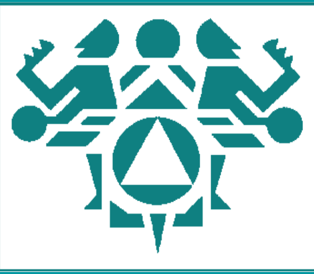


Health News & Notes

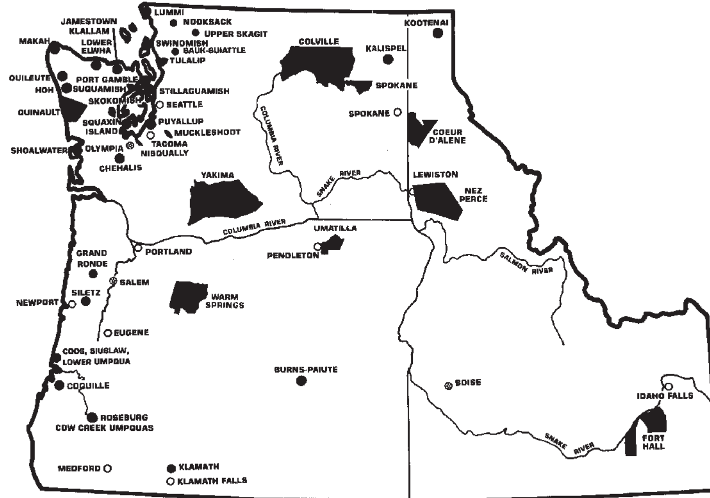
A Publication of the
Northwest Portland Area Indian Health Board

July, 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.

IHS Regional Facility Planning Meeting

Doni Wilder,
Portland Area Indian
Health Service Director



Doni Wilder (Portland Area IHS Director) and
Joe Finkbonner (NPAIHB Executive Director)
were facilitators at the June 16, 2006 IHS regional
facility planning meeting. Article on page 4.

From the Chair:
Linda Holt

Northwest Portland Area Indian Health Board

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Marilyn Scott, Upper Skagit Tribe
Janice Clements, Warm Springs Tribe
Stella Washines, Yakama Nation

I certainly hope everyone is enjoying the nice summer months and taking time to be with family and friends. This is the time of year when many of our gatherings and cultural events take place and it is important that we all take time to participate and understand its significance in preserving our culture and who we are as Indian people.

I want to take this opportunity to provide you an update on two important legislative matters facing Indian health. The reauthorization efforts of the Special Diabetes Program for Indians (SDPI) and the Indian Health Care Improvement Act (IHCIA) are two of the most important issues affecting Tribes today. Fortunately, we are seeing movement on both of these important legislative matters.

In April the Tribal Leaders Diabetes Committee (TLDC) met in Reno to discuss activities associated with the Special Diabetes Program for Indians (SDPI). This particular meeting was important in that the TLDC adopted changes to its charter by including expanded responsibilities for other chronic disease issues besides diabetes. It also expanded its membership to allow advisory capacity members from national Indian organizations (National Congress of American Indians, National Indian Health Board, Tribal Self-Governance Advisory Committee, National Council of Urban Indian Health, and the Direct Service Tribes Advisory Committee). It is important to note that voting privileges associated with TLDC participation are restricted to Tribal leaders and the national organizations will serve solely to provide advice and input and not have voting privileges on issues the TLDC deliberates.

The TLDC also recognized that efforts need to begin to reauthorize the special statutory funding that authorizes the SDPI. These critical programs expire October 1, 2008 and Indian Country needs to begin the important work to renew these programs. Understandingly, the TLDC is limited in its advisory role to the IHS Director and a separate body is needed to organize and oversee the reauthorization of this program. In response to this need, the Juvenile Diabetes Research Foundation (JDF), American Diabetes Association (ADA), and NIHB held a stakeholders meeting in Washington, D.C. to develop a strategy to guide the reauthorization process. Both, JDF and the ADA, were instrumental in passing previous SDPI legislation and will play a key role in renewing the authorization for diabetes funding in Indian Country.

