Health News & Notes

A Publication of the
Northwest Portland Area Indian Health Board

October, 2006

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.

Department of Justice derails Reauthorization of IHCIA

Julia Davis Wheeler (Nez Perce tribal member), testifying at the Senate Indian Affairs Committee Hearing in Washington DC on April 2, 2003. Ms. Davis Wheeler was a former National Indian Health Board Chair and former Northwest Portland Area Indian Health Board Chair. Article on page 6.

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From the Chair:

Linda Holt

Northwest Portland Area Indian Health Board

Executive Committee Members

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Andy Joseph, *Vice Chair*
Colville Tribe
Janice Clements, *Treasurer*
Warm Springs Tribe
Pearl Capoeman Baller, *Sergeant-At-Arms*
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Stella Washines, *Secretary*
Yakama Nation

Delegates

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Leta Campbell, Coeur d'Alene Tribe
Andy Joseph, Colville Tribe
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Kelle Little, Coquille Tribe
Sharon Stanphill, Cow Creek Tribe
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Bill Riley, Jamestown S'Klallam Tribe
Darren Holmes, Kalispel Tribe
Nadine Hatcher, Klamath Tribe
Velma Bahe, Kootenai Tribe
Rosi Francis, Lower Elwha S'Klallam Tribe
William Jones, Sr., Lummi Nation
Debbie Wachendorf, Makah Tribe
John Daniels, Muckleshoot Tribe
Gary Greene, Nez Perce Nation
Norine Wells, Nisqually Tribe
Rick George, Nooksack Tribe
Shane Warner, NW Band of Shoshone Indians
Rose Purser, Port Gamble S'Klallam Tribe
Rod Smith, Puyallup Tribe
Bert Black, Quileute Tribe
Pearl Capoeman-Baller, Quinault Nation
Billie Jo Settle, Samish Tribe
Ronda Metcalf, Sauk-Suiattle Tribe
Marsha Crane, Shoalwater Bay Tribe
Belma Colter, Shoshone-Bannock Tribes
Judy Muschamp, Siletz Tribe
Marie Gouley, Skokomish Tribe
Vacant, Spokane Tribe
Francis De Los Angeles, Snoqualamie Tribe
Whitney Jones, Squaxin Island Tribe
Tom Ashley, Stillaguamish Tribe
Linda Holt, Suquamish Tribe
Leon John, Swinomish Tribe
Marie Zacouse, Tulalip Tribe
Sandra Sampson, Umatilla Tribe
Marilyn Scott, Upper Skagit Tribe
Janice Clements, Warm Springs Tribe
Stella Washines, Yakama Nation

This last quarter has been very busy for us all. It has been less than a year since I was elected as the NPAIHB Chairperson, yet I have been on many visits to Washington DC to testify, meet with members of Congress and their staff, and represent Portland Area Tribes at IHS meetings. I always knew that Portland Area Tribes were active on important issues, but just never quite realized how involved we really are and how busy it can be. Many Tribal leaders across Indian Country look to the Northwest for representation and to provide analysis on the issues. I am proud to report that our Board enjoys a national reputation to conduct this work and commend you all for making the Board what it is!

When I assumed the Chair of the Board, there were three priorities that I discussed with our Executive Director and staff. Those priorities are to elevate the methamphetamine issue and its affects in our Tribal communities, to improve the quality of health services to our Indian veterans, and to raise the level of awareness associated with the lack of funding for Indian health programs. Although the progress is never what we quite hope, I am pleased to report that we are seeing some progress on at least one of these very important issues.

At this week's National Congress of American Indians (NCAI) in Sacramento, there was a significant amount of time dedicated to methamphetamine issues in Indian Country. In addition to focusing on the topic during general assemblies, Tribal leaders held two special sessions to discuss and address the effects of methamphetamine in our communities. The drug contributes to higher rates of suicide, HIV infection and hepatitis, and leads to depression and other problems. It is estimated that 30 percent of our youth have experimented with methamphetamine and that 2 percent of Indian youth over the age of 12 are current users. This is 3-4 times higher than the national rate for other groups in the United States.

NCAI's Methamphetamine Task Force has been working with Tribes to help them develop anti-methamphetamine strategies—and as part of this effort—both NCAI and our Board will be working to expand this effort. A new partnership involving a number of Tribes and Tribal organizations with the Department of Health and Human Services (HHS) will provide $3-5 million to address methamphetamine in Indian Country. Dr. Garth Graham, Deputy Assistant Secretary for HHS Office of Minority Health, announced the first $1 million towards the new effort. The money will help the Choctaw Nation of Oklahoma, the Crow Tribe of Montana, the Navajo Nation, the Northern Arapaho Tribe of Wyoming, and Winnebago Tribe of Nebraska combat methamphetamine in their communities. Other partners in this very important effort include NCAI, the Association of American Indian Physicians, the Northwest Portland Area Indian Health Board, and the United South and Eastern

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From the Executive Director:

Joe Finkbonner

Greetings. As fiscal year 2006 closes, I want to share with you some of the Board activities that I believe will have an impact on heightening awareness of American Indian/Alaska Native health status. We have long sought ways to develop partnerships beyond the Indian Health Service and Tribal link as a means of developing knowledge of our situation and ultimately develop allies that would assist us in adding resources to address our health disparities.

I want to highlight two major events which occurred within this last quarter, the Emergency Preparedness Conference and the American Indian Day celebration.

Emergency Preparedness

The Emergency Preparedness Conference was held on August 3rd and 4th this year in SeaTac. This is the third gathering of this nature that we have hosted and is by far the most successful. This conference is the result of a successful partnership with the University of Washington's Northwest Center for Public Health Practice (www.nwcphp.org) and the State of Washington Department of Health (www.doh.wa.gov).

These partnerships have developed, in part because of the long-standing relationship that Tribes have with the leadership in these two organizations, and in part due to the overlapping of our missions. These partnerships are the product of awareness of our shared objectives and collaborative use of scarce resources to achieve our goals.

The State of Washington's Department of Health was formed in 1989 to promote and protect public health, monitor health care costs, maintain standards for quality health care delivery, and plan activities related to the health of Washington citizens. Secretary of Health, Mary Selecky, takes this charge seriously and soundly believes that she will not be effective without being inclusive of ALL Washington citizens, including tribes and American Indians. Mary Selecky has long been an advocate of working with Tribes and understands that all of Washington is not protected if any single population is left unprotected.

