. In Washington we work closely with the American Indian Health Commission for Washington State to advance health care concerns. This partnership is an example of a good relationship despite the bureaucratic environment of Washington state. Our EpiCenter and several of our projects work closely with state universities in Washington and Oregon on an array of successful and sophisticated health promotion and health research projects.

At our Strategic Planning session this January, we will discuss some of our partnerships in more detail. I will share some stories of difficulties with some of our partners and seek guidance on how to more effectively build partnerships or restore them. I hope you have all brought your ideas about how to build partnerships with you so we can continue to gain from our shared efforts.

Metabolic

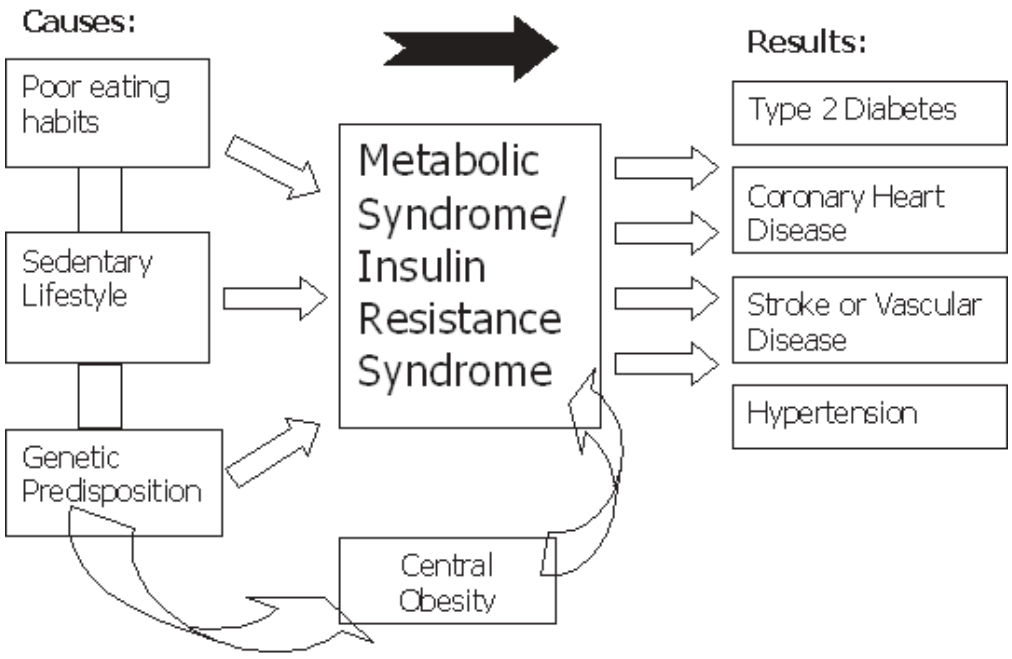
by Jen Olson

What is the metabolic syndrome?

Metabolic syndrome is also known as insulin resistance syndrome. Insulin is a hormone that allows glucose to move into tissue cells, where is it is used for energy production. Insulin resistance is an impaired response to our body's own insulin so that active muscle cells cannot take up sugar (glucose) as easily as they should. In that situation, the blood insulin levels are chronically higher which inhibits our fat cells from giving up their energy stores to let us lose weight. Obesity worsens insulin resistance, making it increasingly difficult for cells to respond to insulin. When the body can't produce enough insulin to overcome insulin resistance, blood sugar levels rise, ultimately leading to diabetes.

Some people are genetically predisposed to insulin resistance. Acquired factors, such as excess body fat and physical inactivity, can elicit insulin resistance and the metabolic syndrome in these people. Most people with insulin resistance have central obesity.

Obesity and lack of exercise tend to lead to insulin resistance. Insulin resistance can lead to fatty plaque deposits in the arteries which, over time, can lead to cardiovascular disease, blood clots, and strokes. Insulin resistance also leads to increased insulin and glucose (sugar) levels in the blood. Excess insulin increases sodium retention by the kidneys, which increases blood pressure and can lead to hypertension. Long term elevated glucose levels may also lead to type 2 diabetes.



Who has the metabolic syndrome?

