Health News & Notes

A Publication of the
Northwest Portland Area Indian Health Board

January, 2006

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.

Joe Finkbonner
New NPAIHB Executive Director

Joe Finkbonner with NPAIHB Executive Committee.
LtoR top row: Rod Smith, Joe Finkbonner, Andy Joseph
LtoR bottom row: Janice Clements, Stella Washines,
Pearl Capoeman Baller
Article on page 4.

In This Issue

From the Chair:

Pearl Capoeman-Baller

As we begin the New Year, it would be good for all of us to take a moment to reflect on the work that the Board has engaged in over the past year. Too often we get caught up in the challenges and do not take the opportunity to relish our accomplishments. Many of the positive things happening nationally can be attributed to the work of Northwest Tribes. Although the IHS never receives enough funding, compared to other federal agencies, a decent budget was received this year. For the first time since 1993, Indian health programs received funding to cover the costs of inflation and population growth. Funding the mandatory costs of our health programs has always been a basic budget principle of Northwest Tribes. This is a point that is made year after year in our annual budget analysis and finally Congress and the Administration have heard us.

As your representative on the Tribal Technical Advisory Group (TTAG) to the Centers for Medicare and Medicaid Services (CMS), I have come to understand that there are many issues that Tribal health programs face in the Medicare and Medicaid programs. The inception of the TTAG can be attributed to a resolution that began at the Board. It was later passed at ATNI and then passed at the National Congress of American Indians. Tribal leaders might not have the opportunity to work on these important issues had CMS not adopted the TTAG.

While there continues to be many unresolved Medicare/Medicaid issues for Tribes, we have made some progress. The TTAG has developed a strategic plan for CMS on Indian specific issues. While it remains to be seen if CMS will implement the strategic plan recommendations, the fact is CMS now has a documented record of Indian issues with a strategy to address them. The TTAG has also been successful in working with CMS to develop a tribal consultation policy—something the Agency has never had. Tribal leaders now have a mechanism to engage CMS on our issues and we can utilize it to access their progress in implementing the strategic plan. Finally, the TTAG along with the National Indian Health Board's Medicare/Medicaid Policy Committee was successful in getting Indian specific provisions included in the Medicare Modernization Act (MMA). The Medicare-like rates provision will save our Contract Health Service programs millions and the expanded Part B billing authority will allow Indian health programs to be reimbursed for services they could not previously bill for.

Last year we saw a significant victory for Tribes with the Supreme Court decision on contract support costs. While the Supreme Court's decision does not rectify many of the issues associated with inadequate contract

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From the Executive Director:

Joe Finkbonner

Happy New Year! As we enter 2006, we look forward to continuing the momentum that we closed out the year with in 2005. I am very excited to be serving the tribes in this position and will strive to build our capacity to meet the needs of our member tribes and to fulfill the mission of the Board!

As stated many times, I intend to incorporate the Strategic Plan in our daily activities in meaningful and measurable ways. The Management Team has worked closely together to draft a transition plan that is reflective the priorities and values set forth by you, our Delegates. This will be apparent to you in my Executive Director's Report before the Board and is the basis for which we used to develop the Transition Plan.

Transition Plan

The transition plan will be shared at our January Quarterly Board Meeting. It is a tool that will be used as a guide and a tool to measure our activities. The priorities presented come from the Strategic Plan and input from key individuals at the Board.

I will be implementing various management tools that will facilitate efficient operations aimed at increasing communication amongst projects and staff. One such example is the use of monthly activity reports (MARs). These are succinct reports that have assisted management in many ways. For example, during the audit process, if there was a question regarding the allocation of hours, we have been able to review the MARs for the time period in question to support our allocations. This allows an efficient response while providing definitive evidence that our allocations are correct.

Fiscal Year 2005 Audit

I would like to commend our Finance Department for another stellar performance this year! This year was the smoothest, most efficient, and responsive yet. We are on track for a final Audit report by January 31, 2006. All indications thus far are very promising for another clean audit! Great work!

Finances on track

Our projects budgets are on track for spending. We foresee Indirect Recovery to be much more manageable as we have a more diverse and secure grant base to support our activities and we are fully staffed in our Indirect cost pool. As all tribes are experiencing, our PL 93-638 funds have lost purchasing power over the years and we are striving to maintain our activity level and services with fewer funds. As such, we are carefully monitoring our spending in Program Operations seeking to realize efficiencies in areas that will

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Northwest Portland Area Indian Health Board

Projects & Staff

Administration
Joe Finkbonner, Executive Director
Verné Boerner, Administrative Officer
Sue Lara, Finance Officer
Bobbie Treat, Controller
Mike Feroglia, Business Manager
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
Joe Finkbonner, Director
Joshua Jones, Medical Epidemiologist
Tom Becker, Medical Epidemiologist
Doug White, NW Tribal Registry Director
Ticey Casey, EpiCenter Administrative Assistant
Katrina Ramsey, Navigator Project Coordinator
Tam Lutz, TOT's and ICHPP 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 Administrative Assistant
Don Head, WTD Project Specialist
Crystal Gust, WTD and National Project Specialist

Tobacco Projects
Gerry RainingBird, NTTPN Project Director
Nichole Hildebrandt, WTPP Project Director
Brandy Moran, WTPP Project Specialist

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

Project Red Talon
Stephanie Craig, Project Director
Lisa Griggs, PRT Administrative Assistant

Joe Finkbonner
New NPAIHB Executive Director

The Northwest Portland Area Indian Health Board (NPAIHB or the Board) announced Joe Finkbonner as their new Executive Director during their Quarterly Board Meeting on October 25-27th, in Grand Ronde, Oregon. Pearl Capoeman Baller, NPAIHB Chair, speaking on behalf of NPAIHB stated, "We are very excited to have Joe as our new Executive Director. He is a member of the Lummi Nation, one of our own Northwest Tribes. He has served as our EpiCenter Director for the past four years and is a pharmacist that has managed a Tribal health care program. His experience will be invaluable to us at the Board."

Prior to being named the Executive Director, Mr. Finkbonner served as the Director of the Northwest Tribal Epidemiology Center (The EpiCenter) at the Northwest Portland Area Indian Health Board. The EpiCenter is one of eleven tribal epidemiology centers that focus specifically on American Indian and Alaska Native health data surveillance. Before joining NPAIHB, Joe worked for the Lummi Nation as the Health Director and Chief Executive Officer where he was very active at the State and Federal levels.

Throughout his career, Joe has worked to heighten the awareness of disparities of American Indian and Alaska Native people. His work on policy development includes his Governor appointed seat on the Washington State Board of Health, participation in the Washington Public Health Improvement Plan, and other work groups for the Indian Health Service. He also served as chairperson of the American Indian Health Commission of Washington State. Mr. Finkbonner holds a Masters of Health Administration and a Bachelor of Science in Pharmacy both from University of Washington, and is a Registered Pharmacist.