The Northwest Center for Public Health Practice (NWCPHP) is part of the Department of Health Services at the University of Washington School of Public Health and Community Medicine. The Center's staff and faculty are experts in public health instructional design, adult education, and information technology. Their mission is to improve the quality and effectiveness of public health practice by linking the academic and practice communities.
The leadership at the NWCPHP believes that a strong, capable public health workforce requires personnel that is adequately trained in the basic competencies of public health. It understands that tribes utilize a larger percentage of their health public health budgets than any other jurisdictions. Jack Thompson is the Director of the NWCPHP and has served on many public health devel-

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Northwest Portland Area Indian Health Board

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National Tribal Tobacco Prevention Network
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Northwest Tribal Cancer Control Project
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Cicelly Gabriel, Project Assistant
Eric Vinson, Survivor & Caregiver Coordinator

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

Northwest Tribes

by Sonciray Bonnell, Health Resource Coordinator

During the April 2005 Quarterly Board Meeting in Ocean Shores, our delegates were moved and inspired by the methamphetamine (meth) presentation given by Yakama tribal staff. At the end of their presentation, though we were way behind in our agenda, the audience erupted with questions, comments, and testimonials about the methamphetamine problem in their communities. And because NPAIHB delegates direct our QBM agendas, Northwest tribal representatives will not be surprised that meth presentation have been given at several of our recent QBMs.

Methamphetamine is a powerfully addictive stimulant that dramatically affects many areas of the central nervous system. The drug can easily be made in clandestine laboratories from relatively inexpensive over-the-counter ingredients and can be purchased at a relatively low cost. These factors make methamphetamine a drug with a high potential for widespread abuse. Meth addiction is associated with serious health conditions, including memory loss, aggression, violence, psychotic behavior, and potential heart and neurological damage. It also contributes to increased transmission of infectious diseases, especially hepatitis and HIV/AIDS.

National Trends

- Eighty percent of meth consumed in the United States comes from Mexico, leaving just twenty percent being produced in home labs.
- There is emerging evidence that methamphetamine is being administered increasingly via the intravenous route. Injecting this drug puts the user at increased risk for engaging in behaviors (both sexual and non-sexual) that could increase his/her chance of contracting HIV/AIDS, hepatitis, and other infectious diseases
- Methamphetamine is not usually sold and bought on the streets like many of the other known illicit drugs. Users report that they obtain their supplies of methamphetamine from friends and acquaintances. It is typically a more closed or hidden sale, prearranged by "networking" with those producing the drug.
- Methamphetamine is often being used in dangerous combination with other substances, including cocaine/crack, marijuana, heroin, and alcohol.

How is Meth Different?

Methamphetamine is classified as a psychostimulant, as are other drugs of abuse such as amphetamine and cocaine. We know that methamphetamine is structurally similar to amphetamine and the neurotransmitter dopamine, but it is quite different from cocaine. Although these stimulants have similar behavioral and physiological effects, there are some major differences in the basic mechanisms of how they work at the level of the nerve cell. However, the bottom line is that methamphetamine, like cocaine, results in an accumulation of the neurotransmitter dopamine, and this excessive dopamine concentration appears to produce the stimulation and feelings of euphoria experienced by the user. In contrast to cocaine, which is quickly removed and almost completely metabolized in the body, methamphetamine has a much longer duration of action and a larger percentage of the drug remains unchanged in the body. This results in methamphetamine being present in the brain longer, which ultimately leads to prolonged stimulant effects.

Tribal Solutions

Several Northwest tribes are taking the lead in developing creative solutions to combat their local meth problem and these strategies range from grassroots activities, to developing tribal codes. Following are two Northwest tribe's efforts to address the meth problem in their communities.

Coeur d'Alene

Coeur d'Alene enjoys strong support and collaboration with their law enforcement, tribal prosecutor, housing, medical center, and tribal council. At the NPAIHB July 2006 Quarterly Board Meeting, a small but diverse group from the Coeur d'Alene community presented and we learned many useful techniques. Coeur d'Alene tribal police are deputized by the state which allows them work within adjacent counties, but more important they enjoy a strong relationship with the Idaho

Fight Methamphetamine

state police in their joint efforts to address the methamphetamine problems. Coeur d'Alene Tribal Housing requires potential residents to submit hair samples for drug testing, even requiring residents to foot the bill.

The Coeur d'Alene community has taken several creative grassroots approaches to attend to their meth problem. Situated in rural Idaho, the Coeur d'Alene reservation is a small community with a dedicated group of citizens who are a part of their Meth Focus Group whose purpose is to fight meth in their community. The community has scheduled meth house cleanups, which not only provides needed clean up, but sends the message that the community is aware of the illegal activity happening at that location and does not support it. A simple but effect technique is to park a police car in front of a known meth house, which plays off of the paranoia of meth users or cookers and it give the consistent message that Coeur d'Alene will not stand by and allow methamphetamines to destroy their community.

Lummi

The Lummi Nation has taken a policy approach to dealing with their substance abuse problem in their communities, though have stated that methamphetamine was not the main focus of their codes, but other substances. Regardless, their courageous efforts and definitive tribal codes have gained national attention. Lummi's Exclusion Code gives an excellent description of the purpose of banishing drug dealers from the Lummi Nation. Title 12 Exclusion Code section12.01.010 (b) "The fundamental purposes of this Exclusion Code are two-fold: the first is to protect the health, safety, and welfare of the Lummi Nation and the Lummi Reservation community; the second is to provide the person to be excluded with the motivation and means to seek treatment and rehabilitation so that their conduct may no longer be a threat to the health, safety, and welfare of the Lummi Nation." Section 12.02.020 (a) Felony offenses involving the manufacture, delivery, or sale of a controlled substance. "Involving" shall be liberally interpreted to cover actions at all stages of the manufacture, sale, or delivery process.

At the July 2006 Direct Service Tribes meeting, Darrel Hillaire, former Lummi Tribal Council Member, presented on how the Lummi Nation is dealing with substance abuse. Many had questions of Mr. Hillaire about the ramifications and fallout of a tribal council enacting an exclusion code, specifically, how does a council person protect themselves and their families against retaliation. Knowing that Lummi tribal council surely had to deal with retaliation for the passing of their exclusion code, after a long pause Mr. Hillaire responded, "Well, you have to walk into straight on." Indeed, some might find such codes drastic, but a drastic substance abuse problem plagues Indian Country and if drastic measure are going to save lives then our warrior spirit must surface to meet the challenge.

Future

Addressing the current problem of methamphetamine abuse in the Northwest tribal communities is composed of several issues including prevention, treatment, and clean-up of meth homes. It is a complicated challenge, with many issues to explore, and is sometimes overwhelming. Despite this, or maybe because of the complexity, several of our Northwest tribes have developed creative ways to deal with their meth problems. From neighborhood walks celebrating sobriety, to pushing the envelope on civil rights, tribes will not let methamphetamines destroy us.

