Health News & Notes

A Publication of the
Northwest Portland Area Indian Health Board

October, 2005

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.

Medicaid Roundtable a Huge Success

LtoR: Sonciray Bonnell, Verne Boerner, Jim Roberts Northwest Portland Area Indian Health Board Staff at the Medicaid Roundtable. Article on page 4.

In This Issue

From the Chair:

Pearl Capoeman-Baller

Over this summer, the Board has been extremely busy working on national health policy issues. This edition of *Health News & Notes* features a summary report on the "National Roundtable on the Indian Health System and Medicaid Reform" held in Washington, D.C. on August 31, 2005. The meeting was a great success with 85 people attending. Tribal leaders, health directors, and other Indian health advocates came together with health policy organizations to develop recommendations on Medicaid reform. It was very strategic to align ourselves with the Urban Institute and Kaiser Family Foundation to conduct this event. It provided exposure on Indian health issues with organizations not familiar with our issues; many of these organizations are responsible for shaping health policy on a national level and with Congress. We hope to forge these relationships to make positive changes for Indian people and Medicaid.

As many of you know, the IHS has a final FY 2006 budget and it includes decent increases for our programs. The FY 2006 budget will fund population growth and inflation for our health programs, something we have not received since 1994. Even though the IHS has a final budget it may still fall under attack by Congress and future appropriation rescissions. This year's budget does contain a .476% rescission that results in a $14.7 million loss. The recent hurricanes mean that Congress will continue to provide funding for relief and recovery efforts. Compound this with the growing deficit and it may spell future cutbacks for Indian health programs. We will discuss at our Board meeting what we need to do to protect and exempt IHS programs from future cuts.

The Senate Committee on Indian Affairs is set to mark-up the Indian Health Care Improvement Act (IHCIA) on October 20, 2005. We have hill visits scheduled during the week of the TSGAC conference and hope to gain support from our Congressional delegation on the reauthorization of the IHCIA. The Northwest continues to be very active and focus a great part of our work on the passage of this very important legislation.

The Board has been actively engaged is working with the IHS and CDC to develop their tribal consultation policies. We continue to be very active on the federal/tribal work group to finalize the revision of the IHS policy. We have also worked with CDC on their newly proposed consultation policy. While not perfect, CDC's policy has been improved over what was sent out for Tribal comment, in part due to our participation in the process. The Board continues to be very active on the TTAG and is pushing to advance Medicaid and Medicare issues that are important for Northwest Tribes. Our policy analyst attended the September TTAG meeting in Washington, D.C. and serves on a number of their subcommittees.

As you can see, we continue to be a national leader on Indian Health policy issues and will continue to work hard on this front.

From the Acting Executive Director:

Verné Boerner

In Memoriam of our friend, Geneva Charley

I would like to express my deep regret at losing our friend, Geneva Charley. Her gentle approach to addressing the healthcare needs of American Indians and Alaska Natives was an effective way in which we built awareness of the health issues and concerns of the tribes of the Northwest. Her commitment was an inspiration to many and her warm smile will be greatly missed. Farewell our dear friend, Geneva.

Joint CRIHB/NPAIHB Meeting

It was a great honor to host our friends from California at this year's 8th Bi-Annual Joint Quarterly Meeting hosted by the Confederated Tribes of Siletz Indians at the Chinook Winds Casino in Lincoln City, Oregon. We had a full agenda and were glad to welcome Dr. Grim to our meeting. I personally cannot express the complete gratitude that my family and I felt for your generosity and support that CRIHB's tribes and our tribes have extended to our family dealing with the tragic loss of my younger sister. Thank you all so very much!

I also have to specially recognize the Executive Committee, Sonciray Bonnell, Joe Finkbonner, and Erin Moran for their support and for stepping up to the plate to take over the facilitation responsibilities of our committees and presenters during my absence.

Personnel

This quarter has seen some major changes in personnel. The most prominent position is the fact that Ed Fox resigned as the Executive Director effective on September 15, 2005. The Executive Committee quickly mobilized to advertise the position and are prepared to offer their recommendation for the Executive Director position. This was not an easy charge and I offer my gratitude for decisive and efficient action.

Unfortunately we have said goodbye to three other employees this quarter due to project sunsets. We have said goodbye to Gary Small and Alethea Boyer from the Northwest Tribal Recruitment Project and Terresa White from the National Tribal Tobacco Prevention Network. Gerry RainingBird is able to remain on with some carry forward dollars for the next few months. During that time, we hope to see a new funding announcement to apply for the next generation of tobacco program funding. With some of the new awards recently received, we are hoping that opportunities will arise for current staff to reposition, allowing the Board to bring back those employees that have recently left.

I also have to report that Liling Sherry will be resigning from the Board in December. She has been a part of our Board family for the last nine years. We welcomed her two handsome boys to our offices. Liling will be taking time off from work to devote to her family. She hopes to remain in touch and welcomes the

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Northwest Portland Area Indian Health Board

Projects & Staff

Administration
Verné Boerner, Acting Executive Director
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Sue Lara, Finance Officer
Bobbie Treat, G/L & Contracts Accountant
Mike Feroglia, A/P & Payroll Accountant
Erin Moran, Executive Administrative Assistant
Elaine Cleaver, Office Manager

Program Operations
Jim Roberts, Policy Analyst
Sonciray Bonnell, Health Resource Coordinator
James Fry, Information Technology Director
Chris Sanford, Network Administrator
Chandra Wilson, Human Resource/Special Projects Assistant

Northwest Tribal Epidemiology Center
Joe Finkbonner, Director
Joshua Jones, Medical Epidemiologist
Doug White, NW Tribal Registry Director
Ticey Casey, EpiCenter Project Assistant
Katrina Ramsey, Navigator Project Coordinator
Tam Lutz, TOT's and ICHPP Director
Julia Putman, TOT's Project Coordinator
Clarice Hudson, IRB & Immunization Project Coordinator
Luella Azule, NTRC Project Coordinator
Kerri Lopez, Western Tribal Diabetes Director
Rachel Plummer, WTD Project Assistant
Don Head, WTD Project Specialist
Crystal Gust, WTD and National Project Specialist

Tobacco Projects
Gerry RainingBird, NTTPN Project Director
Terresa White, NTTPN Project Specialist
Nichole Hildebrandt, WTPP Project Director
Karen Schmidt, WTPP Project Specialist

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

Project Red Talon
Stephanie Craig, Project Coordinator
Lisa Griggs, Project Assistant

A National Roundtable on the Indian Health System

Article produced by the Urban Institute. The views expressed in this report are those of the Roundtable participants and do not necessarily reflect the views of the Urban Institute, its board, or its funders.