"I am pleased that my work and preparation is of use to the Northwest tribes. I have worked over many years on building my skills through both academic and professional endeavors. The basis of my work has always been and must be rooted in a single tenant, tribal sovereignty."

The tribally appointed NPAIHB Delegates have invested much time and energy in developing NPAIHB's Strategic Plan. NPAIHB's Strategic Plan will be the basis of a 180 day transition plan which will focus on what needs to get done while addressing NPAIHB's long term priorities. This plan also clarifies lines of responsibility and accountability. This document also outlines the self-identified priorities from key personnel who must balance broad ranging responsibilities with regard to both internal and external operations. So, while the transition plan is intended to be used as a tool for day-to-day operations, it will also build a general and broader understanding of how the Strategic Plan affects management and staff, particularly the activities of key staff.

The Northwest tribes have consistently worked hard for more than three decades to build NPAIHB as a nationally reputed leader in Indian health. They have faced difficult questions and issues and have consistently put health improvement above all else. "I am proud to be a part of such an approach," said Joe Finkbonner "We have a bright future and a great team to continue our important work."

Joe assumed his new position on November 16, 2005. Please join us in welcoming him to his new role at the Board!

FY 2006 Rescissions will cost IHS Programs $46 million

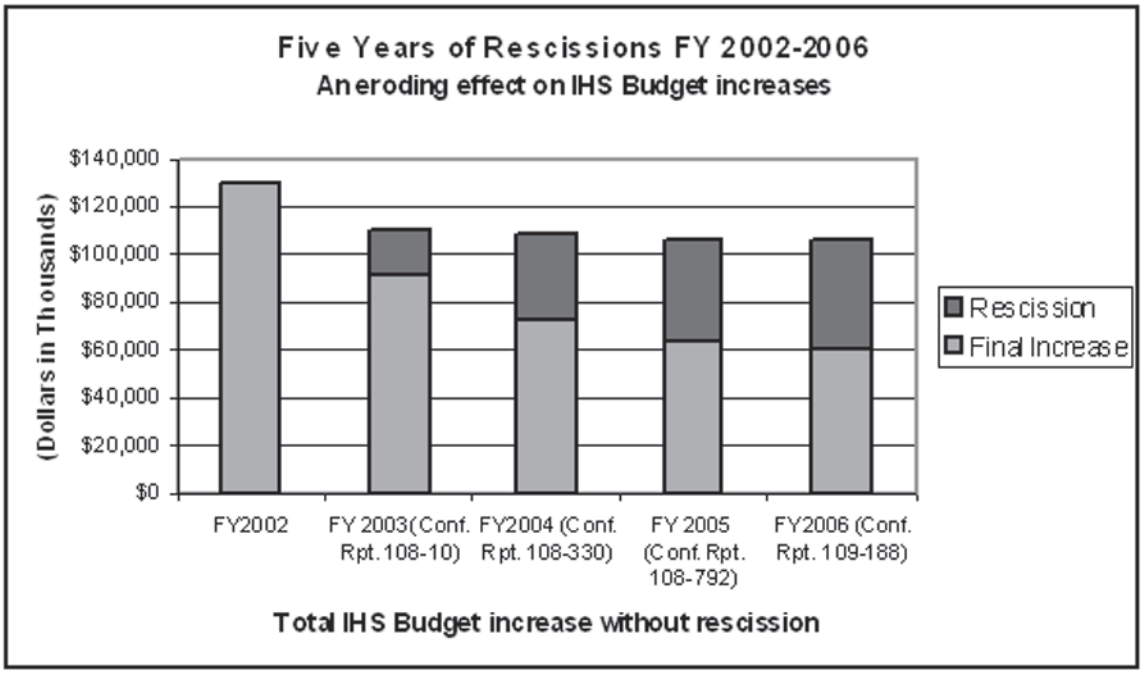
by Jim Roberts, Policy Analyst

January 2, 2006 — President Bush approved the Department of Defense (DOD) spending bill on December 30th, which included a provision to apply an across-the-board cut to almost all "discretionary" programs, including both defense and domestic programs. The medical care programs for veterans will likely be exempt from the cut. The effect of the one percent cut will reduce FY 2006 discretionary spending by approximately $8.6 billion.

The FY 2006 Interior Appropriations and Related Agencies bill (H.R. 2361) provides $3.09 billion for the Indian Health Service (IHS) which already contained a 0.476% across-the-board reduction. The reduction resulted in a $14.7 million loss to the IHS budget. The effect of the second cut to the IHS budget will be a loss of an additional $30.8 million. The IHS will lose a total of $45.5 million due to rescissions (44% of its approved increase) in this fiscal year.

Rescissions have had a growing effect on Indian health programs over the last five years. The reductions as a percentage of the approved IHS budget are growing at a disproportionate rate. Five years ago, the rescissions were a mere one percent of the approved budget increase. In FY 2006, the rescissions will eat up almost half of the approved IHS budget increase. It is not understandable why IHS health programs are not exempt from across-the-board reductions, but Veterans Administration (VA) programs are exempt from the rescissions. IHS health programs are subject to the same rates of medical inflation that VA programs are and should be give the same consideration.

The effect of any rescission is merely an illusion for DOD programs. It will not be the same for IHS and Tribal health programs which will have to cut services. Defense programs are likely to be fully restored next spring, when supplemental appropriations for Iraq will be enacted. Based on past Iraq supplemental bills, the supplemental is likely to be structured in a way that allows the Pentagon to move funds around and undo the across-the-board cut. IHS programs on the other hand will have to deny health services to Indian people.



Pearl's Report Continued

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support cost funding, it was a vindication for Tribes that have never received adequate contract support costs. It also sent a message to Congress and the Administration that you cannot treat Tribes as second class contractors when they contract with the government to carry-out the objectives of federal programs.

Finally, the Board continues to support quarterly meetings of state and Tribal officials. While our experience is sometimes bittersweet, these meetings continue to be very productive for Northwest Tribes. In Washington, the American Indian Health Commission (AIHC) and the Board recently finalized a spending plan for the Tribal Medicaid Administrative Match program that will soon be presented to CMS. In Idaho, the Board has worked with Tribes to develop a memorandum on Tribal consultation with Idaho's Department of Health and Welfare (DHW). The memorandum acknowledges the sovereignty of Tribes in working with the state to carry out its programs and instructs each of its Divisions to develop a consultation process. This will institutionalize state/Tribal meetings with Idaho's DHW and will be very beneficial for tribes in working with the state on Medicaid issues. In Oregon, we have seen the development of the targeted case management (TCM) program and out-stationed eligibility workers for Tribes. The TCM will provide a new revenue stream for Tribes and the costs of having eligibility workers at Tribal sites is being paid for by the state. So as you can see, our state meetings have been productive and keep tribes informed on important issues effecting the funding of our health programs.