Resources:

http://www.methwatch.com/flash.html
http://methpedia.org/
http://narf.org/nill/Codes/lummi/index.htm
http://www.ncai.org/Meth_in_Indian_Country_Initiat.192.0.html

Department of Justice derails

by Kitty Marx, National Indian Health Board Legislative Director; Jim Roberts, NPAIHB Policy Analyst

October 5, 2006—Tribal leaders criticized the Bush Administration for its last minute objections to S. 1057, a bill to reauthorize the Indian Health Care Improvement Act (IHCIA) at the National Congress of American Indians (NCAI) annual conference in Sacramento, California. The Senate bill was cleared for passage last month by the Senate Committees on Indian Affairs (SCIA) and Health, Education, Labor, and Pensions (HELP). Two weeks ago the bill was "hot-lined" for passage with amendments from the Finance and HELP Committees. Hot-lining is a legislative procedure in which a bill is circulated to all Senate members with a 72 hour window to raise objections; if no Senator objects, the bill passes by unanimous consent.

The DOJ objected to principles that are inconsistent with President Bush's policy memoranda on Tribal consultation and government-to-government relationships; and question the Federal government's responsibility to provide health services under the federal trust relationship.

There were four holds placed on the bill after the hot-line call went out. The IHCIA National Steering Committee was working to clear the final hold by the Republican Steering Committee, when an unofficial Department of Justice (DOJ) white paper was provided to key Senators objecting to fundamental Indian health policy principles. The DOJ objections are inconsistent with President Bush's policy memoranda on Tribal consultation and government-to-government relationships; and questions the Federal government's responsibility to provide health services under the federal trust relationship.

The DOJ white paper has not killed the bill, but it has served to derail passage of the IHCIA. The DOJ subterfuge occurred during the late hours on the final day before Congress recessed for the November elections; and quite possibly leaving the bill to linger and die in a lame duck session when Congress reconvenes in November.

Tribal leaders have requested the Administration's views on S. 556 since it was first introduced in the 108th Congress, as well as S. 1057 for well over three years. At last week's NCAI's meeting, Rueben Barrales, Deputy Assistant to the President and Director of the White House Office of Intergovernmental Affairs, indicated he was not aware of the DOJ white paper and was as surprised as Indian Country. Linda Holt, NPAIHB Chairwoman, challenged Mr. Barrales commenting that Administration officials have been given numerous opportunities to provide comments on the IHCIA and have never met with the National Steering Committee in a deliberative process. "They've never done that and then at the last minute they turn around and say, "We have these objections, and the bill is pulled, that is not true government-to-government relations," Holt said. Barrales defended the Administration's handling of the overall talks, "I do have to disagree with you," he said, "We were working in good faith on the issues."

Tribal leaders question the sincerity of Mr. Barrales' rebuttal. The IHCIA National Steering Committee (NSC) is on record with numerous requests to meet with the Administration. Three years ago during Tribal consultation meetings in Anchorage, the NSC requested meetings with HHS officials to discuss the IHCIA. The Tribal Technical Advisory Committee to the Centers for Medicare & Medicaid (CMS) has also requested numerous meetings with CMS officials to meet on Title IV provisions that deal with Medicare, Medicaid, and SCHIP. In a number of regional and national Tribal consultation meetings Tribal leaders have requested to meet with the Administration to discuss their concerns related to the IHCIA. Not once have members of the Administration agreed to meet with National Steering Committee representatives to discuss IHCIA concerns. This brings Tribal leaders to be skeptical of Mr. Barrales' comments.

Reauthorization of IHCIA

Why it has taken DOJ so long to provide its views is anyone's guess. On Friday, September 29, there were two remaining holds remaining from the hot-line request to pass the bill. This was also the final day for Congress to meet prior to recessing for the November elections. One objection was held by Senator Coburn (R-OK) and the other by the Republican Steering Committee. At 2:30 p.m., on September 29 the DOJ white paper surfaced assaulting the fundamental government-to-government relationship between the United States and Indian Tribes. The Republican Steering Committee placed a two week hold on the bill to afford DOJ operatives sufficient time to issue its white paper. Because Tribes received the DOJ document late on the afternoon of September 29, they were not afforded the opportunity for Tribal leaders to respond before Senate recessed. The DOJ document is very suspicious—in that it is not printed on DOJ letterhead, is not dated, nor signed by anyone—and does not include any information as to what office or person issued it. Even with sufficient response time, to whom would the Tribes respond? Tribes were placed in the untenable position of having to respond to the Administration's objections with no notice, no warning, and no person to be held accountable. Consequently, there was no action taken on the bill prior to Congress recessing and unless Tribal leaders can meet with DOJ representatives or the White House, the passage of the IHCIA seems doomed.

Department of Justice Objections

The basis of DOJ objections implies that there is an increased potential for liability of the United States through coverage of Tribal and urban Indian program employees under the Federal Tort Claims Act (FTCA). However, as noted by the DOJ, Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA) are covered by the FTCA for activities carried out within the scope of an ISDEAA contract, compact or funding agreement. While the DOJ writes that it opposes legislation that would make the American taxpayers liable for torts of persons who are not Federal employees, S. 1057 does not amend existing law that currently provides for FTCA coverage to tribal employees acting under the authority of the ISDEAA.

In July 2000, the General Accounting Office (GAO) issued a report, *Federal Tort Claims Act: Issues Affecting Coverage for Tribal Self-Determination Contracts,* in which it describes the process for implementing FTCA coverage

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FTCA Coverage to Indian Programs
Years 1997 - 1999

Agency	Number of Claims for All Tribal Programs	Number of Claims Federally Operated Programs	Number of Claims Tribally Contracted Programs	Percent of Tribally Operated Claims	Amount Claimed (millions)
BIA	228	182	46	20%	$219
IHS	114	74	40	35%	$487
Total	*342*	*256*	*86*	*55%*	*$706*

Source: General Accounting Report GAO/RCED-00-169: "FTCA Issues Affecting Coverage for Tribal Self-Determination Contracts", p. 8-9, July 2000.

Meet our new Tribal EpiCenter Director

Please allow me to introduce myself. My name is Victoria Warren-Mears and I am the new EpiCenter Director at NPAIHB. I am excited to have an opportunity to work on your behalf.

I was born in Everett, Washington and lived in Washington State prior to moving to Portland from Kingston, Washington about four years ago. I am a dietitian by training and have a bachelors and masters degree from Washington State University and a PhD in Nutritional Sciences from the University of Washington. Prior to beginning my PhD work, I worked at the Thurston County Public Health Department in Olympia, WA for ten years, in public health nutrition and management. I also have worked as a clinical dietitian and an outpatient dietitian in the Seattle and Olympia areas. My primary areas of practice were weight regulation disorders, HIV/AIDS care,

geriatrics, and dental care. Most recently I worked at Oregon Health & Science University for the Dietetics and Clinical Nutrition Program. If I could sum up my research interests, I would say that I am most interested in knowing why people chose the foods they do and how to develop programs and information that is beneficial for health improvement. I also am keenly interested in encouraging and promoting individuals to consider the health care professions as a career option.

