Health News & Notes

A Publication of the
Northwest Portland Area Indian Health Board

Volume 33, Number 1

October, 2003 Issue

Our Mission is to assist Northwest tries 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.

In This Issue

Region X Tribal Consultation with the Department of Health and Human Services

LtoR: Mike Zacherof (Chair Alaska Native Health Board),Verne Boerner (Administrative Officer NW Portland Area Indian Health Board), Trudy Anderson (Acting Executive Director Alaska Native Health Board), Chris Mandregan Jr. (Alaska Area Director), Ed Fox (Executive Director NW Portland Area Indian Health Board), Pearl Capoeman-Baller (President Quinault Indian Nation), and Wilson Justin (Health Director Mt. Sanford Tribal Consortium).

Diabetes Funding

Harvard's Honoring Nations

One-Sky Center

From the Chair: Pearl Capoeman-Baller

On July 16, 2003 I was nominated as the Chair of the Northwest Portland Area Indian Health Board. In my address to the Board I noted that my busy schedule could not be anywhere near as busy as the one maintained by the previous Chair, Julia Davis-Wheeler. I asked the delegates if they would support my request to have Julia assist me in health issues at the national level, as a condition of accepting my nomination. I do thank the delegates for approving my request to have Julia at my side and for electing me as Chair of this great organization. Like many of us, I would welcome Julia back as Chair should circumstances make that a possibility.

August was a good time to start my new role as Chair, because there are fewer meetings. There was one very important meeting, however, on August 8th and August 9th where I traveled to Anchorage Alaska on behalf of my tribe and as the Chair of this Board. I was very pleased that I was able to participate with other tribal leaders in a frank and honest dialogue with the Secretary of the Department of Health and Human Services, Tommy Thompson. This meeting was billed as a consultation between the Department and Region X tribes, and for once it did meet most of our standards for meaningful consultation. I was very proud of the 35 Northwest representatives who traveled to Alaska for this important consultation meeting. As most of you well know, the department is the largest in the federal government. In his address Secretary Thompson promised 1) his support for significant increases for the Indian Health Service budget, 2) to reduce the barriers tribes face in securing grants from agencies like the Centers for Disease Control and Prevention, the National Institutes of Health, the Substance Abuse and Mental Health Services Administration, and the Health Resources Services Administration, and 3) strong support for new initiatives to train native health care providers.

In my role as President of the Quinault Nation, I have attended fund raisers for various candidates and you can be sure health care is on the top of my list of agenda topics when speaking with political candidates. In September I attended the 50th Annual Conference of the Affiliated Tribes of Northwest Indians (ATNI) meeting at the Umatilla Reservation and can report that elected leaders are satisfied with the work of the Board. The health committee meetings at ATNI are very well attended and often provide specific direction to the Board on the health priorities of tribal leaders. The Board also provided support for the annual National Indian Health Board Consumer Conference in St. Paul Minnesota. I am looking forward to a busy fall with our October Quarterly Board Meeting hosted by Shoshone Bannock Tribes in Pocatello, Idaho. I will attend the November NCAI Annual Session where I will present to the Harvard Honoring Nations Board of Directors as our final competition for the high honors award. This is my personal invitation to you to attend this presentation, as support to myself and

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From the Executive Director: Ed Fox

In my consideration of the success of our organization, I reflect on the challenges inherent in the growth and expansion we have experienced as well as the fundamental strength of the Board's framework to meet those challenges.

A gauge of our success, as well as a significant challenge to it, is whether we are managing our growth in a way that allows us to retain the identity and function of a true "Indian Organization." I believe we are effectively meeting this challenge, and will continue to do so, only by deliberate efforts. Two things guarantee the successful management of our growth: first, the continued employment of Indian staff, and second, the participation of active Delegates who challenge us to fulfill our mission according to our stated values. I believe we are able to grow as a highly professional organization and to remain true to the values of our tribes.

By many measures, we are successful. We now have 60 paid employees, 80% of which are American Indians or Alaska Natives; we have a $2 million annual budget for salaries; and we support (well over 100 thus far in 2003) the travel expenses of scores of tribal members, tribal council members, and tribal employees to participate in workgroups, committees, and projects. I am satisfied with the current size of the Board and find it quite manageable. I do, however, have concern about how much larger it can grow without beginning to exhibit some of the dysfunctions associated with large bureaucracies. Doni Wilder told me in my first month on the job that we will not become another BIA. I took that to mean we should never become unresponsive, rule bound, and distant from our member tribes. Our success is ultimately measured by how much we have raised the health status of American Indians and Alaska Natives, not by how much the Board has grown.

Not surprisingly, it has become evident to me that the Board should prepare itself for charges that it has grown too big (or bureaucratic), too distant from tribes, and perhaps too arrogant in its daily work. You have my assurance that any and all such charges will be considered and examined in earnest for their validity. Similarly, I request that you make careful consideration of such charges against the Board. While the danger of over-confidence is a legitimate threat given our growth and the success of our endeavors on behalf of the tribes, it should be recognized that the self-interest of individuals and perhaps even of individual tribes will, on occasion, result in charges that we have not acted in the best interest of our member tribes. I agree that success breeds confidence, but hold that it need not result in arrogance.

I believe there are several reasons that we can expect charges of dysfunctional behavior that are unrelated to the self-interest of individuals or of individual tribes. Many still lack knowledge of the Board's legitimate authority to fulfill our mission, achieve our goals, and

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Northwest Portland Area Indian Health Board

Projects & Staff

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Mylen Shenker, Finance Officer
Bobbie Treat, G/L & Contracts Accountant
Mike Feroglia, A/P & Payroll Accountant
Elaine Dado, Executive Secretary
Lila LaDue, Receptionist

Program Operations
Jim Roberts, Policy Analyst
Sonciray Bonnell, Health Resource Coordinator
James Fry, Information Technology Coordinator
Brian Moss, Information Technology Specialist
Ed Lutz, Information Systems Specialist
Ginger Clapp, Ombud

Womens Health Promotions Project & Health Promotion Injury Control Project
Lynn DeLorme, Project Coordinator

Northwest Tribal Epidemiology Center
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Francine Romero, PhD, Epidemiologist
Josh Jones, PhD, Epidemiologist
Mary Brickell, RPMS Specialist
Emily Puukka, Tribal Registry Project Director
Shawn Jackson, STOP Chlamydia Project Specialist
Chandra Wilson, Project Assistant
Tam Lutz, TOT's and ICHPP Director
Julia Putman, TOT's Project Assistant
Lisa Angus, ICHPP Project Specialist
Sayaka Kanade, Technical Writer
Luella Azule, NTRC Project Coordinator
Vacant, FAS & Dental Project Assistant
Kerri Lopez, Western Tribal Diabetes Director
Rachel Plummer, WTD Project Assistant
Jennifer Olson, WTD Project Specialist
Mike Severson, WTD Trainer
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Angela Mendez, National Project Specialist - Lead
Crystal Gust, WTD and National Project Specialist
Crystal Denney, National Project Assistant