The meeting included presentations from the National Institutes of Health and IHS on diabetes issues affecting Indian people. Former Congressman George Nethercutt

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From the Executive Director:

Joe Finkbonner

It has been a busy quarter, especially since we are still searching to fill our EpiCenter Director position. Filling this position has been a challenging endeavor and we want to make sure we select a candidate that is the best fit for our program and Northwest Tribes. I hope to introduce you to the successful candidate at the Quarterly Board Meeting in October. The beginning of this quarter I attended the DHHS Region X Tribal Consultation in Anchorage, Alaska and was accompanied by Sonciray Bonnell and Jim Roberts. The critical issues discussed during the consultation session included the Indian Health Service (IHS) budget, Medicare and Medicaid concerns, methamphetamine issues, TANF reauthorization, emergency preparedness and pandemic flu planning, preparation for CDC's new Tribal Consultation Advisory Committee, and Title VI Self-Governance expansion for other HHS programs.

I also participated in the HHS Department-wide Budget Consultation meetings held in May in Washington, D.C. Pearl Baller and I both provided testimony on Tribal research needs and issues that the National Institutes of Health (NIH) could address on behalf of Tribes. We provided recommendations around eight specific topics that NIH could work with Tribes. These items included research needs associated with substance abuse addictions and treatment, diabetes, outcomes data with inaccessibility to state block funding, long-term and elder care issues, outcome data associated with unmet needs and health disparities, recruitment and retention of health professionals, and other issues like access to care, domestic violence, and assessing the impact of denied and deferred services in the Contract Health Service program. The Board also recommended that NIH organize a Technical Tribal Advisory Group modeled after the CMS-TTAG to provide advice and guidance on research and funding issues that affect Tribes. Our message seemed well received by CMS and we will continue to track our recommendations.

On May 10, 2006, the Board met with Dr. Grim at the Tribal Self Governance Advisory Committee Meeting in Acme, MI. Linda Holt, Jim Roberts, and I met with the IHS Director to discuss a number of important issues to Northwest Tribes. Our meeting included Indian health financing issues (IHS budget and Medicare/Medicaid), Section 813 non-beneficiaries concerns, Contract Support Cost funding for new and expanded programs, and language concerns that IHS is making a condition of 638 agreements, grandfathering issues associated with the new Health Facilities Construction Priority System, and reauthorization for the Indian Health Care Improvement Act and Special Diabetes Program

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Northwest Portland Area Indian Health Board

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Project Red Talon
Stephanie Craig, Project Director
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IHS Regional Medical

by Sonciray Bonnell, Health Resource Coordinator

Congressional language – FY 2000 Conference Report, Interior Appropriations Bill

"The Service should work closely with the tribes and the Administration to make needed revisions to the facilities construction priority system. Given the extreme need for new and replacement hospitals and clinics, there should be a base funding amount, which serves as a minimum annual amount in the budget request. Issues which need to be examined in revising the current system include, but are not limited to, projects funded primarily by the tribes, anomalies such as extremely remote locations like Havasupai, recognition of projects that involve no or minimal increase in operation costs such as the Portland Area pilot projects, and alternative financing and modular construction options. The Service in re-examining the current system for construction of health facilities, should develop a more flexible and responsive program that when developed will more readily accommodate the wide variances in tribal needs and capabilities."

On June 16, 2006, Northwest Tribal Representatives, Portland Area Office (PAO) Indian Health Service staff, and Northwest Portland Area Indian Health Board (NPAIHB) staff met in Seattle, Washington to discuss the concept of a Portland Area regional medical facility. NPAIHB and PAO initiated the meeting to identify tribal issues and concerns and to see if there was Tribal support for the concept. There are two existing resolutions from NPAIHB and the Affiliated Tribes of Northwest Indians supporting the concept. If Northwest tribes decide to go forward with this idea it is essential that PAO identify key tribal representatives who are willing and able to work on the planning phases. That work would take place this summer with a decision to proceed to a full scale project justification document (PJD) this fall.

The Facility Construction Priority System (FCPS), the IHS formula that determines which medical facilities are funded, has long been criticized for not equitably assisting all Areas. The current formula is weighted toward larger facilities such as hospitals and large clinics which are not feasible for Portland Area Tribal communities. Significantly, the current FCPS already has facilities on the list that are not likely to be funded for over thirty years. The Portland Area has worked long and hard to develop alternative funding mechanisms to build clinics outside the IHS priority system. Unfortunately, the reward for creativity is inadequate support for the most costly aspect of facility expansion and replacement--the staffing package. Staffing packages are recurring dollars that are worth more than ten times the actual value of new facility construction (one time appropriations) noted Rich Truitt, PAO Office of Environmental Health and Engineering.