Many of the risk factors are the same as they are for developing diabetes. Men and women who are even slightly overweight, especially with central obesity, a strong family history of diabetes, a history of gestational diabetes in pregnancy for women, hypertension, low HDL cholesterol and high triglycerides.

Metabolic syndrome is identified by the presence of three or more of these components:

- Central obesity as measured by waist circumference:
  - Men — Greater than 40 inches
  - Women — Greater than 35 inches
- Triglycerides greater than or equal to 150 mg/dL
- HDL cholesterol:
  - Men — Less than 40 mg/dL
  - Women — Less than 50 mg/dL
- Blood pressure greater than or equal to 130/85 mmHg
- Fasting glucose greater than or equal to 110 mg/dL

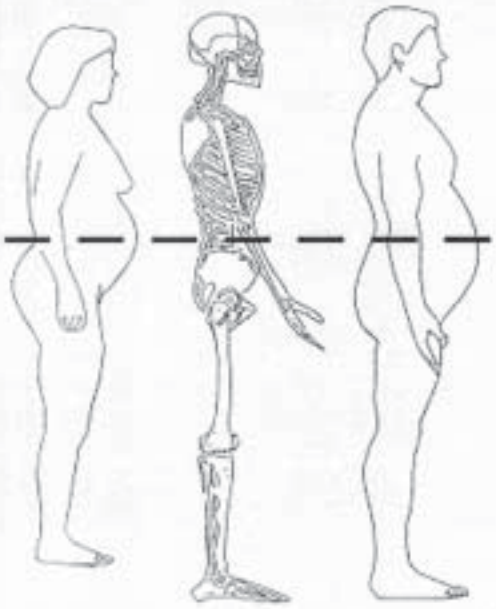
(According to the ATP III criteria)

Syndrome

Figure 3

Waist Circumference Measurement

To measure waist circumference, locate the upper hip bone and the top of the right iliac crest. Place a measuring tape in a horizontal plane around the abdomen at the level of the iliac crest. Before reading the tape measure, ensure that the tape is snug, but does not compress the skin, and is parallel to the floor. The measurement is made at the end of a normal expiration.



Measuring-Tape Position for Waist (Abdominal) Circumference in Adults

How do you develop Metabolic Syndrome?

Poor eating habits, sedentary lifestyle, and genetic factors can lead to metabolic syndrome (also known as insulin resistance syndrome). This condition is becoming increasingly common; it is estimated 47 million adults in the U.S. have metabolic syndrome. The syndrome poses a significant health risk to individuals and is a growing health crisis for our country.

Treating Metabolic Syndrome

The safest, most effective and preferred way to reduce insulin resistance in overweight and obese people is weight loss and increased physical activity. Other steps for managing metabolic syndrome are also important for patients and their doctors:

- Routinely monitor body weight (especially the index for central obesity), blood glucose, lipoproteins and blood pressure.
- Treat individual risk factors (hyperlipidemia, hypertension, and high blood glucose) according to established guidelines.
- Carefully choose anti-hypertensive drugs because different agents have different effects on insulin sensitivity.

Resources:

http://www.americanheart.org/presenter.jhtml?identifier=4756
http://www.diabetes.org/weightloss-and-exercise/weightloss/metabolicsyndrome.jsp
http://www.nlm.nih.gov/medlineplus/metabolicsyndromex.html
http://www.cdc.gov/nccdphp/dnpa/obesity/trend/metabolic.htm
Diabetes Care, November 2003

October 2004 QBM Pictures

Executive Committee LtoR: Rod Smith (Puyallup), Janice Clements (Warm Springs, Stella Washines (Yakama), Linda Holt (Suquamish), Pearl Capoeman-Baller (Quinault)

NPAIHB Delegates during the October 2004 QBM at the Davenport Hotel in Spokane, Washington

Cheryl Bittle, PAO IHS

Eric Broderick, DHHS

Andy Joseph, Colville Delegate

Pearl Capoeman Baller, NPAIHB Chair

October 2004 QBM - Spokane Tour

Spokane hospitality - Spokane parent group vollunteered their time to cook a delicious dinner for the NPAIHB QBM attendees. Thank you!

Spokane Welcome

NPAIHB October 2005 QBM attendees at the Spokane dinner.

Warren Sayler, Spokane Tribal Council Member, welcomes our group.