Project Red Talon
Karen McGowan, Project Director
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Tobacco Projects
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Gerry Rainingbird, NTTPN National Coordinator
Joe Law, WTPP Regional Coordinator
Stephanie Craig, WTPP Regional Project Specialist
Terresa White, NTTPN Project Specialist
Nichole Hildebrandt, Circle Leadership Fellow

Northwest Tribal Recruitment Project
Gary Small, Director
Eric Vinson, Project Assistant

Northwest Tribal Cancer Control Project
Ruth Jensen, Project Director
Cicelly Gabriel, Project Assistant

Dinner with Tommy Thompson

by Verne Boerner, Administrative Officer

On August 8, 2003 Region X tribes joined Secretary Tommy Thompson, Department of Health and Human Services (HHS), on his annual trip to Alaska for dinner during the Region X tribal consultation process. Region X, including Washington, Oregon, Idaho, and Alaska, is the only region that had the pleasure of having dinner with Secretary Thompson. During the dinner, tribal leaders laughed and celebrated as Secretary Thompson shared his experience on how he was initiated into the Polar Bear Club (taking a dip into the Bering Sea) and joked that H. Sally Smith of Alaska was his girlfriend.

Tribal leaders also learned of the Secretary's priorities and commitment to revitalizing the Commission Corps, as well as focusing on recruitment and growing our own health professionals. Tribal leaders also had the opportunity to share their concerns with the Secretary. Some of the issues that tribal leaders discussed included: the Indian Health Service budget; increasing access to funding opportunities within DHHS; Title VI Self-Governance Demonstration project; social services programs; elevation of the IHS Director to an Assistant Secretary; One HHS Initiative; concerns with the Centers for Medicare and Medicaid Services; and the reauthorization of the Indian Health Care Improvement Act (See Summary of Consultation Issues on page 6-7).

The Secretary agreed to review such practices as placing caps on administrative costs for funding opportunities, which prohibit many tribes and tribal organizations from responding to requests for proposals announced by HHS.

Northwest Tribal Leaders
Back row LtoR: Woody Pattawa (Umatilla), Carol Wewa (Warm Springs), Geneva Charly (Warm Springs), Billie Jo Settle (Samish), tribal leader
Front row LtoR: Pearl Capoeman-Baller (Quinault), Jim Roberts (NPAIHB), Bob Brisbois (Spokane)

On April 29, 1994, Executive Order 13175 created the policy that confirms the government-to-government relationship with American Indian and Alaskan Native tribal governments. The memorandum directs federal departments and agencies to honor this relationship by consulting with tribal governments prior to taking actions that will affect them. Sovereignty is a right of American Indian and Alaska Native tribes. It is also a responsibility. The Northwest tribes are models in practicing this responsibility. Northwest tribes took the initiative to prepare for the meeting by compiling a detailed briefing book on the HHS agencies and programs, and past consultation issues. This allowed the tribes to take full advantage of their time with Secretary Thompson and with agency heads. The tribes first discussed their concerns and issues at a caucus meeting in order to select which Northwest tribal leaders would address the Secretary directly, as well as those issues that would be presented to the agency heads the following day. After the respective Northwest and Alaska Area caucuses, tribal leaders from both areas joined together to complete a planned approach and presentation of issues to the Secretary. Willie Jones of the Lummi Indian Nation, Bob Brisbois of the Spokane Tribe, Pearl Capoeman-Baller of the Quinault Indian Nation, and Mel Tonasket of the Colville Tribes presented the Northwest issues.

Special thanks to the Alaska Native tribes for hosting the meeting. Thank you to all the tribal leaders that presented and supported the consultation process.

Nuts and Bolts of Funding

by Sonciray Bonnell, Health Resource Coordinator

Every so often, the Northwest Portland Area Indian Health Board (NPAIHB) revisits our internal protocol for seeking funds to remind our Delegates of that process and to assess its efficacy.

NPAIHB's internal process for seeking funds is described in our "Grant Application Process." The process includes (1) identifying potential funding; (2) informing the appropriate Board personnel of this opportunity by filling out a NPAIHB Request For Proposals (RFP) form; and (3) determining if the RFP meets the needs of our member tribes, fits with the Board's mission and values, and is supported by our Delegates. The grant proposal may be a clear health issue identified in our strategic plan or it may be a new health project to the Board. In either case, it must be approved via resolution by our Delegates. It should be emphasized that our Delegates guide the direction of the health issues for which we seek funding.

Because the Board has many projects that are seeking grant opportunities, the grant application process allows the management team to stay informed of all activities and guide the overall process. A Lead Contact is designated for each grant proposal. The Lead Contact is also responsible for completing the NPAIHB RFP Information Sheet, which identifies the funding source, Lead Contact, purpose of the RFP, amount requested, whether a resolution has been passed to seek funding, and a grant writing team. The grant writing team, which requires approval by the Executive Director, is a group of project staff identified as having the knowledge and expertise to design and write the particular grant application. Staff knowledgeable about health issues, grant writing, and program development may make up an effective grant writing team. NPAIHB is fortunate to have so many staff with expertise to design and implement excellent health programs. As the Heath Resource Coordinator, I collect all RFP Information Sheets and am aware of all grants the Board is considering for application. It is my responsibility to report to the Executive Director on which of our projects or individuals are seeking funding and for what purpose. This position is also responsible for keeping track of past and present relationships with funders, which is tantamount to securing grant money. NPAIHB enjoys a stellar reputation with our funders and we are cognizant that we must actively nurture that status.

The actual grant writing is normally divided among the grant writing team, with staff researching specific sections or contributing their expertise. Staff are assigned the task of notifying tribes of NPAIHB's intent to apply for funds and to request letters of support. Contacting our tribes consists of emails, Friday mailout, phone calls, and faxes. We keep a copy of this communication.

NPAIHB follows a general policy of not competing with our 43 Northwest tribes, so that tribes may expand their own health programs and increase capacity at the local level. This sounds pretty straight forward, but there are exceptions. If we find we are interested in the same grant opportunity, we contact the Tribal Delegate, Health Director, and Chair to ask if they agree to the Board applying too. Tribes understand that by allowing NPAIHB to compete for a grant, chances of those funds benefiting the Northwest doubles. We encourage dialogue about grant opportunities and respect tribal requests to abstain from applying for the same funds, however, some situations are not so clear. If we have a request from a tribe to not compete, but have requests from other tribes encouraging us to apply, we would communicate with the tribes involved, and possibly ask our Executive Committee to make a decision on whether the Board should apply. Of course, the Board is particularly well qualified to operate regional grants, but that is not to say NW tribes would not support a single tribe operating such a project.

Eighty percent of our budget comes from grants and contracts, so it is in our best interest to develop an internal funding process that is effective. In addition to guiding our internal funding, I research and prepare our monthly funding report and am available to assist our tribes in negotiating the funding process. The monthly funding report is sent via our Friday mailout to our 43 Delegates, Tribal Health Directors, and Tribal Chairs. We do not add names to this list, but we have plans to post the monthly funding report on our webpage.

If you have any questions about our internal funding process, the monthly funding report, or a general question about funding, please contact Sonciray Bonnell at (503) 228-4185 extension 260 or sbonnell@npaihb.org.

