Health News & Notes

A Publication of the
Northwest Portland Area Indian Health Board

April 2004

Our Mission is to assist Northwest tribes to improve the health status and quality of life of member tribes and Indian people in their delivery of culturally appropriate and holistic health care.

NPAIHB Awarded One of Oregon's 100 Best Companies To Work For

NPAIHB 2002 Staff Retreat
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Native Fitness Training

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From the Chair:

Pearl Capoeman-Baller

Executive Committee Members

Pearl Capoeman-Baller, *Chair*
Quinault Nation
Bob Brisbois, *Vice Chair*
Spokane Tribe
Janice Clements, *Treasurer*
Warm Springs Tribe
Rod Smith, *Sergeant-At-Arms*
Puyallup Tribe
Vacant, *Secretary*

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Dan Gleason, Chehalis Tribe
LetaCampbell, Coeur d'Alene Tribe
Andy Joseph, Colville Tribe
Mark Johnston, Coos, Lower Umpqua & Siuslaw Tribes
Eric Metcalf, Coquille Tribe
Sharon Stanphill, Cow Creek Tribe
Carolee Morris, Cowlitz Tribe
Cheryle Kennedy, Grand Ronde Tribe
Vacant, Hoh Tribe
Bill Riley, Jamestown S'Klallam Tribe
Tina Gives, Kalispel Tribe
Nadine Hatcher, Klamath Tribe
Gary Leva, Kootenai Tribe
Rosi Francis, Lower Elwha S'Klallam Tribe
LaVerne Lane-Oreiro, Lummi Nation
Debbie Wachendorf, Makah Tribe
John Daniels, Muckleshoot Tribe
Jennifer Oatman, Nez Perce Nation
Midred Frazier, Nisqually Tribe
Rick George, Nooksack Tribe
Shane Warner, NW Band of Shoshone Indians
Rose Purser, Port Gamble S'Klallam Tribe
Rod Smith, Puyallup Tribe
Bert Black, Quileute Tribe
Pearl Capoeman-Baller, Quinault Nation
Billie Jo Settle, Samish Tribe
Norma Joseph, Sauk-Suiattle Tribe
Marsha Crane, Shoalwater Bay Tribe
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Jessie Davis, Siletz Tribe
Marie Gouley, Skokomish Tribe
Robert Brisbois, Spokane Tribe
Katherine Barker, Snoqualamie Tribe
Whitney Jones, Squaxin Island Tribe
Tom Ashley, Stillaguamish Tribe
Linda Holt, Suquamish Tribe
Leon Tom, Swinomish Tribe
Marie Zacouse, Tulalip Tribe
Sandra Sampson, Umatilla Tribe
Marilyn Scott, Upper Skagit Tribe
Janice Clements, Warm Springs Tribe
Stella Washines, Yakama Nation

I was not able to attend the January Board meeting due to the grave condition of my dear friend Valerie Biegler. I stayed close to her during some difficult days in the hospital in Aberdeen, Washington. She struggled valiantly and stayed with us until March, when she passed away.

I attended the initial meeting of the CMS Tribal Technical Advisory Committee (TTAG), which is described in the Executive Director's report. These are important meetings, but the topics are detailed and not inherently interesting. I am glad Ed was appointed the alternate so we can attend these meetings together. Ed and I attended the first regular meeting of the newly established TTAG. As the meeting proceeded we elected our co-chairs (Alaska's Valerie Davidson Vice Chair of the Yukon-Kuskokwim Health Corporation, and Navajo's Vice President Shirley), identified some ground rules, established tentative procedures, and heard from several important CMS officials. At lunch we went to the 8th floor of the Hubert H. Humphrey Building to a reception where we were joined by HHS Deputy Director Claude Allen, HHS Deputy Chief of Staff Andy Knapp and Intergovernmental Affairs Director Regina Schofield. The reception was the 'grand opening' of the new suite of offices for tribal representatives who work at HHS headquarters including Gena Tyner-Dawson (now acting IHS Deputy Director in Rockville) and Rick Broderick Senior Advisor for Tribal Health, Staff Specialist Stacey Ecoffey, and Phyllis Wolfe, Executive Director of the Secretary's Intradepartmental Council on Native American Affairs.

I was extremely busy during the National Conference of American Indians meeting in February. I meet with Ross Swimmer of the BIA. I was glad that our delegates from Lummi (Laverne Lane-Oreiro), and Yakama (Stella Washines), were able to join Ed Fox, Jim Roberts, and Sonciray Bonnell for our lobbying activities. I did personally contact Senator Patty Murray, Senator Maria Cantwell, and Representative Norm Dicks to stress our disappointment with the President's IHS budget request. I also got the opportunity to advocate for Indian health at the nation's capitol at a small meeting chaired by Senator Hillary Clinton and Senate Minority Leaders Tom Daschle. As many of you know, everyone is being told there is no money for any funding increase this year for any program, but we are pressing forward with the argument that the obligation for Indian health is not 'discretionary,' and must be funded or lives will be lost.

I did attend the Board's March 4, 2004 Budget Analysis and Workshop and the All Tribes meeting of the Portland Area Office of the Indian Health Service. I want to thank tribes for sending their representatives to this meeting. It is so important to add tribal views to the analysis prepared by our staff, Jim

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From the Executive Director:
Ed Fox

January Board Meeting

We had excellent attendance at our January Board meeting at the Embassy Suites Hotel in Downtown Portland. The Board took advantage of the Portland location and generously sized meeting rooms by having staff set up displays and information booths, so they could have an opportunity to meet with delegates and discuss their projects during the breaks and lunch hour. I thought this format worked well and look forward to the next opportunity to do this again. We also had excellent interaction with Dr. Michael Trujillo, HHS Region X Administrator Bev Clarno, and as always, the IHS Area Office Director Doni Wilder.

Senate Briefing

In February 2004 the National Indian Health Board organized a briefing with Congressional staff following the first hearing on the President's FY 2005 IHS budget request. Pearl Capoeman-Baller, Sally Smith, Mickey Percy, and I were invited to the hearing room (Russell 485) to present our analysis and opinions on the President's FY 2005 IHS budget. The audience included mainly new staff and many tribal representatives. The staff present was attentive and seemed eager to learn. I think this type of briefing, scheduled shortly after the President's February budget submission to Congress, should be an annual event sponsored by the National Indian Health Board, and I commend them for organizing this years briefing.

Tribal Technical Advisory Group

The Centers for Medicare and Medicaid (CMS) has sanctioned a new Tribal Technical Advisory Group (TTAG) to provide advice on issues relating to these two increasingly important health insurance programs. The first task of this group is to guide the implementation of the Medicare Modernization Act. Most think of this act as the Prescription Drug Bill, but thanks to tribal advocacy it also includes some provisions that will not only include Indian programs in the prescription drug program, but also promises to reduce costs to our health programs. So it was with a great sense of accomplishment, relief, and recognition of the challenge ahead, that Pearl Capoeman-Baller and I attended the first regular meeting of the newly established TTAG (as the delegate and alternate respectively).

