# Health News & Notes

A Publication of the
Northwest Portland Area Indian Health Board

July, 2007


*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.*

# US Census 2010: Stand Up And Be Counted

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## In This Issue

## *From the Chair:*
# Linda Holt



In typical fashion, the Board continues to take a proactive role on issues affecting our Indian health programs. Often this means representing the views and interests of Northwest Tribes at state, regional, and national meetings and it is not always an easy task.

I am pleased to re-announce that the Board will be hosting the National Indian Health Board's (NIHB) 24th Annual Consumer Conference! This year's conference will be held September 24-28, at the DoubleTree Hotel-Lloyd Center in Portland, Oregon. The last time the NIHB conference was in the Northwest was in 1997 in Spokane, Washington. Northwest Tribes stepped up to the plate to put on a wonderful traditional feed, a festive cultural night, and social gala all of which were enjoyed by conference attendees.

This year's conference theme is *HOPE for Mental Health, Substance Abuse, and Addiction Recovery in Indian Country*. The conference will focus on the issues of mental health, alcohol/substance abuse addiction and recovery, suicide prevention, diabetes prevention, HIV/AIDS and drug use, fetal alcohol spectrum disorder, and depression. Federal partners will include the Indian Health Service (IHS), the Substance Abuse & Mental Health Services Administration, Centers for Medicare & Medicaid, and the Centers for Disease Control and Prevention. The conference also marks the 35th Anniversary of NIHB, an organization that Northwest Tribal leaders were instrumental in establishing and continue to support.

We are anxious to once again show the rest of Indian Country what gracious hosts Northwest Tribes can be. In this regard, I want our Tribal leaders and health directors to know that the Board may call upon your support to assist in putting on this year's event. And I know you all will respond to assist in putting on this important health event!

The Board continues to be active on many issues from the Indian Health Care Improvement Act (IHCIA) to the reauthorization of the Special Diabetes Program for Indians (SDPI) and continues its important advocacy on the IHS budget. Our activism on these important issues often means a hectic travel schedule for members of the staff, our Executive Board members, and myself. I am proud of the fact that when our Board members represent Northwest Tribes, we are always accompanied by a staff member for technical assistance and follow-up. This often means working into the evening hours on commitments made in meetings, late night runs to Kinko's for copies, or the development of position papers following the meetings. If there is one thing understood in the

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*From the Executive Director:*

# Joe Finkbonner

## STAND UP AND BE COUNTED

Every decade a census is conducted in the United States, as mandated by the U.S. Constitution. There is a lot at stake in the upcoming 2010 census beyond the demographic information that it provides to your grant writers or tribal epicenters. The census data will directly affect how more than $200 billion in federal grant funding is distributed to state, local and tribal governments each year. In addition, the census data will be used to ensure proper apportionment of seats in the U.S. House of Representatives and that federal and state funding is distributed fairly. Therefore, if we want a fair and equitable distribution of federal funds directed at our populations as well as better congressional representation, the participation of tribal populations in the 2010 census is critical.

In past decades, tribal populations have often avoided participation in the census data collection for a variety of reasons including lack of trust in an external government, as well as lack of trust in the person asking the questions, historically a non-Indian. In the 2000 census, Tribes undertook aggressive efforts to improve participation. These efforts included advertising in tribal newspapers that census takers will be on the reservation and stressing the importance of participation, as well as encouraging tribal members to become census takers for the reservation. Tribes have also placed on General Council meeting agendas the importance of participation in census data collection. These actions were taken so as to increase tribal participation.

The 2010 census, unlike the censuses of past decades, which date back to the first census in 1790, will have one of the shortest questionnaires in the history of the United States. The Questionnaire, consisting of only seven or so questions, will take most households about ten minutes to complete and will likely result in a simpler, less costly and more accurate census.

The shortened census questionnaire is the result of the removal of the bulk of the demographic questions which are now included in the American Community Survey (ACS) which was fully implemented in January of 2005. The ACS is a large, continuous demographic survey that produces annual and multi-year estimates of the characteristics of the population and housing. Each year the ACS is administered to 3 million addresses throughout the U.S. and Puerto Rico.

To facilitate more accurate census taking, the Census Bureau is also embracing new technology to count this nation's growing and changing population. The census Bureau anticipates using 500,000 hand-held computers for data collection in the 2010 census. These secure devices

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## Northwest Portland Area Indian Health Board

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# Indian Health

*by Jim Roberts, Policy Analyst*

## A Final FY 2007 Budget!

The FY 2007 appropriations for the Indian Health Service (IHS) proved to be a very complicated process this year. In a series of appropriation twists and turns, the IHS finally has a budget for the 2007 fiscal year. The budget includes a 4.4% increase of $134.8 million for Indian health programs, and at last, an increase of $25.8 million for the important Contract Health Service (CHS) program. At one point in the appropriation process it was questionable whether the CHS program would receive an increase at all in FY 2007.

Prior to adjourning the 109th session, Congress passed a third continuing resolution (CR) that funded government operations until February 15, 2007. Shortly after the new Democratic controlled Congress came in, it acted to pass a year-long CR that held most government operations to FY 2006 spending levels. Fortunately, Congress included an increase of $134.8 million for IHS programs, however, IHS was required to comply with statutory cap language of the FY 2006 appropriations bill. The appropriations bill language annually caps funding for the CHS and Contract Support Cost (CSC) programs. Recognizing this oversight, Congress included language in the Iraq emergency supplemental bills that would have allowed the IHS to reprogram a portion of its budget to provide an increase of $25.8 million for the CHS program, $5 million for CSC, and $7.3 million for facilities accounts. President Bush vetoed the first emergency supplemental bill and after key compromises on troop withdrawal provisions, a bill was finally passed by Congress and signed by the President on May 25, 2007.