Summary of Region X

by Jim Roberts, Policy Analyst

Indian Health Service Budget

The IHS budget has not seen significant increase in its budget since FY 2001 when it received a 9.6% increase. This was the first year in a generation that an increase was sufficient to meet mandatory cost increases approved by Congress. For the past two years the IHS has received less than a 2% increase. This was even less for Portland Area Tribes since it receives no funding for staffing of new facilities; we receive modest funding under the Indian Health Care Improvement Fund and only small amounts were approved for new facilities. Compounding this lack of increase is the unique problem faced by Areas with a heavy dependence on CHS dollars and the eroding effect of medical inflation on the purchases of specialty care. Medicaid collections are no longer increasing in the Northwest, another example that funds are diminishing for Portland Area Indian Health Programs.

Recommendations: The Office of Management and Budget clearly considers the IHS no different than other non-defense discretionary programs. Tribes have been told they can expect no more than 2% increases in the near future. In his visit to Portland, CMS Administrator, Tom Scully, indicated that the Medicare and Medicaid budgets would increase by 9% and 11% respectively. We request the Secretary recognize that American Indians/Alaska Natives are one of the fastest growing populations in the U.S. with the greatest health care needs and should receive similar increases. The Portland Area recommends the Secretary advocate for increases in the IHS budget that are sufficient to not only maintain current programs, but also sufficient to address health care disparities.

Health Promotion and Disease Prevention

A promising strategy to reduce health disparities is to increase tribal health promotion and disease prevention activities. Many tribes and tribal organizations have received funding from the Centers for Disease Control and Prevention, private foundations, and states to design and implement health promotion and disease prevention projects. Their success has proven that tribes are capable of designing culturally appropriate programs that will decrease future health care expenditures. Unfortunately, despite a recent emphasis on these projects, tribes have encountered several difficulties. Tribes and tribal organizations are not consistently listed across the agencies as eligible to apply for funds. A recent grant announcement set the minimum threshold at 10,000 tribal members. Consequently, no Portland Area tribes were eligible applicants. Many CDC grants have limits on allowable administrative costs. These caps inhibit tribes from applying for funds, as the programs cannot cover actual costs. Tribes do not enjoy the same economies of scale as states. Many grant announcements have matching fund requirements that make it impossible for many tribes to apply.

Recommendations: Portland tribes recommend that the Secretary advocate for increased health promotion and disease prevention programs by supporting increased funding, by permitting tribes to use their indirect cost rates for allowable administrative costs, by eliminating matching fund requirements for tribes, and by minimizing the use of minimum thresholds for tribes.

Title VI Demonstration Project

When Congress enacted the Self-Governance legislation, it included a provision requiring the Department to carry out a study of the feasibility of tribes and tribal organizations assuming responsibility for non-IHS programs of the Department of Health and Human Services. This is commonly referred to as Title VI Demonstration project. A team of tribal leaders and technical and legal staff worked with HHS to design and carry out the feasibility study. This year-long effort resulted in a report by the Secretary to the Congress finding that such a demonstration is feasible

Recommendation: The Secretary should endorse and encourage the Administration and Congress to move swiftly to enact a non-IHS self-governance demonstration project and instruct HHS staff to sit down with tribal leaders to work through any objections to the tribal bill. The Department should begin to work with Tribes in the demonstration design of Self-Governance projects for some or all of the 11 programs identified in the feasibility study.

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Consultation Issues

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for 11 programs of the Department. In addition, the Secretary recommended he have authority to add as many as six additional programs during the course of the demonstration project. Tribal leaders have since developed draft language for a bill to authorize a non-IHS, HHS self-governance demonstration project.

Tribal Administration of Social Services Program

Because Tribes have demonstrated to be successful and innovative managers, many are now interested in expanding their management experience into Social Services programs. Tribal TANF is a social security program. Tribal TANF programs have overcome many obstacles to become successful in their efforts. Recent legislation allows Tribes under Title VI of P.L. 93-638, to operate some of the programs of the Department of Health and Human Services. There are many obstacles for Tribes who choose to operate social services programs including additional restrictive requirements of federal funding placed on Tribes by State offices, even to the extent of adding regulations not prescribed by the federal government. Another obstacle is the lack of infrastructure for Tribes. States, as federal TANF grantees, are not required to provide the State's share of funding. Again, this inhibits any Tribes' abilities to develop infrastructure to efficiently and effectively manage social services programs. Tribes believe the added layer of regulations denies them the ability to manage social services programs with the same level of success as with health care programs.

Recommendations: The Secretary should advocate for increased direct contracting of HHS programs with Tribes. The Department should communicate and monitor the expectation that states will consult and facilitate the delivery of block grant programs to Tribes, which includes the need for greater flexibility for Tribes to administer these programs without the inappropriate interference of

Elevation Of IHS Director

Tribal leaders have long advocated for the elevation of the IHS Director to that of an Assistant Secretary within the Department of Health and Human Services. This position is supported by NCAI, NIHB, ATNI, and members of Congress. The Department recently announced the re-establishment of the Inter-Departmental Council on Native American Affairs (IDCNAA), which is co-chaired by the Administration for Native Americans (ANA) Commissioner and the IHS Director. The purpose of the Council is to coordinate activities and encourage the cooperation of the Department's operating divisions in order to improve access to resources by Tribes. It has been indicated that the elevation of the IHS Director might not be in the best interest of the Tribes and that it might be more beneficial to maintain the current status of the position. This argument is centered on the re-establishment of the IDCNAA and the ability of the IHS Director to effectively advocate for IHS through his participation on the Council and working through the existing structure of the Department.

Recommendations: Tribal leaders believe that the elevation of the IHS Director to an Assistant Secretary level position within the Department would facilitate greater Consultation across the Operating Divisions, while respecting the government-to-government relationship that Tribes have with the United States. The persistent whittling away of resources from within the Department, together with insufficient budget increases, casts doubt on the Department's ability and commitment to improve health care funding in Indian Country. It is clear the IHS does not have the same level of respect and advocacy as other agencies within the Department. The IHS Director, as an Assistant Secretary would commend the respect and advocacy necessary to bring funding to the unmet needs of Indian health.

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Meet Our New Epidemiologist

Joshua Jones joined the EpiCenter in July as a physician epidemiologist. He is a commissioned officer with the Portland Area IHS office and will be working full-time with the NPAIHB EpiCenter.

Josh was born and raised outside of Boston, Massachusetts. He studied political science at Brown University, but somehow got confused and ended up in the other kind of science, and went to medical school at McGill University in Montreal, Canada. After surviving four Canadian winters, he moved to San Diego, California for a three-year residency training in adult Internal Medicine. In San Diego he worked mainly with the medically underserved Latino population in San Diego, but discovered the impact that could be made in the public health side of things and set off for the Centers for Disease Control and Prevention (CDC) in Atlanta. He spent two years working at CDC as an Epidemic Intelligence Service officer with the National Center of Infectious Diseases. He worked on many outbreak investigations including the anthrax attacks in 2001, the SARS epidemic in 2003, and a six-month stay in Burkina Faso (West Africa) working with the Burkina Ministry of Health to control a large epidemic of bacterial meningitis.