Rich Truitt, PAO Offfice of Environmental Health and Engineering

While not every tribe is going to get equal benefits from a Regional Facility, the long term goal would be three regional facilities located to provide maximum benefit for Portland Area Tribes. While a regional facility would bring patients to a centralized location, it could also allow providers from the regional facility to hold specialty clinics at outlying Indian health facilities.

Facility Planning Meeting

FAAB

The Facilities Appropriations Advisory Board (FAAB) is an IHS workgroup with tribal representation from each area that makes recommendations to the Director on facility issues. The FAAB was asked by the Director to take the lead in assisting the Agency to respond to the Congressional directive quoted at the beginning of this article. To address this task, the FAAB appointed a Facility Needs Assessment Workgroup whose charge was to review the present facilities construction system, suggest mechanisms to identify the total need, and to finally make recommendations to the FAAB. The Facility Needs Assessment Workgroup recommended that reach IHS Area develop a Facility Master Plan and a concept paper for prioritization process for new facilities. Over the past few years Portland Area FAAB representatives included Julia A. Davis-Wheeler, Tribal Council Member, Nez Perce Tribe; Rod Smith, Tribal Health Director, Puyallup Tribal Health Authority; and currently Cecile Greenway, Tribal Health Director, Lower Elwha Tribe.

Master Plans

Each IHS Area was given only $150,000 each to develop their master plan. All forty-three tribes are represented in the Portland Area Master Plan. The Portland Area Master Plan indicated that given the proposed FCPS criteria, a regional facility in the Portland Area is most likely to score high enough to be placed on a new IHS Facility list.

Gene Kompkoff, PAO Office of Environmental Health and Engineering

Why a Regional Facility

Potential benefits of a regional facility include significant savings in Contract Health Services (CHS), increased third party collections, promote local jobs, increased ability to attract other funding and services, and new direct services for non-CHS eligibles. By capturing economies of scale, a regional facility could likely offer some carefully identified specific services to tribes at a lower cost.

Some important statistics to remember when considering a Northwest regional facility: in the last ten years FY 99-FY06 Congress appropriated $569,199,830 for health care facility construction—a one time appropriation. Congress has also funded $195,184,000 million for staffing packages for those new facilities, funds that recur each year as part of the base budget for that new facility. Since 1993 not a penny of recurring staffing dollars has come to the Portland Area. Staffing generates third party collections, a critical component of NW tribal clinic ability to operate.

A Tribal Health Director Panel which included Rod Smith, Tribal Health Director for Puyallup Health Authority; Leslie Dye, Chief Executive Officer, Neah Bay Service Unit; John Stephens, Tribal Health Director for Swinomish Tribe, and Steve Gobin, Tribal Health Director for Tulalip Tribes indicated strong support for all PAO tribes accessing a mail order pharmacy from a Regional Facility. Most agreed that prescriptions are a huge drain to many tribal clinic CHS budgets. Tribes could also propose physical therapy and transportation costs as part of the list of services that a regional facility could provide.

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Regional Facility Planning Meeting Continued

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Other issues brought up by the Tribal Health Director Panel include: tribes have already spent money to build facilities and provide (supplement) medical services, huge unmet urban need, concerned for lack of service to tribal members because they spend it on direct care, and one panelist shared that less than half of their CHS money goes to tribal members.

"We have little to lose and much to gain. A Regional Facility would bring in new money and if it doesn't come to the Portland Area, it will go somewhere else; and there is the substantial potential for third party income generation."
Doni Wilder,
Portland Area Indian Health Service Director

Potential or Risk
One of the first items for discussion was our chances of getting funding for a regional facility, considering that the FAAB estimates it will take between thirty and sixty years to get through the current facilities list. A related question, one that has not yet been answered by Dr. Grim, is how will tribes currently on the list be grandfathered into the system or not.

If a new Facility Construction List is created, the Portland Area could benefit from getting on the list without yet knowing the details of location, services, or one large versus three small facilities; though the IHS Portland Area Health Services and Facility Master Plan data suggests that the best chance the Portland Area has to score high on the new list is a Regional Facility in the Puget Sound Area.

Location
Of course, much was discussed about the location of a regional facility. Northwest tribes could decide to build three satellite facilities instead of one regional facility. The proposed locations are the Puget Sound Area, Portland, and Spokane. The service population of the facility would change over time as first one then another and finally three become operational. The first facility would be charged with serving all of the Northwest with true regionalization of services only after a second and then third facility come online. What was clear from this planning meeting was that Northwest tribes want to position ourselves in a way that gets us a place high on a new IHS facility list and more discussion on the issues needs to take place.