I know the history of the formation of this important committee very well, but hesitate to tell my version fully, since there were a few serious struggles where wounds are still fresh. I will only note that no other Area of the Indian Health Service did more than the Portland Area to get this committee established. I will also note that we joined Alaska, Nashville, and Oklahoma in the heavy lifting that was needed over

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Project & Staff

Administration
Ed Fox, Executive Director
Verné Boerner, Administrative Officer
Mylen Shenker, Finance Officer
Bobbie Treat, G/L & Contracts Accountant
Mike Feroglia, A/P & Payroll Accountant
Elaine Dado, Executive Secretary
Amanda Wright, Receptionist

Program Operations
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Sonciray Bonnell, Health Resource Coordinator
James Fry, Information Technology Coordinator
Brian Moss, Network Administrator
Ginger Clapp, Program Operations Assistant

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Joe Finkbonner, Director
Joshua Jones, Medical Epidemiologist
Emily Puukka, Tribal Registry Manager
Shawn Jackson, STOP Chlamydia Project Specialist
Chandra Wilson, Project Assistant
Tam Lutz, TOT's and ICHPP Director
Julia Putman, TOT's Project Assistant
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
Vacant, WTD Trainer
Angela Mendez, National Project Specialist
Crystal Gust, WTD and Natl' Project Specialist
Crystal Denney, National Project Assistant

Tobacco Projects
Gerry RainingBird, NTTPN Project Director
Vacant, NTTPN Project Specialist
Nichole Hildebrandt, WTPP Project Director
Joe Law, WTPP Regional Coordinator
Stephanie Craig, WTPP Regional Project Specialist

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

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

Project Red Talon
Karen McGowan, Project Director

Womens Health Promotions Program
Lynn DeLorme, Project Coordinator

NPAIHB One of Oregon's

Chairra Bettega

M'yka Bettega

Josephine Lutz

Rowan Lutz

Kala Bernard

Samuel Sherry

Joseph Sherry

by Verné Boerner, Administrative Officer

Last fall, the Northwest Portland Area Indian Health Board (Board) enrolled in Oregon Business Magazine's, "100 Best Companies to Work for in Oregon," survey (100 Best). The goal of the Oregon Business Magazine is to measure how self-selected businesses that operate in Oregon compare in the following six categories:

1. Attraction, retention, and rewards,
2. Working environment,
3. Decision making and trust,
4. Performance management,
5. Career development and learning,
6. Employee benefits

The process for participating in the 100 Best includes a company survey that captures policies, procedures, benefits, and values; and an employee survey used to measure and rate employee attitudes and opinions on what makes a great company. There were over 200 companies that participated in this survey and over 16,000 employee respondents.

On February 27, 2004 at the 100 Best awardees luncheon, the Board learned that it was one of the top 100 Best Companies and ranked 32 among the top 50 small companies. We were also very excited to learn that the Board was the top ranked small company in the category of Employee Benefits. This is particularly meaningful because the rankings were derived mainly from surveys completed by Board employees.

This is the first year that the Board has participated in the 100 Best and it is an honor to make the cut in the first year; some companies have taken part for three years or more before achieving this honor. This is a credit to the 43 member tribes of the Board, as they set the tone, mission, values, direction, and policies of the Board. This is also indicative of the appreciation and credit that the Board's staff members have for the mission, values, policies, and benefits.

The Board is honored for the recognition, but also appreciates it as a tool to learn how we can improve with regard to the six categories that were measured. A detailed report will help management understand which categories need improvement. The Board's 43 member tribes and management expect excellence from our employees. At the same time, we expect excellence from our organization so that we can best serve our tribes and to provide a productive work environment for our employees. We do plan on continuing our participation in the 100 Best and we hope to move our ranking further up the list in the upcoming year!

100 Best Companies

Lauren Hildebrandt

Clara Boerner

Conrad Boerner

Pakak Sophie Boerner

Kody Gust

Shaylee Clapp

Willa Wise

by Ed Fox, Executive Director

Why does the Northwest Portland Area Indian Health Board (Board) continue to attract some of the best talent in Indian Country? Why have so many staff returned to work at the Board after a time in school or a brief stint with another tribal organization? Why do Board staff seem so motivated and willing to work the extra amount needed to produce such high quality work? Why have so many staff indicated their desire to remain at the Board after 5 or 10 years of service? The best reasons include that they feel appreciated by the tribes, they feel their work makes a difference, and they also feel they are treated fairly by the Board.

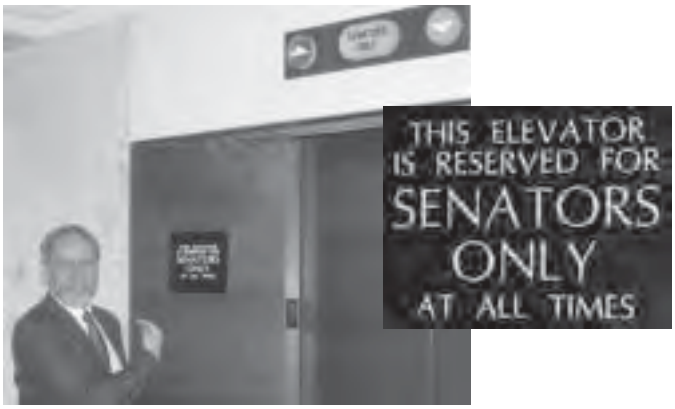
The Indian and non-Indian employees who work at the Board not only know that they are paid at competitive rates, but they have also helped design a benefits package and work environment that reflect the values of an Indian organization. A few examples include:

- Board employees enjoy full medical and dental benefits package that includes their families. Board Delegates approved adding domestic partners to the 100% premium-paid health care benefits, stating "that it is the ethical thing to do."
- Board employees enjoy a fairly applied sick leave and disability insurance policy. Illness or dependent care is supported through this policy. When a family member of a Board employee is sick, the employee can care for that family member knowing that, to the extent possible, management and fellow staff will chip in to see that the work gets done if that employee has to take leave.
- Board employees are allowed up to three days off work after the loss of an immediate family member.
- Board employees enjoy work hours which are flexible as long as the position allows and high performance is maintained.
- Board employees enjoy a reasonably generous tax sheltered annuity that starts at 5% of their income and are fully vested immediately.
- Board employees enjoy training and in-house promotions.
- Board employees are allowed 3 hours per week of education leave to attend school.
- Board employees may take up to 30 minutes paid time per day to engage in a wellness activity.

Of particular note and source of pride, is that the Board allows parents to bring in their infant children into the office until they are six months old. There are currently three women who bring their babies to work with them. In the past 10 years, the Board has welcomed 16 Board babies! Additionally, the Board welcomes older children in the office on an occasional basis. Spring break is an example when one might find young visitors in the office. These specific benefits and the spirit of support for family and work was recently recognized by the Oregon Business magazine when it determined that the Northwest Portland Area Indian Health Board ranks #1 in Oregon for Employee Benefits of all the state's small companies. The value of these benefits far exceeds the costs associated with them, but the Board recognizes that we must use creativity in continuing to respond and improve the benefits provided to our employees as they go about the work of the 43 Northwest tribes in improving the health care status of American Indians and Alaska Natives.

Lobbying on the Hill . . . .

by Sonciray Bonnell, Health Resource Coordinator



Sorry Ed Fox, this elevator is for Senators only.

Every year the Northwest Portland Area Indian Health Board (NPAIHB) asks our tribes and supporters of Indian Country to contribute to our lobbying fund. Designated lobbying funds allow our staff and delegates to travel to Washington DC to advocate for the health care needs of our Northwest tribes, which often proves beneficial to tribes across the nation. Without these contributions, we would not be able to perform this important and effective work.

NPAIHB delegates establish their legislative priorities and approve the positions stated in the final draft of the Legislative Plan. Although many of these priorities remain the same over the years, delegates are always alert to emerging issues and opportunities for success. NPAIHB's Legislative Plan has produced real results. Last year we adopted, by resolution, support for increased funding for prescription drugs This allowed us to be prepared to shape the legislation that made Indian health programs eligible to participate in Medicare part C and part D the new prescription drug program. Our goal when lobbying in Washington DC is to share most of the issues presented in our annual Legislative Plan (visit our website to view the full plan www.npaihb.org) and this year some of our priorities include reauthorizing the Indian Health Care Improvement Act, increasing the Indian Health Service budget, and improving Medicare and Medicaid access.

When we lobby during the National Congress of American Indians' (NCAI) Annual February Executive Session, we are competing with our own tribes for meetings with members of Congress. If you plan ahead, you may meet with a Congressperson depending on their schedules or you may meet with their staff or "staffers." The most effective lobbying trip is scheduled when we expect a vote on the Indian Appropriations bill in the Senate and the House – this is usually prior to the August recess often in July, but sometimes in June. If we can get to a committee member or key staff during this time period our views may be reflected in the approved budget.

In February 2004 we predominately met with staffers. The knowledge base or experience staffers have with American Indians/Alaska Natives covers the spectrum and is the natural starting point of our conversation with them. Turnover, competing issues, and knowledge of issues important in Indian Country are also factors that determine the information we share with congressional staffers. If they have knowledge of healthcare issues in Indian Country then we are able to proceed directly to our Legislative Plan.

LtoR: Bob Brisbois, Stella Washines, Representative Jim McDermott, and LaVerne Lane-Oreiro

I had the honor of lobbying with three of our delegates during the NCAI February Executive Session: Stella Washines (Yakama Nation), LaVerne Lane-Oreiro (Lummi Nation), and Bob Brisbois (Spokane Tribe). Both LaVerne and Stella advocated for an increase in the Indian Health Service budget. As I sat and listened to these Northwest tribal leaders explain the healthcare issues in their communities, I couldn't help but wonder what impact their words had on the staffers. Stella, LaVerne, and Bob were eloquent, clear, and honest. I am honored to have such great role models. I do feel that when our delegates spoke, their words had a

. . . . NPAIHB Delegates Make Their Point

greater impact than NPAIHB staff did because they were speaking about the experience of their own tribal programs.

LaVerne clearly illustrated how the Lummi population growth has impacted their dental program. Lummi has two dentists and five chairs, but a recent audit indicated that they require 12 chairs and four full-time dentists to meet to needs of the community. Currently, their waiting list to see the dentist is over 350. As a result of the long wait list, some will suffer further damage from deteriorating dental conditions. Others will become so frustrated with the slow dental system that they will refuse to use the facility. Furthermore, the lack of funding for the IHS conveys an important message to Indian Country: Indian treaty obligations are not important enough to be honored by the federal government. LaVerne, Health Administrator and past Councilwoman, made it very clear that the medical and dental needs at Lummi require additional money to provide adequate services to their community.

Stella shared a moving story about a tribal member who needed corrective surgery, but because the procedure was not priority one (a life or limb threatening emergency), the woman was prescribed pain medications and told to wait. Depressed, unable to work, and becoming more dependent on pain medications, she questioned the quality of her life. Stella explained her clinic often runs out of contract health service money by midyear, leaving Yakama tribal members without certain medical services (see Jim Roberts IHS Budget article for definition of priority one). Screenings for cancer detection are heavily dependent on Contract Health Services (CHS) money. Without an adequate IHS budget the Yakama people cannot prevent cancer related deaths (cancer is the second leading cause of death for Native Americans in the lower 48 states). (Native American Cancer Research:4-1-04:http://natamcancer.org/page12.html.) Again, the Indian Health Service budget must be increased in order to provide adequate services to our community members.

For the most part we were able to present the Legislative Plan during our meetings. We didn't get to the Legislative Plan in only one of our visits because we spent our time explaining the obligation of the federal government to provide a respectable level of health care to American Indians. This young staffer was so enthusiastic to learn about Indians, attentive, smiling, and pleasant that his questions, which were often quite good, were met with thoughtful explanation from our delegates. We silently agreed that we liked this guy. The highlight of this meeting came when he started his sentence reminding us that most Americans pay about thirty percent of their incomes on medical expenses and "do Indians using the Indian Health Service system have a co-pay?" Bewildered, because we've had our whole lives to think about our prepaid "co-pay," it took us a few seconds to respond and even then it was a softly spoken "no." Then, in true form, Bob Brisbois clearly and calmly answered, "That would be the United States." Through a huge smile, our young staffer says, "Right on! I get it." And he did.

LtoR: LaVerne Lane-Oreiro (Lummi Nation) and Senator Maria Cantwell

LtoR: Senator Maria Cantwell and Stella Washines (Yakama Nation)

DONATE TO NPAIHB'S LOBBYING FUND

The Northwest Portland Area Indian Health Board cannot use federal or state funds to directly lobby on behalf of pending legislation. In order to continue our lobbying activities, we depend on annual contributions – usually in the amount of $500 - $1,000.

To make a donation to the Board go to www.npaihb.org

Priority One:

by Jim Roberts, Policy Analyst

On March 4, 2004, the Northwest Portland Area Indian Health Board (NPAIHB) and Northwest Tribes met to continue a long standing tradition of developing analysis and recommendations for the Indian Health Service (IHS) budget in its annual All Tribes meeting. This year's "Priority One: FY 2005 IHS Budget—Analysis and Recommendations" marks the 15th year that Northwest Tribes have worked to provide the Administration and Congress, as well as Tribes nationally and other Area Health Boards with recommendations on the annual funding for IHS and tribally operated health programs. This year's analysis is dedicated to those Indian people suffering right now and as a result of health programs being put on "Priority One" status.

"Priority One"

What is Priority One? There are probably only a few members of Congress, a handful of bureaucrats at the Department of Health and Human Services (HHS), and quite possibly a reporter or two that understand what Priority One status means. Priority One refers to a description of medical priority levels for contract health services within the IHS system. It is defined as diagnostic or therapeutic services that are necessary to prevent the immediate death or serious impairment of the health of an individual, and which, because of the threat to the life or health of the individual, necessitates the use of the most accessible health care available. When people talk about "life or limb" tests applying, they are talking about Priority One—it literally means there are no funds for preventive care or extended care services. For many American Indian people Priority One means dishonor for all Americans and ill health for American Indians—this is beyond dispute for members of Northwest Tribes (see Lobbying article on page for a tribal example of Priority One).