Josh has long been interested in working in Indian country since a short clinical experience at Tuba City Indian Medical Center in Arizona in 1999. He is very excited to have the opportunity to work with the Tribes in the Northwest and with the EpiCenter in reducing health disparities affecting Indian communities. One of his roles at the Board will be to increase the coordination and communication on public health issues between the many groups concerned with the health of American Indians (including tribal organizations, NPAIHB, state health departments, IHS, and other federal agencies such as CDC). He hopes to be a useful epidemiology resource person for the EpiCenter in addressing the health priorities set by the Board's Delegates. Other roles will include sitting on the Portland Area IHS Institutional Review Board and facilitating the Board's connections with the resources at OHSU, where he will be a clinical faculty.

Brand new to Portland, Josh has enjoyed the sunny summer very much. He lives with his girlfriend in Southwest Portland and is convinced that everyone is lying when they say it rains all the time. He likes doing all the usual outdoor things and is looking forward to getting to know his new city and everyone working at the Board.

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participate in a wide variety of activities that are approved by our member tribes. To address this issue, I will outline the Board's authority, values, mission, goals and activities, which provide a strong foundation for meeting the challenges of our success.

Our Authority

We advocate for increases in the Indian Health Service budget, we manage over $5 million in health projects, and we convene important regional and national meetings. All of this is under the authority granted to us by our member tribes. Each tribe 'delegates' someone and as many alternates as they desire to participate in the governance of the Board. This delegation of authority is not abused, as it is understood by all Board employees that the tribes retain their sovereignty and authority on all matters, including decisions relating to health care.

Our Values

The values that guide the Board are clearly stated in the strategic plan that was adopted in January 2003. These values flow from the traditions and cultures of our member tribes.

Our Mission

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.

Our Goals

Our external goals and internal goals stem from our values and mission. Internally, we support the goal of

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Trickle Down Preparedness

by Joe Finkbonner, EpiCenter Director

Following the attacks of September 11, 2001 and the anthrax distribution through the postal system, the federal government has become increasingly concerned with the safety and security of the United States. Quickly, the federal government moved to develop the Department of Homeland Security to protect against offenses of terrorism, especially bioterrorism (BT). Grants were developed and RFPs issued to States from both the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) to bolster the readiness of the State Public Health Departments and Hospitals. The funding was issued to States and the intention was to have the resources trickle down to local jurisdictions (including Tribes) to participate in regional coordination and logistics. To date, only one State (Montana) has allocated resources to Tribes to participate in the planning development of BT plans.

In FY2002 $1.1 Billion was allocated to States and Territories for development of BT preparedness plans. The CDC allocated $918 Million to the Public Health System and HRSA allocated $125 Million for Hospitals for training and equipment purchases. Plans have been developed by Public Health Departments, Emergency Medical Services (EMS), and hospitals and the Tribes in the Portland Area have, at best, been invited to attend in some of the information gathering meetings. I believe that some local health jurisdictions have done their best to include Tribes in their areas in the process of developing their plan and in the logistics of the plan itself, however Tribes must be included in the training and tabletop exercises to ensure that AI/AN population living on reservations have the same protections as the rest of the communities. Tribes need to integrated into the overall plans or develop their own plans that complement the Regional plans.

It is that very reason that the Northwest Tribal EpiCenter has begun discussions with the Northwest Center for Public Health Practice located in the School of Public Health at the University of Washington to provide a regional conference. The conference will discuss some of the tools that are currently available to assist Tribes in the development of Emergency preparedness plans including tools that would measure current capacity to respond to events or assessment tools to develop a training curriculum for their personnel. More details will be distributed in the weekly mail out as the details and funding for the conference become clearer. I look forward to your participation and assisting you in anyway of the development of your emergency preparedness plans.

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advancing the careers of our staff. We support the family life of our staff through comprehensive benefits that respect the needs of families while accomplishing the mission of the Board. Externally, our chief goal is to be the leading Indian health care organization in the country by fulfilling our mission.

Our Activities

The Board manages 18 projects for health promotion and disease prevention. In addition, we convene meetings that address health care issues. Most importantly, we are governed by Quarterly Board Meetings that keep our staff focused on tribal concerns. Our advocacy efforts over the years have resulted in increased appropriations for Indian health.

I hope this introspective article results in comments from you or other tribal members regarding the challenges the Board faces as it continues to grow and succeed in carrying out the work of our member tribes.

July CRIHB/NPAIHB Joint QBM

CRIHB Board Member Jim Adams with his wife and daughter

CRIHB employee Shelley Whitebear

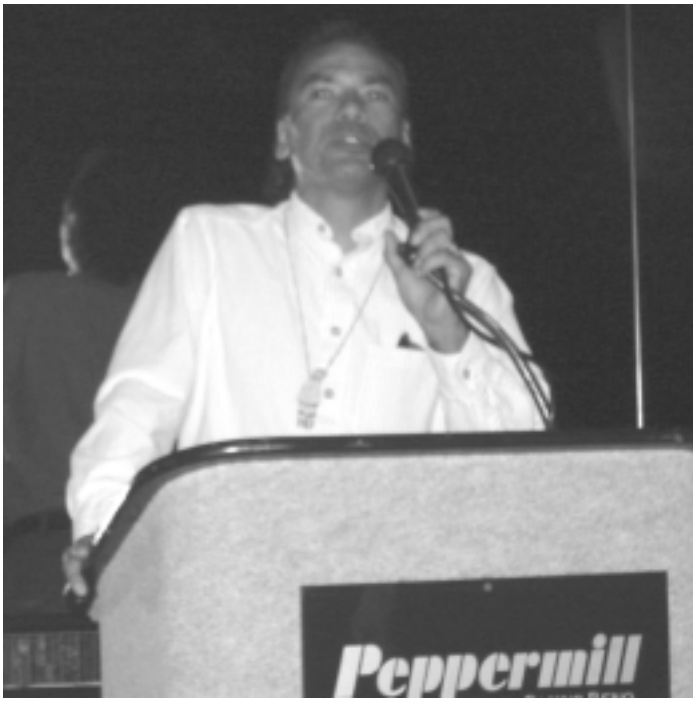
NPAIHB's Tribal Registry Manager Emily Puukka

NPAIHB staff LtoR: Penny Schumacher, Mary Brickell, Stephanie Craig, Mike Severson, Jennifer Olson

NPAIHB's Western Tribal Diabetes National Project Specialist Angela Mendez

July CRIHB/NPAIHB Joint QBM

CRIHB Board Members LtoR: Laura Rambeau-Lawson, Brenda Snooks, Barbara Bird, Charlotte Brown



NPAIHB's NTTPN National Coordinator Gerry Rainingbird

CRIHB Reception LtoR: Mathew Tomaskin (Yakama), Susan Wilbur (Swinomish), Brenda Snooks

LtoR: Kerri Lopez-Johnston with her nephew and mother

NPAIHB Delegate Debbie Wachendorf

NPAIHB Is A Harvard Honoring Nations Finalist!