## Revised outlook for President's Budget

Initially, when the President released his FY 2008 proposed budget for the IHS, the reported increase was a whopping $212 million—an increase of 6.9 percent—over the previous year's funding level. In this case, the budget baseline for comparison purposes was the CR that was passed by Congress prior to adjourning the 109th session. How wonderful would it be for Indian health programs to receive an increase of this size every year? The President's budget was no silver lining for Tribes as the new Congress moved to finalize the FY 2007 appropriations by providing IHS with $134.8 million increase. At one point, some members of the Administration were touting the IHS budget increase as a reflection of the President's commitment to Indian health programs. Unfortunately, this commitment was short lived as the new budget baseline reduced the President's proposed increase for the IHS to only $90.6 million.

This is an overall increase of only 2.8% and based on the Board's projections to maintain current services in FY 2008, the President's budget will fall short by over $350 million. This makes the FY 2008 budget request for the IHS one of the worst budget requests for the Bush Administration. In FY 2004, President Bush requested a 1.4% increase for Indian health programs. The President's request for the IHS will meet less than 25% of the level needed to maintain current services. This is a far cry from the Administration's previously boasted claim of a $212 million increase for the IHS. Fortunately, Congress has taken action to enhance the funding for Indian health programs in FY 2008.

## FY 2008 Appropriations

Both the House and Senate have take action to move the FY 2008 Interior Appropriations bills that provide funding for the Indian health programs. On June 27, 2007 the full House voted to approve their Interior Appropriations bill (H.R. 2643) by a vote of 272-155. The House bill will provide $3.38 billion for the IHS and is an increase of $204.3 million over the FY 2007 final enacted level. This is a significant increase for the IHS and will meet almost 50% of the level needed to maintain current services in FY 2008. The House recommendations are consistent with many of the recommendations contained in the President's FY 2008 request, however, it includes an additional $15 million for methamphetamine treatment and prevention, includes an additional $25 million for the Indian Health Care Improvement Fund, and provides an additional $20 million to support the facilities accounts. Many of the facilities accounts lost funding

# Policy Updates

when compared to the FY 2007 final enacted budget.

The House approved mandatory costs that include pay act increases of $41 million, $51.4 million for inflationary costs (non-medical inflation is calculated at 2.4% and medical inflation at 4.2%), an increase for population growth of $36 million (1.6% user growth), and $19 million for phasing in staffing at new facilities. The House moved to restore funding with a slight increase to the Urban Indian Health Programs. The House directs the Agency to use $5 million of the methamphetamine funding for youth suicide prevention associated with methamphetamine use. It is expected that the IHS will consult with Tribes on the distribution of the methamphetamine funds. The Bureau of Indian Affairs also received an additional $20 million for a similar initiative.

The Senate Interior Appropriations subcommittee provided its recommendations for the Interior bill on June 21, 2007. The Senate recommendations provide $187.3 million (5.9% increase) over the final FY 2007 enacted level. Like the House bill, the Senate provides similar recommendations with additional funding for the Urban Indian Health programs and less funding for Indian Health Professions and Contract Support Costs. The Senate bill also provides $15 million more for facilities accounts; with $13 million of this provided for facilities construction projects. Overall, the House bill provides $17 million more than the Senate recommendations.

## HHS Issues Final Rule on Medicare-like Rate Regulations

On June 4, 2007, the Department of Health and Human Services published the long awaited Medicare-like rate regulations to implement Section 506 of the Medicare Modernization Act (MMA), which will prevent Medicare participating hospitals from charging more than Medicare rates when treating Indian patients referred under the Contract Health Service (CHS) program. Previously, there was nothing to limit what IHS would pay for inpatient services delivered by hospitals—public or private—outside the IHS network. The final regulations became effective July 5, 2007, and will apply to claims for services provided on and after that date. The regulations will not apply to services provided before July 5, 2007, even if claims for such services are submitted after that date. A copy of the regulations may be obtained at www.npaihb.org.

## IHS Reimbursement Rates for Calendar Year 2007

On July 2, 2007, the IHS published revised OMB Medicare/Medicaid encounter rates for Calendar Year 2007. The initial reimbursement rates were published incorrectly in the Federal Register on June 20, 2007. The new rates are effective for services provided on/after January 1, 2007. Northwest states will be issuing retroactive billing instructions shortly and we will update you of these requirements when they become available. The adjusted rates for Medicaid Inpatient Hospital encounter is $1,726 and $2,215 (Alaska); Medicaid Outpatient encounter is $242 and $405 (Alaska); Medicare Outpatient encounter rate $201 and $354 (Alaska), and; Medicare Part B Inpatient Ancillary encounter is $353 and $625 (Alaska). A copy of the Federal Register notice is available at www.npaihb.org.

## IHS Published Revised CHSDA's

On June 21, 2007, the IHS published a revised list of Contract Health Service Delivery Areas (CHSDA) as defined under 42 CFR Part 136, Subparts A – C and Service Delivery Areas as defined by the IHS Director. The revised list replaces and supplements the previous list that was last updated in 1984, and amended in 1988. The revised list includes CHSDA designations for newly recognized Tribes. A copy of the Federal Register notices is available at www.npaihb.org.

