Health News & Notes

Northwest Portland Area Indian Health Board | Volume 31, Number 3 | July 2002 Issue

by Julia Davis-Wheeler, (Nez Perce Tribe) NPAIHB Chair

Julia's Report

I hope everyone is enjoying the summer months with family and friends. July and August promise some rest from what has been a busy spring schedule.

The most significant news I have to report is that Dr. Michael Trujillo is no longer the Director of the Indian Health Service. I worked with Dr. Trujillo these past 8 years during his tenure as IHS Director, and I can say without hesitation that he is a man of high integrity, with great knowledge of the health needs of Indian people, respectful of tribal sovereignty, and a director with a deep and abiding love for Indian people. Deputy Director Michael Lincoln is the Acting Director pending the Presidential appointment of Dr. T's successor. Mr. Lincoln is very competent and tribes can feel comfortable in this interim period while various successors are considered for the position of Director. The Board has no official recommendation for a successor at this time. I hope tribes will take time to send Dr. T. a letter of appreciation for his service over the past 8 years. He will continue to contribute to Indian health in a new position within the Surgeon General's office. As many of you know he already held the title of Assistant Surgeon General while he served as IHS Director.

As directed by ATNI, in February the Board organized a national meeting to re-energize the movement to reauthorize the Indian Health Care Improvement Act (PL 93-437). The national meeting in Portland on May 28, 29, and 30 at the Doubletree Hotel was attended by over 220 participants. The Senate Indian Affairs Committee and House Resources committee staff solicited responses to many critical questions concerning the tribal draft of the Indian Health Care Improvement Act. It is expected that these responses will form the basis of a new bill from the Resources Committee and possibly some changes in the Senate bill. Hearings are being planned for later this summer, in part, due to the success of this meeting. It is perhaps too optimistic to expect passage this year, but tribes should continue to advocate for action of the bills if they are taken up in the current 107th Congress.

I was in Bismarck, North Dakota for NCAI in June with Ed Fox. As NIHB chair, I presided over health committee meetings and a special meeting on the Indian Health Care Improvement Act. Letters signed by NCAI President Tex Hall and myself were sent to the House and Senate in support of reauthorization.

The I/T/U Indian Health Service Budget Formulation Team presented its FY 2004 IHS budget to the Department of Health and Human Services on May 29, 2002 in Washington DC. Tribal

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In This Issue

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.

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Indian Health Care Improvement Act 2002 Activities

by Ed Fox, Executive Director

1. The Act expired September 30, 2001, but appropriations were passed effectively extending the act through FY 2002.
2. National Steering Committee Bill developed in 1999 remains the basis for Senate Bill 212 and HR 1662.
3. House Resources Committee will introduce a third Indian Health Care Improvement Act bill in July, 2002.
    a. Act takes the tribal bill and responds to the comments of the members of Congress, the Congressional Budget Office, Department of Health and Human Services, and House Legislative Counsel.
    b. Act will also consider the responses from tribal representatives to the issues raised by the above.
        i. Tribal responses are from communication to the House Resources Committee and the discussion at the National Indian Health Care Improvement Act Meeting held in Portland, OR on May 28-30, 2002.
4. Legislative Strategy to Pass the Indian Health Care Improvement Act
    a. National Steering Committee leadership continues to monitor progress and lead lobbying effort.
    b. H. Sally Smith, Julia A. Davis, Rachel Joseph, Dr. Taylor MacKenzie, Robert Nakai, and Buford Rolin have participated in discussions about 2002 activities.
    c. Conference calls scheduled to update progress and plan activitiesto assit in Summer 2002 legislative activity.
        1. June 7 conference call moderated by Sally Smith and Rachel Joseph.
        2. June 20 conference call moderated by Rachel Joseph with request for information by July 8.
5. Coordination of Activities with tribes
    a. Report to NCAI, Bismarck, North Dakota June 18-20, 2002
    b. Website information posted at www.npaihb.org
6. Contact information:
    a. Northwest Portland Area Indian Health Board Ed Fox, Executive Director, by email only at : efox @ npaihb.org to be added to the Indian Health Care Improvement Act email listing.
        i. Email will be utilized for information updates
        ii. Reports at national and regional meetings (NCAI, NIHB)
    b. National Indian Health Board
        i. Yvette Joseph-Fox by email : yjoseph@nihb.org or call (303) 759-3075
7. Tribal advocates communicated new language to the Senate and House Committees by mid-July for possible 107th Congress hearings.

Legislative Update: Indian Health Service FY 2003 Budget

by Ed Fox, Executive Director

Congress took action on the FY 2003 Indian Health Service Budget. On Tuesday, June 25, 2002 the House Appropriations Committee approved the Interior Subcommittee-reported bill without amendment. The House bill proposes a FY 2003 IHS budget of $2,900,621,000. This is a $141.5 million increase over FY 2002 enacted, but only $76 million over the comparable FY 2002 funding level for IHS.

The House bill increases funding for the Indian Health Care Improvement Fund by $33 million and limits distribution to tribes funded below 40% of need compared to last year's 60% level of need threshold. This excludes all but two or three Portland Area tribes from receiving any of these funds. Contract Health Services increase is only$15 million compared to the estimated $56 million needed just to maintain current purchasing power. The House does recommend full funding for the annuitant health care costs that are estimated at $62 million. The House decreases "self-governance shortfall" funds by $9 million. The Committee did recommend funding for small ambulatory facilities, but the actual amount is not reported. All in all, the Portland Area will receive minimal if any funding increases for FY 2003 if these bills are passed.

The Senate Appropriations Committee slashed the Senate Interior Subcommittee bill on Thursday, June 27, 2002, from a recommended $157 million increase to just $82 million. It is difficult to understand the rationale for the cut, but one can be certain that if the Chairman of the Interior, Senator Robert Byrd, wants to restore the funds, he will. The ranking Republican, Ted Stevens, will have much to say about this as well. One can assume it has to do with the Democratic Senate's desire to match the fiscal restraint of the House. The allocations to the committee are unrealistic in several cases including the virtual freeze in the Labor, Education and HHS committee. So changes are coming.

Continued on page 14

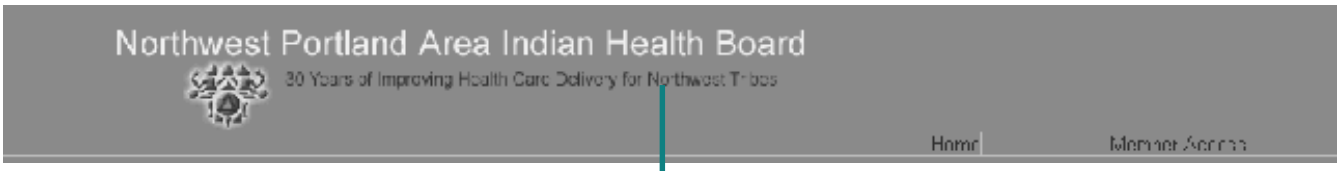
	President	House	Senate Interior Sub	Senate Approp.
Recommended	2,884,143,000	2,900,621,000	2,916,101,000	2,841,101,000
Reported increase	125,042,000	141,520,000	157,000,000	82,000,000
FY 2002 Enacted	2,759,101,000	2,759,101,000	2,759,101,000	2,759,101,000
FY 2002 Comparable	2,824,116,000	2,824,116,000	2,824,116,000	2,824,116,000
Actual Increase for FY 2003	60,027,000	76,505,000	91,985,000	16,985,000
Actual Percent Increase for FY 2003	2.1%	2.7%	3.3%	0.6%

Welcome Back!