The FY 2005 IHS Budget

President Bush's FY 2005 budget request for the IHS is $2.97 billion, a slight increase of $45.5 million or just 1.6% over last year's amount. In their meeting, Northwest Tribes estimate that it will take approximately $380 million increase just to maintain current health services for American Indian and Alaska Native (AI/AN) people. In addition, program increases totaling $228 million were recommended to address health care priorities for a total increase of $608 million for the IHS. Unfortunately, President Bush's request falls short by $335 million to maintain current services and contributes to the Priority One status of Indian Tribes. It will take an estimated $59.3 million just to cover pay costs and staffing for new facilities. This means that the $45.5 million increase will be quickly exhausted and will leave IHS and tribal health programs with no alternative other than to cut services.

A similar inadequate budget increase was made in FY 2004 (See Table 1). Last year Portland Area Tribes estimated it would take $360 million to maintain current services, while the Agency only realized a $72 million increase. Again staffing and pay costs of $61 million quickly exhausted any increase realized and inflation most surely eroded the balance. The year after year effect of inadequate funding of the IHS budget significantly damages Indian health programs. An additional detriment to the IHS budget is the compounding effect of each year's absorption of mandatory cost increases. The NPAIHB projects over $750 million in lost purchasing power during the Bush Administration. Indian health programs cannot afford to absorb such a large portion of mandatory cost increases year after year. How will this funding gap be filled?

Indian Health & Medicaid

Regrettably, some believe increased revenues from tribes or from the Medicaid programs are the answer to filling the funding gap. A decision in the States of Washington will have a significant impact on AI/AN participation in Medicaid programs. The Centers for Medicaid and Medicare Services (CMS) have ruled that AI/AN may not be exempt from cost sharing premiums in the Medicaid program. This means that many AI/ANs will not sign up for Medicaid. Earlier exemptions from cost sharing provisions in state Medicaid plans were allowed by CMS, however a shift in policy has changed this. Why should a tribal member sign up for Medicaid and pay a premium, when they can go to an IHS facility and receive services for free? This will mean a greater reliance on IHS resources and less on Medicaid. It

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The FY 2005 IHS Budget

Table 1. Comparing President's FY 2004 Request to Current Services Budget

	Omnibus FY 2004	President's Request 05	Change over FY 2004	Increase for Inflation		Current Services	(President's is Less)
SERVICES:	11-Nov-03	02-Feb-04					
Hospitals & Clinics	$1,249,781	$1,295,353	$45,572	$99,982		$1,349,763	-$54,410
Dental Health	104,513	110,255	5,742	$8,361		$112,874	-2,619
Mental Health	53,294	55,801	2,507	$4,264		$57,558	-1,757
Alcohol Substance Abuse	138,250	141,680	3,430	$11,060		$149,310	-7,630
Contract Health Services	479,070	497,085	18,015	59,884		$538,954	-41,869
Public Health Nursing	42,581	45,576	2,995	$3,406		$45,987	-411
Health Education	11,793	12,633	840	$943		$12,736	-103
CHRs	50,996	52,383	1,387	$4,080		$55,076	-2,693
AK Immunization	1,561	1,604	43	$125		$1,686	
Urban Health	31,619	32,410	791	3,952		$35,571	-3,161
Health Professions	30,774	30,803	29	1,231		$32,005	-1,202
Tribal Management	2,376	2,376	0	95		$2,471	-95
Direct Operations	60,714	61,795	1,081	2,429		$63,143	-1,348
Self Governance	5,644	5,672	28	226		$5,870	-198
Contract Support Costs	267,398	267,398	0	10,696	[1]	$278,094	-10,696
Total, SERVICES	*$2,530,364*	*$2,612,824*	*$82,460*	*$210,734*		*$2,741,098*	*-$128,274*
			0				
FACILITIES:			0				
Maint. & Improvement	48,897	48,897	0	1,956		$50,853	-1,956
Sanitation Facilities Construction	93,015	103,158	10,143	3,721		$96,736	6,422
Health Care Facilities Construction	94,554	41,745	-52,809	3,782		$98,336	-56,591
Facil & Env Hlth Support	137,803	143,567	5,764	5,512		$143,315	252
Equipment	17,081	17,081	0	683		17,869	-683
Total, FACILITIES	*$391,350*	*$354,448*	*-36,902*	*$15,654*		*$407,109*	*-$52,556*
				~~Increase~~		-	~~Difference~~
Total, IHS	**$2,921,714**	**$2,967,272**	**$45,558**	**$215,692**		**$3,148,207**	**-$170,134**
				Other Increases			Difference
			Population Growth	53,138		53,138	53,138
			Contract Support Cost	111,000	[1]	111,000	111,000
			subtotal	~~164,138~~		~~164,138~~	~~164,138~~
			Program Enhancements			228,000	
Totals	**$2,921,714**	**$2,967,272**	**$45,558**	**$379,830**		**$556,275**	-$334,272
			Percent of Increase:	**12.80%**		**18.75%**	

[1]Contract Support Costs (CSC) are calculated for inflation at 4% however the amount is not calculated as part of the total Increase for Inflation. CSC estimate of $111,000 is provided by the Office of Tribal Activities and includes inflation and shortfalls.

Bringing Data to Life

by Kerri Lopez, Western Tribal Diabetes Project (WTDP) Director and Crystal Gust, WTDP Specialist

The Western Tribal Diabetes Project hosted a NIKE fitness training and provided tools to help strengthen local fitness and nutrition programs.

Participants and staff at the Bo Jackson gym listening to directions for Blob Tag

It cannot be emphasized enough: data is necessary to demonstrate the value of health programs, even fitness programs. Collecting health factor measurements, such as height, blood pressure, and cholesterol, can provide incentives for individuals and validate effective community program activities.

Strength training with certified fitness trainers from NIKE

To train diabetes coordinators and others interested in implementing a fitness program in their community, the Western Tribal Diabetes Project (WTDP) held a NIKE sponsored fitness training on February 11-12, 2004 at the NIKE campus in Beaverton, Oregon. The training focused on how to collect data to track the effects of a tribal fitness program and also gave participants ideas on different fitness activities. WTDP emphasized the importance of data collection and interpretation to determine the effectiveness of community based fitness activities, follow trends, and monitor at risk individuals.

On day one of the training, certified fitness instructors from NIKE taught participants how to conduct fitness activities in tribal communities focusing on three basic areas: cardiovascular, strength and conditioning, and flexability through yoga. Day two focused on nutrition, kid games that are inclusive and fun, and a brainstorming session for organizing an activity in local communities.

Several tools and templates were developed by WTDP staff to assist tribes in establishing fitness programs and collecting data to track change.