The major Medicaid cuts now being discussed by policymakers could have serious ramifications for the health and well-being of American Indians and Alaska Natives. Any changes in eligibility rules, benefits packages, cost-sharing requirements, provider payment rates, and financing might hinder the ability of the Indian health programs to provide essential services to some of the poorest U.S. communities. To respond, the Northwest Portland Area Indian Health Board partnered on August 31, 2005 with the Indian Health Service (IHS), the Kaiser Family Foundation, and the Urban Institute to hold a National Roundtable on the Indian Health System and Medicaid Reform. The Roundtable met at the Urban Institute, in Washington, DC. Urban Institute president Robert Reischauer welcomed program officials, advocates, and health care analysts and remarked that "this Roundtable is occurring at a terribly important juncture in policy history."

"Change is inevitable," Reischauer said, and "the direction of that change is not in question."

The day after the Roundtable, September 1, the Medicaid Commission submitted to Congress recommendations for achieving $11 billion in savings over the next 5 years through changes in prescription drug reimbursement, in rules on transferring assets for Medicaid eligibility, and in cost-sharing. The Commission now has until the end of next year to make longer-term recommendations on the future of the Medicaid program, with proposals that address such issues as eligibility, benefits design, and delivery.

Pearl Capoeman-Baller, Chair of NPAIHB, President of the Quinault Nation

Roundtable participants expressed concerns that any changes in national Medicaid policy may damage the severely underfunded Indian health system—a broad organizational structure that includes services provided directly by the federal Indian Health Service ("I"), tribally operated programs ("T"), and urban Indian clinics ("U"). This health delivery structure, often referred to as ITU (or I/T/U), is considered "prepaid" with the land ceded by tribes in more than 800 ratified treaties and presidential executive orders. So tribal members using ITU health programs are not charged for services.

This provision of health care to American Indians and Alaska Natives falls under the federal trust responsibility, rooted in the U.S. Constitution, that recognizes the debt owed to Indian tribal governments. With the recognized responsibility to indigenous people has come respect for tribal sovereignty and willingness to work with the tribes on a culturally sound health delivery system. A major shortcoming is chronic underfunding, according to Indian participants at the Roundtable.

Medicaid reimburses IHS for services to Medicaid enrollees. But unlike Medicaid or Medicare, the IHS is not an entitlement program in the federal budget process. Indian health funding, subject to discretionary annual appropriations from Congress, currently meets only about 60 percent of need. Roughly 20 percent of the IHS clinical services budget comes from Medicaid, while less than 0.5 percent of Medicaid expenditures go to Indian health.

The patient must be a descendent of a member of a tribe to qualify for Indian health care services. Approximately 1.8 million American Indians and Alaska Natives meet these standards, and 1.6 million are active users of the Indian health system. At present, there are 562 federally recognized tribes spread across 35 states. The Indian health system is

comprised of 49 hospitals, 247 health centers, 5 school health centers, 309 health stations, and 34 urban health clinics, as well as satellite clinics and Alaska community health aide clinics. Access to primary, specialty, and long-term care and emergency services is limited by geographic constraints and by the historic and chronic underfunding of the Indian health system.

Any further cutbacks in Medicaid funding would result in an even greater rationing of services, participants and speakers said. "Because of the small size and relative obscurity of Indian health programs, these negative consequences may go ignored outside Indian health for years," said Kris Locke, a consultant from Washington State. The general public should be better

Kris Locke, a Consultant from Washington State.

educated on the issues, many agreed. Although government has supported some health care services to Indian tribes since 1849, the health status of Indians is far below that of the general

The Medicaid Commission Recommendations

The Medicaid Commission, established by charter in May 2005, is charged with recommending "options to achieve $10 billion in scorable Medicaid savings over 5 years while at the same time mak[ing] progress toward meaningful longer-term program changes to better serve beneficiaries." The recommendations delivered to Congress by the Medicaid Commission on September 1 include:

- **Prescription Drug Reimbursement Formula Reform**
  Allow states to establish pharmaceutical prices based on average manufacturer price rather than published average wholesale price. Estimated Savings: $4.3 billion over five years

- **Assets for Medicaid Eligibility***
  When assets have apparently been transferred to gain Medicaid eligibility, current law requires a three-year "penalty period" beginning on the date of the transfer, during which Medicaid will not pay for long-term care. The Commission proposes the penalty period be extended to five years, with the date of application for Medicaid or admission to a nursing home (whichever is later) as the start date.
  Estimated Savings: $1.5 billion over five years

- **Tiered Copayments for Prescription Drugs**
  Current law limits the copayment that can be charged on prescription drugs and exempts some categories of beneficiaries from copayments altogether. The Commission proposes that states be allowed to increase copayments on nonpreferred drugs when a preferred drug is available.
  Estimated Savings: $2 billion over 5 years

- **State Taxes on Managed Care Organizations**
  States would be required to tax all managed care organizations, not just those with Medicaid contracts. A loophole in current law defines as a separate class of health care services the services of Medicaid managed care organizations and permits states to impose taxes solely on Medicaid.
  Estimated Savings: $1.2 billion

* Valerie J. Davidson, executive vice president of the Yukon-Kuskokwim Health Corporation in Alaska and a nonvoting member of the Commission, asked that this be considered during discussion of this reform option: *At a minimum, all assets of AI/AN individuals be exempt from Medicaid eligibility calculations and estate recovery provisions.* The Commission did not incorporate this language into its recommendations on assets.

Medicaid

John Holahan on Coming Changes in Medicaid

John Holahan, director of Urban Institute's Health Policy Center, delivered the keynote address on *Coming Changes in Medicaid.* Following are some highlights:

John Holahan, Director of Urban Institute's Health Policy Center

- **Medicaid isn't high-cost considering the health problems of those in the program.** Most of the differences in cost between Medicaid and private insurance can be explained by the presence of chronic conditions, disability, and poor health. When simulations ask what would happen if we put a Medicaid population with such conditions in private plans, the answer is that private insurance would cost significantly more.
- **The most prominent reform proposals include changes in the way we pay for prescription drugs.** Drugs are a major driver of cost growth in Medicaid. Alternatives such as charging average manufacturer's prices provided by drug companies, getting larger rebates, and extending those rebates to drugs provided by managed care plans have been discussed.
- **Asset transfers are also getting the spotlight.** When patients turn assets over to their future heirs and then enter nursing homes as a Medicaid patient, nursing home costs are paid by taxpayers rather than the patient's own resources. While transfers get a lot of attention, most observers believe that only a small share of nursing home residents on Medicaid ever had much to transfer. In fact, the administration estimates budget savings from preventing asset transfers at $1.5 billion over five years, or less than 1 percent of nursing home spending.
- **Another issue is cost-sharing—the idea that people should pay more of their Medicaid costs so they'll use health care services more appropriately.** Cost-sharing may reduce some inappropriate care, but evidence shows some appropriate use of services would also be cut back. Careful design of cost-sharing policies would protect the poorest and sickest, thus limiting the savings.
- **"Benefit package flexibility" is another target.** Many states provide a wide range of acute care benefits—like vision, hearing, dental care, and so forth. Often, these aren't part of the benefit packages for low-income people that have private insurance, so why should they be in Medicaid? However, people on Medicaid are generally poorer than those with private coverage and would find these services unaffordable when needed. Moreover, these optional benefits are not very costly and cutting them would yield relatively little savings.
- **The real savings in Medicaid are going to come only with managing high-cost populations better.** Right now, 4 percent of the Medicaid population accounts for 53 percent of Medicaid spending. Another 3 percent accounts for 12 percent of spending. So 7 percent of the Medicaid population, or about 3 million people, get two-thirds of all Medicaid dollars. These cases represent a lot of potential for savings through better management.