Tour of the Spokane tribal council chambers.

Risky Business - "We're Baaaaack"

by Jillene Joseph, Native Wellness Institute Director

Back in the mid-90s, Northwest Portland Area Indian Health Board staff members developed a training called "Risky Business" as a way to collaborate with each other and to bring comprehensive training services to the tribes. The training included information on tobacco, sexually transmitted diseases, and cancer, and focused on risk factors, strategies for prevention, and methods to promote behavior change. These trainings were designed for Community Health Representatives (CHR), health educators, nurses, and other individuals that provide education in the community.

One of the original trainers of Risky Business, Kerri Lopez, shared her memories of the training, "It was great strategic planning for better utilizing the busy schedules of the providers [CHRs, health educators, etc] that we were all trying to serve. Instead of competing for their time, we were working together and still getting invaluable information to them. It also was a great venue for tying together some of the risk behaviors and health factors that plague our communities."

The underlying theme to the training was that by promoting good health and wellness in general, we could prevent many health conditions impacting Indian people. These meetings also gave the Health Board's programs an opportunity to provide updates and encouragement to tribal educators.
Because the health promotion projects at the Board often must "compete" for the attention of the same tribal contact person, Risky Business has been dusted off and will be debuting soon in a community near you!

Project Red Talon, Western Tribal Diabetes Project, Northwest Tribal Cancer Registry Project, Women's Health Promotion Project, Northwest Tobacco Prevention Project and the Maternal and Child Health project will collaborate to bring a dynamic, one-day training to tribal health educators. The topics and tools discussed in this training will provide participants with ready-to-use information for community education.

If your community would like to schedule a "Risky Business" training, please contact any of the above mentioned projects at (503) 228-4185 or www.npaihb.org.

All travel costs can be reimbursed for participants attending the closest training site (one person per tribe): One night hotel for those traveling over 60 miles, airfare for those traveling over 250 miles, and government rate mileage for all!

Please contact Stephanie Craig, at Project Red Talon, for registration materials and additional information – scraig@npaihb.org or (503)228-4185.

Training schedule – Save the Date!

Tobacco – Women's Health – Cancer – Diabetes – STDs – MCH

February 23, 2005 Quinault Lodge
March 30, 2005 Coeur d'Alene Tribe – Location Pending
April 6, 2005 Spirit Mountain Casino and Hotel

Project Red Talon Takes Flight in 2005

by Stephanie Craig, Project Red Talon Coordinator

In September 2004, NPAIHB received a new three-year grant from the Centers for Disease Control and Prevention, continuing the work of Project Red Talon (PRT). This project will provide the 43 federally recognized tribes in Idaho, Oregon, and Washington with education, training, and technical assistance for the prevention and treatment of Sexually Transmitted Diseases (STD) and HIV/AIDs.

To kick off the New Year and commemorate National Condom Week (February 12-19, 2005), Project Red Talon sent a box of condoms to each of the tribe's STD health educators, along with a list of activities that can be used to increase community knowledge about STDs. Take advantage of National Condom Week (NCW) to educate and mobilize tribal members around issues regarding safer sex and responsible choices.

KNOW THE FACTS! In 2003, 46.7% of all high school students reported they have had sexual intercourse.[1]1 out of every 4 sexually active teens will get an STD this year.[2]- One out of five sexually active teen females will get pregnant this year.[3]1 in 10 sexually active adolescents have Chlamydia.[4]Two US teens are infected with HIV every hour of every day.[5]

Project Red Talon can provide STD training and technical assistance to tribal medical providers, health professionals, and community health advocates, and can assist communities with local prevention activities. Our scheduled trainings include the "Risky Business" training series provided by the Board. Through additional regional and on-site training opportunities, PRT hopes tribal partners will come together to develop a three-year STD screening and treatment *Tribal Action Plan for NW Tribal Communities*.

During the upcoming months, Project Red Talon (PRT) will survey each tribe's health department, prevention coordinator, or CHR to identify current strengths and weaknesses in the STD prevention efforts taking place among NW tribes. Likewise, surveys will be conducted with tribal clinicians to document current screening and treatment practices at tribal clinics. This information will be used to generate a comprehensive *STD Profile for NW Tribal Communities* and partners, and will help prioritize the training and technical assistance needs provided by NPAIHB.