- A flow sheet illustration, "Fitness Program – Workflow for Evaluating your Program," that lays out the steps for setting up a training, working with your diabetes team, gathering baseline data, documenting the activities and collecting data at intervals over time.
- A PCC overlay to help capture and track measurements, such as weight, blood pressure, and blood sugar and cholesterol, to assess the fitness activities in achieving goals for the Indian Health Service diabetes standards of care.
- A PAR-Q template form for assessment of people with diabetes and a modified PAR-Q for other groups such as elders and youth.

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Executive Director's Report Continued

Executive Director's Report Continued from page 3

18 months to set up this policy structure that will enable tribes to bring issues to the CMS agenda, react to CMS initiatives, and guide the implementation of new CMS programs and policies. The most important role of all remains separate from and outside the scope of duties of the TTAG: advocating for policies such as the establishment of Indian health as an entitlement, which, once established, will be administered by CMS. Political advocacy (as in pass 'this' legislation) most often remains a lobbying activity to be accomplished by tribes and appropriately funded organizations.

March 4 Budget Analysis Workshop

This year's budget analysis workshop presented a severe scheduling challenge for the Board due to the planning for the March 24 and March 25 IHS and HHS consultation meetings, other competing meetings, and the congressional schedule. In order to have the analysis done in time for possible Senate and House Appropriation Committee hearings, the meeting was planned for the first week of March. Twenty tribes were able to attend, but only about 50 tribal representatives joined IHS and NPAIHB staff at the meeting. The National BIA budget meeting was held the same day in Phoenix and many NW tribal leaders were in attendance at that meeting. I also believe attendance was down this year because there is simply so little money in the IHS budget that we may be a bit demoralized when we consider our chances for significant budget increases. Fortunately, those who did attend were some of our most knowledgeable elected leaders and finance officers, who presented very good arguments for fair and reasonable increases to the FY 2005 IHS budget.

Attendance at state meetings

As many of you know our policy analyst, Jim Roberts, has primary responsibility for state heath care meetings. I try to attend these very important meetings whenever I can. In this past quarter I missed all three state quarterly meetings due to scheduling conflicts including the need to attend the funerals of two of our delegates. The American Indian Health Commission (AIHC) in Washington state continues to have well attended and productive meetings. At the March 5 meeting, Jim Roberts gave his usual update of the health issues being tracked by the Board. The AIHC also has a very active workgroup looking at the development of a Benefits Package, and I was able to attend their last meeting at the Puyallup Tribe. Jim Roberts has been very active in Idaho working with many new tribal representatives at that state's meetings. Oregon, more so than the other two states, continues to reduce programs, and we utilize the state meetings to make our view known.

I joined Pearl Capoeman-Baller to represent the Board at the funeral of Susan Wilbur, our long time delegate and Tribal Vice Chair of the Swinomish Tribe. Susan died on January 29, 2004 after a long struggle with chronic illness. I did get a chance to attend several services and heard how active Susan was in the community. I also attended the funeral of Richard Mullens. Richard was the Couer d'Alene Tribe's alternate delegate and Tribal Vice Chair. Richard was often the one who opened ATNI meetings and NPAIHB meetings with a prayer.

NPAIHB Personnel

This quarter saw some changes in personnel. Liling Sherry resigned as the director of the tobacco projects. Liling has agreed to work on a very limited schedule to help with the Cancer project and other assignments. She will be on leave without pay status for three months this year as she and her husband John take some extended time off to recharge and spend time with sons Sam and Joseph. Gerry RainingBird is the new director of the National Tribal Tobacco Prevention Network, and Nichole Hildebrandt is the new director of the Western Tobacco Prevention Project.

Continued on page 23

Photo Gallery
March 2004 HHS Consultation

NW Delegates enjoying a working lunch during the HHS consultation

Alaskan Representatives presenting to HHS

Bob Brisbois (Spokane) facilitating the NW Caucus

Josh Jones (IHS & NPAIHB) reporting on the leading causes of morbidity and mortality

LtoR: Percy and Verné Boerner visiting

Bernice Mitchell (Warm Springs) introducing herself at the HHS consultation

Photo Gallery
January QBM

Danelle Reed-Inderbitzen (IHS) leading a fitness exercise.

LtoR: Suzie Kuerschner and Carolyn Hartness giving Fetal Alcohol Syndrom presentation

Executive Committe meets with NPAIHB management team

Francine Romero giving BRFSS report

Crystal & Kody Gust

Danette Ives giving Port Gamble S'Klallam Tribal report

LtoR: John Stevens, Cecile Greenway, and Mark Johnston

Second Session of 108th Congress

by Jim Roberts, Policy Analyst

It has been months since Tribal leadership has seen any headway with the reauthorization of the Indian Health Care Improvement Act (IHCIA). The last action taken was in July 2003 when both the Senate Committee on Indian Affairs and the House Resources Committee's Office on Indian Affairs conducted a joint hearing on S. 556, a bill to reauthorize the Indian Health Care Improvement Act and H.R. 2440, Indian Health Care Improvement Act Amendments of 2003. Since that time, Indian Country has seen little movement by the Congress in its efforts to reauthorize the IHCIA.

Progress to Date

Since the bills were introduced during the last session of Congress, Tribal leaders and their advocates have met repeatedly with Congressional leaders and their staff concerning the importance of the reauthorization and to build support to get S. 556 and H.R. 2440 enacted. With the assistance of Senator Jeff Bingaman (D-NM), the inclusion of some of the reauthorization provisions in the Medicare Modernization Act became law in December 2003. The Northwest Portland Area Indian Health Board (Board) and other Northwest advocates worked very hard to assist the Interim Tribal Technical Advisory Committee to get the provisions included as part of the new Medicare legislation.

Tex Hall, National Congress of American Indians (NCAI) President, and H. Sally Smith, National Indian Health Board (NIHB) Chair, co-authored a letter to Chairman Richard Pombo (R-CA) of the House Resources Committee to request a Congressional Budget Office (CBO) score for H.R. 2440, to show how the changes from the original S. 212 (now introduced as S. 556) scored bill reflects a dramatically reduced cost to the Treasury.

During the February NCAI Executive Session, the reauthorization was one of the topics highlighted in Congressional visits and at the White House. The IHCIA National Steering Committee (NSC) members, tribal leaders, and area Indian health board representatives met with members of Congress and Administration officials throughout the week to discuss the importance of reauthorizing the IHCIA this session. H. Sally Smith, NIHB Chair and NSC member, told Administration that the reauthorization of the IHCIA and increasing the IHS budget are their highest priorities. They said they heard that repeatedly during the HHS Tribal consultations in each of the twelve service areas last year.

On February 26, at the First Annual Congressional Forum for Native American and Alaska Native Tribal Leaders and Tribal College Presidents sponsored by Senator Campbell (R-CO) and the Senate Republican Conference, Senator Norm Coleman (R-MN) reiterated the importance of reauthorizing the IHCIA. Pearl Capoeman-Baller addressed the February 26 Senate Democratic Steering and Coordination Committee meeting with tribal leaders. Senator Daschle (D-SD) acknowledged that the reauthorization was a high priority for tribal leaders.