Excerpt from Kennedy School Press Release

Harvard's Kennedy School Announces 2003 Finalists for American Indian Tribal Governance Awards

Administered by the Harvard Project on American Indian Economic Development at Harvard's John F. Kennedy School of Government, Honoring Contributions in the Governance of American Indian Nations ("Honoring Nations") identifies, celebrates, and shares outstanding examples of tribal governance among the more than 550 Indian nations in the United States. Currently in its fourth year of awards, Honoring Nations is a member of a worldwide family of "governmental best practices" awards programs that spotlight innovative public sector initiatives in order to shift public perceptions about government and to encourage the replication of effective problem-solving. Since Honoring Nations' inception in 1999, 48 tribal government programs and initiatives have been recognized. The Ford and Rockefeller Foundations are the primary sponsors of Honoring Nations.

This year's 16 finalists were chosen from a pool of 114 applications from 61 Indian nations and 13 inter-tribal collaborations. At each stage of the selection process, applications are judged on the criteria of effectiveness, significance, transferability, creativity, and sustainability. On Tuesday, November 18, in Albuquerque, New Mexico the finalists will make presentations to the public and the Honoring Nations Advisory Board, which will then select eight programs to receive "high honors" and $10,000 to share their success stories with others.

Followed by the presentations, the Advisory Board is hosting an honoring ceremony and reception in the Ulam Ballroom at the DoubleTree Hotel located at 201 Marquette Avenue, NW from 7:00-10:00 pm. At the honoring ceremony and reception, the Advisory Board will celebrate the achievements of all sixteen Honoring Nations' honorees and announce the eight High Honors for 2003. This event is typically attended by hundreds and is open to the public. The Advisory Board encourages all Honoring Nations' honorees to bring their friends, colleagues, and others to share in the accomplishments of the honorees.

NPAIHB congratulates this year's finalists. Of the 16 finalists, four are from the Northwest. Following is a list of NW tribes recognized as leaders by Harvard's Kennedy School of Government's Honoring Nations Program.

Cultural Resources Protection Program
Natural Resources Department, Confederated Tribes of the Umatilla Indian Reservation (Pendleton, Oregon)
Northwest Intertribal Court System
Confederated Tribes of the Chehalis Reservation (Mountlake Terrace, Washington)
Quil Ceda Village
The Tulalip Tribes (Tulalip, Washington)
Northwest Portland Area Indian Health Board
The 43 federally recognized tribes of Oregon, Washington, and Idaho (Portland, Oregon)

The Northwest Portland Area Indian Health Board congratulates the tribes of the Northwest for their contributions and leadership in Indian Sovereignty.

2003 Honoring Nations is also recognizing 12 other finalists this year. NPAIHB would also like to recognize and congratulate those tribes and tribal programs that are working hard and effectively to promote tribal sovereignty and to serve American Indians to improve their quality of life. Those twelve finalists are:

Assuring Self Determination through an Effective Law Enforcement Program
Gila River Police Department, Gila River Indian Community (Sacaton, Arizona)
Cherokee National Children's Choir
Cherokee Nation (Tahlequah, Oklahoma)
Choctaw Community Injury Prevention Program
Choctaw Health Center, Mississippi Band of Choctaw Indians (Philadelphia, Mississippi)
Chuka Chukmasi Home Loan Program
Division of Housing, Chickasaw Nation (Ada, Oklahoma)

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Dr. Grimm's Decision on Diabetes Funding

by Ed Fox, Executive Director

On August 25, 2003, Dr. Charles Grim announced his decision for the distribution of $150 million for the Special Diabetes Program for Indians (SDPI). The decision establishes a methodology for FY 2004, 2005, 2006, 2007 and 2008. Future year changes will be marginal and will follow revisions in user population, prevalence of diabetes, the calculation of a small tribe's formula and possible modifications to take into account the impact of inflation. The August 25, 2003 announcement also provided the calculations for the FY2004 area distributions and contained information on how tribes can access these funds. Actual amounts will be determined by Area Directors after receiving input from Area tribes. Urban program determine their own nationwide distribution formula for urban program funds. Dr. Grim allocated $6,144,774 to protect any program from reduced funding and allocated an additional $8,855,226 for inflation adjustment calculated at 8.8% for all Areas.

The most significant decision made by Dr. Grim was to allocate over 50% of the $50 million FY2004 increase for competitive grants. It appears that tribes have not, and will not, be consulted directly on how these funds will be distributed.

Dr. Grimm increased urban funding by 50% and increased tribal grants by just 12.5% over FY2003. A new National and Area Data Improvements Set Aside is $5.2 million, but nothing is said about how this money will be spent and how Area level data efforts will access this $5.2 million.. The Tribal Leader's Diabetes Committee had recommended 50% of the $5.2 million be used for Area level data improvement, but Dr. Grimm's decision does not say how areas can access these funds. Finally, administration of the SDPI will increase by 8.8% over FY2003.

The following lists the basic components of the $150 million distribution.

$105,133,626	Basic Distribution Formula with hold harmless and inflation provisions (12.5 %)
$ 27,366,374	Competitive Grant Program (new)
$ 7,500,000	Urban Set-Aside (50% increase)
$ 5,200,000	National and Area Data Improvements Set Aside (new)
$ 3,800,000	Administration of the SDPI(8.8)
$ 1,000,000	National Diabetes Prevention Center (Gallup, NM) (no increase)
$150,000,000	TOTAL (50% increase)

The Basic Distribution Formula (BDF) portion of the distribution methodology has three main components. The percentages remain the same as previously utilized, however, disease burden was revised to include prevalence only and eliminated mortality as a component of this factor.

Basic Distribution Formula

12.5% Tribal Size Adjustment ($11,266,703)
30% User Population ($27,040,088)
57.5% Disease Burden (prevalence of diabetes) ($51,826,835)
100% ($90,133,626)

1. 12.5% of the formula is a Tribal Size Adjustment formula that is not described in the materials distributed by the Director. The TSA has not changed, nor has it been reviewed as directed by the Tribal Leader's Diabetes Committee (TLDC). The Northwest Portland Area Indian Health Board has also requested a review of the TSA formula.
2. 30% of the formula is based on the Area's percentage of total FY2002 users. The Portland Area supported this component and always supports using latest accurate data.
3. 57.5% of the formula is based on the Area's prevalence of diabetes; this factor is termed disease burden. Mortality was eliminated as a portion of the disease burden component of the formula. The Portland Area supported this

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The Effects of Racial Misclassification - Part Two

by Emily Puukka, Project Director, Northwest Tribal Registry Project

Part one of this series examined problems associated with multiple race categories in calculating race-specific disease rates (see Health News and Notes, July 2003). This problem is secondary to the overall issue of racial misclassification. The allocation of multiple race categories into single categories is meaningless if the race does not accurately reflect an individuals' heritage. This article will illustrate the effects of racial misclassification on statistical measures commonly used to characterize disease burden in a population.