Project Red Talon wishes you and your loved ones a happy and healthy 2005!

(Footnotes)

[1] Centers for Disease Control and Prevention. (May 2004). *Surveillance Summaries*. MMWR 2004:53(No.SS-2).

[2] California STD/HIV Prevention Training Center.

[3] California STD/HIV Prevention Training Center.

[4] California STD/HIV Prevention Training Center.

[5] California STD/HIV Prevention Training Center.

FY 2006 Budget Workshop on March 8, 2005

by Ed Fox, Executive Director

FY 2006 Budget Workshop on March 8, 2005
All-Tribes Meeting March 9, 2005

This year's (FY 2005) 1 to 1.5% increase for the Portland Area IHS means that tribes will have to cut much needed services. It means tribal leaders will have to make difficult decisions to balance competing priorities Of course cutting services is not the only method of balancing priorities. Another method has to do with priority setting by tribal councils. Tribal funding for health care is at an all-time high thanks to cuts in federal funding, and increasingly, thanks to cuts in state Medicaid programs. When tribal funding for health care increases, other priorities are often cut. The very economic development successes that have allowed some tribes to add funding to health programs is threatened by the need to support health programs.

This year Northwest Tribes will once again participate in a consultation process to develop the Department of Health and Human Services budget request for FY 2007. This year we need to strategize on how we can improve on the disastrous budgets of the Bush years. The Board will also produce its 16th annual budget analysis of President George W. Bush's FY 2006 budget request submitted to the Congress in February. Indian health programs are being asked to provide health care with diminishing resources. Tribes are being asked to divert funding from economic development and other priorities to address health care needs made worse due to the lack of sustained economic development. This downward spiral may accelerate if tribes and organizations like the Northwest Portland Area Indian Health Board do not succeed in raising awareness of chronic funding shortfalls and their negative effect on health care status. New ideas are needed this year and I invite you to attend the budget workshop this March 8, 2005 so we can together develop a strategy to make our case known to both the American public, and leaders in Congress and the White House.

Meet Our New HR Director

Hi! My name is Eric Metcalf (Coquille). I recently left my position at the Coquille Indian Tribe as their Health and Human Services Director, a position I held for the last 11 years. I've also been the Coquille Delegate to the Board since 1991. I am a Coquille Tribal Member - the Coquille Tribe received Federal Recognition in June of 1989.

After playing a couple years of college basketball and coaching High School Girls basketball, I finally graduated with a double Bachelor's Degree in Education and Health. I went to work with the Coquille Indian Tribe almost immediately after graduating from College in 1993. I inherited a staff of four and a $284,000-dollar budget. When I left Coquille in August, I left behind 30 employees and a multi-million dollar budget. Under my supervision and with some excellent staff, the Community Health Center received the highest Accreditation possible from AAAHC during both of our review periods. We have also been recognized as leaders in our Diabetes and Head Start programs. I have served on numerous committees both nationally and in the Northwest. My wonderful wife Judy and our three kids Margo (10), Eddie (8) and Macy (3) all look forward to living and working in the Portland Area. I have always had the opinion that this Board is a national leader and I feel honored to be part of a great group of committed people working towards bettering health for Indian Country.

Klamath Tribal Health Awarded State Grant

by Jennifer Haake, R.N., MPH, Project Director Klamath Tribal Health & Family Services' State Incentive Grant
Article previously published in the Klamath Falls *Herald and News*

In November, 2004 Leroy Jackson Jr., MPH, Health General Manager for Klamath Tribal Health and Family Services, was notified that Tribal Health had been awarded the Early Childhood System Development Grant by the State of Oregon, Office of Mental Health and Addiction Services. The grant provides $ 312,500 over a 27-month period to streamline, strengthen, and enhance behavioral health services to children (birth to six years old) and their families.

Klamath Tribal Health and Family Services, Klamath County Mental Health Department, and Klamath Youth Development Center formed a unique and historic partnership while collaboratively developing this grant application, and have further extended the collaboration by involving the Migrant Head Start Program and the Klamath Family Partnership in the application's development. The Klamath Family Partnership, a local multi-agency children's planning council, had already identified that Klamath County needed to develop a consistent and inclusive way of looking at systems of care for children and willingly extended their focus to support the requirements of the grant.