I am married and enjoy time with my husband, Jim and my almost 6 year old son, Preston. We own a small business in Portland called Yee-Haw. As a family we enjoy bike riding and gardening. I also am an avid "crafter" - knitting, sewing, card making, and scrapbooking are my main passions, although I love and admire all art and craft forms. The most unusual thing about me is that I am a former bassoon player.

I look forward to a productive future with the NPAIHB. I am anxious to learn more about the Northwest Tribes. I would welcome any conversations you would like to have with me about the future directions of the EpiCenter.

Please join us in welcoming Hannah Magnolia Wise, born Tuesday August 2, 2006 at 1:30 a.m. at a whopping 8 lbs 14 oz., healthy and hungry. Hannah's mom is our very own PTOTS Project Coordinator, Julia Putman. Julia and family are doing fine and enjoying the perfect days of a Portland summer.

Welcome Back National Tribal Tobacco Prevention Network!

by Terresa White, NTTPN Project Specialist

After a several month-long funding hiatus, we at the National Tribal Tobacco Prevention Network (NTTPN, the Network) have taken a running leap back into our activities fostering culturally competent best and promising practices and evidence-based prevention programs among AI/AN communities across the United States. We hit the ground running by launching a smoke-free home pledge drive, updating and distributing the NTTPN Tobacco Facts and Tobacco Prevention Tips sheets, developing an Annual Member Needs Assessment, and creating an announcement style national List Serve to share information with Network partners. Visit our website to check out these and other resources including a national tobacco prevention events calendar, a tobacco news page, and links to Tribal, state, and national tobacco program resources: ***www.tobaccoprevention.net***. Let us reintroduce you to the Network. . .

Overview: The National Tribal Tobacco Prevention Network (NTTPN), funded by the Centers for Disease Control and Prevention, is an expanding alliance of tobacco prevention and education advocates committed to improving the wellness of American Indian and Alaska Native people by working to reduce commercial tobacco use. To support National partners in developing effective and culturally appropriate tobacco prevention and education programs, NTTPN offers technical assistance, trainings, links to valuable resources, and regular opportunities for networking and collaboration with tobacco prevention specialists from around the country. The only requirement for participation in the Network is a shared commitment to improving the health of Native people by working toward the reduction of commercial tobacco use.

Background: Among racial and ethnic groups in the U.S., smoking prevalence is highest among American Indians and Alaska Natives with 33.4% of the adult population smoking tobacco.[1]

The Response: The NTTPN is an expanding alliance of tobacco prevention and education advocates committed to improving the wellness of American Indian and Alaska Native people by working to reduce commercial tobacco use.

Goals: 1) Grow and strengthen the NTTPN; 2) Increase the capacity and infrastructure of Indian and Tribal organizations to implement culturally-relevant tobacco control efforts; 3) Foster culturally competent tobacco control, best and promising practices, and evidence-based prevention programs among AI/AN communities.

Priorities: 1) Prevent youth initiation; Reduce exposure to secondhand smoke (ETS); 2) Promote cessation services; 2) Counter tobacco company advertising targeting AI/AN people; 3) Respect and Promote the sacred use of traditional tobacco.

Activities: 1) Provide leadership in the development, operation, and administration of tobacco-related initiatives serving AI/AN people; 2) Host a National Leadership Institute and regional trainings; 3) Provide technical assistance on the development of culturally- and community-competent tobacco prevention materials; 4) Coordinate a Network response to the use of Native American symbols and images by the tobacco industry; 5) Disseminate tobacco prevention materials that reflect best and promising practices in Native communities; 6) Host a networking activity during the CDC National Conference on Tobacco or Health.

1. Centers for Disease Control and Prevention. Cigarette Smoking Among Adults--United States, 2004. MMWR 2005.

Contact: Gerry RainingBird, Director, 503.416.3287, grainingbird@npaihb.org or Terresa White, Project Specialist, 503.416.3272, twhite@npaihb.org.

Congress Recesses without approving IHS Budget

by Jim Roberts, NPAIHB Policy Analyst

October 8, 2006 — Congress adjourned in September to campaign for mid-term elections and only passed two of the FY 2007 appropriation bills, the Homeland Security and Defense. A continuing appropriation resolution is included in the Defense bill that will provide funding for government operations at the current FY 2006 rate or a lower rate approved by House and Senate actions. In this case, the House approved action is lower and the basis for amounts to be funded in the "Continuing Resolution." The Continuing Resolution is in effect through November 17, 2006.

The full House has approved its Interior Appropriations bill (H. Rpt. 109-465) on May 18th; while the Senate Appropriations Committee has approved its bill (S. Rpt. 109-275), but still needs approval from the full Senate. The House approved and Senate bills provide very similar amounts for the Indian Health Service (IHS) programs. The difference between the two bills is a mere $878,000, with the House providing more funding. However, the Senate bill provides more funding for hospitals/clinics, preventative health, and other services and overall is a much better bill for Indian health programs. The House bill also includes $37.1 million in fixed cost decreases; while the Senate bill only includes $20 million, a difference of $17.1 million. This allows more money to be applied to accounts mentioned previously.

Summary of Congressional Actions
FY 2007 IHS Appropriations
(Dollars in Thousands)

	House (H. Rpt. 109-465)	Senate (S. Rpt. 109-275)
Appropriation, FY 2006	$3,045,310	$3,045,310
President's Request, FY 2007	$3,169,787	$3,169,787
Congressional Recommended	$3,230,806	$3,212,831
"Fixed Cost Decreases"	($37,097)	($20,000)
Final Recommended	$3,193,709	$3,192,831
Comparision*:		
To FY 2006 Actual*	-$3,082,407	-$3,065,310
To President's Request, FY 2007*	-$3,206,884	-$3,189,787
House Difference (vs. Senate)*	-$17,097	

* After Fixed Cost Decreases

Aside from the fact that the Senate bill provides more funding for hospital/clinics and preventative services accounts, the increases will establish a higher baseline for future year's budget formulation activity. Applying a 3 percent increase to the Senate bill rather than the House is much better for Indian health programs. This negates some of the effect of "fixed cost decreases" and does not erode as much of the IHS base budget. Most certainly, those IHS Areas that have construction projects will defend the House mark because it restores $10 million to the Facilities Construction account. Most Tribal leaders will agree that it is better for Indian Country to take an additional $17.1 million to provide health services than to receive a mere $10 million for facilities construction.