Sonciray Bonnell (Sandia Pueblo, Isleta Pueblo and Salinan) returns to the Board as the Health Resources Coordinator (HRC). Raised here in Portland, she has worked for the Confederated Tribes of Siletz Portland office, PPS Indian Education Project, Portland State University and has contracted with NARA and NICWA. Sonciray graduated from Dartmouth College with a Master of Arts in Liberal Studies in Education and Native American Studies and has a Bachelor of Arts degree in Anthropology from the University of Washington. As the new HRC, Sonciray is responsible for the *Health News and Notes*, general board publications, some website maintenance, and is the point person for tribal inquiries. Sonciray has two young children, four teenage stepchildren, and one husband. In her spare time she enjoys hang gliding, scuba diving and climbing Mt Everest, AYY! What she really does in her "spare" time is gardening, ceramics and playing with her kids. With the support of her husband Tom, Sonciray is very excited to be back on the NPAIHB team after three years at home with her children.

Starting July 15, 2002 . . .

by Eric Jordan, Information Systems Analyst



As of July 15, 2002, the Northwest Portland Area Indian Health Board's website will have a new look and feel. Although the website address will remain the same (www.npaihb.org), NPAIHB.org will have a completely different user experience. The new website will have a different presentation (new colors, tagline, etc.), be easier to use (one screen, drop-down menus, site map), and offer more features (search function, members only access, new calendar system, issue briefs, etc.).

Since the last major upgrade to the npaihb.org website occurred back in 1997, we at the Board thought it was time for an overhaul. The web has experienced many technological changes since we first introduced NPAIHB.org back in 1996. Web browsers, CPU speeds, modem speeds, RAM amounts, and monitor sizes have all improved – not to mention the number of people that now access our site (13,806 total user sessions and 97,995 individual hits on the server in May 2002). In other words, NPAIHB needs to keep up with the times, and improving the NPAIHB.org website is an important step to better serve the needs of NW Tribes.

Here's a summary of most of the key changes:

Side Navigation Bar

The new side navigation bar is designed to make navigating the npaihb.org website easier. Instead of having to scroll down the home page in order to find the information that you are looking for (as is the case with the current site), the new site will allow the user to access any point within the site from the home through the use of drop-down menus.

Search Tool

Through the use of a newly implemented search tool, users can now perform keyword searches to find more information on a specific topic. By typing in keywords, the search engine will provide links to both pages and documents that contain the keyword. For example, by typing into the search box, "Diabetes" and clicking the "search" button, a page will open up with a list of links (ala "Google") sorted by relevance.

Member's Only Access

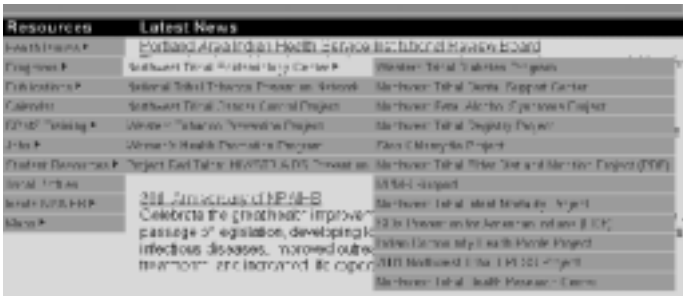
In our continual efforts to keep delegates, tribal leaders, and board members updated with new information, the new NPAIHB.org site will contain a link for "Member's Only." To access this section, users will need to enter a NPAIHB-provided user name and password. The thinking behind adding this section is to slowly begin the transition to paperless communication for items such as:

- Weekly mail outs
- Letters of support
- Meeting minutes
- Reports
- Etc.

WWW.NPAIHB.ORG Has a New Look and Feel!

Initially, we will only duplicate what is normally faxed and mailed to our constituents. The goal is to get users more comfortable accessing documents via the website, so that we can slowly decrease the volume of paper materials that we send out. Please don't hesitate to contact us with any concerns or questions regarding the direction that we are taking.

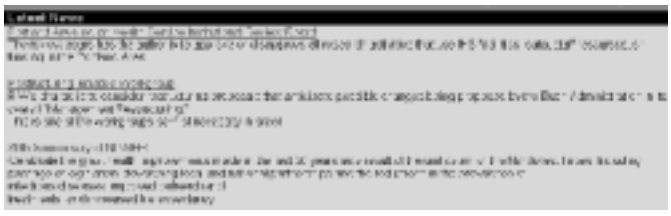
Issue Pages



Another new feature in the redesigned website is the "Health Issues" links that can be accessed from the side navigation bar. These new "Issue" pages are designed to provide an overview and/or resource on a particular topic with which NPAIHB is involved. For each topic, the issue page will have the following:

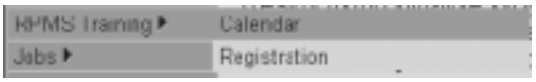
- § Issue Brief
- § NPAIHB Position Statement
- § Links to Related NPAIHB Projects and Workgroups
- § External Links to More Resources
- § Resources on How to Get Involved (if applicable)

Latest News and Upcoming Events



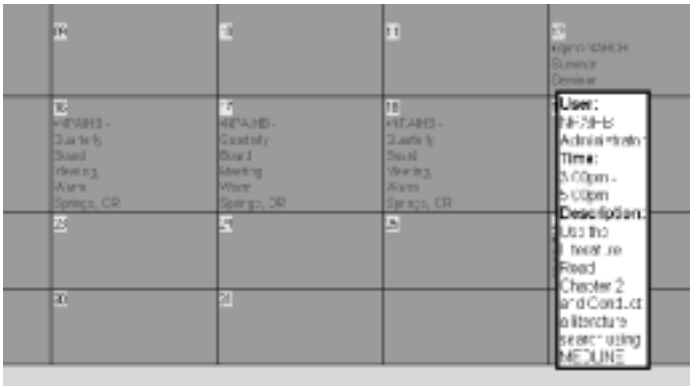
The new home page for NPAIHB.org will contain recent news, announcements, and upcoming events, with links to any background materials.