Historically, Tribal and Hispanic children and families have been underserved by local behavioral health services. While Klamath County has a broad array of services, many of the systems are poorly integrated and the ability of non-traditional child serving providers to access other systems is often dependent on an individual provider's personal knowledge, experience or relationships with community providers. Additionally, language barriers often hamper access for Hispanic individuals, as do legal status and the resultant trust issues with "official providers."

The goals of the project include:

- Improving access to and integration of services to the target population, including providing routine services in non-traditional sites, development of a system to identify and follow at-risk children and families, increasing the availability of behavioral health services through improving referral systems, advocacy, and developing flexible services patterns.
- Development of a model program which will serve 50 at risk families (25 Tribal families and 25 Hispanic families) by providing: opportunities for positive interaction between parents and children, an early prevention and entry system; and access to behavioral health services, case management, and integrated family/professional care coordination teams.

Continuing the collaborative nature of the project is the Project Manager, Jennifer Haake, RN, MPA, (Klamath County Mental Health Department); the Data Collection and Coordination Manager, Francis Crispen, MRC, (Tribal Health and Family Services); and two Family Care Coordination Specialists (1 Tribal and 1 Hispanic). Tribal Health has identified Shawna Gallagher as the Tribal Family Care Coordinator.

Over the next two years the citizens of Klamath County will have a child serving system that is more comprehensive, integrated, accountable, and accessible. The improved system and collaborations developed with this grant will continue to serve our children for many years in the future.

Lobbying 101

by Liling Sherry, Northwest Tribal Cancer Control Project Director

I am leaving our nation's capital this afternoon. Terri Caldwell came through with my requested window seat and I have been admiring the skyline of Washington and the gold and red of the trees below. The fall weather this week was perfect and Washington, D.C. looked amazing.

I had never been on a lobbying trip to DC and had only visited three times prior to this week's trip, mostly for meetings and conferences related to tobacco prevention. I had gone sightseeing, catching many of the memorials and museums on prior trips. This trip was quite different from those visits. On this trip, I had my first lesson on *Lobbying 101*. My instructors were among the best in Indian Country: Ed Fox, Jim Roberts, Linda Holt and Stella Washines. The eloquence of these four leaders was inspirational. I kept thinking of all the Indian leaders who, through these past 500 years, have made the trip out to Washington and of their resolve. I believe the legacy they left is in good hands with our Northwest Tribal leaders.

With the agenda set and meetings with key staff scheduled, we were off. On Capitol Hill, these four raised the issues and strongly advocated on behalf of American Indian Veterans. Members of the northwest congressional delegation are planning to work on Indian Veterans issues, perhaps as early as this spring. The grave concerns for the Indian Heath Service budget are now familiar to the Washington and Oregon delegation. The Indian Health Care Improvement Act will likely see it's day during the 109th congress, and not the 108th congress, as so many people had worked toward. Current political climate aside, there will be strong people fighting ahead to ensure the health of American Indians and Alaska Natives in 2005 and beyond.

I know I was not of much help on this trip and could not add much to the conversations; Linda and Stella reminded me that you have to start somewhere. They are right. I am inspired to learn more about the far-reaching issues, work harder at cancer prevention and awareness, and just do more for our native peoples. I envision a whole new crop of eloquent and resolute leaders coming up behind Ed, Jim, Linda and Stella and I hope I get to be part of that group. If you ever get the opportunity to be part of a lobbying trip, take advantage of it and go. I would venture to bet you would board the plane with as much awe as I have today.