After the November 6th election, a "lame duck" session is tentatively scheduled to convene on November 13th, at which time Congress should resume its work on the remaining appropriations bills. Congress could pass some or all of them during the lame duck session, or enact another Continuing Resolution for an additional amount of time. What will occur depends in large part upon the results of the mid-term elections and whether there are any changes in congressional leadership.

From the Executive Director: continued

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opment advisory boards along with Mary Selecky and myself over the past decade. Over the years, Jack, through the NWCPHP has developed a mutually beneficial partnership with Tribes through the NPAIHB to assist with improving the public health infrastructure in our communities. These partnerships have helped us in hosting the Emergency Preparedness conference three years in a row and expanding our audience from less than 100 participants at our initial conference in 1994 to over 160 attendees this year. Our partners, the NWCPHP and DOH, have assisted by providing funding to sponsor travel for our tribal participants, assisting with conference expenses, providing instructors on key topics, and bringing in other partners such as the State of Oregon.

Our accomplishments have been more than the sharing of materials during the conferences, but greater understanding of our public health system(s) and the process of properly dealing with our governance.

A Reason to Celebrate

Many people through the hallways of the Board have discussed the idea of an Indian Day celebration, however, it was never developed as an activity until September 6, 2006. I spent Labor Day weekend thinking about the Indian Health Care Improvement Act and the complete lack of awareness by the general public of the health status and issues that we face as Indian people. It struck me that even educated individuals who

appeared well-informed on other issues lacked an understanding of our health disparities.

We know through years of working in Indian health that to educate people on our health status, we must also couple that with an explanation of some of the cultural issues that may impact the delivery of health care. Utilizing this method seems to pique the most interest of the non-Indian community. We quickly established a list of volunteers from our NPAIHB staff and asked other Indian organizations such are NARA, NAYA, NICWA, and the Indian Health Service to be our partners in the event. All contributed in various ways either through providing speakers, resource material, or equipment needed to make it happen.

We chose Pioneer Square in Downtown Portland as the venue because of its central location and exposure to Portland's commercial center as well as to foot traffic. So on September 29, 2006, we hosted a cultural celebration (a POW WOW) to get the masses out to Pioneer Square and in so doing, also share important information that may get their attention and develop better understanding of our plight. We were pleased at the attendance of well over 500 people, Indians and non-Indians, especially in light of the short time we had to plan the event. The drummers, dancers, tribal leaders and the general public all voiced consensus in support of making this an annual event.

Each of these events serves to educate different audiences of our culture, infrastructure, and health status. I hope that we find other ways to reach out to the general public and make them aware of our situation. Education can change perception and dispel myths that "Indians get all their health care free." These two events also highlighted some of the best of who we are as well. We share our cultures, our beliefs, our values in every interaction we have with non-Indians and that will only lead to the establishment of people wanting to invoke change to improve the health of all.

NPAIHB staff at the press table.

From the Chair: continued

continued from page 2

Tribes. Last month, our Executive Director and his staff met with HHS Office of Minority Health to discuss this opportunity. It is expected that the EpiCenter will be working to develop and improve data surveillance for tracking the methamphetamine problem in Indian Country. The data will be used to evaluate treatment outcomes amongst partners. We all look forward to hearing more about this very important project.

On August 29-30th, the Portland Area Tribes hosted the Direct Service Tribes Advisory Committee (DSTAC) quarterly meeting. The Board hosted a luncheon for the DSTAC and allowed me, our Policy Analyst, and Diabetes Director to meet with Dr. Grim and Doni Wilder on important issues affecting Portland Area Tribes. Our meeting included a discussion on contract support costs, the work of the Tribal Leaders Diabetes Committee, reauthorization of the Indian Health Care Improvement Act (IHCIA) and Special Diabetes Program for Indians (SDPI), our concerns related to using the SDPI data set-aside for deployment of the electronic health record, and finally the issues associated with the new Health Facilities Construction Priority System and our interest in applying to build regional health centers or a regional medical center under that system. While we did not reach any decision points, Dr. Grim is aware of our concerns, and we will continue to follow up on our issues.

I have been back to Washington, D.C. to lobby twice during this past quarter. In August, our Policy Analyst, Jim Roberts and I met with key Senate republicans to clear S. 1057 (reauthorization bill for IHCIA) for passage with members of the Health, Education, Labor and Pensions Committee. We also met with majority staff members from the Senate Budget Committee to address their concerns about potential budget points of order that might be raised against the bill. In September, I also visited the hill representing the National Indian Health Board (NIHB) to meet with House members. Our focus was to meet with Energy Commerce and Ways and Means Committee members to urge them to consider H.R. 5312 prior to concluding the 109th session.

On September 5-7, I participated in the NIHB Board of Directors annual retreat in Denver, Colorado. The Board addressed outstanding operational issues and continues to struggle to stabilize itself from this past year's challenges. One important announcement is that Kitty Marx, former IHS Director of Regulatory Affairs, has joined NIHB staff as their Legislative Director. This will provide NIHB with a person that has a significant policy background in IHS programs. The NIHB will be conducting it Annual Consumer Conference on October 11-13 in Denver, and the Board of Directors will be meeting to finalize its priorities for the upcoming year.

Finally, the Affiliated Tribes of Northwest Indians (ATNI) conducted their annual meeting in Lincoln City, Oregon. The ATNI meeting included a session on the concept of regional health centers or a regional medical center for the Portland Area. Portland Area Tribal leaders unanimously supported a resolution on the concept and encouraged the Portland Area IHS and Board to move forward in the developing the concept. From ATNI, I flew to Washington, D.C. to attend the TLDC quarterly meeting. Most important on the TLDC agenda is reauthorization of the SDPI and clarifying the recommendation for data set-aside funds. The TLDC will be sending the IHS Director a letter that data funds should be shared equally among federal and Tribal sites.

SAMHSA Tribal Consultation

by Verne Boerner, Administrative Officer

The Department of Health and Human Service's (the Department) Substance Abuse and Mental Health Services Administration (SAMHSA) released its second draft of its Tribal Consultation Policy (TCP) on October 1, 2006. SAMHSA began its work on the recent drafts at the start of this year, sharing its first draft at the Department's Regional Tribal Consultation Sessions. The US Government holds unique legal and moral obligations to American Indian and Alaska Native (AI/AN) people; and sadly American Indian and Alaska Native (AI/AN) people are among the most disparate rates of substance addictions and mental health illnesses, this policy is crucial to reducing burden of disease and developing culturally appropriate and effective prevention and treatment strategies and programs.