Registration Forms



For some of NPAIHB's activities (namely RPMS-Training and sponsored conferences), NPAIHB.org will allow users to register online via web forms. By selecting the "Registration" link, users will be given the option to either print out a form to mail or fax, or to register via the Internet by filling in the relevant fields and clicking the "Submit" button. The data captured from the web forms is then sent to the intended party via an e-mail.

Calendar



The new calendar has a more user-friendly interface that is both easy to read and navigate. As you scroll over a particular event, a small window pops up with even more details.

Closing Remarks

Although we are introducing these changes on July 15th, the process of refining and updating the website with new features, functions, and tools is ongoing. Most importantly, the value of a website is best determined by the benefits it provides to its users. In other words, please comment and provide feedback on what you like, don't like, and would like to see. It is this kind of information that will help guide us to make NPAIHB.org an invaluable resource.

Preventing Diseases with Water

by Tam Lutz, TOT's Prevention Project Director

Although traditional and cultural practices may differ across tribes, it is common for Indian communities to give thanks to all the creator has to offer – including water. Many tribal customs include drinking water either before or after a meal. Water is still thought by many to be the well of life. For many Indian communities water is considered sacred. An elder of the Confederated Tribes of Warm Springs once said that water is sacred to his people and that water is responsible for making life possible. However, outside of the long house or formal ceremonial occasions many Native people do not drink water.

Water is important spiritually as well as physically, and needs to be integrated into the daily lives and diets of our Native children. Water is the best thing to drink to quench a thirst. However, there has been a shift in our lives from primarily drinking water to drinking soda and other sugared beverages. This shift in beverage consumption has been accompanied by an increase in energy consumption (calories) leading to obesity and tooth decay.

Sugared beverages can have a negative affect on your health. A 12-ounce soda pop, such as one of the leading cola drinks contains 110 calories and 29 grams of sugar. If you super size, it would be 410 calories and 113 grams of sugar, equivalent to approximately a quarter of a pound of sugar. In addition, soda beverages also have acidic properties that are harmful to the teeth. The National Dental Association states that people should not drink soda and other sugared beverages, or to at least decrease the amount of sugared beverages consumed. The American Dietetic Association recommends that we drink water instead of soda because of the effects of caffeine and simple sugars have upon the body. A diet high in calories can lead to obesity, which is a major risk factor for diabetes and a condition at epidemic levels in Indian Country. Diabetes, once called adult onset diabetes, is now occurring at younger and younger ages.

There are many ways to encourage you and your children to drink water:

Clara Boerner (with mom, Verné) enjoying a nice cool drink of Water. Mom brings a clean sippy cup to fill with water while out and about.

- Make clean, good tasting water available
- Keep cold water in your refrigerator
- Offer water to your family and guests instead of soda

Continued on page 17, see "Water"

Fetal Alcohol Syndrome

complied by Kathryn Alexander, Project Assistant

The following information is provided in conjunction with the July Topic of Substance Abuse and was taken, with permission, from the website:

www.drugrehabamerica.net/drug-info.htm

What is Fetal Alcohol Syndrome?
Fetal Alcohol Syndrome (FAS) is a cluster of irreversible birth abnormalities that are the direct result of heavy drinking during pregnancy.

Alcohol, like most other drugs, passes easily through the mother's placenta and into the fetal bloodstream. In the fetus, the alcohol depresses the central nervous system and must be metabolized by the immature liver of the fetus, which cannot effectively process this toxic substance. The alcohol stays in the fetus' body for a prolonged time (even after leaving the mother's body) and the unborn child remains intoxicated, possibly suffering withdrawal symptoms after the alcohol is no longer present.

Children born with fetal alcohol

Continued on page 15

The Northwest Tribal Registry Project

by Emily Puukka, Tribal Registry Manager

"It is a capital mistake to theorize before one has data. Insensibly one begins to twist facts to suit theories instead of theories to suit facts."
- Sir Arthur Conan Doyle (1859-1930), *Sherlock Holmes*

Where We Came From

"Garbage in… garbage out." That's what my old professor used to tell me. If you start with bad data, everything that results from that data is also, well, garbage. This was the problem recognized by tribal leaders more than a decade ago. Accurate baseline data are crucial in order to (1) monitor health trends among Northwest American Indians and Alaskan Natives (AI/AN), (2) design and implement effective public health interventions, and (3) evaluate the efficacy and cost-effectiveness of those interventions. Unfortunately, due to high rates of racial misclassification (misclassifying AI/AN as some other race/ethnicity) in many health related data sets, the true health status of Northwest AI/AN remains unclear. In order to address this problem the Northwest Tribal Registry Project (Registry Project) was developed in 1998 with the goal of providing Northwest AI/AN communities more accurate and comprehensive health status data. The Registry is a demographic database of Northwest AI/AN.

Where We're Going

Recently, staff of the Registry Project conducted a repeat linkage with the Oregon State Cancer Registry (OSCaR) to determine the burden of cancer among Northwest AI/AN, to monitor trends with respect to cancer in AI/AN communities, and to increase the accuracy of previous estimates. Upon linking the Northwest Tribal Registry with the OSCaR, we discovered that 54 percent of AI/AN cases in the OSCaR were misclassified as a race other than AI/AN, and 2 percent were misclassified as "race unknown." Race and ethnicity provide extremely valuable information, as the age-adjusted cancer rate for AI/AN in the state of Oregon jumped from 110 per 100,000 before the Registry Project and OSCaR linkage to 238 per 100,000 after the linkage, an increase of 116 percent. In addition, the top five cancer sites for AI/AN also changed as a result of the linkage (see table below).

Future projects for the Registry include repeat linkages with the Washington and Idaho State Cancer Registries, Western Washington SEER Cancer Registry, state mortality files, state STD files, as well as numerous other linkage projects with relevant data sets.

In the meantime, the Northwest Tribal Registry Project will continue in our mission to provide Northwest AI/AN communities with a more timely, accurate, and useful picture of the health status of their communities.

Leading Cancer Sites, OSCaR, 1996-1999

State of Oregon (all races)	AI/AN Pre-Linkage	AI/AN Post-Linkage
1. Breast	1. Lung	1. Lung
2. Lung	2. Colorectal	2. Breast
3. Prostate	3. Breast	3. Colorectal
4. Colorectal	4. Lymphoma	4. Prostate
5. Skin	5. Prostate	5. Lymphoma

The Cycle of Addiction

compiled by Kathryn Alexander, Project Assistant

The following information is provided in conjunction with the July Topic of Substance Abuse and was taken, with permission, from the website:

www.drugrehabamerica.net/drug-info.htm

What Is A Drug? In medical terms, a drug is any substance that when taken into a living organism may modify one or more of its functions. Drugs can provide temporary relief from unhealthy symptoms and/or permanently supply the body with a necessary substance the body can no longer make. Some drugs produce unwanted side affects. Some drugs lead to an unhealthy dependency that has both physiological and behavioral roots.