Future
It makes some sense to gamble our time and effort on something that might not even come to fruition, but what a worthwhile and potential benefit for our communities. Those of us at this historic meeting might not ever see a regional IHS facility in the Northwest in our life times, but wouldn't it be wonderful to be a part of a meeting that brings such a facility to our children and their children. We are known for thinking ahead and not being afraid of taking risks.

"It's not so much where this facility or facilities will be located, but what services are provided so the maximum number of communities can benefit."
Joe Finkbonner,
NPAIHB Executive Director

Western Tobacco Prevention Project Renews Contract With WA State Department of Health

by Brandy Moran, Western Tobacco Prevention Project Coordinator

The Western Tobacco Prevention Project (WTPP) has worked closely with the Washington State Department of Health under a contract for the past two years now. In this contract, the WTPP provides additional training and technical assistance to specifically address the (state the needs here) of Washington Tribes. The Western Tobacco Prevention Project is pleased to announce that it has recently renewed this contract with the Washington State Department of Health for the third year. The contract begins on July 1, 2006 and will continue through June 30, 2007.

In every contact, the WTPP coordinates two tribal tobacco program coordinators meeting every year. We have also started working on youth and media projects which will continue throughout the following contract. The WTPP has also conducted annual needs assessments with Washington Tribes to ensure that the work in the contract is addressing the actually needs of the Tribes.

While continuing the collaboration with the American Lung Association of Washington to revise the Teens Against Tobacco Use (TATU) curriculum and pressing on with the Media Campaign, the WTPP is excited to begin taking on the coordination of the Policy Track for the Many Voices Conference in October of this year. Due to the fact the WTPP has already been focusing strongly around Policy Work with NW Tribes, it seemed appropriate for the project to take on this task and the Washington State Department of Health was highly supportive of this activity. The Many Voices conference will take place on October 12 and 13, 2006 in Clarkston, Washington. More information about this conference will be coming soon.

If you have any questions or concerns please feel free to contact me at (503) 228-4185 or at bmoran@npaihb.org.

Senate Action on FY 2007 IHS Budget

by Jim Roberts, Policy Analyst

On June 29th, the Senate approved its FY 2007 Interior and Related Agencies Appropriations bill (H.R. 5386). The bill provides $26.1 billion in appropriations for the Department of the Interior (DOI) agencies and the Indian Health Service (IHS). The Senate approved bill provides over $3.2 billion for IHS and Tribal health care programs—a 4.8 percent increase ($147 million) over the final FY 2006 enacted level. The President's FY 2007 request for the IHS was $124.4 million (a 4.1 percent increase) over last year's spending level.

Earlier this year, the House approved a similar version of the FY 2007 Interior-related Agencies bill by providing $25.9 billion for DOI agencies. The House mark provided a 4.9 percent increase for IHS programs, while the Senate provides a 4.8 percent increase. The differences in the House and Senate bills lie in funding levels for the Hospital/Health Clinic and Health Facilities Construction budget line items and the recommended amount of "fixed cost decreases." The House recommended fixed cost decreases of $37 million, while the Senate recommended $20 million. The House bill provides $36.6 million for Health Facilities Construction, while the Senate provides $27.6 million. After these variances in funding are factored, the Senate bill provides $19 million more than the House approved amount of $148.4 million.

FY 2007 IHS Budget - Summary of Action		
(Dollars in Thousands)	**House** (H. Rpt. 109-465)	**Senate** (S. Rpt. 109-275)
Appropriations, FY 2006	$ 3,045,310	$ 3,045,310
President Request, 2007	$ 3,169,787	$ 3,169,787
Recommended*	$ 3,193,709	$ 3,192,831
Comparison:		
Appropriation, 2006	$ 148,399	$ 147,521
President's Request, 2007	$ 23,922	$ 23,044
House Difference		$ 878
* After "Fixed Cost Decreases"		

Interestingly, this year Congress devised a different mechanism to comply with budget spending caps. In previous years, Congress applied across-the-board cuts or recessions. This year, Congress applied "fixed cost decreases" in lieu of previous year's cuts and recessions. Whatever they are called, the effect of these actions is the same, it ultimately means less funding for Indian health care by eroding the IHS base budget. Over the last three years, IHS programs have averaged slightly more than a $107 million increase in Congressional appropriations. Over this same period, the agency has lost at least $41 million a year due to cuts or rescissions. This year the House recommended fixed cost decrease is $37 million, while the Senate decrease is $20 million. It is expected when House and Senate conferees meet to compromise the differences in the bill that the cut will be between $30 to $35 million. In the end, the House approved bill provides $878,000 more than the Senate approved amount.