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U.S. population. Factors that contribute to the health disparity in Indian country are the continued underfunding of the IHS, high rates of poverty, low education levels, poor housing, and inadequate transportation. Many of the diseases that plague Indian populations, including obesity and diabetes, are preventable and treatable. If ignored now, these health problems will become more costly to the federal government as Medicare or disability payments.

More than a dozen areas require special consideration in any Medicaid reform, participants said, including the special "trust" relationship between the federal government and American Indians that provides the legal justification and the moral imperative for the federal provision of health care. A distinct disadvantage of Medicaid, from the Indian perspective, is that it is a state program. As states do not share in the federal government's trust responsibility, the challenge has been to ensure the funding from the federal government reflects the federal responsibility.

One of the key Roundtable recommendations is to continue the current 100 percent Federal Medical Assistance Percentage (FMAP), the portion of the Medicaid program paid by the Federal government rather than the states, for all Medicaid services provided to American Indian/Alaska Native (AI/AN) enrollees through IHS, tribal, and urban facilities. The federal government's share of Medicaid normally ranges from 50 percent to 83 percent, with states with lower per capita incomes receiving more federal funds.

The future of the Indian health system is intrinsically tied to Medicaid as the government's health program for the poor, despite the federal trust responsibility that predates Medicaid. As Carol Barbero, a partner in the Washington, DC, law offices of Hobbs, Straus, Dean & Walter, explained, "Congress recognized that it had the responsibility for these individuals as IHS beneficiaries, and should have the same responsibility for them as Medicaid beneficiaries."

Other recommendations included continuing the exemption that many states have requested for AI/AN Medicaid beneficiaries from required premiums, deductibles, copayments, or other cost sharing; and rejecting any waiver without tribal consultation.

The Roundtable audience included a cross section of individuals from the health policy arena, tribal representatives from each of the 12 Indian Health Service areas, and members of the National Indian Health Board and Tribal Technical Advisory Committee. Congressional staff members and representatives from the Medicaid Commission, health policy foundations, the IHS, and the Centers for Medicare and Medicaid Services (CMS) also attended. Indian health policy and Medicaid experts had prepared policy papers on Medicaid reform issues that served as discussion pieces with the audience.

Why American Indian People Should be Treated Differently in Medicaid

Differential treatment for American Indians and Alaska Natives in Medicaid and other programs is based on a political classification (membership in a tribe) rather than a racial one. This practice has been upheld by the courts and should be affirmed in health policymaking, according to Roundtable participants. Indian tribes are governments that predate the governmental status of the United States. More than two centuries of judicial decisions, statutes, regulations, executive branch directives, and ongoing dealings between the federal government and Indian tribal governments have attempted to define the appropriate manner for treating these indigenous nations. The 1976 Indian Health Care Improvement Act underscored that "any effort to fulfill federal responsibilities to the Indian people must begin with the provision of health services." The law recognized that it was the federal government's responsibility to pay the full costs of Medicaid services to American Indians.

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Important cultural distinctions must also be respected. Indian health care advocates feel strongly that the ITU system is *not* an extension of the mainstream health system in America. To the contrary, federal support has built a system designed to serve Indian people. This community-based and culturally appropriate health care approach can accommodate the needs of Indian people and their cultures. It is important not to undo that system, they say, but to instead build on those programs that tribes, the IHS and other Indian health providers have started. The poor state of health among Indians also requires specialized attention to break the cycle of illness and addiction.

An evolving federal bureaucracy does include an Indian voice, albeit a small one. CMS is now the federal agency responsible for administration of Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). In 2003, CMS chartered the Tribal Technical Advisory Group (TTAG) to, among other things, honor the federal trust responsibilities and obligations to the tribes, which includes consultation with tribes before enacting new policies. Serving as an advisory body to CMS, the TTAG provides expertise on policies, guidelines, and programmatic issues affecting the delivery of health care for Indians served by Titles XVIII, XIX, and XXI of the Social Security Act. The TTAG is composed of 12 tribal leaders or employees appointed by area directors, with consultation of tribes in each of the 12 IHS geographic areas, and representatives of three national Indian organizations—the National Congress of American Indians, the National Indian Health Board, and the Tribal Self-Governance Advisory Committee.

Pending Policy Changes: The Medicaid Commission

The fundamental policy principle of Indian health providers and policy experts is that the Medicaid Commission must "first do no harm" when it considers ways to cut $10 billion from what has become the largest source of health care funding for people with limited income. "Sometimes harm isn't intended, but we all know as tribal people that sometimes in the grand scheme of trying to do the right thing for Indians, if you are not really careful, unintended harm can result,"

Valerie J. Davidson, executive vice president of the Yukon-Kuskokwim Health Corporation in Alaska and a nonvoting member of the Commission, told participants.

Valerie Davidson, Executive Vice President of the Yukon-Kuskokwim Health Corporation in Alaska

Many people at Commission meetings with considerable Medicaid knowledge, according to Davidson, know nothing about Indian health programs. They are not aware of the federal trust responsibility to provide health services. As Indian health is a small part of Medicaid, many protections for Indian people could be adopted with little impact on the federal budget. These protections "could make a huge difference to tribes in Indian health programs," she said.

Andy Schneider, Medicaid Policy LLC

Yet, as Andy Schneider, a principal with Medicaid Policy LLC, explained to Roundtable participants, the outcomes from the Commission

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recommendations will vary from state to state. Many of the Commission recommendations released on September 1 are based on proposals put forth by the National Governors Association. The governors urge that any changes to the federal/state program continue to stress state flexibility. For instance, on the benefits package, governors would prefer that states be given the ability to offer a different level of benefits using SCHIP as a model. Under this plan, states could establish different benefit packages for different populations in different parts of the state. An Indian reservation could be defined as a different part of the state and denied benefits available elsewhere in the state.

By December 31, 2006, the Commission will submit longer-term recommendations to Health and Human Service Secretary Michael O. Leavitt. The more extensive plan on the future of the Medicaid program and its sustainability will address such complicated dilemmas as how to expand the number of people covered with quality care while recognizing budget constraints.

Elders and Behavioral Health

Roundtable participants fear that Medicaid reform might hinder innovation or cut off funding to new endeavors. The Indian health system has been slow to confront pervasive health problems, but is now starting to do so. The Indian population has remained relatively young, but changing demographics have put more emphasis on such costly health issues as long-term care for the elderly.