# From the Chair: continued

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Indian health care arena, it is that the NPAIHB and its Tribal leaders always follow up on their work. This is why we are often called upon to represent Tribes on regional and national workgroups and testify before Congress.

After returning from a very refreshing vacation in April, I immediately hit the road attending the TSGAC conference in Garden Grove, California. The IHCIA National Steering Committee (NSC) met during the Self-Governance conference to address the outstanding facilities construction issue that is hampering the IHCIA bills. Those Areas that are contract health dependent support changes to the facilities construction provisions to allow the establishment of an Area fund for facilities construction. A workgroup comprised of NSC members worked to develop compromise language that was unanimously supported by the TSGAC and those NSC members in attendance. While this was seen as good news, with the hope that the entire NSC would unanimously support the language, that did not happen. Thus, this issue and the new language continue to be opposed by those Areas with projects on the IHS facilities construction priority list. We will continue to work with the NSC to reach a consensus on this issue and are hopeful that will happen.

On May 28-30, I attended the NIHB Spring Board meeting in Albuquerque, New Mexico. During the same time NIHB, in partnership with the IHS, held a Tribal Summit for Young American Indian and Alaska Native Adults with Disabilities. The effort was part of the President's New Freedom Initiative, which was designed to bring Tribal, federal, state, and local governments together to promote policies which help increase accessibility to services for the disabled community in Indian country.

On June 4-8, I was in Washington, D.C. meeting with Congressional member staff on the reauthorization of the IHCIA and SDPI legislation, and other IHS budget matters. I also attended the June 7th hearing that was conducted by the Energy and Commerce Health Committee. We were pleased to hear Rep. Diane Hooley (OR) discuss the importance of the health facility issue to Northwest Tribes in the hearing. We also met with House Resources and Senate Committee on Indian Affairs staff to follow up on Rep. Rahall's commitment to Rep. Inslee to work on the facilities construction issue in the IHCIA. While we did reach an agreement, Congressional staff did leave the meeting with a better understanding of how this issue is grossly unfair to CHS dependent Areas like Portland, California, Bemidji, and Nashville.

During the week of June 10, Joe Finkbonner, Elaine Dado and I attended the National Congress of American Indians mid-year conference in Anchorage, Alaska. The meeting allowed us the opportunity to work on the IHCIA bill, the IHS budget, and SDPI. There is currently an effort by Tribes to attach the reauthorization of the SDPI to the State Children's Health Insurance Program (SCHIP) legislation. This would be a great victory to get the SDPI reauthorized on another legislative vehicle like SCHIP. We all know how much time and energy has gone into getting the IHCIA bills done. If we could get the SDPI legislation done on the back of a larger legislative vehicle it would be a great relief and victory. This strategy was also discussed at the recent Tribal Leader's Diabetes Committee meeting held in Washington, D.C. on July 19-21. Prior to the TLDC meeting, a group of Tribal leaders were joined by representatives from the Juvenile Diabetes Research Foundation and American Diabetes Foundation to meet with Congressional members about the importance of reauthorizing the SDPI.

As you can see, the work at the Board never stops and it has already started out to be a very busy summer. I am also happy to report that we will have our new Medical Epidemiologist, Dr. Thomas Weiser, from the Portland Area Office on board shortly. We have also completed our annual audit and are pleased to report that the audit was as "clean as a whistle." This is a tribute to our finance department and the management team at the Board. Finally, look for the festive event at the NIHB annual conference when the NIKE Corporation unveils the new Diabetes Shoe for Native Americans later this summer.

Keep up the good work!

# From the Executive Director: continued

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will be used to update address lists and to conduct follow-up interviews with people who fail to complete and return a census questionnaire.

An important aspect of tribal members' participation in census data collection or the American Community Survey is the proper record keeping of addresses on the reservation. With the success of tribal governments came the housing boom meant to move our tribal members back on the reservation (home). Lack of accurate tribal housing record keeping will lead to under representation of American Indians in either the ACS or census count. Tribal governments can ensure their new housing developments are included in the potential houses to be surveyed by registering with the Local Update of Census Addresses (LUCA). LUCA allows participating governments to review, correct and update the Census Bureau's address list. The information contained in the address list is confidential by law. Governments participating in the LUCA program and reviewing the Census Bureau's address list must take an oath to protect the information they review. Like all census employees, those who review and update confidential address lists are subject to a jail term, a fine, or both if they disclose any protected information.

Your tribe may have already received promotional materials about LUCA and the training workshops that started in February, 2007. To date, over 80 tribes have had representation in some of the training sessions. Beginning in August of this year, LUCA will be sending invitation letters to local governments to participate. Because it is so important for the list of addresses to be reviewed before the census data collection begins, any government that determines they are unable to participate can designate a representative to conduct LUCA for them. The deadline for LUCA sign-up is December 31, 2007 and participants will conduct LUCA review beginning in September 2007 through April 2008. Correction and addition feedback will begin in August 2009 through October 2009. If additional corrections are needed, the appellate process begins in September 2009 and ends January 2010.

**Because it is so important for the list of addresses to be reviewed before the census data collection begins, any government that determines they are unable to participate can designate a representative to conduct LUCA for them.**

I highly encourage all of our Tribes to keep a watchful eye for any material requesting your participation in LUCA or offering training to your staff. If the material is not forthcoming, contact the Geographic Entity Programs Branch at 301-763-1112. A website for general information is; www.census.gov/geo/www/luca2010/luca.html

This is the first critical step to ensure that our membership receives the proper allocation of federal resources and legislative representation. So stand up and be counted.