Other key changes to the IHS budget request include restoration of $32.7 million for the Urban Indian Health Program and $300,000 for the Indian Health Board of Nevada. Conference report language underscores

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FY 2007 Indian Health Service Budget

Comparing President's Request to House & Senate Action

	PRESIDENT'S REQUEST		HOUSE ACTION WITH FIXED COST DECREASES					SENATE ACTION WITH FIXED COST DECREASES				
	Final Enacted FY 2006	FY 2007 President's Request	H. Rpt. 109-465 Recommend.	Fixed Cost Decreases[1]	FINAL HOUSE MARK	Difference versus Enacted	% Change versus Enacted	S. Rpt. 109-275 Recommend.	Fixed Cost Decreases	FINAL SENATE MARK	Difference versus Enacted	% Change versus Enacted
Services:												
Hospitals & Health Clinics	$ 1,339,539	$ 1,429,772	$ 1,439,047	$ 15,099	$ 1,423,948	$ 84,409	6.3%	$ 1,430,072		$ 1,430,072	$ 90,533	6.8%
Dental Health	$ 117,731	$ 126,957	$ 126,957	$ 1,185	$ 125,772	$ 8,041	6.8%	$ 126,957		$ 126,957	$ 9,226	7.8%
Mental Health	$ 58,455	$ 61,695	$ 61,695	$ 616	$ 61,079	$ 2,624	4.5%	$ 61,695		$ 61,695	$ 3,240	5.5%
Alcohol and Substance Abuse	$ 143,198	$ 150,634	$ 150,634	$ 1,827	$ 148,807	$ 5,609	3.9%	$ 150,634		$ 150,634	$ 7,436	5.2%
Contract Health Services	$ 517,297	$ 554,259	$ 554,259	$ 11,633	$ 542,626	$ 25,329	4.9%	$ 554,259		$ 554,259	$ 36,962	7.1%
Sub-total, Clinical Services	*$ 2,176,220*	*$ 2,323,317*	*$ 2,332,592*	$ 30,360	$ 2,302,232	$ 126,012	5.8%	$ 2,323,617	$ -	$ 2,323,617	$ 147,397	6.8%
Preventive Health:												
Public Health Nursing	$ 48,959	$ 53,043	$ 53,043	$ 454	$ 52,589	$ 3,630	7.4%	$ 53,043		$ 53,043	$ 4,084	8.3%
Health Education	$ 13,584	$ 14,490	$ 14,490	$ 155	$ 14,335	$ 751	5.5%	$ 14,490		$ 14,490	$ 906	6.7%
Community Health Representatives	$ 52,946	$ 55,790	$ 55,790	$ 682	$ 55,108	$ 2,162	4.1%	$ 55,790		$ 55,790	$ 2,844	5.4%
AK Immunization	$ 1,621	$ 1,708	$ 1,708	$ 20	$ 1,688	$ 67	4.1%	$ 1,708		$ 1,708	$ 87	5.4%
Sub-total, Preventive Health	*$ 117,110*	*$ 125,031*	*$ 125,031*	$ 1,311	$ 123,720	$ 6,610	5.6%	$ 125,031		$ 125,031	$ 7,921	6.8%
Other Services:												
Urban Health	$ 32,744	$ -	$ 32,744	$ -	$ 32,744	$ -	0.0%	$ 32,744		$ 32,744	$ -	0.0%
Indian Health Professions	$ 31,040	$ 31,697	$ 31,697	$ 244	$ 31,453	$ 413	1.3%	$ 31,697		$ 31,697	$ 657	2.1%
Tribal Management	$ 2,394	$ 2,488	$ 2,488	$ 38	$ 2,450	$ 56	2.3%	$ 2,488		$ 2,488	$ 94	3.9%
Direct Operations	$ 62,194	$ 63,804	$ 63,804	$ 132	$ 63,672	$ 1,478	2.4%	$ 63,804		$ 63,804	$ 1,610	2.6%
Self Governance	$ 5,667	$ 5,847	$ 5,847	$ 64	$ 5,783	$ 116	2.0%	$ 5,847		$ 5,847	$ 180	3.2%
Contract Support Costs	$ 264,730	$ 270,316	$ 270,316	$ 2,234	$ 268,082	$ 3,352	1.3%	$ 270,316		$ 270,316	$ 5,586	2.1%
Sub-total, Other Services	*$ 398,769*	*$ 374,152*	*$ 406,896*	$ 2,712	$ 404,184	$ 5,415	1.4%	$ 406,896	$ -	$ 406,896	$ 8,127	2.0%
Total, Services:	*$ 2,692,099*	*$ 2,822,500*	*$ 2,864,519*	*$ 34,383*	*$ 2,830,136*	*$ 138,037*	*5.1%*	*$ 2,855,544*	*$ 20,000*	*$ 2,835,544*	*$ 143,445*	*5.3%*
Facilities:												
Maintenance and Improvement	$ 51,633	$ 52,668	$ 52,668	$ 414	$ 52,254	$ 621	1.2%	$ 52,668		$ 52,668	$ 1,035	2.0%
Sanitation Facilities Construction	$ 92,143	$ 94,003	$ 94,003	$ 744	$ 93,259	$ 1,116	1.2%	$ 94,003		$ 94,003	$ 1,860	2.0%
Health Care Facilities Construction	$ 37,779	$ 17,664	$ 36,664	$ -	$ 36,664	$ (1,115)	-3.0%	$ 27,664		$ 27,664	$ (10,115)	-26.8%
Facil and Env Hlth Support	$ 150,709	$ 161,333	$ 161,333	$ 1,287	$ 160,046	$ 9,337	6.2%	$ 161,333		$ 161,333	$ 10,624	7.0%
Equipment	$ 20,947	$ 21,619	$ 21,619	$ 269	$ 21,350	$ 403	1.9%	$ 21,619		$ 21,619	$ 672	3.2%
Total, Facilities:	*$ 353,211*	*$ 347,287*	*$ 366,287*	*$ 2,714*	*$ 363,573*	*$ 10,362*	*2.9%*	*$ 357,287*	*$ -*	*$ 357,287*	*$ 4,076*	*1.2%*
TOTAL, IHS	**$ 3,045,310**	**$ 3,169,787**	**$ 3,230,806**	**$ 37,097**	**$ 3,193,709**	**$ 148,399**	**4.9%**	**$ 3,212,831**	**$ 20,000**	**$ 3,192,831**	**$ 147,521**	**4.8%**