Future NPAIHB QBMs

April 19-21, 2005 Quinault Nation in Ocean Shores, WA

July 19-21, 2005 Siletz Tribe in Lincoln City, OR (joint meeting w/CRIHB)

October 18-20, 2005 Confederate Tribes of Grand Ronde in Grand Ronde, OR

Continued from page 3

The Board's office space is expanding by a modest 2200 square feet. With the remodeling completed in March, we will be able to offer additional meeting and training room space to our Tribes for any type of meeting they desire. We will have three classroom-sized meeting rooms. We will also be offering expanded trainings as requested by our Tribes. Our remodeling will coincide with a rent reduction that starts on March 1, 2005. We will be able to have additional space, with improvements throughout all our 15,500 square feet, and for about the same rent we paid last year. I will be sending a letter to Tribes requesting donations of art or cash to purchase NW art for our remodeled offices. We hope to have a grand opening this spring where Tribes can reacquaint themselves with the Board; see for themselves our capacity to do more and our pride in what we have accomplished. Our new lease is for five years with an option for three more so we may be here at Portland State University for an additional eight years and three months. We do have a very liberal arrangement for any reduction in space with notice, necessitated by any loss of funding. The ability to downsize was the most difficult part of our negotiation. I am optimistic that we will be growing over the next two to eight years, but I did not think I should commit the Board to an expensive liability if we actually get smaller.

Upcoming Events

January 2005

HHS Event for Secretary Tommy G. Thompson and Deputy Secretary Claude Allen
January 19, 2005
3:00 to 5:00 p.m.
Hubert Humphrey Building, 200 Independence Avenue SW., Washington, DC

American Indian Inauguration Ball
January 20, 2005
Marriott Crystal Gateway, 1700 Jefferson Davis Highway, Arlington, VA
For more information: www.nihb.org.

February 2005

CMS Tribal Technical Advisory Committee
February 2-3, 2005
Centers for Medicare & Medicaid Services in Baltimore, MD
For more information: www.nihb.org

Affiliated Tribes of Northwest Indians
February 7-10, 2005
Embassy Suites at the Airport in Portland, OR
For more information go to: http://www.atnitribes.org/announc.html

February 8-9, 2005
NIKE Campus in Beaverton, OR
For more information go to: http://www.npaihb.org/epi/cadsp/diabetes_whatsnew.htm

Tribal Leader Technical Advisory Committee
February 10-11, 2005
Denver, CO
For more information contact: althea.tortalita@ihs.gov

State of Oregon SB 770 Health Cluster Meeting
February 16, 2005
Salem, OR
For more information contact: Evonne.J.Alderete@state.or.us
(503) 945-6652

NCAI Executive Council Winter Session 2005
February 28 - March 2, 2005
Wyndham Hotel in **Washington D.C.**
For more information go to: http://www.ncai.org/index.asp

Upcoming Events

March 2005

American Indian Health Commission
March 4, 2005
Seattle, WA
For more information: www.aihc-wa.org

16th Annual Portland Area Annual Budget Analysis Meeting
March 8, 2005
Annual All Tribes Meeting
March 9, 2005
Both Meetings to be held at the Embassy Suites Hotel in Portland, OR
For more information: www.npaihb.org

Idaho State Tribes Meeting
March 17-18, 2005
Site to be Determined
Boise, Idaho
Contact Jim Roberts at (503) 228-4185
For more information: www.npaihb.org

North American Native Wellness Gathering
March 14 - 17, 2005
Reno Hilton in Reno, NV
For more information go to: http://www.nativewellness.com/index.html

April 2005

2005 Direct Service Tribes Conference
April 25-28, 2005
Hyatt Regency in Albuquerque, NM
For more information contact NIHB at (202) 742-4262 or email sleahey@nihb.org.

17th Annual IHS Research Conference
April 29 – May 1, 2005

For more information contact: cybarra@hqe.ihs.gov

International Meeting on Native American Child Health:
April 29 – May 1, 2005
Seattle, Washington
For more information go to: www.aap.org/nach.

New NPAIHB Employees

Hello everyone! My name is Ticey Casey (Siletz) and I am the new EpiCenter Project Assistant. I am a member of the Confederated Tribes of Siletz Indians. My Grandma is the late Madge Mason and my mom is Pamela Rilatos. My mom, brother and youngest sister still reside in Siletz and I have one sister who lives here in Portland. I am a proud parent of two boys that are seven and four. Their names are Devonte and Terrell.

After graduating from Toledo High School, I moved out of Siletz to Albany, Oregon in 1992 to attend college. I resided in Albany for 12 years before moving to Beaverton this month. I am very new to the Portland area! I thought Albany was big compared to Siletz! Now that I'm in the Portland area I'm amazed!