Why People Use Drugs No one wants to be a drug addict or alcoholic, but this doesn't stop many people from getting addicted. The most commonly asked question is simply - how? How could my son, daughter, father, sister, or brother become a liar, a thief - someone who cannot be trusted? How could this happen? And why won't they stop? The first thing to understand about addiction is that alcohol and addictive drugs are generally painkillers. They chemically kill physical or emotional pain and alter the mind's perception of reality. They make people numb. For drugs to be attractive to a person there must first be some underlying unhappiness, sense of hopelessness, or physical pain.

Drug Addiction Follows A Cycle The life cycle of addiction begins with a problem, discomfort or some form of emotional or physical pain. They find this very difficult to deal with. We start off with an individual who is generally healthy. This person encounters a problem or discomfort that they do not know how to resolve or cannot confront. This could include problems such as difficulty "fitting in" as a child or teenager, anxiety due to peer pressure or work expectations, identity problems or divorce as an adult. It can also include physical discomfort, such as an injury or chronic pain. The person experiencing the discomfort has a real problem. They feel their present situation is unendurable, yet see no logical solution to the problem. The difference between an addict and the non-addict is that the addict chooses drugs or alcohol as a solution to the unwanted problem or discomfort.

The Addiction Progresses
Analogous to an adolescent child in a first love affair, the use of drugs or alcohol becomes obsessive. The addicted person is trapped. The problem that initiated the drug or alcohol use fades from memory. At this point, all the addict can think about is getting and using drugs. They lose their ability to control usage and disregard the horrible consequences of their actions.

Alcohol And Drug Tolerance In addition to the mental stress created by addiction, the addict's body has also adapted to the presence of the drugs. They experience an overwhelming obsession with getting and using drugs, and will do anything to avoid the pain of withdrawing from them. The new addict soon begins to experience drug cravings. The addict now seeks drugs both for the reward of the "pleasure" they give him, and also to avoid the mental and physical horrors of withdrawal. Ironically, the addict's ability to get "high" from the alcohol or drug gradually decreases as his body adapts to the presence of foreign chemicals. He or she must take more and more, not just to get an effect but often just to function at all. At this point, the addict is stuck in a vicious dwindling spiral. The drugs they abuse have changed them both physically and mentally. The addict has crossed an invisible and intangible line.

Drug Metabolites
When a person drinks or uses drugs over a period of time, the body becomes unable to completely eliminate them. Drugs and alcohol are broken down in the liver. These metabolites - the substances the body converts the drugs or alcohol into - although removed rapidly from the blood stream, become trapped in the fatty tissues. There are various types of tissues that are high in fat content, the one thing in common – and the problem that needs to be addressed is that these drug residues remain for years. Tissues in our bodies that are high in fats turn over very slowly. When they are turned over,

the stored drug metabolites are released into the blood stream and reactivate the same brain centers as if the person actually took the drug. The former addict now experiences a drug restimulation (or "flashback") and drug craving. This is common in the months after an addict quits and can continue to occur for years, even decades.

The Cycle Of Quitting, Withdrawal, Craving and Relapse

When the addict initially tries to quit, cells in the brain that have become used to large amounts of these metabolites are now forced to deal with much decreased amounts. Even as the withdrawal symptoms subside, the brain "demands" that the addict give it more of the drug. This is called drug craving. Craving is an extremely powerful urge and can cause a person to create all kinds of "reasons" they should begin using drugs or drinking again. The addict is now trapped in an endless cycle of trying to quit, craving, relapse and fear of withdrawal. Eventually, the brain cells will again become used to having lowered drug metabolites. However, because deposits of drug or alcohol metabolites release back into the bloodstream from fatty tissues for years, craving and relapse remain a cause for concern. The presence of metabolites even in microscopic amounts cause the brain to react as if the addict had again actually taken the

Restructuring Initiative Workgroup (RIW), Update

by Pam Lay, Indian Health Service, Extern
Verné Boerner, Administrative Officer

In the fifth Restructuring Initiative Workgroup (RIW) meeting held on May 18 – 20th, 2002 in Albuquerque, NM, the RIW met to finalize the drafted recommendations to be submitted to Dr. Michael Trujillo, Director of the Indian Health Service (IHS). This preliminary report, named "Transitions 2002: A 5-Year Initiative For Restructuring Indian Health", contains 58 recommendations that the RIW believe will best enable accessible and acceptable health care services for American Indians and Alaska Natives during the next five years.

The RIW has met five times since its formulation in February 2002. Dr. Trujillo convened the RIW to consider how the Indian health system fits into the President's Management Agenda and initiatives of the Department of Health and Human Services (DHHS), also known as the One-DHHS initiative. The RIW consists of a group of 20 Indian health leaders – tribal leaders, representatives from tribal and urban Indian health programs, national Indian organizations, and Federal employees.

Background

The draft recommendations contained in the preliminary report are the result of the second formal restructuring process initiated by the IHS since 1995. The first process in 1995-97 was guided by the Indian Health Design Team (IHDT) and resulted in 50 recommendations that shaped today's IHS. The 1995-97 design focused on fixing the organization internally and resulted in streamlining the IHS Headquarters' organizational structure and decreasing administrative positions from the IHS Headquarters and Area Offices. The savings from the downsizing were reinvested in front-line health delivery positions at local IHS hospitals and clinics and increased funding for tribes and tribal health organizations to provide health care under self-determination contracts and self-governance compacts. The IHS downsized to a greater degree than other agencies within the Department of Health and Human Services (HHS).

Restructuring Initiative

Because the IHS had downsized previously and most recommendations were implemented after 1997, the RIW recommends that the IHS be exempt from the current HHS and Office of Management and Budget (OMB) proposals for work force reductions. In response to work force consolidation proposals, the RIW recommends HHS first consult with American Indians and Alaska Natives in accordance with the HHS tribal consultation policy. The RIW proposes alternatives to some of the HHS consolidation proposals and suggests alternatives that would decrease the disruption in services that could be caused by some of the HHS proposed consolidations.

The RIW has concluded that increased resources and access to health care services will eliminate the disparities in funding and health. Therefore, the RIW

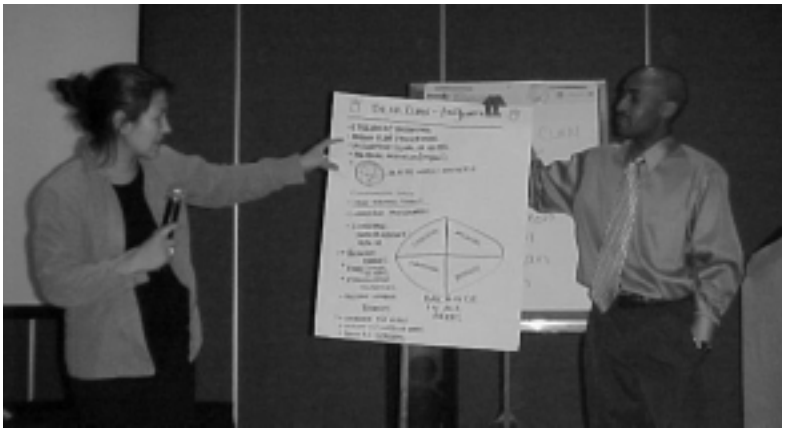
Continued on page 14

April Strategic Planning/ Board Meeting

The April Board Meeting was held at the Quinault Beach Casino and Resort. The main focus of this Board meeting was strategic planning for the Board. Jillene Joseph was hired to facilitate the process.

The Smoke Salmon Clan work through the Seventh Generation exercise, defining what legecy the Delegates would like to leave for their grandchildren's grandchildren

The Executive Committee: Vice-Chair Pearl Capoeman-Bailey, Secretary Norma Peone, and Sergeant-at-Arms Rod Smith



Liling Sherry, Tobacco Project Director and Taalib Madyun, Cancer Control Project Assistant, explain their Clan's goals for the 7th Generation

Ed Fox, Executive Director, and Rod Smith (Puyallup), Delegate of the Year and newly elected Sergeant-at-Arms for the Board, enjoy a morning bagel

The Strategic Planning Process: Dan Gleason leads his group (Smoked Salmon Clan) through the 7th Generation plans.

Jillene Joseph(left) takes a break from the Strategic Planning to visit with Tam and Rowan Lutz(center), and Verné Boerner(right)

The Bear Clan going over the Mission Statement for the Board

The Project Directors
back: *Ruth Jensen, Kathryn Alexander, Joe Finkbonner, Emily Puukka* ***front:*** *Tam Lutz, Karen McGowan, Gary Small, Sharon John, Shawn Jackson, Luella Azule, and Liling Sherry*

Part of the Diabetes Crew ***left to right****: Jennifer Olson, Penny Shumacher, Crystal Denney, Wendi Johnson, and Mike Severson*

Hailey Osborn(left) and Clara Boerner(right) meet in the lobby

Thank you for Supporting Northwest Tribal Cancer Control Efforts

by Ruth Jensen, Northwest Tribal Cancer Control Project Director

The Northwest Tribal Cancer Control Project is working in consultation with tribes to reduce the cancer burden in Northwest tribal communities. NTCCP recently submitted a proposal to CDC to continue this project, and 70 tribes, individuals and organizations have offered their support.

They include three tribes from Idaho: **Coeur d'Alene, Kootenai, Nez Perce**; eight tribes in Oregon: **Burns Paiute, Confederated Tribes of Grand Ronde, Confederated Tribes of Siletz Indians, Confederated Tribes of Warm Springs, Confederated Tribes of the Umatilla Indian Reservation, Coquille Indian Tribe, Cow Creek Band of Umpqua Indians, and the Klamath Tribes**; and 20 in Washington: **Confederated Tribes of Chehalis, Confederated Tribes of Colville, Hoh, Jamestown S'Klallam, Lummi, Lower Elwha Klallam, Makah, Nooksack, Port Gamble S'Klallam, Puyallup, Quileute, Samish, Sauk Suiattle, Shoalwater Bay, Skokomish, Spokane, Squaxin Island, Swinomish, Upper Skagit, Yakama**. The Indian Health Service has also provided support: **Doni Wilder**, Director, Portland Area Office along with three Portland Area service units: **Colville, Fort Hall, and Western Oregon**. **John Saari**, MD, Director, Clinical Support Center, and **Nathaniel Cobb**, MD, Director, Cancer Prevention and Control.

Members of academia provided support. They include a long-time supporter of NTCCP, **Tom Becker**, MD, PhD, Professor and Interim Chair, Department of Family Medicine and Public Health, Oregon Health and Science University, provided support along with his colleagues at OHSU: **Lori Lambert**, MA; **William Lambert**, PhD; and **Jodi Lapidus**, PhD. **Jennie Joe**, PhD, Director, Native American Research and Training Center, and **Robert Young**, Director, Cancer Programs, both of the University of Arizona; and **Gary Meadows**, PhD, Director, Cancer Prevention and Research Center, Washington State University.

The following American Indian and/or multicultural organizations also provided letters of support indicating specific ways they would support the project: **Mark L. Ufkes**, Executive Director, Affiliated Tribes of Northwest Indians; **Jeffrey A. Henderson**, MD, MPH, President and CEO, Black Hills Center for American Indian Health; **James W. Hampton**, MD, Chair, Intercultural Cancer Council; **Terry Cross**, Executive Director, National Indian Child Welfare Association; **Linda Burhansstipanov**, DrPH, Executive Director, Native American Cancer Research; **Jillene Joseph**, Associate Director, Native Wellness & Healing Institute; **Celeste Whitewolf**, Founding Member, Native Women's Circle of Hope; **Judith Salmon Kaur**, MD, Principal Investigator, Spirit of EAGLES, Mayo Clinic; and **Barbara Stillwater**, PhD, RN, Stillwater Unlimited.

Cancer control organizations providing letters of support include the following: **Dave Rogers**, Regional Vice President, American Cancer Society; **Deborah Schiro**, Division Director of Cancer Control, American Cancer Society; **Warden Minor**, President and CEO, American Lung Association of Oregon, **H. Stacy Nicholson**, MD, MPH, Associate Professor, Doernbecher Children's Hospital – Pediatric Hermatology; Oncology, Oregon Health and Science University; **Cherie Minear**, MS, Program Manager, Susan G. Komen Breast Cancer Foundation – Puget Sound Affiliate; **Sue Fratt**, Executive Director, Susan G. Komen Breast Cancer Foundation – Oregon and Southwest Washington Affiliate. Representatives from three cancer centers provided support: **Grover Bagby**, MD, Director, Oregon Cancer Institute, Oregon Health and Science University; **Nancy Zbaren**, MPH, Director, Cancer Information Service of the Pacific Region and **Teresa Guthrie**, MN, RN; Coordinator, Spirit of EAGLES, and **Nancy Hutchison**, PhD, Director, Science Education Partnership – all of the Fred Hutchinson Cancer Research Center; and **Phyllis Pettit Nassi**, Manager, Special Populations of the Huntsman Cancer Institute in Utah, extending service to tribes in Idaho and **Maria Meyer**, Director and Publisher, CareTrust Publications.

NPAIHB Strategic Planning

by Jillene Joseph, Strategic Planning Consultant

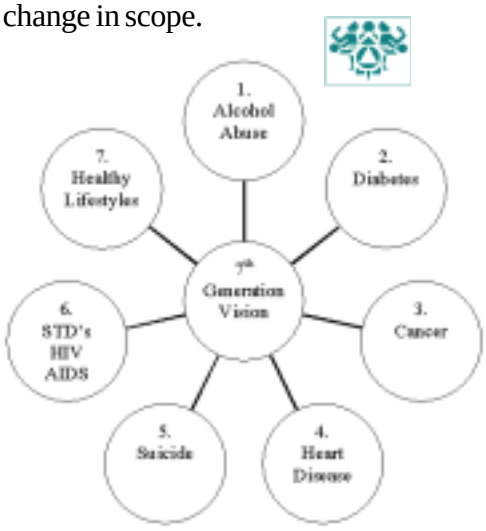
The Northwest Portland Area Indian Health Board held a two-day strategic planning process during the April 2002 Quarterly Board Meeting. This process allowed the Board to receive valuable input from tribes and also provided an avenue to review the accomplishments from the previous sessions. Most importantly, the two-day session helped to set priorities for the future.

Several months before the April Board meeting NPAIHB Administrative staff and a contractor met to discuss the strategic planning process. Notes were reviewed from past strategic planning sessions and a draft agenda was set. The planning team agreed that the activities of the Board fall into four categories: Policy and Legislature; Surveillance and Research; Health Promotion/Disease Prevention; and Training and Technical Assistance (with some overlap).

The agenda was based on textbook strategic planning using the strengths, weaknesses, opportunities and threats (S.W.O.T.) model to examine critical areas. The mission statement was reviewed and priority areas and strategies were identified. In addition to reviewing past strategic planning processes, two brainstorming exercises, the Seventh Generation Exercise and an Idea Carousel, were used to refine the existing values and critical areas and to review the mission statement.

The mission statement of the NPAIHB has not changed much in many years and it was thought that it wouldn't change drastically this time either. After much discussion, new versions of the mission statement were drafted. The process required more time than scheduled and therefore, was tabled. Two final versions of the mission statement were drafted and participants were asked to consider both versions before finalizing it at the next Board's Quarterly Meeting in July.

Overall, the planning session was successful as it provided input from the tribes regarding direction for the Board, provided positive and reassuring feedback, and helped build a history and legacy for the organization. Delegates indicated that the Board has successfully implemented programs that were guided by past strategic plans. The Delegates also specified only moderate changes. As a whole, the delegates felt the course and activities of the Board were appropriate and effective and should not significantly change in scope.



Smoke Salmon Clan's vision for the Seventh Generation

The Henry J. Kaiser Family Foundation

Native American Health Policy Fellowship Program

The Henry J. Kaiser Family Foundation awards fellowships to outstanding American Indian/ Alaska Native (AI/AN) individuals who have made their career in health related fields and are interested in health policy. Fellowships are designed to give AI/AN health professionals an opportunity to learn more about health policy issues and gain a better understanding of the national policymaking process from a first-hand perspective. Fellowships take place annually from January through December in Washington, DC. The Native American Health Policy Fellowship Program offers work and policy research experience, professional development, and a salary provision.

Please contact the Kaiser Family Foundation directly www.kff.org for eligibility criteria and application forms.

Summer Externs Come to the Board

by Don Head, Special Projects Assistant

This summer, the Board will host three summer externs. Gary Small, Project Director for the Health Professions Education Project, helped coordinate the placement of students at various sites and clinics in the Northwest.

The externships are paid for through the Indian Health Service Portland Area Office through the scholarship branch. Each of the externs placed will be gaining valuable experience, as well as enabling them to learn some of the aspects of the health care field. The goal of HPEP is to recruit students in the health professions, and the internship program is an important part of that recruitment, in that it provides hands-on experience.

Joining the Board this summer are Brittany Harris (Pit River, Mountain Maidu), Jim Vinson (Cherokee), and Pam Lay (Creek/Yakama). Brittany is working with the Northwest Cancer Control Project, under Project Director

Ruth Jensen. She comes from Northern California, where she attends school at California State University – Chico. Jim Vinson, a native of Portland, is attending school at Gustavus Adolphus College in Wisconsin. This summer, he will be working for Tam Lutz, the Project Director of the Indian Health Community Profile Project and the Toddler Obesity and Tooth Decay Prevention Project. Pam recently graduated from Yakima Valley Community College, and is working for Verné Boerner, the Administrative Officer, on projects ranging from the Indian Health Care Improvement Act to the Strategic Planning for the Board.

Gary Small aided PAO IHS in placing 12 other students in externships. Ten of the students were placed with clinics in the Northwest (Yakama, Healing Lodge of the 7 Nations, Lummi, Neah Bay, Spokane, Fort Hall), and two others were placed in Alaska (Alaska Native Medical Center in Anchorage), and Nevada (Elko Clinic).

Continued from page 9

recommends that the IHS budget be increased to $5 billion by 2007.

What Next and What You Can Do

The Workgroup provided a preliminary report to the Indian Health Service (IHS) to seek input from American Indian and Alaska Native people throughout Indian Country on the proposed recommendations and to incorporate their feedback into the final recommendations. This report will remain preliminary until consultation with Indian people is complete in August 2002. In order to view the report in its entirety, please go to http://www.ihs.gov/nonmedicalprograms/ihdt2.

Feed back provided by July 19th, 2002, to Verné Boerner (NPAIHB assigned tribal technical staff to the RIW), will be brought forth to the RIW committee. You can reach Ms. Boerner at (503) 228-4185 or email her at vboerner@npaihb.org.

Continued from page 3

There is room for confusion on the actual increases, but the Board has chosen to use a comparable figure for FY 2002 rather than the 'enacted,' since a portion of this year's increases are required to cover the costs of retirees' (annuitants) health benefits that were previously paid by the Department of Defense. This information is from the press releases of the Senate and House Committees (www.senate.gov/~appropriations and www.house.gov/appropriations) and they have yet to report full spreadsheets of the budget by line item.

FAS continued

Continued from page 6

syndrome typically are smaller in size, have smaller heads, and suffer deformities of limbs, joints, fingers, and face, as well as heart defects. They may also have cleft palates and poor coordination.

In some children, FAS does not appear until adolescence, when they exhibit hyperactivity and learning and perceptual difficulties. These impairments are symptomatic of minimal brain dysfunction (MBD), which affects between 5 and 19 percent of schoolchildren, according to a study by the National Institute of Alcohol Abuse and Alcoholism. Studies of children with FAS who are now teenagers have uncovered new physical problems—ear infections, hearing and vision loss, and dental problems— that were not identified when the children were first studied at a younger age.

Only a small percentage of the children born to women who use alcohol suffer FAS. The reasons for this are unknown. Maternal risk factors for this condition include:

Chronic drinking during pregnancy
Previous problems with drinking

Some studies have shown that females who are light-to-moderate drinkers (so-called social drinkers) give birth to babies with subtle alcohol-related neurological and behavioral "problems". Although these "problems" are less severe than those in children of heavy drinkers, these findings indicate that even small amounts of alcohol can also cause developmental and behavioral abnormalities.

Pregnant women should abstain from all alcoholic beverages. Women attempting to conceive should also abstain.

Are certain groups of people more likely to develop alcohol problems than others?

Yes. Nearly 14 million people in the United States—1 in every 13 adults—abuse alcohol or are alcoholics. However, more men than women are alcohol dependent or experience alcohol-related problems. In addition, rates of alcohol problems are highest among young adults ages 18-29 and lowest among adults 65 years and older. Among major U.S. ethnic groups, rates of alcoholism and alcohol-related problems vary.

What are some of the facts about alcohol and its use in life?

Alcohol — including beer, wine, and hard liquor – is the most commonly used and widely abused psychoactive drug in the country. Alcohol is the most widely tried drug among teenagers. Over 50% of 8th graders and 8 out of 10 12th graders report having tried alcohol. Many teenagers report binge drinking — in 1995, 30% of 12th graders surveyed reported binge drinking (5+drinks in a sitting) in the previous 2 weeks. Even young teens report irresponsible use of alcohol — 25% of 8th graders have been drunk. Alcohol use is widespread, although the per capita consumption has varied from decade to decade. While U.S. consumption of alcoholic beverages increased after World II, since 1981 it has declined slightly. But even with declines in alcohol use, two of three American adults drink alcoholic beverages. About half of all alcohol consumed in this country is ingested by heavy drinkers, estimated to be between 6.5 and 10 percent of the total population. The extent and frequency with which these individuals drink cause serious health and behavioral problems—disrupting their own lives and that of their family, friends, and employers—and also extracts a heavy societal toll.

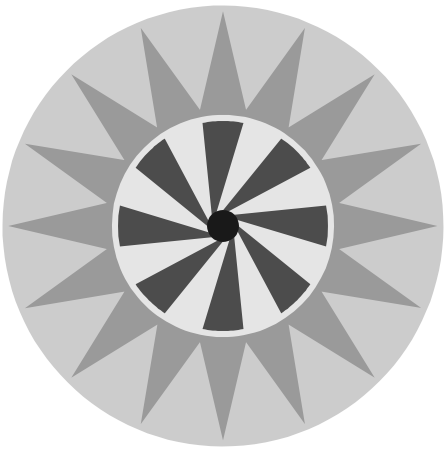
Alcohol use is involved in:

One half of all murders, accidental deaths, and suicides
One-third of all drowning, boating and aviation deaths
One-half of all crimes
Almost half of all fatal automobile accidents

The health problems associated with alcohol include brain damage, cancer, heart disease, and cirrhosis of the liver.

Substance Abuse Links:

www.alcoholism2.com
www.addictionca.com
www.usenodrugs.com



New Staff to the Board

New Leadership Fellow for Tobacco Projects

Nichole Hildebrandt, a member of the Shoshone-Bannock Tribe, is the new Leadership Fellow for the Creating Indigenous Resource Cooperatives Through Leadership Education (CIRCLE) Project. CIRCLE is funded by a grant from the Robert Wood Johnson Foundation. The primary goal of the CIRCLE Project is to develop a comprehensive model for mobilizing American Indian/Alaska Native community members in tobacco prevention and control by conducting a case study and documenting the activities and results.

Nichole lived on the Fort Hall Indian Reservation, and moved to Portland after graduating from high school. She graduated from Portland State University in 1998, receiving a Bachelor of Science degree with a dual major in Business Management and Marketing. She worked for Universal Underwriters Insurance Company as an Account Executive prior to coming to the Board.

New Project Specialist for the Western Tribal Diabetes Project

Wendi Johnson is the new Project Specialist with the Western Tribal Diabetes Project. After graduating from Lewis and Clark College with a Bachelor of Arts degree in International Affairs, Wendi worked as a social worker with youth in the juvenile system. She then transitioned into the health field where she worked as a patient advocate, case manager, and researcher. Wendi is now in the process of completing her thesis for her Master of Public Health Program in the Social and Behavioral Sciences Track at the University of Washington (UW). While at UW she concentrated on health education, program development and evaluation. She is very excited to work with the Western Tribal Diabetes Project.

New Urban Specialist for the National Tobacco Project

Crystal (Colliflower) Gust, Chippewa-Cree from the Rocky Boy Reservation in Montana, is very excited to be working as the new Urban Specialist for the National Tribal Tobacco Prevention Network. As the Urban Specialist, she provides training on tobacco issues and assists in materials development. Before coming to Portland, she was a full-time student at Montana State University and worked for the American Indian Research Opportunities Program updating past minority biomedical research participants for statistical purposes.

Crystal received her Bachelor's degree from Montana State University in 1996 in Animal Science. Currently, she is working part-time on a second degree at Portland State University in Mechanical Engineering.

Some of her hobbies include riding horses, reading, and downhill skiing. She was also recently married on June 15, 2002!

Project Red Talon
HIV/AIDS Project Report

by Karen McGowan, Project Director

The rising rate of HIV infection and AIDS in Native Americans poses a "serious health threat that could devastate Native American communities" if left unchecked.
Dr. David Satcher,
Former Surgeon General

Currently, Project Red Talon is involved with the HIV Testing Study. This study is funded by the Center for Disease Control and Prevention to determine AI/AN knowledge, attitudes and behaviors around HIV, as well as to determine if and where AI/AN are tested for HIV and where AI/AN are receiving prevention information. The findings from the study will assist tribes with HIV prevention education, as well as care and treatment for infected community members. American Indian communities have survived many tragedies.

Human Immunodeficiency Virus (HIV) is a virus that attacks the immune system and is transmitted by three primary routes: 1) sexual, 2) from mother to child during pregnancy, birth, and through breastfeeding and 3) contact with contaminated blood. HIV cannot be transmitted from casual contact. In most cases, the virus can remain unnoticed or asymptomatic for up to 10 years. AIDS is the final stage of an HIV infection. According to the Center for AIDS Prevention Studies and Research Institute the lifetime care and treatment cost is approximately $195,000 per patient. HIV/AIDS is 100% preventable but without a known cure it is also 100% deadly. Currently, communities of color, women, youth and injecting drug users are populations most at risk for HIV infection. Prevention programs targeting these groups will be most effective in reducing infection rates.

What's happening in Indian Country:

There are many factors that place American Indians and Alaska Natives (AI/AN) at risk for HIV infection such as high rates of STD's, teenage pregnancy rates, substance abuse, and poverty. IHS found that HIV infection in rural areas among AI/AN women in their third trimester of pregnancy was at rates four to eight times higher than rates for childbearing women of All Races in the same states (IHS, 1992). Currently, 2,337 AI/AN have been diagnosed with AIDS and 871 HIV cases. At present, available data indicates that American Indians/Alaska Natives are developing AIDS at earlier ages compared to the general U.S. population. This may imply that American Indians are contracting HIV at earlier ages or delaying testing and treatment for an HIV infection.