IHCIA National Steering Committee (NSC) Strategy Session

During the week of February 23rd, Rachael Joseph, Chairperson for the Lone Pine Paiute Tribes and co-chair for the IHCIA NSC met with NPAIHB and the United South and Eastern Tribes (USET) about revitalizing the efforts to reauthorize the IHCIA. During the meeting it was decided to work with NIHB to convene a strategy session of the IHCIA NSC.

On March 10, 2004 the NIHB hosted a strategy session of the national steering committee to prepare for a meeting with Dr. Grim, Indian Health Service (IHS) Director, and to discuss the current status of both bills currently in the Congress. The group also selected Buford Rolin (Poarch Creek) to serve as co-chair of the NSC along with Ms. Joseph. The NSC members received a status report on the pending legislation, which indicated that the Senate Committee on Indian Affairs would begin mark-up of S. 556 on March 31st, while the House Resources Committee will begin mark-up on H.R. 2440 on May 5th. CMS and IHS staff is currently in the process of providing comment on both bills.

The NSC also discussed some of the differences in the two pending bills in order to develop consensus on those issues and to provide Senate and House staff with Tribal recommendations as they begin to prepare for mark-up. Some of those issues include: social security amendments; sanitation language with respect to NAHASDA; life

Resumes IHCIA Activities

expectancy in funding formulas; SIDS; scholarships; facilities reporting requirements; and region specific concerns. The NSC will monitor the committee mark-up closely with follow-up meetings and teleconferences planned as needed.

IHCIA NSC Meets With Dr. Grim

The NSC met with Dr. Grim on March 11th to provide a status report on the pending bills before Congress and an update on planned activities. The NSC discussed the IHS's concerns and recommendations with some of the provisions in the bills. The NSC indicated to Dr. Grim that they would work with their technical and legal advisors to resolve those issues so that the IHS, HHS, and ultimately the Administration do not object to any language contained in bills as they make their way through Congress.

Future IHCIA Activities

The NIHB will host a meeting at their DC office, for IHCIA National Steering Committee members and other interested Tribal leaders on Monday, April 26. This meeting will provide an opportunity to discuss the Senate markup and address any concerns raised by Members of Congress before the House markup. Since Senator Campbell is retiring and Senator Inouye (D-HI) is stepping down as Vice Chair of the Indian Affairs Committee, it is believed that the window of opportunity for the reauthorization of the IHCIA is right now. The National Steering Committee encourages all Tribal leaders to support and push these bills for a vote by both Houses as soon as possible, in this short legislative session. Your assistance in this effort is greatly appreciated.

Diabetes Continued from page 10

- A model consent form for participants of the fitness program.
- A tri-fold pamphlet for tribal members participating in the fitness activity to self-track their progress, and share with providers.
- A flow sheet provided by the Native American Rehabilitation Association that outlines their process for bringing in patients, and encouraging them to participate in the walking club. The walking club currently operating at NARA has been successful in gaining participation and obtaining meaningful results.

The project also provided several resource articles and curricula for tribal participants including Physical Activity and Diabetes; Be Fit – Be Healthy; Sticking with Lifestyle changes: Increasing Physical Activity; Facilitating Treatment Adherence with Lifestyle Changes; and Balancing Your Life with Diabetes – Curriculum Outline and Ordering Information. NIKE generously provided incentive gifts throughout the two-day training, and provided a workbook that outlines activities individuals can use to start their own training at home.

By any measure, the NIKE fitness training was a success. It will take several approaches to combat diabetes in Indian Country and the Western Tribal Diabetes Project is dedicated to that fight. We hope participants brought home information that is valuable to their communities. Thank you to all the participants, volunteers, and partners.

RUSS ALGER RETIRES!

by Chandra Wilson, EpiCenter Project Assistant

It's been Thirty Years! We're going to miss you Captain Russell E. Alger.

Over his thirty-year career working for Indian Health Service (IHS), and serving Tribes and Tribal Organizations, Captain Alger has contributed his expertise in a number of areas.

Russ began his IHS work at the Taholah Service Unit (Quinault) in July of 1975 as the Chief Pharmacist and Lab/X-ray Director. After working there for eight years he transferred to the Warm Springs Health and Wellness Center, in Warm Springs, Oregon where he currently serves as the Service Unit Director. During his time at the Warm Springs Health & Wellness Center (WSH&WC), Captain Alger has served not only as the Service Unit Director (SUD), but the Chief Pharmacist, Site Manager, JCAHO (Joint Commission on Accredidation of Health Organizations) Coordinator and occasionally filled in for LAB/X-Ray. Captain Alger is a "jack of all trades."

He also served as the Acting Portland Area Pharmacy Officer and was involved in various leadership groups such as the National Council of Service Unit Directors (as chair), the Executive Leadership Group (ELG) under the Director of the Indian Health Service, Dr. Trujillo, and was appointed by Dr. Trujillo to serve on the Indian Health Redesign Workforce Redeployment workgroup.

When I asked CAPT Alger about his IHS tenure and what he will miss the most, he said, "There are many memorable events from my time with the Quinault and Warm Springs communities - the completion of the Joint Venture construction of the Warm Springs Health and Wellness Center and providing the input into its design, selection as the USPHS (US Public Health Service) Non-Clinical Pharmacist of the Year in 1986, and the IHS CEO of the year in 2003.

"My Greatest accomplishment has been being the Coach and CEO of a state of the Art Ambulatory Health Care Center in Warm Springs. Having a staff and Tribal leadership that were willing to think outside the box and become overachievers. The technology and services provided at Warm Springs is something to be proud of, and the recognition from a National level and among our Northwest peers of this excellence is truly an accomplishment. This year the Warm Springs Service Unit received the Director of IHS award in Rockville. This was for the entire Health Center including both IHS and Tribal staff. Working together to achieve common Health Goals has been an ongoing joint effort of the Tribe and the Warm Springs Health Center."

"I will miss working with such a highly dedicated staff from IHS, from the Tribe, and visiting with the people of Warm Springs at various social and business events. The warmth and hospitality of all the Indian people I have worked with through the years at Warm Springs, Quinault, the Northwest tribes, IHS Area, Headquarters, and other sites across the country will be truly missed."

"My 30-year career with PHS is up and I must move on, but I will not retire from my dream of improving the health status of the Native American people. I hope to see you all around from time to time."

Ed Fox notes that Russ Alger was an important contributor to many state meetings. "Russ's expertise was critical to resolving many issues relating to the Oregon Health Plan." Russ would often provide technical support to the Warm Spring's Health Committee at various state and IHS Area Office meetings. Ed says that "Russ probably went through many tough meetings at Warm Springs to gain his ability to smile through the difficult debates in other forums."

I feel honored to say I have had the opportunity not only to work with Captain Alger on Indian Health care issues, but also to be a patient under his direction at the WSH&WC. I know I'm speaking for everyone who has had the opportunity and experiences to build a relationship with Captain Alger, when I say he will greatly be missed in Indian Country! Hopefully, Russ Alger will find a way to continue to put his knowledge gained from years of trusted service to good use for NW tribes.