## National Indian Health Board Annual Consumer Conference

September 24-27, 2007
Portland, Oregon
at the
Doubletree Lloyd Center

To volunteer for the conference
contact Elaine Dado
(503) 228-4185
edado@npaihb.org

For sponsorship information
contact NIHB
(202) 742-4262

# Mortality Rates Decrease

*by Don Head, Western Tribal Diabetes Project Specialist*

An article recently published in the Annals of Internal Medicine indicates that the mortality rates for men with diabetes have decreased, while corresponding rates for women with diabetes have increased. Researchers were investigating a correlation between the decrease in Cardiovascular Disease (CVD) mortality, and the mortality rates of people with diabetes, since diabetes is a risk factor for CVD.

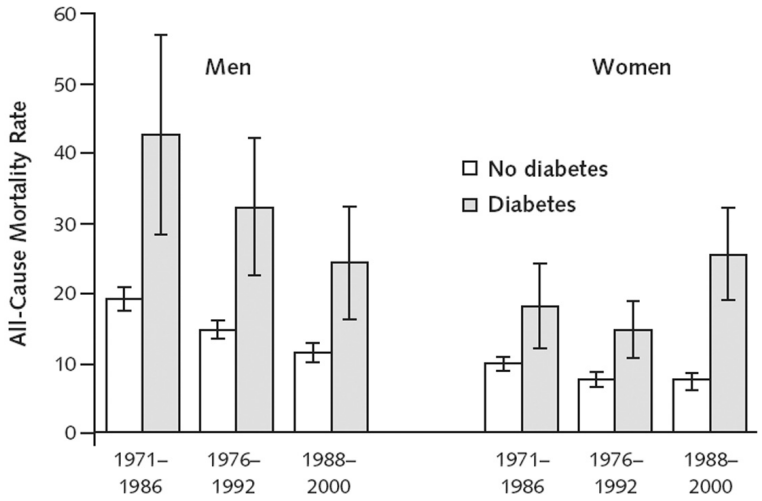
Using the National Health and Nutrition Examination Survey (NHANES) from three time periods, 1971-1980, 1976-1980, and 1988-1994, researchers have found that all-cause mortality rates for men with diabetes decreased 43% from 1971-2000. This ratio was similar to that experienced by men without diabetes.

"Several factors could explain the decrease among diabetic men, ranging from primary prevention of CVD risk factors to improved lifesaving technology among persons with CVD or diabetes complications."[1]

Meanwhile, the mortality rates for women with diabetes over the same time frame did not decrease, and furthermore the difference in mortality rates between women with diabetes and women without diabetes doubled (see figure 1). The reason for the disparity of the mortality rates of the genders was not immediately available, and further research is necessary to answer that question.

1 Edward W. Gregg, Quiuping Gu, Yiling J. Cheng, et al. Mortality Trends in Men and Women with Diabetes, 1971-2000. Annals of Internal Medicine, 7 August 2007, 147:3

*Figure 1.* **Age-adjusted all-cause mortality rates (95% CIs) among the U.S. population with and without diabetes, by cohort and sex.**




The authors of the article have stressed the limitations of the data available to them, such as participants of the survey self-reporting diabetes, and the lack of data from patients hospitalized for CVD or diabetes complications, among others.

The conclusions of the study are 1) reductions in mortality occurred among diabetic men but not among diabetic women, 2) disparities in mortality rates between women with and without diabetes have increased, and 3) the female advantage in mortality rates among the diabetic population has been eliminated.

For more information, or to read the article, please visit the Annals of Internal Medicine website: http://annals.org.

**Family-based weight management interventions found to be more effective than clinical-based interventions**

A recent study published in The Journal of the American Medical Association indicates that weight management interventions are more effective if delivered to the entire household than those interventions that are delivered through pediatric obesity clinics.

# in Men with Diabetes

Mary Savoy-Desanti, a research associate in Yale's Department of Pediatrics, and her colleagues measured the effectiveness of the family-based intervention Bright Bodies. Bright Bodies was created ten years ago by Savoy-Desanti, and includes a three-level approach: nutrition education, behavior modification, and exercise. The exercise portion was tailored to the age groups of the children participating in the study, although both groups played "Dance Dance Revolution" by Konami.

The participants of the Bright Bodies program and the control group were measured for indicators like BMI, body weight, body fat, and percent of body fat. The Bright Bodies program resulted in a reduced BMI of 1.7 units, while the control group increased their BMI by 1.6 units. For instance, if a child with a height of 5'5" weighed 165 lbs, their BMI would be 27.5. As a participant of the Bright Bodies program, they would have fallen to 155 lbs, for a BMI of 25.8. Alternatively, as a member of the control group, they would have increased their BMI to 29.1, with a weight of 175 lbs.

The downside to the program is that it is considerably more expensive than the clinical-based programs at pediatric obesity clinics. Future studies under the grant, funded by the National Institutes of Health and a gift from the McPhee Foundation of Bristol, Connecticut, will focus on cost-benefit analyses.[2]

2 JAMA, Vol. 297, No. 24: 2697-2704 (June 27, 2007)

## DMS Training Frenzy

As of July 18, the Western Tribal Diabetes Project (WTDP) has completed six centralized Diabetes Management System (DMS) trainings. Two of the trainings were conducted out of the Area, at the Albuquerque and Phoenix Area offices, while the rest were conducted at the Health Board's Washington Tribes Training Room.