By 2030, it's estimated that there will be 430,000 American Indian and Alaska Native elders, requiring some creative thinking on the part of the Indian health care system to cope with the elders' very high rates of disability and chronic conditions. Planning for this projected growth should begin immediately, according to Traci L. McClellan, executive director of the National Indian Council on Aging. At this point, there are only 15 long-term care tribal facilities to serve the 562 tribes.

Traci L. McClellan, Executive Director of the National Indian Council on Aging

Yet, designing long-term care services for Indian people must be consistent with tribal sovereignty—allowing the tribes to design and plan how they will administer services. In accord with many cultural values of tribal communities, most elders live with their children, grandchildren, or other members of the extended family. As a result, the daily care of those suffering from chronic diseases and disability falls to family members. McClellan suggested developing family counseling programs to support these caregivers.

Costly long-term care insurance is not an option for most financially strapped Indian families. And licensed, certified home health care is not universally available within the Indian health system. However, waivers from the state Medicaid program can allow tribal health programs to serve as a home health agency and receive the reimbursement. Other models to follow include the Program for All-Inclusive Care for the Elderly (PACE). Designed to prevent or delay nursing home admissions, PACE combines a comprehensive package of services using Medicare and Medicaid funding sources.

The concept of behavioral health encompasses both mental health services and drug and alcohol treatment, which practitioners see as intertwined. "Tribal behavioral health,

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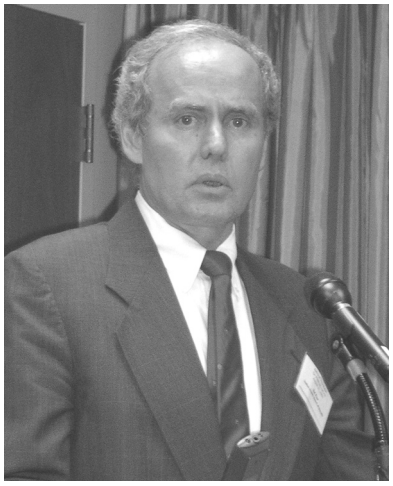
as you all know, has a very different take on health and wellness, and usually it's from a relational world view perspective," explained Holly Echo-Hawk, an independent consultant to the National Indian Child Welfare Association. Many practices that work elsewhere across this country may not work in tribal communities with higher than average rates of suicide, homicide, domestic violence, child abuse, and substance abuse. The geographic isolation of many tribes and the grossly inadequate behavioral health staff and service levels across Indian country are spurring problems to epidemic proportions—for instance, youth suicide and violent death in some Alaska Native villages.

Echo-Hawk said that one area specific to AI/AN people—historical and generational trauma—has finally gotten attention in the last 10 years, with tribes tackling high levels of depression among tribal children and alcoholism. Methamphetamine is also a major problem on the reservations. "I was in a tribal community in Maine and the problem there, needle addiction, has gotten so severe it went through every home, every house on that reservation," she said.

Nancy Weller

Yet, there are some signs of hope. Roundtable participants were heartened to hear about the 16 Circle of Care programs across the country designed to support federally recognized tribal governments and urban Indian programs by providing culturally appropriate mental health service models. Some fear that this progress might be squelched in Medicaid reform. The tribes have not yet met the licensing and accreditation required for reimbursement from Medicaid on these new behavioral health models. "To change the program is like pulling the rug out from under their feet," said Nancy Weller, another consultant to the National Indian Child Welfare Association.



Edward J. Fox, Executive Director of the Indian Health Board of Nevada

State Innovations

Health care services are thriving among the Northwest tribes, with good facilities, an experienced staff active in national Indian health activities, and an ever-increasing array of services. Edward J. Fox, executive director of the Indian Health Board of Nevada, discussed the progress at the Roundtable. "We say the main reason for the success in these expanding programs is the ability to access Medicaid programs in the states of Washington, Oregon, and Idaho," he said. While the budget for the Indian Health Service has remained flat over at least the past ten years, Medicaid funding for the Indian health system has risen. He attributed this, in part, to the states meeting with the tribes not less than quarterly to facilitate Indian health programs' access to Medicaid.

Fox outlined why Medicaid reform could be harmful. "Tribes are fearful that the role of Medicaid is not well understood and that changes to provisions and practices could, however unintentionally, negatively impact our programs." Currently, the states have provided tribes with the flexibility needed to achieve success. Yet, he said, some proposals discuss allowing states flexibility without any minimal standards, without any strict guidelines for cost-sharing, and without any clear recognition that there Continued on page 11

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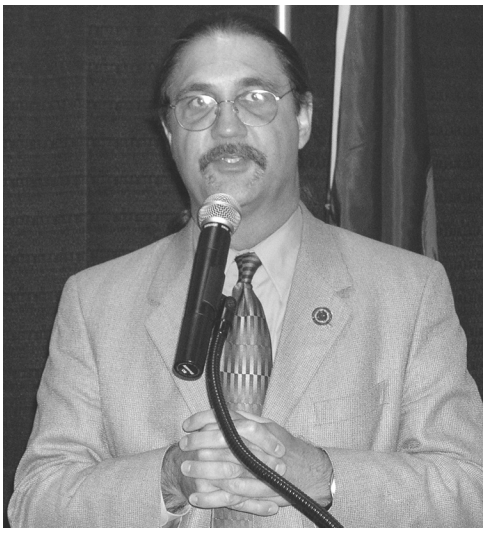
is a federal responsibility to provide health care to Indians.
Already, health status among the tribes in the northwest states is stagnating. Disparities are growing between the Indian and white populations in terms of being healthier longer, mortality, and morbidity. This loss of momentum is yet another call for ensuring a steady flow of funding to the health care services, said Fox.

Innovations in Alaska would also be threatened in any Medicaid cutbacks, participants said. Alaska Natives—Eskimos, Indians, and Aleuts—comprise 40 percent of the state's Medicaid population. Yet, they don't make up enough of the United States population, nor carry enough political clout, to warrant necessary protections. Nancy Weller, who retired last year as tribal health manager for the Alaska Department of Health and Human Services, outlined the collaborations that have occurred despite isolation and poverty.

The Yukon-Kuskokwim Health Corporation (YKHC) received a grant in 1996 to become the first managed care plan under Alaska's Medicaid program. In designing the plan, YKHC identified its major health concerns: children, behavioral health, and long-term care services. Because travel costs to get patients to health care facilities are exorbitant, the state gave YKHC an additional grant for travel management centers in Anchorage and Bethel, which developed into a full-blown air ambulance service.