SAMHSA's administration has made great strides in learning about the intense need in tribal communities, and in devising solutions to meet those needs with its former Administrator, Charles Curie. The new Acting Deputy Administrator, Dr. Eric Broderick, has continued the commitment and energy by heading up the development of the new consultation policy, prioritizing it and setting a definitive timeline for completion. Dr. Broderick hopes to have a final version of the SAMHSA TCP by February 2007. The premise going into the development of this draft was that the Department's TCP was to set the minimum standards and that SAMHSA could extend it further where practicable and permitted by law.

The SAMHSA TCP must be closely aligned to the Department's TCP and must meet all the Federal Government's the legal requirements. For example, the policy clearly states that the SAMHSA TCP does not wave the US Government's deliberative process privilege; but it seeks balance and alternatively recognizes that the policy also "does not waive any governmental rights of Indian Tribes, including treaty rights, sovereign immunities or jurisdiction."

The current draft is compiled of seventeen sections. Of note are two specific sections that are reflective of seeking to develop an "accountable process." The first is Section VI, Objectives, and the second is Section XII, Measuring SAHMSA Tribal Consultation Performance and Collaboration. These two sections present tangible and measurable commitments toward meeting the mutual goal of addressing substance abuse and mental health issues affecting AI/ANs.

Also of note, the SAMHSA TCP devotes a good portion to describing "Consultation with Other Non-Governmental Groups." The draft policy explains that this is to encourage input where the government-to-government relationship does not exist, so long as a conflict of interest does not exist with federal statutes or SAMHSA's authorizing language. Two that are specifically defined are Indian Organizations and Native Organizations.

The comment period is for 90 days, ending on December 31, 2006. A full pdf version can be downloaded at the Board's website, www.npaihb.org.

SAMHSA provides for two options for submitting comments:

1. by posting them on the SAMHSA website at: http://www.samhsa.gov/tribal/index.aspx; or
2. by regular mail addressed to:

   Ms. Ginny Gorman-Gripp
   Senior Advisor for Tribal Affairs
   Office of Policy, Planning and Budget
   Substance Abuse and Mental Health Services Administration
   1 Choke Cherry Road, Room 8-1100
   Rockville, MD 20857

Department of Justice derails

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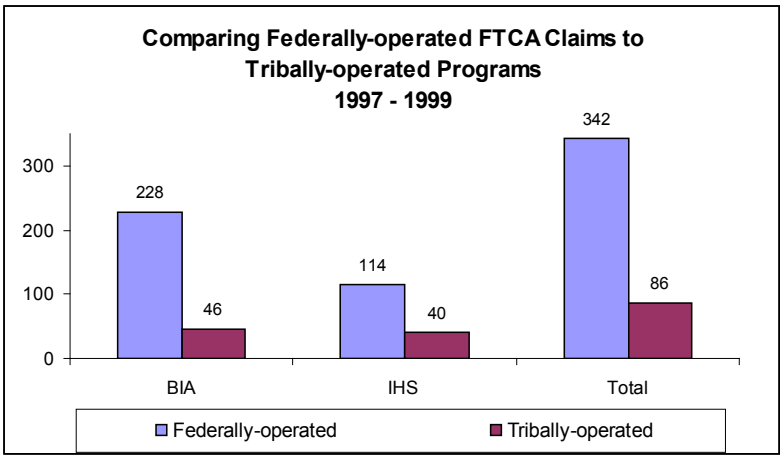


for Tribal Self-determination contracts. The GAO reports on FTCA claims history for Tribal self-determination contracts and discusses other FTCA issues that are unique to Tribal contractors. The report indicates that from 1997-1999, a total of 342 FTCA claims were filed involving Tribal contractors from the Bureau of Indian Affairs and Indian Health Service (IHS). The claims involved a small number of tribes with total claimed damages of approximately $700 million. Less than 17 percent of these claims involved patient care issues associated with Indian health programs and involved only 40 tribal contractors (25 tribes and 15 tribal organizations out of 556 federally-recognized tribes). The median claim amount was $1 million. Clearly, the GAO report demonstrates that the number of tribal FTCA claims and the damages paid is minimal.

The DOJ has objections to section 213, a provision that expands categories of treatment to hospice care, assisted living, long-term health care, and home and community based care. The IHS and Tribes are currently providing many of these services through its Community Health Representative and Long Term Care Programs. The DOJ is concerned that expansion of services under section 213 will increase potential liability under the FTCA. However, to the extent that these services are within the scope of current ISDEAA contracts or compacts, FTCA coverage currently applies. The purpose of section 213 is to clarify existing authorities and describe services that may be carried out by IHS and Tribes.

The DOJ objects to the reference to FTCA coverage under section 807(d) which again, is in existing law at 813(d). This is a very limited application of FTCA coverage that applies to non-IHS health practitioners who have hospital privileges in an IHS or Tribal hospital and provide services to eligible Indians.

The DOJ has objections to the definition of—and various references to—Traditional Health Care Practices. The revised hotline version of S. 1057 does not contain a definition of Traditional Health Care, and was scaled back to current law in an effort to address previous concerns expressed by the Administration.

The DOJ has objections to the definition of "urban Indians" and "Indians" to the extent that definition encompasses persons other than members of federally recognized tribes. The DOJ is concerned that the definitions might present a litigation risk that if challenged; a ruling could find the statute subject to "strict scrutiny." Strict scrutiny is the highest standard of judicial review used by courts in the United States along with the lower standards of rational basis review and intermediate scrutiny. It is a hierarchy of standards courts employ to weigh an asserted government interest against a constitutional right or policy that conflicts with the manner in which an interest is being

Reauthorization of IHCIA - continued

pursued. The definitions of "urban Indians" and "Indians" in S. 1057 are consistent with current law established by regulations dating back to the Transfer Act of 1954 and the IHCIA of 1976. Over the last 50 years these definitions have never been challenged by any Administration!

The DOJ writes that section 512 and 515 of the revised bill extends FTCA coverage to employees of urban Indian programs. However, in deference to previous concerns expressed by the Administration, any provision extending FTCA coverage to urban Indian programs was deleted from the bill. The DOJ objections are not appropriate because the provisions objected to have been removed from the bill.

The DOJ expressed concerns regarding section 705 of the bill regarding licensure of mental health care professionals. The HELP Committee revised this section to clarify that mental health professionals who are not licensed (i.e., graduate students working in a clinical setting) are required to have direct supervision from a licensed mental health professional with evaluations and case work reviews conducted as deemed necessary by the Secretary. The amendments by HELP are contained in the revised hotline version of the bill. Again, the DOJ has raised an unnecessary objection by incorrectly referring to a provision of the bill that has already been revised to address the Administration's concerns.