There are four more centralized trainings scheduled this year for the Washington Tribes Training Room, as well as an invitation by the Phoenix Area Office to return due to the popularity of the first training conducted in February.

Katrina Ramsey, the latest WTDP Specialist, has been working hard on improving aspects of the training dealing with database searches and broadening the participant's understanding of DMS.

For more information on DMS Trainings offered by WTDP, please call or email Rachel Plummer, at (800)862-5497 or rplummer@npaihb.org.

*Don Head and Katrina Ramsey can't seem to stop training*

# The Importance of

*by Jim Roberts, Policy Analyst*

As we embark on another election season it's important to acknowledge the work of Tribal leaders and the sacrifices they make to represent their communities. All too often these contributions go unrecognized and Tribal leaders lose elections because of their travel away from home to serve on committees, attend meetings, and conduct other work in state capitals and in Washington, D.C. representing their Tribe. As a technical person that works with Tribal leaders on health issues, I understand the value of having experienced leadership who understand important policy issues and are knowledgeable of the political process.

In this regard, its important that our communities sustain their Tribal leaders during election time and that we understand the benefits of having experienced leaders. Last year, many key Tribal leaders lost re-election bids. The Great Plains and Southwest tribes have a reputation of changing leadership nearly every election cycle. Former National Congress of American Indians (NCAI) President, Tex Hall lost his bid to serve as chairman of the Mandan, Hidatsa, and Arikara Nation. Harold Frazier, a popular chairman of the Cheyenne River Sioux Tribe, lost his bid for re-election. Rosebud Sioux President Charles Colombe, nationally known for his expertise on Indian economic development issues, also lost his bid for re-election. For the first time in 25 years, the Navajo Nation re-elected a President to lead their nation for a successive term. Imagine that, for the first time since Peter MacDonald left office in 1982, the Navajo Nation elected President Joe Shirley to serve a second term.

Unlike other parts of Indian Country, the Northwest has long been recognized for its stability in Tribal leadership. Tribal leaders like the Quinault Nation's Joe DeLaCruz and Pearl Capoeman Baller, Jamestown S'Klallams' Ron Allen, Swinomish's Brian Cladoosby, Siletz's Dee Pigsley, Upper Skagit's Marilyn Scott, Nez Perce's Julia Davis, Grand Ronde's Cheryle Kennedy, Coeur d'Alene's Ernie Stensgar, Umatilla's Antone Minthorn, and of course Warm Springs' Bernice Mitchell (who served for over forty years on Tribal Council) are fine examples of our stability. There are many more, but simply too many to list.

The stability of Tribal leaders paved the way for the success of the Self-Determination and the Self-Governance movements. Many Portland Area Tribes were part of the Self-Governance demonstration project in 1988. It was the experience and lessons learned by Tribal leaders that served to develop important policies like Indian Self-Determination and Self-governance. These important policies have helped shape and improve the lives of Indian people in the Northwest.

One of the most important things to understand about the political process is that almost everything that happens is a result of personal relationships. When Tribal leaders serve multiple terms, they are able to develop relationships with important legislators and their staff. Developing this rapport can take years, and when Tribal leaders turn over, we all have to start from scratch. It's these relationships that get things done in the political process—understood its not supposed to work this way—but it does. Another benefit to sustaining Tribal leadership is the institutional knowledge and understanding of the political process. Federal and state Indian policy can be quite complicated—especially health policy—and can take years to understand. When Tribal leadership changes, new leaders have to be trained and educated about the issues and process. This takes a tremendous amount of time, energy, and can be quite costly. Often, lawyer/lobbyists representing non-Tribal interests with more money can take advantage of inexperienced Tribal leaders in meetings, Congressional hearings, and other forums where important policy decisions are made.

Tribal members often have a misconception that their council members are wasting Tribal dollars by constantly traveling and missing important meetings at home. For organizations like the Northwest Portland Area Indian Health Board (NPAIHB), we would not be able to accomplish the important work that we do on behalf of Indian people with the support of Tribal leaders. NPAIHB has achieved important work that benefit Tribal health programs and the Indian people they serve. There is a belief that traveling is "glamorous" and filled with fun.

# Sustaining Tribal Leadership

This simply is not the case. Constant travel means time away from family and missing important birthdays, school functions, sporting events, and other important family events. I have been with Tribal leaders when they have lost loved ones while on the road. They couldn't get back for funerals or help their family in these times of need. Trust me when I say, "travel isn't all its cracked up to be!" Financial irregularities are sometimes the reason that Tribal leaders are not re-elected and it is important to disclose when NW Tribal leaders work on health issues for NPAIHB, their costs are covered by NPAIHB.

As our Northwest Tribes prepare for their upcoming elections, I hope you all will consider the importance of sustaining Tribal leaders that work on regional and national issues. The benefits of this work do come back home to Tribal communities and may not be immediately recognized by Tribal members. For example, the work that was accomplished to obtain certain cost saving provisions in the Medicare Modernization Act may not be immediately recognized by Tribal members. This work could not have been accomplished without NW Tribal leader participation at the national level. It will save money in contract health service programs. The main concern of many Tribal members is whether they will get health services or not. However, it's the costs savings from one of these provisions that will allow health programs to save money and deliver more services it members. These benefits are not necessarily seen by Tribal members until they are denied services due to budget constraints.