Getting more of Alaska's eligible Native population to enroll in Medicaid has been a major challenge, though persistent efforts—especially to families with children—cut through such barriers as culture and language. Medicaid reform could hurt the administrative match agreements that many states, including Alaska, have negotiated with the tribes. These administrative funds allow the outreach and education eligibility work. If that activity is capped, tribes are going to be increasingly reluctant to expand critical outreach work. Continued on page 14

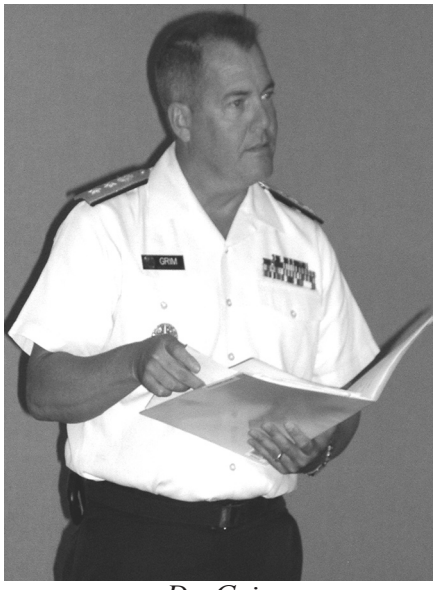
July 2005 QBM Pictures Hosted by the Siletz Tribe in Lincoln City (joint meeting with California Rural Indian Health Board (CRIHB)



Jim Crouch, Executive Director CRIHB

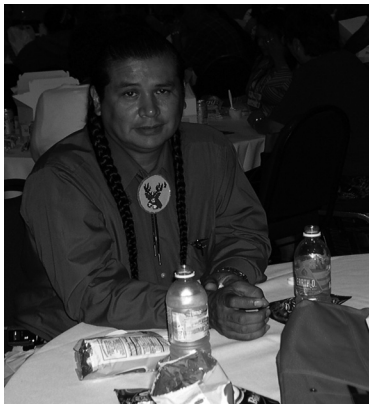
The BIG Card winners!

Marilyn Pollard with Delegates



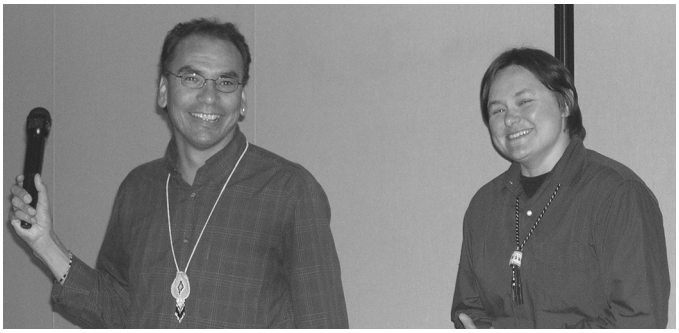
Dr. Grimm

Delegates enjoying lunch



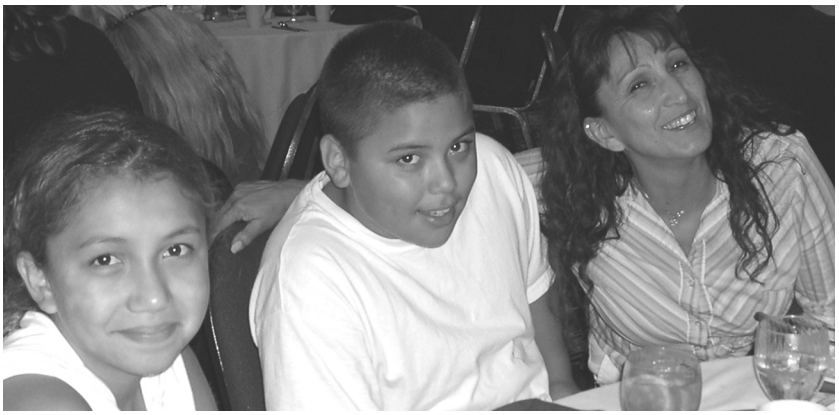
Andy Joseph, Vice Chair of NPAIHB, Colville Tribe

July 2005 QBM Pictures Hosted by the Siletz Tribe in Lincoln City (joint meeting with California Rural Indian Health Board (CRIHB)



Gerry RainingBird and Jacelyn Macedo, MCs for the evening entertainment

LtoR: Ticey Casey, EpiCenter Administrative Assistant and Erin Moran, Executive Administrative Assistant



Barbara Finkbonner and her children

Delegates hard at wok

Sleepy guy

Doni Wilder, POA, with Delegates

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Recommendations

The Roundtable provided a forum for a thorough discussion of Medicaid reform issues and served as the basis of recommendations in response to Medicaid reform proposals by the Medicaid Commission and National Governors Association. Foremost, policymakers are encouraged to "first do no harm" to the Indian health system in any reform proposals. To accomplish this, policymakers must protect Indian health programs by including the following provisions in any Medicaid reform legislation and regulations:

1. **Cost Sharing:** Eliminate or waive cost sharing requirements for AI/AN beneficiaries. Legislation and regulation must extend the current SCHIP premium and cost sharing exemptions to Medicaid.
2. **Federal responsibility for health care services to Indian people:** One-hundred percent FMAP should be applied for all services delivered through Indian health programs.
3. **Benefits Flexibility:** States should be prohibited from offering benefit packages to AI/AN Medicaid beneficiaries that are less in amount, duration, or scope than the benefits packages they offer to any other group of Medicaid beneficiaries anywhere in the state. This "most favored nation" rule should apply with respect to all AI/AN Medicaid beneficiaries, regardless of whether they live on or near a reservation.
4. **Estate Recovery:** Estate recovery inhibits AI/AN participation in the Medicaid programs, and Indian people will simply not enroll if they are subject to any estate recovery claims in the Medicaid program. AI/AN beneficiaries must be exempt from estate recovery rules.
5. **Traditional Practices:** Respect for cultural beliefs requires blending of traditional practices with a modern medical model and emphases on public health and community outreach. CMS should include access to traditional medicine as part of the services available to AI/AN people and fully recognize traditional medicine as an integral component of the Indian health care delivery system.
6. **Access to CMS Program Eligibility:** Simplify and improve AI/AN outreach, enrollment, and eligibility determination. Provide funding to Indian health programs for conducting outreach and linkage activities. Simplify the application process by reducing required documents, providing "real time"
determination, and allowing self-declaration for residency and income. Allow Tribes the option to provide program enrollment and eligibility determination on site.
7. **Managed Care:** If Medicaid reform includes managed care, Indian programs and AI/AN people must have the following flexibility.
   - *Choice*: AI/AN individuals should be allowed to choose an Indian health program or a managed care plan, as they prefer.
   - *Default Assignment to Indian Health Program*: Individual AI/AN must NOT be *involuntarily* assigned to a non-Indian managed care plan when an Indian health program is available.
   - *Out-of-Plan Service*: Medicaid must require managed care plans or contractors to pay Indian health providers when providing services to AI/AN people who exercise their right to use tribal/IHS programs.

Northwest Tribes call for Greater Recognition of Data Ownership

By Stephanie Craig, MPH Project Red Talon, NPAIHB

In July 2005, members of the Northwest Portland Area Indian Health Board unanimously passed a joint resolution calling for greater "Tribal Ownership of Health-Related Data." The Resolution serves as a formal statement to researchers and funding agencies, calling for unequivocal tribal ownership of the data collected.