With existing evidence of high STD rates, teenage pregnancy rates, substance abuse and poverty in Indian Country, it is imperative that AI/AN communities implement aggressive HIV prevention campaigns. Prevention is the key to reducing HIV infections.

Let's not let HIV/AIDS reach epidemic proportions within our communities. For more information regarding HIV, please contact Karen McGowan at (503) 228-4185.

Water, Continued from page 6

- Buy a water bottle that you like using or a fun sippy cup for toddlers
- Carry a bottle of water with you when you go places
- Set a good example for your kids by drinking water
- Serve water with lemon or lime to add flavor
- Use ice, as many people prefer the taste of cold water
- Place a pitcher of water on the table at mealtime

If you have any ideas for promoting drinking water, please contact Jim Vinson or Julia Putman at (503) 228-4185, jputman@npaihb.org, or you can fax them at (503) 228-8182. We would love to share your ideas with others.

Upcoming Events

August

Dental Data System (DDS)
August 14-15, 2002
Location: NPAIHB
Portland, OR
Contact: Mary Brickell or Dr. Crow
Telephone: (503) 228-4185

Referred Care Information System (RFIS)
August 20-21, 2002
Location: NPAIHB
Portland, OR
Contact: Mary Brickell or Larry Tallacus
Telephone: (503) 228-4185

Contract Health Services (CHS)
August 22-23, 2002
Location: NPAIHB
Portland, OR
Contact: Marry Brickell or Larry Tallacus
Telephone: (503) 228-4185

National Diabetes Program
August 20-22, 2002
Location: Westin Hotel
Seattle, WA
Contact: Cyrstal Denney
Telephone: (503) 228-4185

September

Healing Our Spirit Worldwide Conference
Setpember 2-6, 2002
Location: Albuquerque, NM
Contact: www.healingourspiritworldwide.com

Affiliated Tribes of Northwest Indian 49th Annual Conference
September 16-19, 2002
Location: Quinault Beach Resort and Casino
Ocean Shores, WA
Contact: ATNI
Telephone: (503) 249-5770

September Cont.

First National Conference on Birth Defects, Developmental Disabiltities, and Disability and Health
September 17-19, 2002
Location: Hyatt Regency Altanta Hotel
Atlanta, GA
Contact: Annette Gay
Telephone: (770) 488-7150

Third Party Billing and Accounts Receivable
September 16-20, 2002
Location: Portland Area IHS
Portland, OR
Contact: Mary Brickell or David Battese
Telephone: (503) 228-4185

Chehalis Tribal Health Clinic - Health Fair
September 25, 2002
Location: Lucky Eagle Casino
Rochester, WA
Contact: Christina Hicks
Telephone: (360) 273-5504

October

Tribal Health Director's Meeting
October 14, 2002
Location: Umatilla
Umatilla, OR
Contact: Ed Fox
Telephone: (503) 228-4185

NPAIHB Quarterly Board Meeting
October 15-17, 2002
Location: Umatilla
Umatilla, OR
Contact: Elaine Dado
Telephone: (503) 228-4185

July 2002 Resolutions

RESOLUTION #02-03-01 "Support for a $505 Million Increase to the FY 2003 IHS Budget That Reflects Mandatory Cost Increases"

RESOLUTION #02-03-02 "Support for Submission for Proposal to the California Indian Health Service for the Continuation of Diabetes Data Improvement Activities Among California Tribes"

RESOLUTION #02-03-03 "Support for Supplemental Funding for the Western Tobacco Prevention Project to Implement an Adult Tobacco Survey"

RESOLUTION #02-03-04 "Continuing Support for the National Tribal Tobacco Prevention Network"

RESOLUTION #02-03-05 "Continuing Support for the Western Tobacco Prevention Project"

RESOLUTION #02-03-06 "Support for the Comprehensive Cancer Control Project at the Northwest Portland Area Indian Health Board"

RESOLUTION #02-03-08 "Support for the Compromise Funding Methodology for Recurring Distribution of the Contract Health Services Funding"

Continued from page 1

representatives presented the justification for the $18 billion needs based budget and a justification for a $1 billion increase for FY 2004.

The President's budget request for FY 2003 of 2.2% is clearly inadequate. The House and Senate Interior Appropriations Committees have approved increases of less than 3%. As the article by Ed Fox points out, the provisions in the committee bills will result in the Portland Area receiving less than 1/3 of the funds needed just to maintain current programs in the face of inflation and population growth.

One important activity of this spring is the Restructuring Initiative Workgroup (RIW). I am representing the NIHB and Marilyn Scott and Pearl Capoeman-Baller represent NW tribes on this workgroup. Its charge is to consider restructuring proposals that anticipate possible changes being proposed by the Bush Administration in its overall "Management Restructuring." This is one of the workgroups born of necessity in order to minimize negative consequences and just possibly effect some positive changes. Verne Boerner is the staff person to contact about this workgroup and she and Eric Jordan's article summarizes the work completed thus far.

I want to thank delegates for attending the April meeting at Quinault to work together on updating the Board's strategic plan. I am proud of the Board's progress in implementing the direction given in the last two strategic planning sessions. We still have the task in July to update our mission statements and then staff will prepare the final reports on our effor

Newsletter Production Special Thanks to:

Sonciray Bonnell
Sayaka Kanade
Lila Ladue
Lynn DeLorme
Don Head
Jan Groh

Northwest Portland Area Indian Health Board

Executive Committee Members

Julia Davis-Wheeler, Chair, Nez Perce Tribe
Pearl Capoeman-Baller, Vice-Chair, Quinault Nation
Janice Clements, Treasurer, Warm Springs Tribe
Rod Smith, Sergeant-at-Arms, PuyallupTribe
Norma Peone, Secretary, Coeur d'Alene Tribe

Delegates

Wanda Johnson, Burns Paiute Tribe
Dan Gleason, Chehalis Tribe
Norma Peone, Coeur d'Alene Tribe
Colleen Cawston, Colville Tribe
Mark Johnston, Coos, Lower Umpqua & Siuslaw Tribes
Eric Metcalf, Coquille Tribe
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Shane Warner, NW Band of Shoshoni Indians
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Rod Smith, Puyallup Tribe
Bert Black, Quileute Tribe
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Billie Jo Settle, Samish Tribe
Norma Joseph, Sauk-Suiattle Tribe
Gale Taylor, Shoalwater Bay Tribe
Wesley Edmo, Shoshone-Bannock Tribes
Jessie Davis, Siletz Tribe
Marie Gouley, Skokomish Tribe
Robert Brisbois, Spokane Tribe
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Marlice DeLys, Stillaguamish Tribe
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Susan Wilbur, Swinomish Tribe
Marie Zacouse, Tulalip Tribe
Sandra Sampson, Umatilla Tribe
Marilyn Scott, Upper Skagit Tribe
Janice Clements, Warm Springs Tribe
Stella Washines, Yakama Nation

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