I hope we all will think seriously about how we cast our votes in our upcoming Tribal elections. Tribal leaders do jeopardize their role by traveling to represent their Tribes and Indian people and it's unfortunate that they are penalized by doing so. Organizations like our the Northwest Portland Area Indian Health Board, the National Congress of American Indians, Affiliated Tribes of Northwest Indians, and many others could not accomplish their work without the support of Tribal leaders. We hope you will consider this when you cast your vote. And most importantly, do get out and vote in your Tribal, state, and national elections!

## Meet Our New Physician Epidemiologist

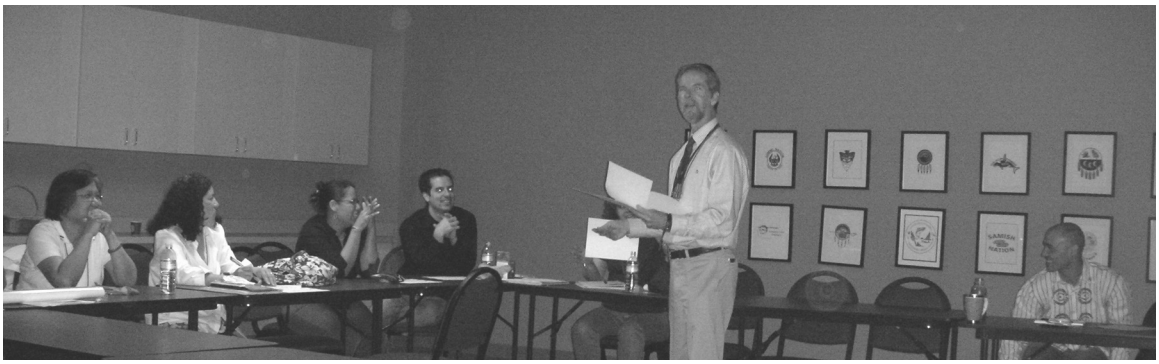
Hi, I'm Tom Wieser and I'm the new Physician Epidemiologist at the Northwest Portland Area Indian Health Board. I am married to Yasuyo Tsunemine who is originally from Osaka, Japan. We have three children, Haruka (10), Nobo (8) and Naomi (5). We are looking forward to coming back to the west because we miss the mountains. We enjoy skiing, fishing, camping, and biking. My oldest daughter enjoys dance and art, my son has been taking karate. The youngest will be starting kindergarten in the fall and is looking forward to that.

I received my M.D. at State University of New York, my M.P.H., Epidemiology at UCLA, and my B.S. at UC Irvine. We lived in Whiteriver, AZ for seven years where I worked as a full-time clinician until 2005 when we moved to Missouri where I completed my Epidemic Intelligence Service training at the Centers for Disease Control and Prevention.

My personal interests include music (I play guitar) and woodworking. My interests in public health include infectious diseases and especially tuberculosis, but this past year I have also been involved in projects looking at environmental issues and maternal child health topics and found that really interesting, too. I am very happy to be back working with IHS and in a new capacity with the NPAIHB as a medical epidemiologist, since I think it will allow me an opportunity to use the new skills and knowledge I have acquired in epidemiology for the benefit of Native American communities, hopefully going beyond what I was able to accomplish as a clinician.

# Summer Institute for American Indian/Alaska Native Scholars

*by Tom Becker, NPAIHB Medical Epidemiologist*



Dr. Tom Becker teaching at the Summer Institute for AI/AN Scholars in July, 2007.

Marked contrasts in disease incidence and mortality rates have been documented among tribal peoples in the US. Although high rates for many diseases are reported among many Native groups-- including American Indians and Alaska Natives (AI/AN), few etiologic studies have been directed toward understanding causes of disease or methods of disease prevention among AI/AN tribal people. Further, involvement by Native researchers in different studies has been particularly infrequent. Because cultural factors are central to the design and implementation of many biomedical studies, increasing the involvement of AI/AN people to carry out effective research in AI/AN populations should be a priority concern.

Towards this end, the Northwest Portland Area Indian Health Board (NPAIHB) and Oregon Health Sciences University (OHSU) implemented the *Summer Research Institute for American Indian Alaska Native Health Professionals* to increase the research capabilities of Native researchers to conduct well-designed studies within Native populations. Funded by Indian Health Service (IHS) and the National Institute of Health (NIH), our Summer Institute for AI/AN health professionals is held each summer at the NPAIHB. Experienced epidemiologists and biostatisticians at OHSU and NPAIHB offer an intensive three-week training program for qualified AI/AN researchers. The training program introduces participants to cancer prevention and control research strategies, principles of epidemiology, study design considerations, data management, data analysis, grant preparation, cost effectiveness analysis, human subjects concerns, evaluation of programs, focus groups, and manuscript preparation. Demonstrations and workshops are tailored to students' needs. Following the summer training sessions, faculty serve as mentors, provide consultation for grant writing and project implementation, and are available for on-site problem solving. Evaluations from the students have been consistently excellent, and NPAIHB is proud to host this important activity each year.

The Summer Institute builds upon the Native American Research Center for Health (NARCH), which is an existing grant-funded training program based at NPAIHB and at OHSU. NARCH will further disease control efforts by working with AI/AN researchers in capacity building and research skill development. This effort may ultimately serve to reduce disease incidence and mortality among diverse AI/AN populations.