For decades, Tribes have been the subject of medical and anthropological research, with few benefits returning back to the tribe as a result of their participation. In doing so, researchers have failed to recognize tribal sovereignty and their right to self-determination.

Both in the Northwest and in other regions of Indian Country, concerns about tribal "ownership" have arisen upon discovery of unethical research practices. The most recent notable example involved the Havasupai Tribe, which filed a lawsuit against Arizona State University in 2004 after learning that nearly 400 blood samples were used by the University to study schizophrenia, migration, and inbreeding without the consent of the Tribe. Tribal members originally provided the samples to support diabetes testing and research, and were not told that a their genetic information would be used for alternate purposes.

The "Tribal Ownership" Resolution passed by the NPAIHB was designed to pre-empt such occurrences in the Northwest, and to help safeguard Tribal interests from unauthorized scientific research.

Portions of the Data Ownership Resolution

WHEREAS, Northwest Tribes have the right to self-determination, and in exercising that right must be recognized as the exclusive owner of… intellectual property; and

WHEREAS… Tribal members have been the subjects of research for decades, with virtually no benefits returning back to the community from the research; and

WHEREAS, members of the NPAIHB recognize that one way to help safeguard the best interests of Northwest tribal communities is to utilize the Portland Area Indian Health Service Institutional Review Board (PAIHS IRB) to review proposed research protocols… and

WHEREAS, members of the NPAIHB recognize that it must: (1) protect the people, culture, and natural resources of the NPAIHB from unauthorized scientific research; (2) reduce the adverse effects of research on Tribal communities; (3) ensure that researchers recognize Tribal control of research activities and Tribal ownership of all data and information generated…; (4) …review and govern any research, collection, database, or publication undertaken on their Reservations; and

WHEREAS, any tribe that participates in health-related research must be given possession of the primary data (with the necessary protections taken to protect the rights and privacy and confidentiality of individuals).

NOW THEREFORE BE IT RESOLVED, that the NPAIHB hereby recommends that all health-related research undergo review and approval by the PAIHS-IRB… ; and

BE IT FURTHER RESOLVED that tribes… have the opportunity to review and give input on publications… while they are in draft form.

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BE IT FINALLY RESOLVED, that there will be a formal process by which tribes and tribal organizations will give input as how data concerning their community is presented, and the following principles are adhered to in research projects concerning Northwest Tribal communities:
that investigators will not transfer the data to any other party without formal agreement from the tribe (and oversight by the PAIHS IRB, if involved), and
that no secondary analyses are performed on the data that are different than those proposed in the original research protocol without a formal request to the affected tribe, and
that there are measures taken to meaningfully inform the community of the results of research, and
that the tribe has the opportunity to benefit from gains that come out of the research…, and
that the tribe has control over how and when data is disposed of… .

Rationale for Tribal Ownership of Health Research Data
American Indian and Alaska Native (AI/AN) Tribes and Bands have the right to self-determination, and in exercising that right must be recognized as the exclusive owner of indigenous knowledge, biogenetic resources, and intellectual property. These elements have been, and continue to be, damaged, destroyed, stolen, and misappropriated during research, with virtually no benefits returning back to the Tribes. It must be recognized that data derived from health research conducted in AI/AN communities are the property of the Tribe. There are several important principles that support this rationale:

Participatory Research Models - Ethical standards for culturally sensitive research in Indian communities should employ the use of participatory research models wherever possible. Research protocols that involve local community members in the study design, data collection, and analysis help to build local capacity, improve trust in the research at hand, and help foster community empowerment on a variety of levels. For NW Tribes, this requires considerable consultation and collaboration between researchers and Tribal Health Departments, the Tribal Council's Health Committee, Tribal Health Clinics, community Health Educators, and local health advocates. When openly discussed, limitations that exist within participatory models can be identified and addressed without compromising the integrity of the research.

Ownership of Data - Data collected from tribal members within the community setting must be returned to the community from which it was obtained. Tribal Institutional Review Boards (IRBs)have been established to review proposed research protocols, and in so doing, help prevent research-related abuses of individuals and tribal communities, protect human subjects and traditional knowledge, and identify research-related benefits and risks to the Tribe. Tribal IRBs serve to: (1) protect the people, culture, and natural resources of Tribes from unauthorized scientific research; (2) reduce the adverse effects of research on Tribal communities; (3) ensure that researchers recognize Tribal control of research activities and Tribal ownership of all data and information generated or produced by such research, and; (4) Establish and provide a statutory basis to review and govern any research, database, or publication undertaken on their reservations. As required by the IRB, data can only be gathered with Tribal consent. Permission to carryout research must be granted by both the IRB and the Tribe, often in the form of a resolution, which specifically outlines how the data will be used, reported, and disseminated.

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Beyond the scope of work listed in the original research proposal, the Tribe is the only entity that has the authority to decide how the data will be used in the future, and thus must retain ownership and control over the data upon the study's conclusion. After all, without the Tribe and its consent to participate, there would be no data to begin with. Sponsorship alone does not give the government or any other entity the right to the data obtained. Such is the case with genomic data, which is consistently patented and commercially developed by researchers supported by government grants. Likewise, external research support does not lessen the authority of the Tribe to maintain control over the results of their participation. Ethics demands consistency, honesty in handling and interpreting data, and privacy protection. All of these standards can be met while recognizing tribal ownership.

Obligation to Follow-up - The future health and welfare of Tribes requires complete data disclosure and ownership. After external researches have gone home and funds have subsided, it is the Tribe who must ultimately respond to the outcomes and enact community change. While it is a noble goal for researchers to help solve the problems discovered by their research, realistically, few research teams are able to implement culturally appropriate changes to improve community health. Only the local Tribe, Health Department, and clinic are positioned to implement long-term, sustainable preventative programs that address community health issues. Without complete access to the data collected, tribes will not have the information needed to improve heath outcomes for their people.

Future Participation - External entities that do not promptly return data to Tribes that are involved in health research compromise the possibility of future tribal partnerships. Tribes are not apt to contribute to research that courts their participation, only to identify health issues that aren't positively impacted. Further, any breach to Tribal data sharing agreements endangers Tribal trust, and jeopardizes future participation in all forms of research.

This effort was supported by the NW Tribal EpiCenter, the Portland Area IHS Institutional Review Board, Project Red Talon, and the Northwest Portland Area Indian Health Board.

Resolution and Ownership Rationale References:

A great deal was learned from and contributed by the following sources:
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The Indigenous Research Protection Act. Available at: [http://www.ipcb.org/publications/policy/files/irpa.html]
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Methamphetamine and STI

By Kristyn Bigback, Project Red Talon Intern

As the media has portrayed with increasing ferocity in recent years, methamphetamine (meth) use in the United States has become an enormous problem for citizens and policy-makers alike. Meth continues to touch more and more people, and is not limited to those who are addicted – it also affects their family, friends, and the community at large. The actions and behaviors of meth users produce tremendous social implications that radiate out to non-users as well. This web of destruction can, in turn, lead to physical maladies, not the least of which is the transmission and spread of sexually transmitted diseases (STDs), including HIV/AIDS.