Racial misclassification can be described as the incorrect coding of an individual's race or ethnicity. For smaller race groups, misclassification generally occurs in one direction. For example, American Indian/Alaska Native (AI/AN) peoples are often misclassified as white, whereas white individuals are rarely misclassified as AI/AN.

Correct racial classification is essential for the accurate characterization of disease within a population. Race-specific disease rates which are used to express the force of a disease in a given population can increase or decrease significantly based on the number of cases or persons (correctly or incorrectly) included in either the numerator or denominator. The potential for error and corresponding impact is greatest among small populations and race groups such as AI/AN populations.

An example of the effect of racial misclassification on disease rates is shown in table 1. In this example, disease "X" shows the true number of cases among the AI/AN population to be 650 of 75,000. As illustrated, the resulting rate of disease (with no racial misclassification) would be 867 per 100,000 person-years. As racial misclassification increases, (i.e. fewer records are correctly classified as AI/AN in the state disease registry), the disease rates decrease, falsely suggesting a lesser overall burden of disease. At first glance, low disease rates may be interpreted as an indication of a healthy population, however, it is necessary to consider the data source and possible limitations prior to drawing conclusions. As with the example presented here, low disease rates may actually be the result of an error or bias (e.g. low screening rates, racial misclassification, etc.) rather than an actual decrease or difference in the number of cases of disease in a population.

It is also important to recognize that because the burden of disease in a given population is often used in the allocation of funding for planning and management of public health programs, it is especially important that racial misclassification and other potential sources of error be addressed.

For additional information, please contact:
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Table 1. Effect of Racial Misclassification on Disease Rates - Example

True Number of Cases of Disease "X" Among AI/ANs (No Racial Misclassification)	Percent Racial Misclassification in State Disease	Number of Cases of Disease "X" in State Registry Coded Registry	Denominator (From 2000 US Census) as AI/AN	Resutling Disease Rate (per 100,000)
650	0%	650	75,000	(650/75,000)*100,000 = 867.0
650	20%	520	75,000	(520/75,000)*100,000 = 693.0
650	40%	390	75,000	(390/75,000)*100,000 = 520.0
650	60%	260	75,000	(260/75,000)*100,000 = 347.0

One-Sky Center

by Jim Roberts, Policy Analyst

On July 21, 2003, the Substance Abuse and Mental Health Services Administration (SAMHSA) announced a $1 million award to the Oregon Health Sciences University (OHSU) to operate the "One Sky Center: American Indian and Alaska Native (AI/AN) Resource Center." The One Sky Center will be located on the campus of OHSU and includes the partnership of the Northwest Portland Area Indian Health Board (NPAIHB).

The One Sky Center is an innovative national resource center dedicated to the identification and fostering of effective and culturally appropriate substance abuse prevention and treatment programs for American Indian people. The goal of the resource center is to improve prevention and treatment of alcohol and substance abuse among native people. The Center will conduct conferences, workshops, and coalitions, and utilize distance-learning to facilitate technology transfer, technical assistance, and interaction with AI/AN providers.

Activities of the Center include identifying culturally appropriate best practices in prevention and treatment services designed for AI/AN people, and facilitating the implementation of these practices as evidenced based programs and systems of care. The Center will also provide continuing education in substance abuse prevention and treatment in order to enhance the capabilities of education and health care programs that work with AI/AN people.

LtoR: Dale Walker (OHSU), Doni Wilder (IHS Portland Area Director), Ed Fox (NPAIHB Executive Director), Verne Boerner (NPAIHB Administrative Officer)

The Center will take policy direction from a Council of Stakeholders representing Tribal people throughout the country, while operational activities will be conducted under the leadership of a National Steering Committee representing tribal governments, educators, clinicians, and federal agencies. The One Sky Center also includes the participation of organizations like the Alaska Native Tribal Health Consortium, National Indian Youth Leadership Project, United American Indian Involvement, and White Bison, and anticipates working with tribal community colleges and universities to facilitate entry of AI/AN youth into education and health careers focused on substance abuse prevention and treatment.

It is expected that the One Sky Center will receive funding at the same level for the next three years. NPAIHB is excited about the opportunities that the One Sky Center presents and will be working in close collaboration with OHSU to ensure the needs of tribes are met. A website for the One Sky Center is currently being developed. For additional information, contact Jim Roberts, who is serving as NPAIHB's One Sky Center Liaison, at 503-228-4185 extension 276 or jroberts@npaihb.org.

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the Board (plus the media will be there). As always, the Northwest Portland Area Indian Health Board comes to each of these meetings prepared with all the necessary background material necessary for NW tribal leaders to be active participants in the leading health care issues of the day. I look forward to seeing each and every one of you in the days ahead.

Continued from page 13

change.

The Portland Area will receive $5,734,543 in FY 2004 (and each of next five years unless Congress appropriates additional funds) compared to $4,972,408 in FY2003. This represents an increase of 15.3%. Each program is likely to receive a 'prorata' increase according to their 2002 user population, after setting aside 5% of the total for the Northwest Portland Area Indian Health Board Data Project and $20,000 for the Cowlitz Tribe.

The overall IHS-wide increase in funds distributed by formula was 12.%. This year California's distribution increased by 28%, Nashville by 24.1%, Phoenix by 18.7% and Oklahoma by 13%. Seven areas received 8.8% increases. Their lower increase was largely due to the discontinuation of mortality factor in the disease burden component of the formula, but in most cases they would have received decreased funding if the Director has not provided the 'hold harmless' principle. The formula utilized the latest prevalence data (2002) and it used FY2002 user population.

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Family Violence and Victim's Services
Department of Family and Community Services, Mississippi Band of Choctaw Indians (Philadelphia, Mississippi)
Gila River Telecommunications, Inc.
Gila River Indian Community (Sacaton, Arizona)
Honoring our Ancestors: The Chippewa Flowage Joint Agency Management Plan
Lac Courte Oreilles Band of Lake Superior Chippewa Indians (Hayward, Wisconsin)
Kake Circle Peacemaking
The Organized Village of Kake (Kake, Alaska)
Menominee Community Center of Chicago
Menominee Indian Tribe of Wisconsin (Keshena, Wisconsin)
Na'Nizhoozhi Center, Inc.
The Navajo Nation in cooperation with Zuni Pueblo, City of Gallup, McKinley County, and the State of New Mexico (Gallup, New Mexico)
Navajo Nation Corrections Project
Department of Behavioral Services, Navajo Nation (Window Rock, Arizona)
Trust Resource Management
Office of Support Services, Confederated Salish and Kootenai Tribes (Pablo, Montana)

National Indian Health Board Award--Congratulations!

Area Awards

Pearl Capoeman-Baller (Quinault): National Leadership on Indian Health Issues.

Eric Metcalf (Coquille): Passage of Oregon's SB 878 which promises to protect healthcare benefits of AI/AN in the Oregon health plan.

Tom Becker: Years of Leadership in the field of Indian health research and fostering careers of AI/AN health researchers.

Francine Romero (Jemez Pueblo): For involving tribal members and their communities in health care research design, conduct, and use of data.