For the past two years I have worked for the State of Oregon Employment Office as the Lead worker for Employment Services. Prior to that, I worked for the Siletz tribe for six and a half years as a Tribal Services Specialist. I graduated from OSU with a Bachelor's of Science degree in Sociology and worked for my tribe while attending school. I was able to gain valuable experience along with education at the same time. I love working for tribal organizations and look forward to the experience that I will gain from the Northwest Portland Area Indian Health Board!

Hello! My name is Lisa Griggs (Blackfeet). I'm the new Program Operations & Project Red Talon Assistant here at NPAIHB. I live in Vancouver, Washington and have been there for 10 years. I grew up in Fairfield, California in the northern Bay Area. I enjoyed growing up there and occasionally miss the BIG city hustle and bustle. Then I go to visit my sister in Santa Rosa and it reminds me that it's a great place to visit, but not to live.

I enjoy spending my time with my two sons Javon (age10) and Bishop (age 7) who are very active in sports. I take pleasure in watching them play sports and cheer from the sidelines. We enjoy camping and going to the Oregon coast whenever possible. In the quiet moments I like to read, listen to music, and haven't given up on my attempts to garden. Spending time with friends and family as often as I can is very important to me.

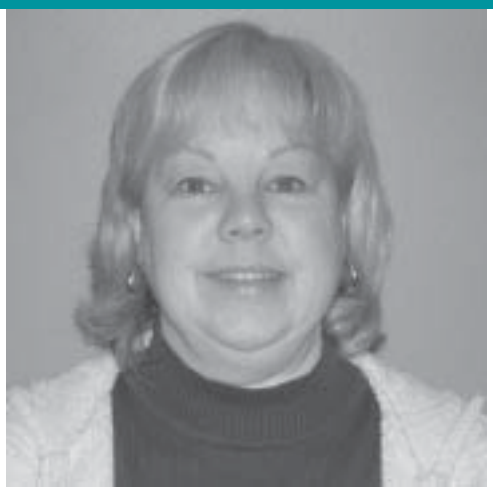
I'm excited to be here and am enjoying the opportunity to be part of great organization like NPAIHB.

New NPAIHB Employees

Hello, my name is Erin Moran (Wichita and Affiliated Tribes, OK) and I am the new Executive Administrative Assistant for the Management Team at NPAIHB.

I have lived in Oregon all my life and grew up on a little farm outside of North Plains. I am a graduate of Pacific University in Forest Grove and had previously been working for a small non-profit called the Oregon Health Career Center. At the Oregon Health Career Center I worked first as the Administrative Assistant and later as a Program Coordinator for K-12 Programs.

In my spare time I like reading, coaching basketball, and fishing with my Dad. I am very excited about this new opportunity and thankful to be employed with the Board. I look forward to learning about and working with Northwest Tribes.



Hi, my name is Elaine Cleaver (Cheyenne River Sioux). I have lived in and around Vancouver, Washington my whole life, where I raised my three children - mostly as a single Mom. All three children are now grown. The oldest, Michelle, lives in North Carolina with her Husband (A US Marine) and two children. My second child, Mike, works here at the NPAIHB in accounting. He is married with three children. My youngest son in going to school in Finland right now. He has traveled extensively for last six years with the Navy and Navy reserve.

Before working for the Health Board, I worked for Consolidated Freightways as an office assistant, answering phones, doing collections, and providing support for the accounting department. More recently, I owned my own sharpening business, and continue to sharpen tools in the evenings and on weekends.

I have settled into the Office Manager position here at the Health Board. I am in charge of sending out the weekly mail-out, and I answer the phones at the front desk. I'll be the first one you talk to if you call in, and will help direct your calls! If you know any good jokes, I'd be happy to hear them. And I look forward to seeing you at the QBM.

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.

October 2004 QBM Resolutions

RESOLUTION #04-01-01
Support for Health Careers Opportunity Program Proposal
to be Submitted to the Health Resources Services Administration

RESOLUTION #04-01-02
Support for the Sue Crystal Indian Health Act to Enhance Tribal-State Relations in Washington State

RESOLUTION #04-01-03
Support the Development of a Center for the Prevention of Family and Self-Violence in Native Communities

NORTHWEST
PORTLAND
AREA
INDIAN
HEALTH
BOARD

527 SW Hall Street • Suite 300 • Portland, OR 97201