Elder Abuse in Indian Country

by Chandra Wilson, Human Resource Specialist

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Congress' commitment to support the urban programs and directs the IHS to refrain from eliminating any urban programs until Congress has completed its FY 2007 budget negotiations. The Senate also designed $15 million for alcohol prevention and treatment programs in Alaska. The Senate language also addresses the mental health needs of Indian Country by encouraging tele-health technology and ongoing collaborations with the Substance Abuse and Mental Health Services Administration to address the needs of at risk youth.

While the Senate bill provides adequate increases for the IHS budget and restores badly needed funding for the Urban Indian Health Programs it will continue to fall short of funding mandatory costs of current services. In FY 2007, the NPAIHB estimated that it will take at least $436 million to maintain mandatory costs of inflation, population growth, and other administrative costs associated with operating health programs. The Senate approved increase of $147 million will fall short by over $289 million. This means that IHS and Tribes will be faced with severe budget shortfalls as they balance the need to provide services and maintain the financial solvency of operating health programs.

A clear definition of abuse is the basis of any tribal code. It should be clear so as not to extend beyond the spirit intended, yet broad enough so that protection is not limited or victims do not fall through the cracks. ***"Abuse or neglect" means abuse, sexual abuse, exploitation, neglect, or self-neglect.***

Elder abuse is an issue and concern throughout Indian Country. Often our elders are not aware or clear of what constitutes abuse. What we do know is that our elderly population is growing, and if we don't address the issues within our tribal communities or provide services to our elders to protect them from the abuse, our tribal communities and elders will suffer poorer health status and decreased quality of life.

I serve as the staff member on the Elder's Committee and our Delegates constantly express their concerns about elder abuse in their communities. Elder abuse is such a broad area to address particularly since many don't know how to identify it in their community. The data is not very descriptive, particularly since many either don't recognize that they are being abused or are reluctant to report such abuse. The first step is to build overall community awareness of elder abuse and investigate existing elder abuse codes. Eventually, as each tribe develops their own system and implements it in their public safety branches, the overall community awareness will rise as a result.