What is Meth?

In the strictest sense, meth is a highly addictive synthetic stimulant that creates a strong feeling of euphoria in its users. It directly affects the central nervous system (CNS - the brain and spinal cord) by interfering with the neurotransmitters that facilitate communication between CSN nerve cells and with the rest of the body.[8] Meth can be taken in four different ways: it can be swallowed in pill form, snorted as powder, smoked, or injected.[7]

Meth was developed early in the 20th century, and was originally used in nasal decongestants, bronchial inhalers, and in the treatment of narcolepsy and obesity[7]. In the 1970's, the DEA classified meth as a Schedule II drug, finding that it had a high potential for abuse and few medical benefits.[7] Since then, meth has grown in popularity as a recreational stimulant.

Today, meth is a major focus for the U.S. "war on drugs." Many law enforcement agencies, including Pierce County in Washington, have formed special police task forces to address problems surrounding meth production.[1] From 1995 to 2001, meth lab seizures in Oregon increased from 67 to more than 590, and in the U.S. as a whole the number of seizures has doubled since 2000.[1]

On the Street

Meth has many street names, often referring to different forms of the drug. The crystalline form of meth is known as "crystal meth," "crystal," or "cristy." The pure, smokeable form is produced as clear, chunky crystals that resemble broken glass or frozen water -- slang names for this form include "glass," "ice," "quartz," and "tina." The less pure crystalline powder is often referred to as "crank" or "speed." The rock form of the drug is known as "tweak," "dope," "raw," "P" (in New Zealand), and "batu" (in Hawaii).[7] This list is incomplete, as many additional "street names" exist throughout the country.

Increasingly, meth is being produced in "meth labs" that are found in rural, urban, and suburban residences, barns, garages, businesses, apartments, hotels, vacant buildings, and vehicles.[7] Of particular concern, many of the chemicals involved with meth production are highly explosive and/or toxic, and are now being found in close proximity to unsuspecting, innocent community members and children. Between 2000 and 2002, the number of children present during meth lab seizures doubled, and from 2001-2002, Oregon ranked third in the nation for the number of children found at meth labs, with 241 children.1

Why do people take meth?

Besides being strongly addictive, meth is relatively cheap, readily accessible, and gives a high that lasts longer than other drugs.[4] Many young people express that they use meth because it is more accessible to them than alcohol, and it gives them a more intense high than marijuana.[5]

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"I had unsafe sex while on crystal. I think I was lonely, bored, and meth gets me close to the guys I like and makes me closer to them."[5]

-Anonymous young woman

Meth, and substance use in general, can also be used to mask painful emotions and circumstances. For young people, meth can be a tempting way to escape the challenges that come with puberty and adolescence. For others, meth may serve as a distraction from the realities of life, including poverty, low self-esteem, and a lack of opportunity that is common in many tribal communities.[4]

How did it become so accessible?

Meth production is relatively cheap, the ingredients relatively accessible, and directions for production easily accessible. These factor have contributed to the geographic expansion of meth use, but there are also loopholes and omissions in Tribal law that exacerbate the problem for many tribes. For example, as of February of this year, there were *no laws* to criminalize the sale, possession, or manufacture of meth on the Navajo reservation, the largest reservation in the country.[6] Issues associated with police jurisdiction can also hinder appropriate enforcement strategies.[9] In addition, some tribes whose reservations border Canada or Mexico do not have adequate funds to monitor and police their borders.[9]

Research conducted by the San Francisco Department of Public Health suggests that gay men who use crystal meth are *four hundred times* more likely to become infected with HIV.

What is the Link between Meth and STDs? Meth use is associated with a higher frequency of sexually transmitted diseases, including HIV/AIDS. Meth users are at greater risk for an acquiring an STD, due largely in part to behavioral changes. This is especially true among gay and bisexual men who use meth. Men who have sex with men (MSM) and are meth users are over four times more likely to be infected with HIV than other gay men.[2]

Why meth increases STD risk.

Typically, meth use increases the need and urgency for sex; it increases the user's energy and ability to have sex for extended periods of time; and it creates an inability to ejaculate or achieve physical release.[3] This combination can result in tearing, chafing, and physical trauma (including rawness and friction sores) to the sex organs, the rectum, or the mouth.[3] These injuries radically increase the risk of STD/HIV transmission, as pathogens are able to enter the body through the resulting wounds and sores.

Like alcohol and other drugs, meth also lowers inhibitions and causes users to behave in ways that they normally would not. People on meth may be more apt to "throw caution to the wind" and put themselves in dangerous situations. This leads to less condom use and fewer safe sex precautions – one study found that meth users were *six times less likely* to use condoms when having sex.[2]

In addition, meth is immuno-suppressive, meaning that it weakens the body's immune system. This happens because people who use meth often miss meals, do not get enough vitamins, lose weight, and have disrupted sleep patterns.[3] Each of these factors cause the body's immune system to decline, and makes it even easier for disease-causing pathogens to infect the body. As a result, meth users are not only exposed to STDs more often, but are also more susceptible to them when exposed. Continued on page 20

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Meth and HIV/AIDS

Perhaps most disturbing, meth use is intimately connected to the HIV/AIDS epidemic. It is estimated that nearly 90% of all patients at inpatient treatment centers for meth abuse are HIV-positive.[2] Some clinics report that two-thirds of their clients that test positive for HIV indicate that meth contributed to their infection.[3]

Compounding this problem, those infected with STDs (through meth-related high-risk sexual behavior or otherwise) are 2 - 5 times more likely to acquire HIV when exposed through sexual contact. Consequently, elevated STD rates among American Indians put them at even greater risk for HIV transmission. As is true among other ethnic populations, chlamydia and gonnorhea rates in Indian Country are typically highest among those aged 15-29. Given the "young" demographic distribution in many AI/AN communities, and the growing prevalence of meth use, this disparity is particularly troubling to STD and HIV prevention programs.

In 2003, American Indians were nearly six times more likely than Whites to have chlamydia, over three times more likely to have gonorrhea, and twice as likely to have syphilis.[11]

Broadly generalized, many Tribes are further affected by factors that promote STD and HIV transmission (geographic isolation, early sexually debut, small populations, and close knit social and sexual networks). Consequently, many predict that HIV/AIDS could have the same devastating consequences to Native communities that smallpox, typhus, and measles had in the 1800's.[10] While STD rates vary by region and by Tribe, this issue clearly compromises the health of Natives throughout the U.S.[12]

Finding Solutions

Fostered by increasing meth production and use in Oregon, Washington, and Idaho, a simple STD or HIV outbreak could cause a debilitating blow to NW tribal communities. In response to these complex issues, it is imperative that Tribal leaders, policy makers, clinics, treatment centers, health departments, and law enforcement agencies work together to find common solutions, intervene with those at greatest risk, and establish programs to prevent future addiction and transmission.