Colic in Babies – NPAIHB Mothers' Experience

by Crystal Gust, WTDP Specialist and Ginger Clapp, Program Operations Assistant

In November 2003, NPAIHB was blessed with the birth of three babies all within five days of each other. Two of the babies had colic. Mothers Crystal Gust and Ginger Clapp had heard the stories about babies crying for hours at a time, but like others, thought it could never happen to them. Or, being relatively naive first-time mothers, just knew that if it did happen, they would be able to console their infants and experience minimal crying.

Colic is defined as uncontrollable, extended crying for more than three hours a day, three to four days a week in an otherwise healthy baby. Colic usually affects babies between the ages of two weeks to four months of age. Although the actual cause of colic is not known, there is much conjecture about contributing factors. These range from intestinal gas pain, overfeeding, immature nervous system, temperament, and possible lactose intolerance. The majority of these factors are beyond our control and the only advice given by doctors and providers tends to be non-medical in nature.

Ginger and Crystal received a great deal of advice from doctors and others. The advice ranged from walking the babies, wrapping them tightly, playing music, driving in the car, using a pacifier, using mylicon drops for gas, burping them more often, to putting warm towels/cloths on their stomachs. It turned into a trial and error treatment.

Different remedies helped on different days. For both baby Kody Gust and Shaylee Clapp, the one thing that helped the most was running the vacuum cleaner. Ginger never imagined her voice would be soothing to anyone's ears, but desperation led to singing church hymns and pow-wow songs in combination with a walking bounce that, on occasion, put Shaylee to sleep and ceased the crying for the time being.

At times, it appeared that nothing was able to prevent or relieve the outbursts of crying spells. Once the babies were diagnosed with colic, it seemed as if they had a license to cry non-stop for three months without looking for any type of solution. As new parents, it was hard for Crystal and Ginger to hear that there is no clear remedy for colic. It left them feeling powerless and, at times, embarrassed and frustrated to go outside of the home with the new baby regardless of how much they would like to share the new additions with friends and family.

During these colic-crying bouts, it is safe to say that the babies were generally not the only ones crying. The parents also needed remedies. It was essential that a relative or other close friend give the parents a break, even if for only a few hours. Parents should NOT feel bad about taking a few moments to regain a measure of sanity and return to the babies refreshed.

Even though colic may seem like an eternity to new parents, it does end. For some babies, little by little, day by day they improve, and for others at the third or fourth month the crying subsides. Ginger and Crystal are glad to report that when their babies reached their third month, they began to feel much better and became less fussy. The babies are now almost five months old and colic is practically a distant memory! There is light at the end of the colicky months but if you find yourself or a loved one in the same situation, take every measure to keep yourself healthy, and if you find that you are not able to cope, please contact your doctor.

Shaylee Clapp

Kody Gust

FY 2005 IHS Budget continued

Continued from page 8

seems that Congress takes Medicaid, Medicare, and other third party collections into consideration when determining the final IHS budget. It is simply unacceptable to think that funding shortfalls of the IHS can be addressed through third party collections and the Medicaid program.

FY 2005 Budget Recommendations

A crisis is looming for Indian health programs if Congress and the President do not adequately fund the FY 2005 IHS budget. The NPAIHB recommends a $608 million (18.8%) increase to the IHS FY 2005 budget to meet the true healthcare needs of AI/AN people. In addition to the $380 million estimated cost to maintain current services, NPAIHB also recommends $228 million for program enhancements that include unfunded need for CHS, small facility construction, facilities maintenance, pharmacies, information technology improvements, behavioral health programs and increases above current services for other budget line items. NPAIHB's IHS budget analysis adequately funds mandatory cost increases and provides funding for program expansion in order to move American Indian people off of Priority One status.

In the words of former NPAIHB chairperson Julia Davis-Wheeler, "If the Administration and the Congress are serious about addressing health disparities, the best thing they could do is to fully fund the IHS." Former chairperson Davis-Wheeler's point was that the IHS could do more to address health disparities than by making resources available for Indian health through other HHS agencies like the Centers for Disease Control, the Substance Abuse and Mental Health Services Administration, the Centers for Medicare and Medicaid Services and others. A position often promulgated by HHS is that there may not be significant increases in the IHS budget, however, there are opportunities for additional funding within Secretary Thompson's "One HHS" or "One Department" initiatives. Developing tribal health infrastructure and capacity cannot be predicated on grant programs. Grant funding comes and goes, and so do the staff that comes with it.

The President's FY 2005 IHS budget request is less than 13% of what is needed to maintain the FY 2004 level of services. If the Administration and Congress are not willing to take Ms. Davis-Wheeler's recommendation to heart, then they at least ought to be willing to preserve the basic health program of the IHS by funding mandatory costs. This would at least provide IHS and Tribally operated health programs the necessary resources to provide health services to many AI/AN people and quite possibly move them from Priority One to Priority Two status.

NPAIHB Mourns Loss of Two Delegates

Susan Wilbur

Susan Mae Wilbur, our long time delegate and Vice Chair of the Swinomish Tribe died on January 29, 2004 after a long struggle with chronic illness and a series of strokes. Her Swinomish name was Lop-che-alh. She was just 49, but had endured years of pain and suffering with courage and an indomitable will to continue to serve her people.

When she was in her late 20s, Wilbur was elected to the Swinomish Senate and the La Conner School Board - the first American Indian to serve on the latter. She was director of the Swinomish Day Care Center since its inception in 1992. Previously, Wilbur was the tribe's recreation director. She also spent time as a youth alcohol counselor. Susan served as chair of the La Conner School Board. A scholarship fund has been established in her name and you can contact the Swinomish Tribe if you would like to contribute.

In addition to serving as vice chairwoman, she chaired the Senate's Budget Committee and the Swinomish Housing Authority Board. Wilbur served on the Skagit River System Cooperative Board, the American Indian Health Commission, the Northwest Washington Service Unit Health Board, the tribe's Personnel Committee, and the Swinomish Gaming Commission.

About 200 people attended the prayer service February 1, 2004 in the Swinomish Social Services Building. About 500 attended the funeral February 2nd in the La Conner High School gymnasium. Her dear friend Marilyn Scott spoke at the funeral. NPAIHB Chair Pearl Capoeman-Baller, several Delegates, and the Executive Director attended the funeral as friends and co-workers. Her contributions to the health of her tribal members and her years contributing on behalf of all Northwest Tribes as a Board Delegate were much appreciated. Susan will be missed, but her contributions serve as a model for all who follow her example of hard work, dedication, and love of Indian people.

Richard Mullens

Richard Mullens, Couer d'Alene Tribe's alternate delegate to the Northwest Portland Area Indian Health Board and Tribal Vice Chair, died at the age of 46 on March 1, 2004. Richard was often the one who opened ATNI meetings and NPAIHB meetings with a prayer and you may remember him speaking at our 30th Anniversary celebration where he closed our proceedings with a prayer. Richard was a very spiritual young man who served as the chaplain to the Tribal Council.

Ed Fox attended the services, burial, and feast. There were about 400 friends at the Longhouse on March 5 as he was laid to rest under a blanket of fresh snow. Many of you will long remember his smile as big as his broad shoulders. It is sad to think how quickly cancer could take this young man.

The loss of these two coworkers and Board delegates is a reminder to us all to cherish those who we work with every day. I know many in their communities had hoped for many more years of their company and the sadness from this loss was evident when I visited their communities. I heard the appreciation of each community had for the work of both of these very active and inspiring individuals. The time they gave to their tribes was gratefully acknowledged.

Upcoming Events

April 2004

4th Annual Center for AIDS Prevention Studies Conference April 16, 2004
At the San Francisco Marriott Hotel
For more information go to: http://www.caps.ucsf.edu/2004conference.html

Northwest Portland Area Indian Health Board Quarterly Board Meeting April 20-22, 2004
Hosted by the Tulalip Tribe at the Embassy Suites Hotel in Lynnwood, Washington
For more information, please contact Elaine Dado at (503) 416-3264

IHCIA National Steering Committee Meeting April 26, 2004
At National Indian Health Board
For more information, please contact Jim Roberts at (503) 228-4185

Indian Health Service FY 2006 Budget Formulation Meeting April 27-8, 2004
At Crystal City Virginia Hilton Hotel
For more information, please contact Jim Roberts at (503) 228-4185

Free Telephone Education Workshop for Breast Cancer Survivors April 28, 2004
At 1:30-2:30 pm Eastern Time
Register online at: www.cancercare.org

May 2004

Ninth Annual Woman's Health Conference May 1, 2004
At Oregon Health Sciences University
For more information call (503) 494-0515

Northwest Regional Institutional Review Board Training May 3-4, 2004
In Portland, Oregon
For more information go to: http://www.ohsu.edu/research/rda/education/irbconference/

National Council of Urban Indian Health Spring Conference May 2-5, 2004
In Washington, DC
For more information go to: http://www.ncuih.org/conf_callforpresentations.htm

Fighting the Obesity Epidemic in Indian Country Live Video Conference May 4, 2004
For more information go to: www.ihs.gov/medicalprograms/nutrition

Tribal Self-Governance Meeting May 4-7, 2004
In Orlando, Florida
For more information please contact Jim Roberts at (503) 228-4185

Upcoming Events

May 2004

Indian Health Service 16th Annual Research Conference on May 11-13, 2004
In Scottsdale, Arizona
For more information go to: http://www.nihb.org/conf_ihs_research.htm

DHHS Budget Consultation Meeting May 12-13, 2004
From 9:00 am-4:40 pm in Room 800 of the Hubert H. Humphrey Building in Washington, DC
For more information call Jim Roberts at (503) 228-4185 ext. 276

Quileute Health Fair May 13, 2004
In LaPush, Washington
For more information call Brenda Nielson at (360) 374-9035

American Indian Health Commission Meeting May 14, 2004
At NPAIHB in Portland, Oregon
For more information go to: www.aihc-wa.org

Affiliated Tribes of Northwest Indians Meeting May 17-20, 2004
At the Siletz Chinook Winds Casino in Lincoln City, Oregon
For more information go to: www.atnitribes.org

Return to Your Roots Diabetes & Wellness Conference May 18-19, 2004
In Tulsa, Oklahoma
For more information go to: www.traditionalhealth.org

Oregon Tribal-State Quarterly Meeting May 19, 2004
For more information call Jim Roberts at (503) 228-4185 ext. 276

National Native Conference on Tobacco Use May 22-26, 2004
At the Bahia Resort Hotel in San Diego, California
For more information go to: www.npaihb.org/tnet/index.html

Free Telephone Education Workshop for Breast Cancer Survivors May 26, 2004
From 1:30-2:30 pm Eastern Standard Time
To register call Ms. Carolyn Messner at: (800) 813-HOPE

Upcoming Events

June 2004

Direct Service Tribes 1st Annual Meeting June 2-4, 2004
In Phoenix, Arizona
For more information go to: www.nihb.org

2004 Council of State & Territorial Epidemiologists Annual Conference June 6-9, 2004
In Boise, Idaho
To register go to: www.cste.org or call Shundra Clinton at (770) 458-3811

Portland Area Indian Health Service Institutional Review Board Meeting June 10, 2004
At the Northwest Portland Area Indian Health Board in Portland, Oregon
For more information call Sayaka Kanade at (503) 228-4185 ext. 284

NCAI Mid Year Session June 20-23, 2004
At the Mohegan Sun in Uncasville, Connecticut
For more information call Jim Roberts at: (503) 228-4185 ext. 276

Self Determination & Wellness Conference June 30, 2004
In Orlando, Florida
For more information go to: www.floridasdc.info/Pages/SDSHome.html

Pearl's Report continued from page 2

Roberts and Ed Fox. I know the Area Office Director, Doni Wilder, also depends on the input from tribal leaders as she reviews the Area Office budget and their planned activities.

I traveled to Portland to attend the 2nd Annual Department of Health and Human Services Consultation and IHS Budget Formulation meetings on March 24 and 25, but I was so ill when I got to Portland that I could only briefly visit with Ed Fox and Elaine Dado during the meeting. I was so glad that we had such a great turnout for these two meeting. Our Vice Chair Bob Brisbois filled in admirably for me over the two days. Thank you Bob and thank you to Garland Brunoe, Warm Springs Chair who joins Bob as our two delegates to the National IHS Budget Meeting this April 26 and 27 in Rockville, Maryland. With so much work to do and the uncertainty that any of us can make it to all the meetings, we are lucky to have so many elected tribal leaders make health a high priority.

Executive Director's Report Continued from page 11

The Board budget is down about 20% from one year ago and the consequent decrease in indirect revenue necessitated a staffing reduction in Administration. Unfortunately, this meant we no longer have the technology and meeting support services of Ed Lutz at our Quarterly Board and other Board meetings. Ed was also our property and facilities manager. Those duties are now performed jointly by our finance office and IT shop.

Lobbying Activities

Finally, I want to thank all the tribes who sent in their donations to our lobbying fund in a year with such dismal results for the Indian Health Service Budget and the Indian Health Care Improvement Act. It is always hard to say where we would be if we did not go to Washington DC to lobby, but I truly believe that the work of the Board still earns the respect of the Administration, the Congress, tribes, and tribal organizations nationwide. There were very positive results from our lobbying on the Medicare bill last year that could bring millions of dollars in savings to tribal programs. Our education of Congressional staff is vital to creating an environment where positive action can happen if a more favorable budgetary climate ever returns to Washington DC. Thank you for allowing the Board to turn the information we create into legislative accomplishments. I believe that's what the founders and long time tribal advocates of the Board have had in mind for us for these past 32 years.

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January 2004 Resolutions

RESOLUTION #04-02-01
HIV Prevention Projects for Community-Based Organizations

RESOLUTION #04-02-02
Support for The Northwest EpiCenter to Participate in Washington Tribal Emergency Preparedness Needs Assessments

RESOLUTION #04-02-03
Support for the Veterans Administration and HHS/Indian Health Service Memorandum of Understanding

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