The DOJ objects to section 708 authorizing an Indian Youth Tele-mental Health Demonstration Project to prevent youth suicide. Indian youth have the highest rates of suicide of any other U.S. population and is third leading cause of death for Indian youth. This provision was written in an effort to address the high rates of Indian youth suicide and any potential tort liability risks to the Federal government are minimal compared to the benefits derived from this program. The DOJ infer that the lives of Indian youth are not worth saving because of potential liability, which has clearly been demonstrated by DOJ's own FTCA claims data to be trivial.

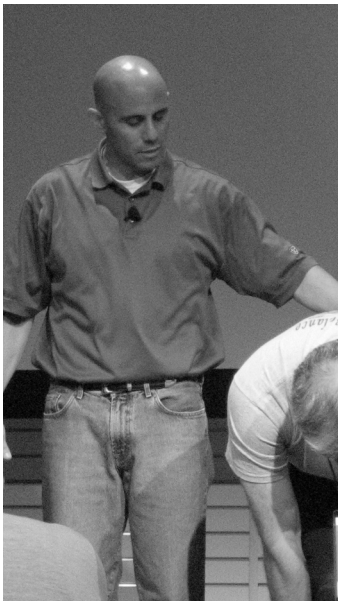
Throughout the 108th and 109th Congresses, Tribes have negotiated in good faith to revise and delete certain provisions of the bill in order to accommodate the Administration's concerns. For example, all significant Medicare provisions have been stripped from the bill, removal of FTCA coverage for urban programs, revisions to Medicaid and SCHIP provisions with the Senate Finance Committee, and other compromises with the HELP Committee. Despite our willingness to cooperate, the IHCIA has been high jacked by an anonymous DOJ white paper and gave two Senators reason to hold up passage of the bill.

Tribal leaders, regional, and national Indian organizations are now calling upon the White House to intervene and request that the DOJ retract its position outlined in its white paper. Clearly, the President's commitment outlined in his September 23, 2004, *Memorandum for Heads of Executive Departments and Agencies,* supporting Tribal consultation and Tribal sovereignty will be tested in the coming days. This test will be whether the President intervenes to assist Tribes to pass the IHCIA.

Native Fitness III

On August 15 and 16, 2006 Northwest Tribal participants and tribes from across the country converged on the Nike World Headquarters in Beaverton, Oregon for the Native Fitness III Training. One hundred seventy-five attendees from seventy Indian Nations were in attendance. The first two Native Fitness trainings focused on Northwest tribes and hosted an average of seventy-five attendees each year. This year registration doubled by inviting tribal participants from across the nation. Recruitment for the event was broadly disseminated through Indian Health Boards, Area Diabetes Programs, Native Organizations, Indian Health Service Area Diabetes Consultants and Health Promotion/ Disease Prevention Coordinators as well as Diabetes programs currently listed as part of the Nike Diabetes Incentive Program. Feedback and comments received indicate this year's Native Fitness III event was extremely successful.

The agenda combined American Indian culture and issues, with diabetes data at the forefront. Nike's portion of the event focused on interactive modules in fitness, including the10,000-step program, chair aerobics, fundamentals of fitness, kids play, and coaching. Nike's team of nationally recognized trainers provide interactive workshops; highlighting the importance of baseline measures, the latest fitness techniques, and athletic motivation for all ages. Tribal keynote speakers emphasized the unique native voice and perspective by promoting a better understanding of native culture, history, exercise science, diabetes case management, and social aspects of health. Darryl Tonemah was back by popular demand with his native focused diabetes prevention and lifestyle change messages. Chris Frankel, personal fitness trainer for Notah Begay and creator of the "Walk With Notah" fitness curriculum for the Boys and Girls Club, energized the participants with his fitness ideas. Participants acquired tools to take back to their communities, to create or incorporate physical activity programs for tribal health and wellness.



The training event closed on a positive note by showcasing tribal programs that had successfully implemented Native Fitness Training components garnered from past trainings. Overall, the Native Fitness III Training Event proved to be both productive and enjoyable, with an overwhelming majority requesting more Native Fitness Trainings in the future. One of the many highlights of the event was the unveiling of the American Indian diabetes exercise shoe, yet to be named. Participants were shown a short video on Nike's history and development of the shoe. All were encouraged to submit creative suggestions for the "Native Air Warrior" prototype.

As tribal staff return home, the real challenge is implementing the energy, ideas, fitness curriculum, and resource materials needed to create and sustain fitness programs. The Native Fitness Training Series continues to support tribal programs with this honorable endeavor, and would like to recognize them in their efforts to promote wellness in native communities. The Native Fitness Planning Committee would also like to extend a warm thanks to Northwest and National tribes, Native Organizations, and all staff and presenters for investing valuable time to attend and participate in the Native Fitness trainings.

Wasting Away – The Effects of Methamphetamine

by Victoria Warren-Mears, EpiCenter Director

Short term starvation is common with street drug use. Methamphetamine users report major health problems including sleep disturbances, irritability, dehydration and weight problems. Street drugs, like many drugs given by doctors, can cause nausea and loss of appetite. The risks of use include weight and nutrient loss. Additionally, poor oral function, such as dry mouth and teeth grinding, can limit food choices and intake.

Physical Changes with Meth Use:
Temporal wasting, or loss of fat and muscle on the side of the head above the cheek bones, is common among methamphetamine users. It is a sign of long lasting low calorie intake and poor nutrition. Wasting becomes more severe as users increase their use and time goes by without treatment.

Dental health changes with drug use. Drug users report more problems in getting dental care and are less likely to visit the dentist. Additionally, drug users have much higher self reported dental problems that non-abusers.

"Meth mouth", consists of progressive severe erosion and loss of teeth, is a large problem in those who use methamphetamine. Factors that contribute to "meth mouth" include: dry mouth, teeth grinding, nerve damage to teeth, and poor oral care. Methamphetamine users' teeth have been described as blackened, stained, rotting, crumbling, or falling apart. If methamphetamine is smoked, enamel is exposed to hydrochloric acid in smoke, creating a highly acidic environment and therefore, enamel erosion. Damaged teeth often cannot be saved and must be pulled. The pictures show the progressive nature of meth mouth.

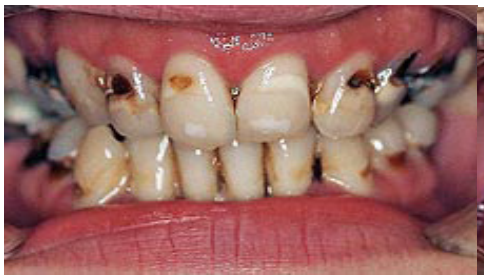
Skin problems. Almost all meth users suffer from what they call "bugs". Methamphetamine is made with chemicals that are toxic to the body. Once the drug is taken chemicals are in the body. The body attempts to eliminate the toxins. Users itch and scratch which causes sores. Users may also have skin sores due to poor diet.

Treatment
As with most addictive drugs, withdrawal from methamphetamine following chronic use is hard. Patients may be depressed and/or paranoid.
One point of intervention for users is to try to prevent malnutrition. Clinicians can suggest fast and inexpensive foods to have on hand while the user is on a drug run. Families can have quick and easy foods on hand for their loved one who is using.

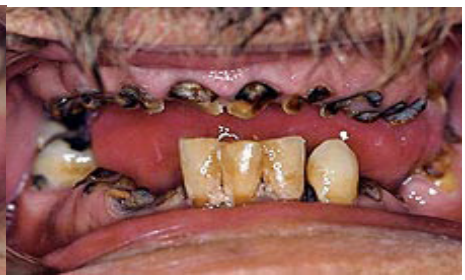
We also are aware that many people use methamphetamine to control their weight. Clinical specialists should assess users for the presence of eating disorders and methamphetamine use. In this situation, as with any counseling situation, a team approach should be used to assess social, medical and nutritional issues.

Improving diet for better health is an important consideration for those using and recovering from meth use. Appetite changes with chronic meth use and health care professionals don't yet know why. Users often have nutrient deficiencies related to loss of appetite and weight loss.

Mild Meth Mouth



Late Stage Meth Mouth



Sister Study

The Sister Study Continues Major Effort to Enroll American Indian and Alaska Native Women for Landmark Breast Cancer Study

American Indian and Alaska Native women can play an important role in discovering the causes of breast cancer by joining or supporting the Sister Study.

The goal of the Sister Study is to discover how our environment and our genes may affect the chances of getting breast cancer. By joining the Sister Study, American Indian and Alaska Native women whose sisters had breast cancer, can have a lasting impact on the fight against this disease. Conducted by researchers at the National Institute of Environmental Health Sciences, one of the National Institutes of Health of the U.S. Department of Health and Human Services, the Sister Study is enrolling 50,000 ethnically diverse women.

Women ages 35 to 74 are eligible to join the study if their sister (living or deceased), related to them by blood, had breast cancer; they have never had breast cancer themselves; and they live in the United States or Puerto Rico. American Indian and Alaska Native women who participate in the Sister Study can help leave an important legacy for future generations – a world where daughters, granddaughters and nieces don't have to experience breast cancer.

Breast cancer is the second leading cause of cancer death among American Indian and Alaska Native women. In recent years, their rate of death due to the disease has risen in certain areas of the United States, and the 5-year survival rate is lower than that of any other race or ethnicity of women. Yet, scientists have very little information on cancer histories in American Indian and Alaska Native families.

Sister Study participant Becky Dreadfulwater, United Keetoowah Band of Cherokee Indians in Oklahoma, enrolled in the Sister Study in honor of her sister who died from breast cancer. "The worst time in my life was sitting with my sister, Rosalee, who wasted away in body and mind every day," said the Oklahoma resident. "I felt so helpless because there was nothing I could do to cure her of this disease, but I think it's important to join the Sister Study and I look forward to being a useful part in this research."

Sisters may be the key to unlocking breast cancer risk mysteries. "By studying sisters, who share the same genes, often had similar experiences and environments, and are at twice the risk of developing breast cancer, we have a better chance of learning what causes this disease," said Dr. Dale Sandler, principal investigator of the Sister Study. "That is why joining the Sister Study is so important."

Joining the Sister Study is not difficult and can be done from home when it is convenient for participants. "At the beginning, women will answer some over-the-phone and written surveys and provide blood, urine, household dust and toenail samples," said Dr. Sandler. "Then we'll touch base once a year, for up to 10 years, to learn about changes to their address, health or environment." She added, "The Sister Study does not require participants to take any medicine, visit a medical center, or make any changes to their habits, diet or daily life."

The Sister Study needs American Indian and Alaska Native communities to help spread the word via their tribes, villages, places of worship, sororities, clubs, alumni associations, labor and professional organizations, civic organizations, and other non-profit organizations.

The Sister Study has a number of active nationwide partners including the American Cancer Society, the Susan G. Komen Breast Cancer Foundation, the National Center on Minority Health and Health Disparities, Sisters Network, Inc., and the Y-ME National Breast Cancer Organization.

To volunteer or learn more about the Sister Study, visit the web site www.sisterstudy.org or call toll free 1-877-4SISTER (877-474-7837). Deaf/Hard of Hearing call 1-866-TTY-4SIS (866-889-4747).

New NPAIHB Employees

Renewed funding of the National Tribal Tobacco Prevention Network brings Terresa White back to her position of Project Specialist here at the Board. Terresa has helped coordinate this national alliance of tobacco prevention advocates since April, 2002. She is Yup'ik (Eskimo) and her family is from the area along the Kuskokwim River near what is today the village of Bethel, Alaska. Terresa is committed to working toward the wellness of American Indian and Alaska Native people and is excited to reunite and work together with colleagues and friends here at the Board and throughout Indian Country.

Bridget Canniff has joined the Northwest Portland Area Indian Health Board as the Project Director for the Tribal EpiCenter Consortium. This new project will work towards the establishment of a national network of Tribal EpiCenters to promote the collection and dissemination of high-quality health data, with the aim of eliminating health disparities facing American Indian and Alaska Native communities.

Originally from Massachusetts, Bridget has worked in community health for over a decade, and was previously employed by Global Health Through Education, Training and Service, and the Massachusetts Immigrant and Refugee Advocacy Coalition. She holds a Bachelor's degree in Linguistics and Russian from Dartmouth College, and a Master's degree in Law and Diplomacy from the Fletcher School at Tufts University.

Bridget and her husband Dan Fellini are thrilled to be relocating to Portland, where they look forward to continuing their passion for cycling, exploring the area with their greyhound, Duke, and learning about the rich cultures of the Northwest tribes.

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.

NPAIHB Resolutions
July 2006

06-04-01 NPAIHB to Restructure Committee Systems

06-04-02 CDC to Maintain and Enhance Tribal STD Prevention Activities

06-04-03 Cancer Surveillance

06-04-04 Health Disparities Study among Minorities and Underserved Women

06-04-05 RWJF Application for Northwest Tribal Tobacco Prevention Network (NTTPN)

06-04-06 Intergenerational Approaches to HIV/AIDS Prevention

06-04-07 Application to ALFF for Northwest Tribal Tobacco Prevention Network (NTTPN)

06-04-08 Support for Reauthorization of SDPI

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