NPAIHB is aiming to host a Northwest Tribal Elder's Conference this fall or winter. The conference will focus on health and well being of tribal elders. We anticipate having sessions in the areas of health education in cancer screenings, STD/HIV, fitness, diabetes, methamphetamine impact on elders, wills and/or directives, and elder abuse.

The health status and safety of our elders should be a commitment to all tribal communities. They are our teachers; their wisdom should be preserved and passed down from generation to generation. We are responsible for protecting them, and keeping our community circle healthy.

For more information on Elder's Abuse directives please contact Chandra K. Wilson at 503.228.4185 or cwilson@npaihb.org

From the Chair:
Linda Holt - continued

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(WA) covered a history of the SDPI funding in past legislative sessions. Congressman Nethercutt was instrumental in passing past legislation. He also discussed the fiscal realities of achieving reauthorization in the current political climate and a legislative strategy for ensure success. The stakeholders agreed that a reasonable financial objective for the new legislation would be $200 million a year for five years. This is an increase of $50 million a year in the current program. Recommended follow up activities included a national Tribal consultation session to identify legislative objectives for the new diabetes legislation. It is expected that this session would occur sometime this summer. The goal is to have a draft of the legislative priorities by October in order to share at the NIHB's Annual Consumer Conference. The Board and I will continue to be active in moving this very important issue.

The month of June was a very important month for reauthorization of the Indian Health Care Improvement Act. Over the past weeks, the IHCIA National Steering Committee has been working with Senate Committee on Indian Affairs and Finance Committee staff to relocate provisions from Title IV of the IHCIA (S. 1057) as amendments to the Social Security Act (SSA). The Title IV provisions are those that directly affect Medicare, Medicaid, and SCHIP and relocating them as amendments to the SSA is viewed as a good strategy by the National Steering Committee. The strategy accomplishes two objectives. First, the proposed relocation of the Title IV provisions to the Social Security Act is a good as the subject matter directly impacts Medicare, Medicaid and SCHIP. By including them as amendments to the SSA, it will give them greater visibility and enhance the likelihood of implementation by CMS. It will also ensure compliance by the States. A second objective is accomplished in that the Finance Committee moving the Title IV provisions as an amendment to the SSA, allows S. 1057 to move onto the Health, Education, Labor, and Pensions (HELP) Committee. The HELP Committee is the last Senate committee that has jurisdiction over the bill and it is expected that these negotiations can be wrapped up easily.

I am happy to report that the Finance Committee did complete its mark on the IHCIA reauthorization provisions under its jurisdiction. All of the Title IV issues were addressed favorably and validated the strategy of the National Steering Committee to move the provisions as a separate legislative vehicle. The Finance Committee created a new bill that includes the Title IV provisions that were rewritten by the National Steering Committee and Finance Committee staff. The new bill is entitled the Medicare, Medicaid and SCHIP Indian Health Care Improvement Act of 2006. It was passed unanimously by the Finance Committee. It is expected that S. 1057 will make it to the floor of the Senate at which point Senator McCain will offer an amendment to include the work of the Finance Committee so that all the parts of the IHCIA bill are included as one comprehensive package once again.

As we all realize, Representative Don Young (AK) has introduced a companion bill to reauthorize the IHCIA in the House. There is still much work to do on the House side and the committee referral process is more complicated there. We can expect to meet many of the same objections that we had in moving S. 1057 in the Senate and it will take a tremendous effort by Tribal leaders to ensure passage in the House. The fall elections and Congressional agenda will complicate matters. It is important that we as Tribal leaders begin to work members of the House to let them know how important it is that this legislation gets passed in the Congressional session.

In closing, I want to thank delegates for attending the April meeting at Quinault. We had a wonderful turnout and a very successful meeting. The discussion was heated at times but the issues facing our people are important and I am glad that we could discuss such matters in a positive and productive manner. My thanks to the Quinault Nation for hosting our meeting and I look forward to our meeting in Coeur d'Alene in July!

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for Indians (SDPI). We also took the opportunity to share some of the IRB and data concerns related to the SDPI competitive grant program that were discussed at the last Board meeting.

The Board continues to work on expansion of its programs in the EpiCenter. The Board recently completed its renewal application to the IHS to fund the EpiCenter. The core activities in our application will continue to be surveillance for disease conditions, epidemiologic analysis, interpretation, and dissemination of surveillance data for Northwest Tribes. Earlier this year the EpiCenter received a grant from the HHS Office of Minority Health (HHS-OMH) to develop a data into action project. The project will assess how Portland Area tribes utilize data obtained in previous research projects and other data sources available to them to transform "data into action" and develop programs for intervention. The project intends to evaluate the barriers that Portland Area Tribes face in fully utilizing data sources available to them by conducting assessments of six to ten tribes in the Portland Area. The results will be presented to HHS-OMH with the hope of developing a larger funding opportunity for the agency around research and data needs of Tribes. The Board is in the process of staffing two positions for this project.

The EpiCenter was also awarded a grant from CDC to develop a Tribal EpiCenter Project with the California and Oklahoma Area EpiCenters. The Board is in the process of negotiating for a Project Director and Outreach and Training Coordinator for this effort. We hope to be able to introduce to delegates the individuals selected for the jobs at the next Board meetings.

I also want to take this opportunity to welcome a familiar face back to the Board. Peggy Biery has accepted a job and will be our new RPMS Support and Diabetes Training Specialist. Peggy will be responsible for providing RPMS technical support to Tribes and coordinating RPMS trainings. She will also provide DMS support to Tribal diabetes programs and work closely with the Diabetes Project.

Finally, I want to take this opportunity to say "good-bye" to Dr. Josh Jones who has worked the last three years as our Epidemiologist. Josh will be moving to Chicago to be with his fiancée, Amanda, where she has chosen to complete her residency program.

NOTES

New NPAIHB Employees

Hello, my name is Matthew Town (Choctaw) and I am the new Project Coordinator for the Northwest Tribal Cancer Navigator Program. I am an enrolled member of the Choctaw Nation of Oklahoma. My parents are Alan and Carrie Town. My father, Alan, is the third of seven children of Jess Town (Choctaw) and Jane Olney-Town (Yakama). My mother, Carrie, is the second of three children of Duane and Millie Moffenbier originally from Aberdeen, South Dakota. My sister, my only sibling, lives in Salem, Oregon as do my parents.

I grew up in Rapid City, South Dakota and have since lived in various places throughout the world. I obtained my Bachelors of Science in Sociology from Black Hills State University in 2001. I then moved to Oregon to pursue a graduate degree. I am a graduate of the Department of Public Health at Oregon State University with a Masters in International Health. I have spent time working in the area of education as a health education in Tanzania and as an adjunct faculty member at Western Oregon University. Recently, I have spent time working with the Tribes of the Northern Plains as a staff member of the Aberdeen Area Tribal Chairmen's Health Board.

When I am not busy, I advocate for youth development and have spent much of my life mentoring and teaching youth. I am a former gymnast and gymnastics coach, but have spent time coaching other sports such as swimming, rock climbing, and track & field. I enjoy spending time with my family, camping, music, and traveling.

I am excited to be back in the Northwest and look forward to working with the Tribes of the Northwest.

Hi my name is Debi Creech and I have recently been hired to fill the Accounts Payable/Payroll position here at NPAIHB. I am excited about working here and being a part of such a great organization. I am originally from Southern California. When I was seven years old my family and I moved to Reno, where I lived for twenty-five years. I met and married my wonderful husband Dwayne there and I am happy to share that we've been married for twenty-seven years. We have two beautiful daughters, Nicole (22), Breanna (12), and a busy, but very cute 2 year old granddaughter Madison. We have lived in the Gresham area, where my husband grew up, since 1992. I enjoy traveling, the outdoors (especially the beach), reading, but most of all, I enjoy being with my family.

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.

Northwest Portland Area Indian Health Board

Resolutions

06-03-01 Support for the Renewal Application for the Northwest EpiCenter

06-03-03 Support the Development of a Teen Suicide Prevention Porject in Northwest Native Communities

06-03-04 Data in Action Proposal with the Department of Health and Human Service's Office of Minority Health

06-03-05 NPAIHB Opposition to Closing the Walla Walla Veterans Administration Hospital

06-03-06 Support for a Needs Assessment to identify Health Services and Opportunities for Collaboration under the VA-IHS Memorandum of Understanding

06-03-07 Maximizing Nutritional Benefits and Reducing Toxic Risks in Northwest Tribal Diets

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