Local Award

Mark Johnston (Coos, Lower Umpqua, Siuslaw): Developing tribal dental health services for Coquille, Coos, Lower Umpqua, and Siuslaw tribes.

Region X Consultation - Continued

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Elder Abuse

Title VII of the Older Americans Act, "Vulnerable Elder Rights Protection," was created in 1992. Part B of the Act authorizes $5 million for Indian tribes to initiate elder protection programs, however 11 years after its inception this essential initiative remains unfunded by Congress and lacks the necessary support by the Department. Part B of the act was intended to assist Indian tribes in prioritizing elder rights issues and carrying out elder rights protection activities. The stress that often accompanies deteriorating economic and social conditions in much of Indian country, is a contributing factor to the rise in elder abuse. Prevention programs for tribes are desperately needed, yet funding has not been provided. While state programs currently receive $4.5 million for ombudsman services and $4.7 million for prevention of elder abuse programs, these programs rarely reach Indian country.

Recommendation: The Secretary should advocate within the Administration and within the Department to fund tribal programs under Part B of the Act. Few long-term care services exist in Indian communities; currently, there are only 15 known tribal nursing homes in the nation, letting the burden of long-term care fall heavily on Indian families. Indian elders are living longer and are consequently bringing substantial burden to their caregivers who may not have the skills or resources to provide adequate care. Studies show that up to 90 percent of reservation families provide long-term care. Future in-home care burdens, perhaps leading to increased abuse, will be dramatically complicated by the epidemic of diabetes that now pervades Indian country. Indian caregivers already deal with daily diabetes management: shots, dietary restrictions, amputations, blindness, and kidney dialysis.

One HHS Initiative

The One-HHS initiative consolidates some functions now carried out in all HHS agencies and moves them to the Departmental level. The goals of One-HHS are to achieve economies of scale, communicate with one voice, and to save money by reducing full-time equivalents or FTEs in all HHS agencies. To save money, the HHS wants to reduce the number of government workers and proposes to consolidate the personnel office functions to selected sites that may include: Baltimore, Bethesda, Rockville, and Atlanta. For IHS, this means a reduction of an estimated 100 FTEs by the end of FY 2003 with more to follow in subsequent years. A report recently completed by the Restructuring Initiative Workgroup (RIW) reported that the IHS has already addressed many of the goals outlined in the President's Management Agenda through reforms implemented by the agency in past years. The cost saving provisions of One HHS will further diminish IHS resources, which are already under-funded, and will make the funding gap worse for AI/AN people.

Recommendations: The cost saving provisions of One HHS detract from the Government's responsibility to preserve Tribal sovereignty and will have an adverse effect on Indian Preference, which is a fundamental doctrine to Indian Self-Determination. Congress has expressed concern about the Department's initiative to consolidate human resource functions explaining that proposals have not fully justified the savings, costs, and benefits provided to the IHS and has made recommendations to prohibit the use of IHS funds to carry out or administer its human resources consolidation plan. (S. 108-89 and H.R. 108-1950). The Secretary should acknowledge the unique status and functions of the IHS exempt the IHS from the proposed consolidation.

Indian Health Care Improvement Act (IHCIA)

The Northwest and Alaska Tribes have been very active in the reauthorization efforts. The IHCIA plays a critical role in assuring that Tribes continue to have the authority and flexibility to carry out the Federal health programs they have assumed from IHS and to respond to the needs of their communities. Tribes understand that compromises may be needed to get action on legislation as substantial as the IHCIA. Tribal leaders have led efforts to assure that the Administration's concerns about the original bills introduced were taken seriously. This resulted in major provisions that were objected to by the Department being removed. These included the creation of a new Medicare and Medicaid provider type: the Qualified Indian Health Program, the

Continued on page 22

"The dream . . .

by Sonciray Bonnell, Health Resource Coordinator

The Portland State University Native American Student and Community Center is a learning center that provides an opportunity to unite all communities; it is a place for remembering, affirming, and empowering all people. The center will be a symbol of health, goodwill, and community pride.
Native American students of PSU, 1996

For over 20 years, American Indian and Alaska Native students at Portland State University (PSU) and the Portland Indian community have dreamed of having a gathering place on campus to call their own. "The dream . . . becomes reality." The grand opening of the new PSU Native American Student and Community Center (NASCC) will be on Friday October 24, 2003 on SW Jackson, between SW Broadway and SW Park in downtown Portland. Festivities begin at 11:00 AM.

Portland State University Native American Student and Community Center Grand Opening

October 24, 2003

on PSU campus at SW Jackson (between SW Broadway and SW Park)

Grand Entry 11:00

Dedication .....Noon

Tours throughout the day starting at .....Noon

Traditional Feast.....4:00

It is hard to describe just how beautiful the interior is – the lighting, the art, the welcome. Native American art for the NASCC was donated, purchased, and commissioned and is integrated into the building, landscape, and decor. Giant wood poles in the main Gathering Area symbolize a teepee, there is a smoke hole prism, the grounds are landscaped with NW native plants, NW art is sketched into a glass story wall, and cast bronze figures adorn the grounds. The line up of artists includes: Larry Ahvakana (Inuit), Doug Hyde (Nez Perce, Assiniboine, Chippewa), Jim Jackson (Klamath, Modoc), Lillian Pitt (Warm Springs), and Preston Singletary (Tlingit). PSU Indian students and the Native American Community Association (NACA) worked closely with the architect, Don Stasyn, on the design and integration of Native American art.

Walkway through the eco garden

A special feature of the building is the eco roof garden, where PSU graduates will walk through as a rite of passage and leave a special marker on the roof. The eco roof is a place of honor and was inspired by students and community members.

. . . becomes reality"

The Place of Honor is located on the roof of the Native American Student and Community Center

Imagine what it will mean to the Indian community to honor our graduates in this way. Tours of the new building provide opportunities to admire the impressive art collection, to tell the story of the Indian Community's perseverance in getting the building built, and to enjoy the pleasant atmosphere of the building.

Even though the architecture and art collection are museum worthy, the NASCC is truly a student and community center. Indeed, both PSU Indian student groups, United Indian Students in Higher Education (UISHE) and American Indians in Science and Engineering (AISES), will be housed in the new building. The Center has two large classrooms, a computer center, two conference rooms, a children's play area, fully equipped kitchen, salmon pit, and a large meeting space. Day to day activities in the Center include tours, PSU student groups office hours, Native American Studies classes, community and PSU meetings, and gathering of students. There are 260 American Indian/Alaska Native students enrolled at PSU for Fall 2003. It has always been the hope of the Indian Community that this Center, along with a true Native American Studies Program, would help attract and more importantly, retain and graduate our students.

The NASCC relies on an Advisory Committee consisting of PSU staff, PSU students, and Portland Indian Community members to help establish the Center's policies, including the fee schedule. By the request of PSU students and NACA, the Center is alcohol free. Requests to use the building are already coming in. To schedule a room in the NASCC or the entire building, please contact the PSU Educational Equity Program and Services (EEPS) at (503) 725-4457. Eventually the NASCC will have phones and we will be able to call directly, but until then call EEPS to get the most current information on scheduling the Center.