Need More Information?

✦ To find treatment centers near you, call the Substance Abuse and Mental Health Services Administration (SAMHSA) at **(800) 662-HELP (4357)**.

✦ For information and treatment referrals, call the National Clearinghouse for Alcohol and Drug Information at **(800) 729-6686**.

✦ You can contact the Crystal Meth Anonymous (CMA) hotline at **(213) 448-4455**. You can also visit the CMA website at **www.crystalmeth.org**.

✦ Another website, **www.lifeormeth.com**, is a good resource that offers a lot of helpful information and current news about meth. Continued on page 21

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Before and after Meth addiction.

Methamphetamines

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12. Craig, s et. al. Red Talon STD Profile. Northwest Portland Area Indian Health Board. 2005.

Graphics if needed:

thought of working with us on special projects. Liling's position will be updated and announced. We are hoping to provide some overlap to assist in the transition in project leadership.

I am happy to report that the Western Tobacco Prevention Project's Doug White has accepted the Northwest Tribal Data Registry Manager position. He is already getting out there in the communities and representing the project in a highly professional manner. Congratulations Doug! Keep up the good work! I am excited to report that we are increasing Tom Becker's FTE at the Board from .2 FTE (full time employee or in this case one day a week) to .25 FTE. Finally, I am so very happy to report that Nichole Hildebrandt gave birth to her second child, Sydney Grace Hildebrandt on September 19, 2005. We look forward to having our another Board baby in the office! Nichole is on maternity leave, but is working on a very limited basis. Nichole plans to be out for about three weeks. Gerry RainingBird is assisting with directing project operations for the Western Tobacco Prevention Project while Nichole is on leave.

Finally, I want to recognize all staff for taking a very proactive and involved approach to addressing various issues with in the organization. We have very active and consistent participation in the following employee committees: Art committee, Wellness Committee, Staff Retreat Committee, Safety Committee, and Weekly Grant writing meetings.

Finances

We are starting the year in a strong position with our new awards. This is a relief from the concern that we had all the way up until the last week of September. Sue Lara provides a schedule of our awards in her financial report. These are exciting new programs along with some of our long-standing projects.

Our Western Tobacco Prevention Project was approved but as of yet, not funded. We will be advocating for this program funded by the Centers for Disease Control and Prevention. WTPP has been in existence for over a decade and has had several great outcomes, including assisting the states in developing state policy regarding tobacco funding and tribes, assisting tribes in developing tribal second hand smoke and tobacco policies, and producing products such as the tobacco policy workbook. WTPP is currently operating on supplemental funds and a contract with the State of Washington. I am happy to say that WTPP also submitted a grant to the Robert Wood Johnson Foundation of which it is a finalist for consideration for the award.

Affiliated Tribes of Northwest Indians

Ernie Stensgar was re-elected as President. Ernie has long supported the work of the Northwest Portland Area Indian Health Board. We congratulate him on his re-election!

The Health committee was chaired by Andy Joseph Jr. and Pearl Capoeman-Baller. The Health committee submitted two resolutions to ATNI: Recommendations to the Commission for Medicaid Reform and Declaring Methamphetamine manufacturing and use as a health crisis in Indian Country. The participants also indicated that they wanted continued dialogue on the IHS National Core Drug Formulary.

Tribal Technical Advisory Group

The Centers for Medicare and Medicaid Tribal Technical Advisory Group continues to meet in very active teleconferences. The first task of this group is to guide the implementation of the Medicare Modernization Act. 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.

Citizens' Health Care Working Group

Senators Hatch and Wyden initiated this Citizen's workgroup. "The Citizens' Health Care Working Group is a nonpartisan two-year federal effort to learn what kind of health care system Americans want. The Citizens' Health Care Working Group was established in 2003 to engage Americans in "a nationwide public debate about improving the health care system to provide every Americans with the ability to obtain quality, affordable, health care coverage;" and to develop recommendations for the President and Congress to provide 'health care that works for all Americans,' in fall 2006."

I met Senator Ron Wyden and asked that this workgroup include representation from individuals that are aware of the unique moral and legal obligation that the federal government has to American Indians and Alaska Natives. We will continue to follow the efforts of this working group.

Lobbying Activities

As this is the start of a new Fiscal Year, we will be sending out requests for donations to our Lobbying fund. We follow all federal lobbying restrictions on the use of federal funds. All of our lobbying monies have come from your donations and we do not use any federal funds to conduct lobbying activities.

Conclusion

I wish to thank Ed Fox, the Executive Committee, and the entire Delegation for the opportunity to serve as the interim Executive Director. It has been my honor to serve the tribes of the Northwest in this capacity. I wish to recognize the staff for coming together, getting involved and rallying to secure funding, for suggesting and for taking action that facilitates communication and creates more opportunities for collaboration. The Board is a fantastic place to work and it is because of the balance of Delegate involvement and staff involvement. You all have done something great in creating an organization that is effectively striving to meet its objective.

Upcoming Events

October

October 30 - November 4, 2005 - NCAI 62nd Annual Convention, Tulsa, OK

November

November 7 - 9, 2005 - Annual Contract Health Services (CHS) Officers Meeting, Rockville, MD 20852

November 14 - 15, 2005 - Tribal Self-Governance Advisory Committee Quarterly Meeting, Washington, DC

November 16 - 17, 2005 - AI/AN Long Term Care Conference,Albuquerque, NM

November 17 - 19, 2005 - National Alaska Native American Indian Nurses Association Summit, Washington, DC

December

December 7, 2005 - Director's Executive Council Meeting, Palm Springs, CA

December 10 - 14, 2005 - American Public Health Association (APHA) Annual Meeting, Philadelphia, PA

December 14 - 15, 2005 - Area Directors' Meeting, Oklahoma City, OK

January

January 29 - February 3, 2006 - 2006 National Combined Councils Meeting, Phoenix, AZ

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

July 2005 Resolutions

05-04-01
Support for PhD Dissertation Research under Native American Research Centers for Health

05-04-02
Support for three Regional Health Centers and one Area Medical Center in the Portland Area Health Services and Facilities Master Plan

05-04-03
Support to Protest NPAIHB Dental Support Center Award

05-04-04
Tribal Ownership of Health-Related Data

05-04-05
Support an Application to CDC Funding for Cooperative Agreement for Tobacco Prevention and Control

05-04-13
Support for NTRC to submit grant application to CDC to fund Using Data to Bring About Positive Change in Tribal Communities

05-04-14
Support for Native American Research Centers for Health (NARCH)

05-05-15
Support for IHS Tribal Planning Grant to Evaluate the EpiCenter Program and Services

05-04-16
Support for funding application by the National Tribal Cancer Control Program to the Education Network to Advance Cancer Clinical Trials Program

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