# National Tribal Leaders Gather for Tobacco Policy Summit

*by Gerry RainingBird, National Tribal Tobacco Prevention Network Project Director*

Tribal Leaders and Tobacco Policy Advocates from all parts of Indian Country will join together later this Summer to engage in discussions of tobacco policy issues specific to tribal communities and native nations. The first ever, "National Tribal Leaders' Tobacco Policy Summit" will take place in Minneapolis, Minnesota, August 19 – 21, 2007 at the Sheraton Bloomington, and is sponsored by the Northwest Portland Area Indian Health Board (NPAIHB) through a grant from the Robert Wood Johnson Foundation.

The role of tobacco in economic and cultural decision-making at the Tribal level will be a focus of the Summit as well as the development, and successful implementation of tobacco policies. Participants will be invited to assist in drafting a National Position Statement regarding tobacco policy in Indian Country.

According to the Centers for Disease Control and Prevention, thirty-three percent of adult American Indians and Alaska Natives are smokers. As a result, the Indian Health Service devotes approximately $200 million in healthcare costs for commercial tobacco related illnesses on a yearly basis. Also, the secondhand smoke from the burning end of cigarettes and exhaled by smokers causes premature death and disease in children and adults who happen to be in the same space.

Tribal leaders, tribal health program administrators, elders, and spiritual leaders are encouraged to attend the National Tribal Leaders' Tobacco Policy Summit as part of their efforts to improve the wellness of our communities!

Goals:

~Provide a forum to discuss tobacco policy issues specific to Indian Country

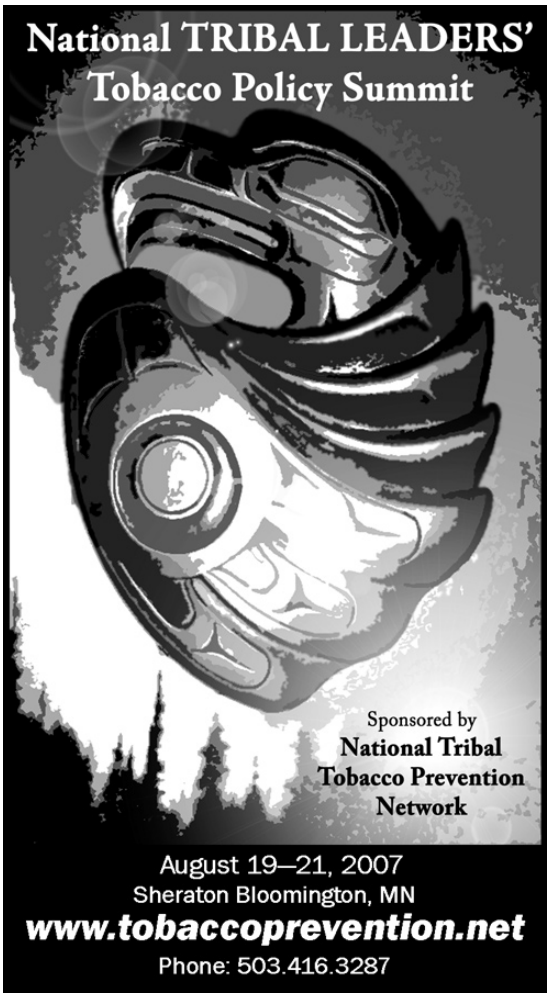
~Provide accurate information regarding commercial tobacco use among Native people.

~Provide an opportunity to network with other tribal leaders and advocates involved in tobacco prevention

~Strategize around tobacco abuse and prevention issues.

~Provide information on current policy, media, and cessation efforts in Indian country.

For more information, visit the NTTPN website: www.tobaccoprevention.net or contact Gerry RainingBird at 503.416.3287 or by Email: grainingbird@napihb.org.



# New NPAIHB Employees

Vanessa Short Bull (*Oglala Lakota*) will be joining the Tribal EpiCenter as the Training and Outreach Coordinator on July 31, 2007. She is excited to move to the Pacific Northwest and use her expertise at the Board.

Vanessa was born on the Pine Ridge Indian Reservation. She is an enrolled member of the Oglala Sioux Tribe. She is a direct descendent of Chief Red Cloud, Young Man Afraid of His Horses, Little Wound and the Ghost Dance leader Short Bull. Her parents are Tom and Darlene Short Bull. Tom Short Bull is the president of Oglala Lakota College. Darlene Short Bull recently retired from Indian Health Service with thirty-one years of service as a Registered Nurse. Vanessa and her parents are all graduates of the University of South Dakota. She is working on her Masters in Public Health. She is a Second Lieutenant Medical Service Corps Officer in the Army Reserve.

Vanessa was also the first American Indian to win the titles of Miss South Dakota USA 2000 and Miss South Dakota 2002. She went on to compete for the titles of Miss USA and Miss America where her talent was classical ballet. She is the only woman in South Dakota to garner both state titles. She was featured in the American Indian College Fund's media campaign *Have you seen a real Indian?* and made the cover of the book *Real Indians*. She is currently the spokesperson for NIKE's new Native Wellness Shoe along with Notah Begay.

## Portland Parks Go Smokefree

by Aron Stephens, Oregon Public Health Program graduate

Our kids can breathe easier now that our playgrounds, picnic areas, and Pioneer Courthouse Square are smokefree thanks to new rules passed by the Portland City Council for public parks. If someone is smoking near a playground or picnic area in Portland, you can politely let them know about the smokefree rules and ask them to smoke elsewhere.

Secondhand smoke is very dangerous for our children. It is linked with more ear infections, more frequent and severe asthma attacks, as well as bronchitis and pneumonia[1]. In 2005, American Indian youth had the highest smoking rates in Oregon with almost 20 percent of 8th graders and over 20 percent of 11th graders smoking[2]. Smokefree areas help us set a good example for the youth and protect children from dangerous smoke.