Main conference room

Upcoming Events

OCTOBER

NPAIHB QBM at the Holiday Inn Pocatello October 14-16, 2003
At the Holiday Inn Pocatello in Pocatello, Idaho
For more information, please call Elaine Dado at (503) 416-3264

Executive Leadership Group Meeting October 16, 2003
In Phoenix, Arizona
For more information, please call Christine Brittell at (503) 326-2020

Area Clinical Director's Meeting October 23-24, 2003
At the Portland Area IHS Office in Portland, Oregon
For more information, please call Christine Brittell at (503) 326-2020

Palpitations and Common Arrhythmias in Women: When Do You Worry? October 23, 2003
Available via Satellite, ISDN connection, or via the web
For more information, please call the Office of Women's Health at (507) 255-2287

Alcohol & Women's Health Seminar October 23, 2003
At the Lipsett Amphitheater, Building 10 at the NIH Campus
For more information, please call (301) 402-1770

NOVEMBER

Area Director's Meeting November 3, 2003
Held at IHS Headquarters in Rockville, Maryland
For more information, call Christine Brittell at (503) 326-2020

Indian Health Leadership Council Meeting November 4-5, 2003
At IHS Headquarters in Rockville, Maryland
For more information, call Christine Brittell at (503) 326-2020

IHS Awards Ceremony November 6, 2003
At IHS Headquarters in Rockville, Maryland
For more information, call Christine Brittell at (503) 326-2020

Executive Leadership Group Meeting November 6, 2003
At IHS Headquarters in Rockville, Maryland
For more information, call Christine Brittell at (503) 326-2020

Idaho State & Tribes Meeting November 6-7, 2003
Held in Boise, Idaho

Portland Area IHS IRB Meeting November 13, 2003
For more information, contact Sayaka Kanade at (503) 228-4185 ext 284
At NPAIHB in Portland, Oregon in conference room 300

Upcoming Events

NOVEMBER

Portland Area Awards Ceremony November 14, 2003
At the Portland Area IHS Office in Portland, Oregon
For more information, call Mike Smith at (503) 326-2014

NCAI 60th Annual Session November 16-21, 2003
At the Hyatt Regency in Albuquerque, New Mexico
For more information, please go to: www.ncai.org

Indian Child Welfare Training November 18-20, 2003
At the Monarch Hotel & Convention Center in Portland, Oregon
For more information, please call Shannon Romero at (503) 222-4044 ext 133

DECEMBER

Advanced Diabetes Management System December 3-4, 2003
For more information, contact Mary Brickell at (503) 228-4185 ext 302
At NPAIHB in Portland, Oregon in the Library

Third Party Billing & Accounts Receivable December 8-12, 2003
For more information, contact Mary Brickell at (503) 228-4185 ext 302
At NPAIHB in Portland, Oregon in the Library

9th Annual MCH Epi Conference December 10-12, 2003
In Tempe, Arizona at the Wyndham Buttes Hotel; interested parties should contact mchepi_conf@psava.com or call (404) 633-6869

Portland Area IHS IRB Meeting December 11, 2003
For more information, contact Sayaka Kanade at (503) 228-4185 ext 284
At NPAIHB in Portland, Oregon in conference room 300

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(IHCIA) continued ⇨ ⇨ ⇨

waiver of Medicare late enrollment penalties for Indians and Alaska Natives, and application of negotiated rulemaking to CMS. The National Steering Committee has worked very hard with Representative Young and his staff to incorporate these and many other compromises have resulted in H.R. 2440.

Recommendation: We request the Secretary to instruct the Department (primarily CMS) to undertake immediate review of the IHCIA legislation. To make this happen, and to be respectful of the government-to-government relationship that is the underpinning of self-governance and the IHCIA, we need the Secretary to convene work sessions between CMS and members of the National Steering Committee and its technical and legal advisors to discuss any provisions the Administration cannot endorse. This process of negotiation worked extremely well with self-governance legislation and can work to resolve differences quickly and help the IHS and tribes achieve their common goal of passage of this important legislation.

CMS Tribal Technical Assistance Group (TTAG) ⇨ ⇨ ⇨

Medicare and Medicaid programs have become an important part of the funding of Indian health programs. Participation in Medicare and Medicaid also provides quality standards that guide Tribally operated health programs. For all the benefits these programs provide, the complexity of the Medicare and Medicaid programs present huge operational challenges for IHS directly operated programs and for tribally operated health programs. The National Indian Health Board, the National Congress of American Indians, and the Tribal Self-Governance Advisory Committee have adopted resolutions endorsing the formation of a Tribal Technical Advisory Group (TTAG) with CMS. CMS currently has many Technical Advisory Groups that provide opportunities for States to interact with CMS staff on issues of common concern. These groups provide an opportunity for technical experts to work with CMS to clarify issues and work toward program improvements.

Recommendation: We recommend a directive from the Secretary to CMS that the TTAG be formed immediately and that its charter be structured to allow the participation of the tribal representatives identified in the compromise draft charter.

RESOLUTION #03-04-01
Support for the STEPS Grant Application to the Centers for Disease Control

RESOLUTION #03-04-02
Support for Participation in the National Tribal Tobacco Prevention Network

RESOLUTION #03-04-03
Sale of StanCorp Financial Group, Inc. Stock

RESOLUTION #03-04-04
Support for a Fetal Alcohol Syndrome Prevention Grant Application submitted to the Centers for Disease Control

RESOLUTION #03-04-05
Support for PhD Dissertation Research Under NARCH. Project Entitled: "The Assessment & Confirmation of Socio-Cultural Barriers that Inhibit Diabetes Self-Management & Glucose Control Among Northwest Native

JOINT RESOLUTION - NPAIHB and CRIHB
Support to increase the FY 2004 IHS Budget by $360 million to keep pace with Mandatory Costs Inflation and Program Expansion

JOINT RESOLUTION - NPAIHB and CRIHB
Joint resolution in support of a California EpiCenter

JOINT RESOLUTION - NPAIHB and CRIHB
In support of Tribes and Tribal Organizations contributing amounts equal to their tribal shares directly to NIHB to support legislative advocacy

JOINT RESOLUTION - NPAIHB and CRIHB
Support of creating a new Category of Eligibility with a uniform benefits package for all AI/AN

JOINT RESOLUTION - NPAIHB and CRIHB
Recommendations to address Tribal concerns on the impact of the One HHS Initiative

JOINT RESOLUTION - NPAIHB and CRIHB
Support for the Reauthorization of the Indian Health Care Improvement Act

JOINT RESOLUTION - NPAIHB and CRIHB
To support consultation with tribal governments in the Homeland Security Act of 2002 and the implementation of a tribal consultation policy

JOINT RESOLUTION - NPAIHB and CRIHB
To support the establishment of a Tribal Technical Advisory Group by the Center for Medicare and Medicaid Services

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 the tribes of Washington, Oregon, and Idaho to address health issues.

Newsletter Production
Special Thanks to:

LISA ANGUS
Sonciray Bonnell
Lynn DeLorme
Sayaka Kanade
Mike Severson
Teressa White
Chandra Wilson

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