While we have had some success last year, there continue to be many challenges and a tremendous amount of work still ahead of us, we can not rest on our laurels. I did indicate the IHS had a decent budget, however, the Defense appropriations will subject our health programs to a cut of over $30 million. The FY 2006 budget reconciliation bill will subject Indian Medicaid enrollees to co-payments and premiums that probably will not be waived by CMS. We have had experience trying to get cost sharing provisions waived for Indian people in Washington and Oregon without much success. Now suddenly what has been a Northwest issue will become a national issue when other states and Tribes attempt to waive Medicaid cost-sharing for their Indian people. Northwest Tribes were met with civil rights objections by the Administration when we attempted to protect our people from cost-sharing, and we should expect the same when we respond to the Medicaid changes of the budget reconciliation bill. We all understand the fiscal realities of this country and the relief efforts of Katrina and financing the War in Iraq will continue to effect Indian programs. The President will release his FY 2007 budget later in February and we as Indian health advocates will have to work harder than ever to protect our health programs.

This year, we will also have to work extremely hard for the passage of the Indian Health Care Improvement Act (IHCIA). The draconian cuts in the federal budget and changes in the Medicaid program raise the level of importance for reauthorization of the IHCIA. While Congress continues to provide funding for Indian health programs under the Snyder Act, having our programs operate under expired legislation in the current fiscal environment is a very dangerous thing. Without current legislation, it would be too easy for the Administration and Congress to cease funding certain aspects of Indian health program.

So as you can see, there is a tremendous amount of work for us all ahead and we at the Board will continue to work hard on behalf of our Northwest Tribes.

NPAIHB - 100's Best Oregon Companies

by Sonciray Bonnell, Health Resource Coordinator

The Northwest Portland Area Indian Health Board is among the 100 Best Companies to Work For in Oregon, an honor we first received in 2004. The *Oregon Business Magazine's* annual 100 Best Companies list recognizes 50 large companies (with more than 250 employees) and 50 small companies for excellence in five categories: attraction, retention and rewards, work environment, decision making and trust, performance management, and career development and learning.

To participate, NPAIHB management filled out an extensive questionnaire about the Board's policies, procedures, benefits, and values. Staff were asked to voluntarily participate in a survey used to measure and rate employee attitudes and opinions on what makes a great company. We had 16 staff complete surveys. With this information, NPAIHB was ranked among the 100 best Oregon companies to work for. The top five finalists for the large and small company categories will be announced on March 2, 2006 at the 100 Best Companies Awards Dinner held at the Oregon Convention Center in Portland, Oregon.

The success of NPAIHB is attributed to our delegates' strong leadership and support, for they set the tone, mission, values, and direction. With our strong leadership and stellar reputation, we are able to attract and retain some of the best talent in Indian Country. Our family friendly policies reflect a true Indian organization. We have an awesome staff and will continue to strive to do our best for the Indian communities we serve.

The rankings will be published in the Oregon Business Magazine on March 2, 2006. A detailed report is also given to participating companies and is useful to management in understanding which categories need improvement.

Doni Wilder Receives Indian Health Service Presidential Rank Award

from December 16, 2005 Indian Health Service Press Release

Phyllis Eddy, Indian Health Service (IHS) Deputy Director of Management Operations, and Doni L. Wilder, IHS Portland Area Director, have been selected as recipients of the 2005 Presidential Rank Awards for Meritorious Executives.

Each year, the President recognizes a small group of career Senior Executives with the Presidential Rank Award for exceptional long-term accomplishments. This prestigious award is given to executives who achieve results and consistently demonstrate strength, integrity, industry, and a relentless commitment to excellence in public service.

"This award recognizes Ms. Eddy's and Ms. Wilder's exemplary management skills and leadership. Through their personal conduct and their results-oriented program management, they have established and maintained a high degree of public confidence and trust. Their high levels of creativity and initiative have helped the IHS improve health care for American Indian and Alaska Native people," said IHS Director Charles W. Grim, D.D.S., M.H.S.A. "Their achievements have been recognized as advancing the President's Management Agenda while producing results that will have a lasting positive effect on the care we provide to our patients and support for Tribal health programs. The IHS is honored to have Ms. Eddy and Ms. Wilder selected for their sustained accomplishments, which are recognized throughout the Government."

Ms. Eddy, a member of the Yankton Sioux Tribe, serves as the principal advisor to the IHS Director for the management of IHS operations. She is responsible for providing management direction to the IHS program offices, including implementing agency goals and mission; providing overall organization management to improve agency performance; developing strategic plans; and planning, directing, and evaluating the operations of the Headquarters functions, authorities, and responsibilities in support of the Director. Ms. Eddy's ability to lead change has significantly contributed to the IHS ability to delivery quality health care. For example, through Ms. Eddy's leadership, the IHS grants program has grown and developed significantly. The grants program has gone from being at a branch level to a full division, the grants offered by the IHS have increased significantly, and staff morale and productivity has increased.

Doni L. Wilder, an enrolled member of the Rosebud Sioux tribe, is the IHS Portland Area Director. The Portland Area provides health care for 91,000 American Indians, primarily members of the 43 federally recognized Tribes in Oregon, Washington, and Idaho. Ms. Wilder administers a total health program including prevention, clinical care, and public health activities. An important aspect of her position is consultation with Tribal leaders at local, state, and national levels to promote full participation in carrying out health programs that affect American Indian communities. She keeps Tribes informed of new legislation, policy changes, management actions, and available resources. Ms. Wilder also manages a large Contract Health Service program through which inpatient and specialty care are purchased. The Portland Area also provides funding to three urban health clinics located in Seattle and Spokane, WA, and in Portland, OR, and two youth residential treatment programs. Under Ms. Wilder's leadership, the Portland Area led the way for the IHS in implementing the electronic health record. The electronic health record allows health providers quicker access to an individual record and can allow a provider to see a patient's complete medical history in different facilities, which helps to improve health care for American Indians and Alaska Natives.

ADULT TOBACCO SURVEY UPDATE

by Karen Schmidt, Project Specialist Western Tobacco Prevention Project

From February through December 2005, the Western Tobacco Prevention Project has been collaborating with the Klamath and Nez Perce tribes to implement the first American Indian Adult Tobacco Survey in tribal communities. The original Adult Tobacco Survey (ATS) was designed by the Center for Diseases Control and Prevention (CDC), and was first administered by individual states in 2001. The original ATS was conducted over the phone, using random digit dialing. The American Indian Adult Tobacco Survey (AI ATS) was designed in collaboration by seven regional Tribal Tobacco Support Centers (including the NPAIHB) and CDC over a two-year period. The AI ATS specifically distinguishes between commercial and traditional tobacco use, and has undergone extensive focus group and cognitive testing to assure cultural appropriateness.

The goals of the survey were 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 culturally appropriate prevention policies. This information is critical 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.

Survey interviews began in March 2005 and ended in September 2005. All Interviewers were hired from within participating tribal communities and each Interviewer completed an average of 70 face-to-face interviews during that time period. No personally identifiable information was collected during the interviews, and all participants were assured that their answers would be held confidential by the survey staff. The initial goal of 200 completed interviews was successfully achieved in both tribal communities. From September through November 2005, the data was entered and analyzed by WTPP staff at the NPAIHB office in Portland, Oregon. Upon completion, the final report and dataset were presented to both tribes in December 2005. In accordance with the data sharing agreement signed between NPAIHB and the participating tribes, all data from the survey belongs to the tribes and its members. How the information is used has been left to the tribe's discretion.

Based upon the experiences of the six participating Tobacco Tribal Support Centers, the CDC is developing an Implementation Manual to accompany the survey instrument as a guide for other tribes who wish to implement the AI ATS in their communities. This manual and the survey instrument will be available in spring of 2006. If you are interested in receiving the survey and manual, you may contact the WTPP for more information.

The WTPP would like to acknowledge the Klamath and Nez Perce tribes for their hard work and motivation throughout the duration of this project. We would also like to thank all the 2005 AI ATS respondents for participating in the survey.

Please contact the Western Tobacco Prevention Project for more information on the AI ATS project or for information on tobacco use in American Indian communities. You can find us on the web at www.westerntobaccoprevention.org or by calling 503.228.4185.

Joslin Vision Network

by Lori Bernard, Nursing Supervisor at Warm Springs Health and Wellness Center

The Joslin Vision Network (JVN) is a program that offers diabetic patients access to vision saving retinal examinations using a specialized retinal camera, and other activities involving eye care and treatment for diabetic retinopathy. The IHS/JVN Teleophthalmology Program at the Warm Springs Health & Wellness Center is working toward increasing the annual diabetic retinopathy (DR) examination rate and improving the management of referred patients.

Is Diabetic Retinopathy Preventable?

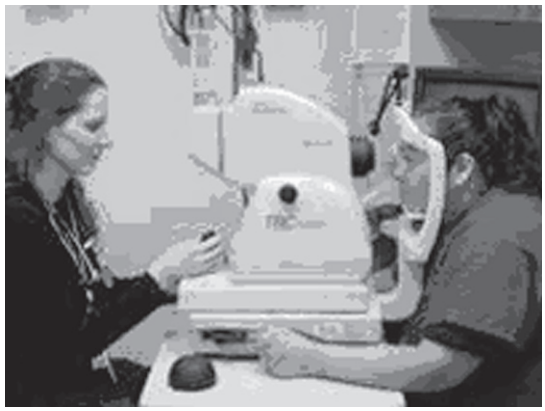
Diabetic retinopathy is the leading cause of blindness among adults. The Early Treatment Diabetic Retinopathy Study (ETDRS) has shown serious vision loss and blindness due to DR. Blindness is preventable in more than 95% of cases, if identified and treated in a timely fashion. The procedure is painless and does not require your pupils to be dilated. At the Warm Springs Health & Wellness Center the procedure is performed in the clinic while patients are waiting for their doctor's appointment.

LtoR: Tama Schjoll (Nursing Assistant) and Joy Ramirez (Medical Receptionist)

Who performs JVN testing?

We have two imagers at the Warm Springs Health & Wellness Center who actively recruit diabetic patients who are lacking a DR examination. Recruiting patients for imaging is done during clinic hours in order to utilize wait times in the clinic.

The JVN Imagers have attended a week-long training session in Phoenix, AZ prior to deployment of the equipment. The IHS/JVN Readers perform remote based interpretation and reporting of the retinal images when appropriate. The outcome of an IHS/JVN retinal image is a report that contains a diagnosis of the level of DR and a recommendation for the next follow-up examination. In some instances this may include a recommendation for a live examination of the retina. Referrals will be handled by in-house evaluation at the Warm Springs Health & Wellness Center Optometry Department or referral to a non-IHS facility to confirm the IHS/JVN diagnosis and determine the need for intervention.



Imager Tama Schjoll and volunteer Margaret Zacarias

Lori Bernard, RN, Director of Ambulatory Care Nursing is the Project Manager for the IHS/JVN for the Warm Springs Health & Wellness Center. She serves as the liaison between IHS/JVN and the Warm Springs Health & Wellness Center.

Since deployment of the JVN equipment in December of 2004, there have been 68 examinations performed at the Warm Springs Health & Wellness Center. This year's Performance Improvement project has joined forces with the Diabetes Program. The Warm Springs Diabetes Program is able to schedule appointments at the JVN clinic, provide prevention education, and send reminder letters to patients needing retinopathy screening. All nursing assistants have been trained to watch for the patients' needs and direct them to the imagers during wait times.

Western Tribal Diabetes Project and Partnerships in Action

by Crystal Gust and Kerri Lopez, Western Tribal Diabetes Staff

NPAIHB has several exciting trainings scheduled for 2006. These include Risky Business, Health Promotion/Disease Prevention Northwest Diabetes Conference and the highly successful Native Fitness trainings.

Risky Business is here again!

The collaborative training provided by NPAIHB Projects is scheduled to include the Western Tribal Diabetes Project, the Northwest Tribal Cancer Control Project, Project Red Talon, the Women's Health Project, and the Maternal Child Health Project. This year the Risky Business planning committee is working in conjunction with the Portland Area Indian Health Service Health Promotion Program to encompass even more material!

While not all training sites have been confirmed, the following dates and locations have been established:

February 22, 2006	Warm Springs, Oregon
March 29, 2006	To be decided-Washington state tribe
April 25, 2006	Coeur d'Alene, Idaho

Look for one coming to a site near you.

Northwest Tribal Diabetes Conference: April 26& 27

Coeur d'Alene will be the site of an exciting and innovative conference for NW diabetes programs. The event is being sponsored by the PAO Health Promotion Disease Prevention, Area Diabetes Coordinator, Western Tribal Diabetes Staff, Native Wellness Institute, and tribal representatives partnering to bring a "not to be missed" diabetes conference to the Northwest. Surveys completed by tribal programs helped formulate the agenda which will feature keynote speakers, innovative programs, wellness activities, and offer tribal programs a chance to network and find out what is working in tribal communities. The event is planned to be packed with hands on, interactive exercises. The two-day event will jump from the clinic to the Wellness Center offering a variety of formats for workshops. Local and out of area programs will be featured.

Native Fitness III: August 15 & 16 - Nike Campus!

And don't forget to pull out your schedules and fill in August 15 and 16 for the Native Fitness III training to be held at the Nike World Headquarters in Beaverton, OR. This is scheduled to be the third round of the highly innovative and popular fitness training coordinated by the Western Tribal Diabetes Project and the Portland Area Indian Health Service. Several speakers have already been confirmed including Chris Frankle and Darryl Tonemah. We are looking forward to seeing fresh new faces this year from tribal diabetes and fitness programs across the Northwest and beyond.

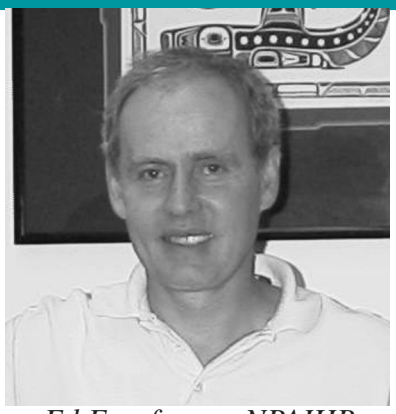
For additional information on the Risky Business training, please contact Lisa Griggs, lgriggs@npaihb.org or (503) 228-4185.

For additional information on the Northwest Tribal Diabetes Conference and Native Fitness III training, please contact Rachel Plummer, rplummer@npaihb.org or (503) 228-4185.

Ed Fox's Farewell Party

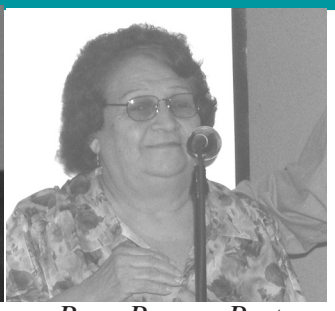
Jim Sijohn, former NPAIHB Delegate

Janice Clements, Warm Springs Delegate and NPAIHB Treasurer



Ed Fox, former NPAIHB employeee extraordinaire

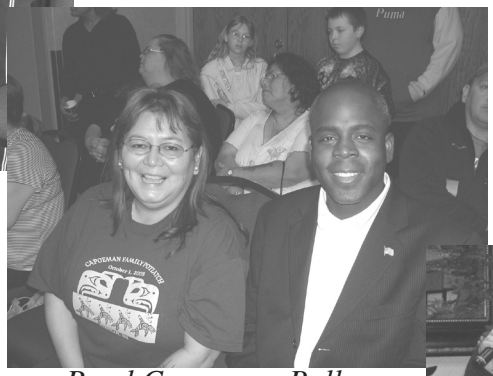
Julia Davis Wheeler, Nez Perce, former NPAIHB Chair



Rose Purser, Port Gamble S'Kklallam Delegate

October 2005 QBM Mini Pow Wow

Pearl Capoeman Baller (NPAIHB Chair) presenting Verne Boerner (Administrative Officer) with a gift on behalf of the Delegates for her work as the Acting Executive Director



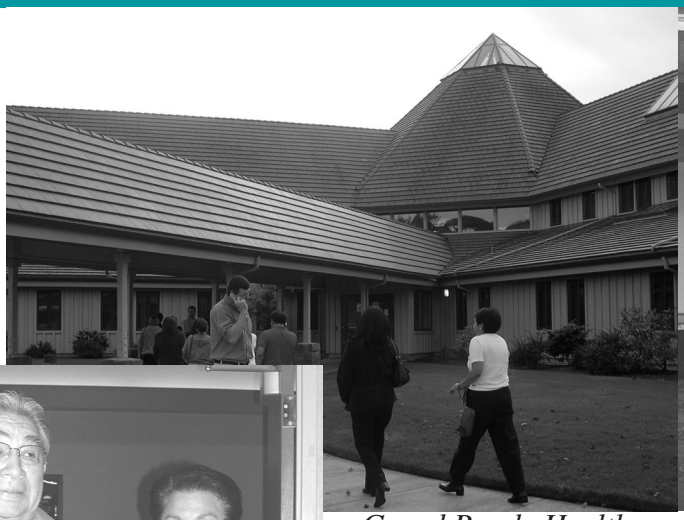
Pearl Capoeman Baller (NPAIHB Chair) and James Whitfield (HHS Region X Director) enjoying the Pow Wow

The pink shawl project is a support group for cancer survivors, cancer patients, and families dealing with cancer. Grand Ronde members displaying their shawls in honor of family members who have cancer or have passed from cancer.

Cicelly Gabriel, (NPAIHB Cancer Project) presents the pink shawl project. Stella Washines (NPAIHB Yakama delegate and cancer coalition member) watches.

October QBM Pictures

Cheryle Kennedy, Grand Ronde Chair welcoming NPAIHB Delegates and attendees to the QBM



Grand Ronde Health and Wellness Center

Grand Ronde Color Guard

Chips and Patti, Grand Ronde tribal members

NPAIHB employees LtoR: Leslie Randall (Epidemiologist), Julia Putman (TOTS Coordinator), and Tam Lutz (TOTS Project Director) presenting the TOTS Update

GPRA Cheerleaders LtoR: Cherly Bittle and Mary Brickell, Portland Area IHS

Methampetamine presenters from the Polk County Sheriff's Department and Grand Ronde

Working the Hill:

by Becky Johnston, Director American Indian Health Commission for Washington State

With all of the recent attention to lobbying scandals in Washington, you may be wondering what type of impact that you – as a grassroots advocate for Indian health – can have in our Nation's Capitol. As someone who's been lobbied as a Congressional staffer and as someone who's lobbied on behalf of tribes, I know from firsthand experience that there are some basic things you can do that will help you to get in the door, make your "pitch," and build lasting relationships on the Hill.

Getting In The Door

It's Who You Know. Let's start off with a true or false question. The Chief of Staff is the most important person – outside of the Member – in a Congressional office. Not necessarily! If the first step to effective advocacy relies on access, then the person you need to know first is the scheduler, the keeper of the calendar and the watcher of the clock. It pays to make life easier for the scheduler, and here's some ways to do it.

Put It In Writing. Request your appointment as soon as possible, and do it in writing. It's good to call the Member's district or Washington office to find out the name of the scheduler so that you can fax the request to his or her personal attention. In your request, state who will be attending the meeting and what issue you'd like to discuss, which will help to make sure that the appropriate staff are at the meeting and that the Member is briefed on your issue beforehand. I've found that, given the cramped quarters of Congressional offices and limited time available for meetings, smaller groups and keeping your list of issues to a few major topics is the most effective approach.

The Time Crunch. Members of Congress and their staff are extremely busy, so be realistic in requesting a meeting. If you expect to visit with the Member, try to ask for 15 minutes. If you end up meeting with staff for all or most of your time, don't be disappointed. Members really do rely on them for policy advice. As a related issue, call the office if you're running late (be sure to schedule enough time to walk the sometimes long distances between Congressional office buildings) or if you are bringing more people to your meeting. Finally, be flexible. Your meeting might and probably will start late and you might very well conduct your meeting in a hallway, outside a hearing room, or while "walking" with the Member.

Making The Pitch

You're in D.C, through the security checkpoint, and walking down the marble halls on your way to your first Hill visit. Soon, you'll be starting your meeting and you'll only have a few minutes to make your "pitch." Again, there are some basics to follow for making the most effective use of your time.

The Elevator Principle. You should be ready to explain your issue and make your request in the amount of time it takes to ride in the elevator with the Member. This can be harder than it looks, which is why it's important to . . .

Do Your Homework. If you have a group visit, appoint a spokesperson. Rehearse, rehearse, rehearse – even get together for breakfast or lunch beforehand for a pre-meeting. Don't just focus on your presentation. Think of some likely questions and practice answering them in a straightforward way.

Start with a KISS. Assume that the Member and staff know nothing about your issue. Take a minute to describe who you are and why you're there. Some people call it "Keep It Simple, Stupid." In a nutshell, that means "don't use acronyms and bill numbers and assume that they will know what you're talking about." This is an important principle because many Hill staff who handle American Indian/Alaska Native issues have other policy areas on their plate.

Make the "Ask." Don't beat around the bush. Do you want the Member to sponsor a bill or take the lead on a

How to Get the Most Out of Your Advocacy Visits

funding request? Do you want her to cosponsor legislation or vote against an amendment in Committee? Ask her, directly and specifically.

Play Nice. If someone opposes your issue, stay polite. Try to understand why and be prepared to engage in a respectful dialogue. After all, that "right-winger" just might live next door to your Member of Congress or that "special interest group" just might have supported him in his bid to be a Committee chair.

Give 'Em A Hand (Out). Provide briefing materials – the briefer, the better. Have a fact sheet that summarizes key points that you can leave behind. If you have a legislative proposal that you're shopping around for sponsors, it can be helpful to have a draft and a section-by-section summary available. Don't forget to provide contact information in case staff or the Member would like to follow up with you.

Thank You, Thank You Very Much. If your Member doesn't support your request, thank tham and move on, because you never know when you'll need their support on another issue. If they support you, thank them and offer to work with him/her and their staff to achieve your mutual goal. If they are non-committal, thank them and follow up with staff.

Later, Back At The Office (Or The Clinic)

Don't Forget To Follow Up. Send a short note thanking the Member and staff for the meeting. If you promised additional information, now's the time to provide it. If you're still waiting for a commitment, now's the time to ask for it.

Become A Hill Staffer. Congressional staff are overworked creatures and often don't have the time to dive into Indian health issues as much as you'd like to think they would. In those instances, let them know that you're willing to carry some of the load. You can offer assistance in contacting their colleagues, drafting legislation and supporting materials, or providing background information for a hearing. This will help you to provide your expert perspective on Indian health at the same time you build a long-lasting working relationship with the Member and staff.

Some Final Thoughts

While personal visits are a critical piece of the advocacy puzzle, there are many other ways to make your voice heard. You can make calls and write letters to Congress and to local media, invite Congressional staff to tour your health facility, or publicize your health promotion and disease prevention programs to a wider audience. Organizations like the National Indian Health Board, the Northwest Portland Area Indian Health Board, and the American Indian Health Commission for Washington State are available to help you as you embark on your role as an advocate for Indian health.

Becky Johnston serves as Director of the American Indian Health Commission for Washington State. She has over a dozen years' experience as an advocate for tribal governments. She has worked as a legislative assistant for U.S. Senator Byron Dorgan (D-ND) on Indian Affairs Committee matters, as a legislative specialist at a Washington, D.C. law firm specializing in American Indian/Alaska Native issues, and as a legislative associate at the National Congress of American Indians. Prior to joining AIHC three years ago, she served as a Seattle-based government affairs consultant to NCAI and several tribes on various matters, including federal budget, technology, transportation, and health care issues, including the successful authorization of the Special Diabetes Program for Indians.

Appreciation to . . . .

by Verné Boerner, Administrative Officer

As we start FY 2006, the Northwest Portland Area Indian Health Board extends its appreciation to Ed Fox for his 10 years at the Board! Ed has long recognized NPAIHB as the premiere Indian health organization in the country. He has stated time and again just why he believes this to be true: he is awed by the tribal leadership in the Northwest! Leaders such as Joe Delacruz, Pearl Capoeman-Baller, Julia Davis-Wheeler, Cheryle Kennedy, all of the Executive Committee members that he has worked with and so many others. He has long respected the wisdom of the Board Delegates and the history of the Board. This was evident as he oversaw events such as the Board's Strategic Planning Process and the 30th Anniversary Celebration. For any such event, Ed put in the resources to bring those that have made the Board what it is today, Jim SiJohn, Mel Sampson, Julia Davis-Wheeler, Doni Wilder, and many more. Tribal leaders and advocates that have given so much of themselves; people like Bernice Mitchell of Warm Springs who has served more than 50 years on council, was both a pleasure and an honor for Ed to speak with. I could take pages and fill them with the folks that have touched his life while he worked for the Board, but that would take me from my main point, and that is working for the Board was never simply a job for Ed, it was a passion. His passion is not only for a cause or the mission of the Board, it is also based in a reverence for the Northwest tribes, the leaders and people, and the cultures.

What is so significant about this fact about Ed? Quite simply it is the basis of how he managed the Board. From the moment he started at the Board, he sought opportunities to recruit and build up American Indians and Alaska Natives in their careers and embraced the tribes and their leadership as a treasure. Ed considered his work for the NPAIHB a privilege. He also shared this passion and reverence with Congressional staff, with federal agency heads, with university department heads, other Indian organizations, and tribes nationally! This facilitated their understanding of Indian health. This, coupled with his keen intellect, the breadth and depth of his knowledge of Indian health issues ranging from AIDS to Welfare helped us focus energy on refining the strong foundation developed by the Delegates and Ed's predecessors.

Under Ed's leadership, he took innovative programs started by Doni Wilder and Cheryle Kennedy and refined them further. As he did so, he always recognized Doni and Cheryle for their vision and leadership in the development of the Board's working environment. Doni began the initiative to allow employees to bring in their infant children to the office for the first six-months. Ed took this practice and initiated the process to formalize it into written policy. In this, Stella Washines recalls how Ed treated people and helped with the kids. She stated, "We all trusted him, it showed in how all the staff babies would go to him if their mom's were occupied." Something that my family and I have greatly appreciated!

Verne Boerner presenting Ed Fox with a blanket - a gift from her and her family.

Doni also championed extending health coverage benefits to employees' spouse and dependents based on the ethical grounds that as a health organization and one that strives to improve the health of Indian families and an Indian employer, providing health coverage to family members helps the Board to meet its mission. Ed also took this to the next level and sought coverage for domestic partners, not only for same sex couples, but he recognized that families in Indian families don't always meet the western legal definition of family. He was greatly moved by the support from the Delegates, which can best be summed in Bob Brisbois' comment that he made during the discussion of the motion to approve the policy. Bob simply said, "This is the only ethical thing to do."

It was Ed's immediate goal that the Board reflect the values of Indian people not just in appearance but in our actions, our policies and leadership. He sought project involvement in the development of the Board's

Edward J. Fox!

current strategic plan, which again he started with prior completed work and molded it to the tangible, marketable, meaningful document it is today. He utilized ad hoc staff committees that were employee lead to help him achieve this goal of refining a professional Indian organization.

One fine example is that Ed solicited employee input on the domestic partner coverage of health and dental programs via one such ad hoc committee. The employees showed interest immediately. They researched existing programs, the Board's contracts with our insurers and other options as to what was both allowed and what was required. They learned of issues such as tax implications to the beneficiary, legal requirements and terminology, and developed official documents such as affidavits and guidelines. It was both a learning opportunity and professional development opportunity at once. He initiated it but, more significantly, he let staff take ownership.

Ed also established the Stress Reduction Committee, which later became to be known as the Wellness Committee, this committee initially looked for ways to reduce or provide positive coping mechanisms for dealing with stress initiated in or affecting the workplace. This was another active committee that established items such as in office yoga classes, communal activities such as lunchtime movies and summer concerts, and the sunroom for those who do not have the benefit of a workspace location with direct access to natural daylight. A number of innovative proposals have been implemented through this program as a result.

As a leader, Ed also established the line of responsibility for one's professional development. It begins with the individual, moves on to the immediate supervisor, and then up the chain of command to the Executive Director and the Delegates. His leadership showed and demonstrated that we each have a responsibility in realizing the optimum from each staff member by recognizing his or her goals, objectives, skills and knowledge to his or her destination point, rather than relying on a single individual. It is a shared responsibility that starts with the individual and recognizes the obligations of each level of leadership along the way.

Ed learned from Cheryle that systems development is an important step in integrating an Indian organization into the allowable and legal mechanisms of western culture, regulation, and government. He picked up where she had left off by further developing hiring and personnel policies, human resources departments, and the finance department. These are no easy tasks and he acknowledged Cheryle's foresight in starting the systems development while at the Board. Cherlye had focused on items that would produce positive outcomes in our productivity levels as well as provide documentation that contributed to the board's reputation as a professional Indian organization as it also protected the organization legally.

While Ed learned from others and built on their good works, he did act independently and took great pride in his work. The list of Ed's contribution to the Board is long and distinctive. Just some examples include work and advocacy in: IHS Budget Formulation, IHS Budget Analysis, estate recovery issues, Centers for Medicare and Medicaid issues (including Medicaid Reform), Indian Health Care Improvement Act, many federal agency consultation policies, impacts of Welfare Reform, and a number of specific health issues and concerns. Many congressional and federal agency staff members have included language and conclusions of Ed's in their legislative drafts and policy proposals. His work has greatly contributed the Board's national prominence! The best aspect of Ed's work is that he always started with tribal sovereignty and he instilled in others that our Delegates and tribal leaders are dignitaries. Outside of Indian Country, this is a lesson greatly needed. Ed is very effective in teaching others this.

In closing, we are so appreciative of Ed's contributions to the Board and his leadership approaches. Ed is willing to learn from others. In all that he does, he is also willing to share what he has learned over the years. His goal is to build capacity within Indian Country to improve the health status and quality of life of American Indians and Alaska Natives. Thank you, Ed, we are sorry to see you leave NPAIHB as the Executive Director, but we are very happy that you continue our relationship and we look forward to working with you and the Nevada tribes in promoting understanding of Indian health concerns and issues.

The Sister Study Launches Major Effort to Enroll American Indian and Alaska Native Women for Landmark Breast Cancer Study

by Kim Varner, Sister Study

American Indian and Alaska Native women can play an important role in discovering the causes of breast cancer by joining or supporting the Sister Study. At the 2005 National Alaska Native American Indian Nurses Association (NANAINA) summit in Washington, D.C., the Sister Study announced its effort to attract additional, much needed participants in the study-- American Indian and Alaska Native women.

The goal of the Sister Study is to discover how our environment and our genes may affect the chances of getting breast cancer. By joining the Sister Study, American Indian and Alaska Native women whose sisters had breast cancer, can have a lasting impact on the fight against this disease. Conducted by researchers at the National Institute of Environmental Health Sciences, one of the National Institutes of Health of the U.S. Department of Health and Human Services, the Sister Study is enrolling 50,000 ethnically diverse women.

Women ages 35 to 74 are eligible to join the study if their sister (living or deceased), related to them by blood, had breast cancer; they have never had breast cancer themselves; and they live in the United States. American Indian and Alaska Native women who participate in the Sister Study can help leave an important legacy for future generations – a world where daughters, granddaughters and nieces don't have to experience breast cancer.

Breast cancer is the second leading cause of cancer death among American Indian and Alaska Native women. In recent years, their rate of death due to the disease has risen in certain areas of the United States, and the 5-year survival rate is lower than that of any other race or ethnicity of women. Yet, scientists have very little information on cancer histories in American Indian and Alaska Native families.

Sister Study participant Becky Dreadfulwater (Cherokee) enrolled in the Sister Study in honor of her sister who died from breast cancer. "The worst time in my life was sitting with my sister, Rosalee, who wasted away in body and mind every day," said the Oklahoma resident. "I felt so helpless because there was nothing I could do to cure her of this disease, but I think it's important to join the Sister Study and I look forward to being a useful part in this research."

Sisters may be the key to unlocking breast cancer risk mysteries. "By studying sisters, who share the same genes, often had similar experiences and environments, and are at twice the risk of developing breast cancer, we have a better chance of learning what causes this disease," said Dr. Dale Sandler, principal investigator of the Sister Study. "That is why joining the Sister Study is so important."

Joining the Sister Study is not difficult and can be done from home when it is convenient for participants. "At the beginning, women will answer some over-the-phone and written surveys and provide blood, urine, household dust and toenail samples," said Dr. Sandler. "Then we'll touch base once a year, for up to 10 years, to learn about changes to their address, health or environment." The Sister Study does not require participants to take any medicine, visit a medical center, or make any changes to their habits, diet or daily life.

Debra Smith, President of the National Alaska Native American Indian Nurses Association (NANAINA) said, "Breast cancer is one of the leading causes of death for American Indian/Alaskan Native women, so NANAINA is eager to partner with the Sister Study to identify native

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women who may be eligible for their study." She added, "As native nurses, we are acutely aware of the health care needs of women and their families, so we believe we have a responsibility to cooperate with other organizations to promote health and prevent disease in American Indian/ Alaska Native peoples."

The Sister Study needs American Indian and Alaska Native communities to help spread the word via their tribes, villages, places of worship, sororities, clubs, alumni associations, labor and professional organizations, civic organizations, and other non-profit organizations.
The Sister Study has a number of active nationwide partners including the American Cancer Society, the Susan G. Komen Breast Cancer Foundation, the National Center on Minority Health and Health Disparities, Sisters Network, Inc., and the Y-ME National Breast Cancer Organization.

To volunteer or learn more about the Sister Study, visit the web site www.sisterstudy.org or call toll free 1-877-4SISTER (877-474-7837). Deaf/Hard of Hearing call 1-866-TTY-4SIS (866-889-4747).

Risky Business: An Integrative Approach to Wellness and Risk Reduction

by Stephanie Craig, Project Director Project Red Talon

Tobacco use, physical inactivity, and risky behaviors cause most of the morbidity and mortality present in Indian Country – Cardiovascular Disease, Obesity, Diabetes, Cancer, Asthma, SIDS, and Sexually Transmitted Diseases. Acknowledging these underlying behaviors, the NPAIHB developed a Health Promotion and Disease Prevention training called "Risky Business," which takes an integrative approach to Tribal wellness and risk reduction.

The training will be collaboratively provided by several of the NPAIHB's Health Promotion Projects and Joe Law at IHS, and will include information about risk factors, behavior change, and effective prevention strategies.

Target participants: Tribal Health Directors, CHRs, health educators, nurses and other individuals doing community education.

2006 Risky Business Training schedule:

February 22, 2006 Warm Springs
March 29, 2006 Muckleshoot Tribal Wellness Center (Tentative location)
April 25, 2006 Coeur d'Alene Casino and Hotel (In conjunction with the NW Tribal Diabetes Conference)

Please contact Stephanie Craig Rushing at scraig@npaihb.org or Lisa Griggs at lgriggs@npaihb.org or 503-228-4185 for more information.

Executive Director Report Continued

Continued from page 3

not reduce outcomes. We continue to advocate for sufficient funding of the Indian Health Service budget so that tribes and the Board can maintain current services.

Personnel

As Verné had announced in her report last quarter, Liling Sherry did resign from her position at the Board. She is doing well in her transition to home life with her two young sons and is still involved with the project during the transition period. We are happy to have her continue to assist us.

I am happy to announce that Kerri Lopez, Western Tribal Diabetes Program Director, applied for Liling's position proposing an innovative approach to building capacity at the Board while providing professional development opportunities for many staff at the Board. Kerri will be directing both our Diabetes project and our Cancer Control project. This will create mentoring opportunities for her current staff which will include increased responsibility and cross training. She is supported by Verné Boerner, NPAIHB Administrative Officer, who oversees our health promotion and disease prevention projects, and Tom Becker, NPAIHB Medical Epidemiologist, as well as a talented staff pool in both the Diabetes and Cancer projects. We expect that the staff will rise to the challenge and new opportunities, growing and performing as they have in the past, with excellence!

Strategic Plan

This is the key document that I will use, holding myself and the NPAIHB Management Team accountable to meet the goals and priorities. We are on track to present a final draft for Board consideration and ratification at our upcoming quarterly board meeting. We utilize the Strategic Plan in our daily activities and appreciate the Delegates' commitment to the development of this document.

100 Best Companies to work for in Oregon

I am happy to announce the Board has achieved this designation for the second time since we started participating. The commitment of our member tribes, the leadership of our Delegates, and the dedication of our staff make this a great organization to work for!

UPCOMING EVENTS

February, 2006

February 3, 2006
American Indian Health Commission Meeting
Seattle, WA at the Seattle Indian Health Board
www.aihc-wa.org

February 6 - 8, 2006
Honoring the Gift of Heart Health Workshop
Oklahoma City, OK
http://www.nhlbi.nih.gov/health/prof/heart/other/aian_manual/index.htm

February 7 - 9, 2006
Indigenous Suicide Prevention Research and Programs in Canada and the United States: Setting a Collaborative Agenda Conference
Albuquerque, NM

February 13-16, 2006
Affiliated Tribes of Northwest Indians
Portland, Or
www.npaihb.org

February 22-23, 2006
Idaho State Tribes Meeting
Boise, ID

February 27 – March 1, 2006
National Congress of American Indians Winter Session
Washington, DC
http://www.ncai.org/

March, 2006

March 7 – 9, 2006
FY 2008 National Budget Meeting
TBD

March 10, 2006
National Divisional Tribal Budget Formulation and Consultation Session
Washington, DC

April, 2006

April 2-5, 2006
National American Indian Conference on Child Abuse & Neglect
San Diego Marriott – Mission Valley, San Diego, CA
http://www.nicwa.org/

April 11 - 12, 2006
Tribal Self Governance Advisory Committee Quarterly Meeting
Nashville, TN

April 18-20, 2006
Northwest Portland Area Indian Health Board QBM
Ocean Shores, WA

April 26, 2006
Direct Service Tribes Advisory Committee Meeting
Albuquerque, NM

Welcome to the HR Corner!

by Chandra Wilson, Human Resource/Special Projects Assistant

The Human Resource Management (HRM) department of the Board would like to take the time to introduce itself. HRM belongs in all organizations. Human resource activities involve people, and people make an organization. Here at the board, 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. For the HRM department, our goal is supportive of the overall mission by improving employee relations and the Board's working environment.

The idea of the HR corner in the Board newsletter is to inform our member tribes of some of the HRM activities that the Board engages in to create a productive and supportive work environment, that is also reflective of a tribal organization and the values set forth by our Delegates in our Strategic Plan.

One such example is our Safety Committee, which keeps our office in compliance with Occupational Safety and Health Act (OSHA) regulations and ensures a safe working environment for our staff, their children, and our guests. Another example is providing training to staff on various HR issues including preventing and addressing harassment, effective supervision approaches, meaningful performance evaluation, and other employee human relations. The Board has had the honor of being one of the 100 Best Companies to work for in Oregon. HR provides our staff the opportunity to participate proactively in creating and maintaining such an environment.

HRM is a vital component of a healthy and productive organization. I have hopes that these articles will become a useful tool for growth, , not only the Board, but also to the departments and entities of our member tribes.

Feel free to provide comments and or healthy feedback to our HR department by contacting Chandra Wilson, HR Assistant at 503.228.4185 ext 297 or by email at cwilson@npaihb.org

HR Tidbit:

The Occupational Safety and Health Administration is the regulatory arm of the US Department of Labor, which promulgates safety and health standards, facilitates training programs, and enforces regulations on work sites. The Department of Labor publishes a website that allows your HR professionals to register and create their own "MyOSHA" webpage that is customized to your organization's needs. To register just visit the website at www.OHSA.gov.

New NPAIHB Employee

Michelle Edwards joined the *EpiCenter* as the Development Specialist in November 2005. Michelle is originally from Prescott, a small town in Arizona. In 2002 she moved to Tucson to attend the University of Arizona where she studied Psychology and Women Studies, primarily focusing on disparities in mental and physical health. Before joining the Board, Michelle was working with the Arizona Cancer Center - University of Arizona as a Program Coordinator in the Cancer Prevention and Integrative Medicine Office. She has experience coordinating grant submissions, research/office administration, publication assistance, IRB, conference planning, etc. Prior to her employment with the Arizona Cancer Center she worked with the USDA Forest Service. Michelle has an ardent interest in behavioral research and community medicine; she is devoted to supporting efforts to increase health promotion and research.

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.

Resolutions
October, 2005

Resolution # 06-01-01
Support for Methamphetamine Conference Grant Application

Resolution # 06-01-02
In support of CDC funding opportunity PS06-604, entitled "Translating Proven Interventions for Underserved and Emergent High-Risk Populations"

Resolution # 06-01-03
Support for Funding Application by the Northwest Tribal Cancer Control Project (NTCCP) to the Susan B. Komen Breast Cancer Foundation Community Grant

Resolution # 06-01-04
Tsunami Preparedness Act: Senate Bill 50

Resolution # 06-01-05
Support Grant to the NIAAA to Address the Effects of Underage Drinking in Northwest Tribal Communities

Resolution # 06-01-06
Addressing Sexually Transmitted Diseases in the American Indian/Alaska Native Population