If you would like to say "thanks" to the City Council and share your thoughts on smokefree rules for other areas of parks such as ball fields, ball courts, and bike/running paths that your child uses, send an email through the American Lung Association of Oregon website at http://lungaction.org/campaign/portlandparks07_clone_clone_2. Let's make all of our parks a safe place for our children. By sending an email, you can help to create more smokefree outdoor environments which will send healthy messages to American Indian youth and discourage commercial tobacco use. The email letter writing campaign is a project of the Tobacco-Free Tri-Counties Coalition. For more information, contact the Tobacco Prevention Program at: 503-988-4163.

If you or someone in your family smokes, now is a great time to quit! You can call the Oregon Tobacco Quitline at 1-800-QUIT-NOW for free counseling, referrals, and medication.

**References**


[1] U.S. Department of Health and Human Services. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.

[2] Oregon Tobacco Prevention and Education Program. Oregon Tobacco Facts. Available at: http://www.orgeon.gov/DHS/ph/tobacco/docs/facts05.pdf

[3] Oregon Tobacco Prevention and Education Program. Multnomah County Factsheet. Available at: http://oregon.gov/DHS/ph/tobacco/2007countydatasheets/a07MultCoTobData.pdf Accessed: May 7, 2007.

# New NPAIHB Employees

Waq'lis'I (how are you), my name is Amanda Wright; I am the first-born daughter of Harold Wright and Theresa Hubbard. My paternal grandparents are Harold "Plummy" Wright and Maryanne Jackson. My maternal grandparents are Everett Hubbard and Jerri McLish. I am an enrolled member of the Klamath Tribes and listed as a descendent of the Chickasaw and Choctaw Nations. I am from Klamath Falls/Chiloquin but now reside in Portland with my partner of 9 years, Becky and our 3 year daughter, Yukpa Sophie. Now that I have formally introduced myself I am proud to announce that I am the new Project Assistant for PTOTS.

I have worked for the NPAIHB in previous years starting as the Office Manager and also working with the Western Tribal Tobacco Prevention Project and Project Red Talon. The dedication of the staff to their work and the contributions the NPAIHB makes to the tribes actually inspired me to go back to school and not only finish my degree but change my major to Public Health Education. In June 2007 I accomplished my educational goal and walked with my peers to receive my Bachelor of Science in Public Health Education from Portland State University.

I am excited to be back at the NPAIHB and contributing to the forty-three tribes.

Sepk'eec'a

Hello, my name is Kristyn Bigback, and I am the new Office Manager for NPAIHB. I was raised in Vancouver, Washington, and attended Stanford University where I earned my Bachelors Degree in Human Biology, with a concentration in Infectious Diseases. In the summer after my sophomore year, I worked as an intern for Project Red Talon at NPAIHB. During my junior year at Stanford, I studied abroad at Oxford University in England, where I learned about international health care systems and completed a tutorial on immunology. I was also able to travel around Europe, which I'd have to say was one of the major highlights of my four years of college. After graduation, I returned to Vancouver and worked as an Administrative Assistant at a nutritional supplement company.

During my four years of education at Stanford, I learned a lot about public health, which made me want to pursue a career in that field. I am an enrolled member of the Northern Cheyenne tribe of Montana, and have always been interested in tribal health issues. I love the Portland area, and feel very grateful to be a part of this organization.

***Health News and Notes*** is published by the Northwest Portland Area Indian Health Board (NPAIHB). NPAIHB is a nonprofit advisory board established in 1972 to advocate for tribes of Washington, Oregon, and Idaho to address health issues. Previous issues of *Health News and Notes* can be found on the NPAIHB webpage www.npaihb.org.

Contact Sonciray Bonnell (503) 228-4185 or sbonnell@npaihb.org., *Health News and Notes* Editor, to submit articles, comments, letters, and requests to receive our newsletter via mail.

# Northwest Portland Area Indian Health Board

## NPAIHB Resolutions April, 2007

**RESOLUTION #07-03-01** Support for the Submission of a Grant to the Centers for Disease Control and Prevention for Funding for the Northwest Tribal Comprehensive Cancer Program

**RESOLUTION #07-03-02** Support Community Participatory Research to Address Fetal Alcohol Spectrum Disorders

**RESOLUTION #07-03-03** Support for Health Promotion/Disease Prevention Initiative for Healthier American Indian/ Alaska Native Communities

**RESOLUTION #07-03-04** Support for the Northwest Portland Area Indian Health Board Annual Budget Analysis

**Resolution #07-03-05** Support for the Northwest Portland Area Indian Health Board 2007 Legislative Plan

**Resolution #07-03-06** Native Nutrition and Activity Evaluation

**RESOLUTION #07-03-07** Support for the Submission of a new Competing Access to Recovery Grant Application to the Substance Abuse and Mental Health Services Administration SAMHSA) by the California Rural Indian Health Board, Inc. (CRIHB) to Service Indians in the States of California, Idaho, Oregon and Washington

**RESOLUTION #07-03-0**8 Recommendation for Institutions of Higher Education and State Health Agencies to Conduct Cultural Competency Training to Healthcare Professional

**RESOLUTION #07-03-09** Racial and Ethnic Approaches to Community Health across the US (REACH) Centers for Excellence in Elimination of Disparities and Action Communities

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NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD