California Tribal Epidemiology Center Newsletter

Our Mission

Indian people have been conducting health studies for thousands of years. Investigating and finding ways to heal is an inherent part of Indian culture. CTEC is built on those very same foundations and our mission is to improve American Indian health in California to the highest level. We carry this out by engaging American Indian communities in collecting and interpreting health information to establish health priorities, monitor health status, and develop effective public health services that respect cultural values and traditions of the communities.

IMPROVING AMERICAN INDIAN HEALTH IN CALIFORNIA

Volume 1, Issue 1

What is Epidemiology?

Gather

We gather health information about disease and wellness within our communities.

Understand

We use health information to understand what leads to health problems.

Act

Based on the understanding gained, together we can act to prevent disease and improve wellness.

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Our Background

CTEC began in September 2005. CTEC works to expand the availability of epidemiological services to Native communities throughout California to establish health priorities, monitor health status, diagnose and investigate health problems and health hazards, and conduct evaluation and research on programs and policies. An Advisory Council of tribal community members, tribal health providers and technical advisors makes recommendations on the operations and products of CTEC. CTEC currently has 19 member tribal health programs spread throughout the state which represent 73 of the 107 federally recognized California tribes. However, we offer technical assistance to all tribes, Rancherias, and Indian Health programs in California.

CTEC is one of 12 Tribal Epidemiology Centers (TEC). The TECs follow the IHS areas, except the Phoenix and Tucson areas are both served by the Inter Tribal Council of Arizona TEC, and there is an Urban EpiCenter based out of Washington state. The TEC directors meet annually. Currently all of the TECs are partnered to assist the IHS Department of Epidemiology and Disease Prevention in developing a national community health profile for Indian Country. CTEC is also part of the TEC Consortium (TECC) with the Northwest Portland TEC and the Southern Plains TEC, which is funded by the CDC. TECC has worked on assessing Tribal Health Program capabilities, and developed an Injury Prevention Toolkit for Indian Country.

Director's Introduction...

I was born on the Colville American Indian (AI) Reservation in Coulee Dam, Washington. I am a member of the Colville Confederated Tribal (CCT) Nation, a descendent of the Spokane Nation, and a citizen of the U.S. I was raised in a family speaking two different dialects of Salish and having several cultural perspectives. My mother, provoked by racial and social injustices endured by AIs, serves as an AI rights leader. She instilled in me the value of human equality and often reminded me that her social justice work was not an AI issue per se, but a human rights issue. This aspect of my upbringing is one of my strengths, and it has helped me to greet life with an open mind and has heightened my awareness of the discrimination faced by AIs and other marginalized persons in the U.S. and elsewhere.

To this day, there is tremendous poverty on the reservations, a lack of healthcare resources, an enormous burden of infections, inadequate nutrition, alcoholism and other social problems. Yet, it was during my undergraduate education in Community Health Education that I became acutely aware that the health status of AIs is not equal to those of non-AIs. My public health awareness grew during my internship at the CCT Health Department and Diabetes Prevention Program. These experiences spurred my search for a career that would challenge me to gain skills and knowledge to benefit the AI communities I am committed to serving.

Beginning in September 2002, I worked at the Office of Health Disparities, National Center for HIV, STDs, and TB Prevention, Centers for Disease Control (CDC) in Atlanta, Georgia on a one-year fellowship. Working with epidemiologists and CDC Epidemic Intelligence Service alumnae, I gained an appreciation for epidemiology and felt my investigative spirit awakening. Thereafter I received my MPH degree in both Epidemiology and Biostatistics at Boston University in 2005, and my PhD in Epidemiology from the University of North Carolina in 2009.

Since June 2009, I have been the Program Director of CTEC. In addition to my regular duties as Director, I have been actively involved in writing the proposal that funded our Tribal Asthma Project Survey, and I am currently writing a proposal to address dental decay in our American Indian Youth in California. It is a great honor to hold this Directorship position at CTEC and personally, it was a natural choice to combine my public health education and my upbringing in social justice into a career that serves the indigenous peoples in California.

Sincerely,

Kristal Chichlowska

Getting to know the staff...

Our CTEC Staff

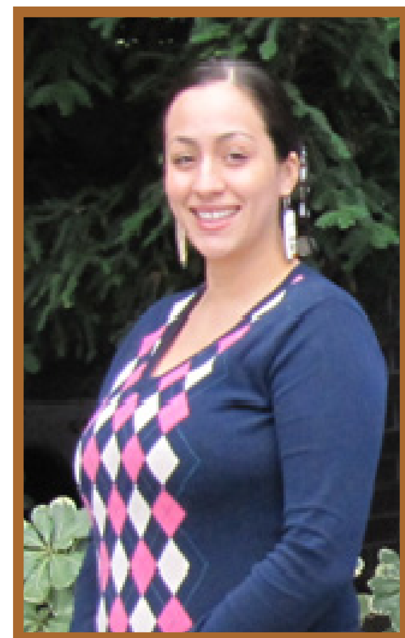
From L to R: Jared Dunlap, Richelle Harklerode, Virginia Myers, Kristal Chichlowska, Thomas Kim, and Rebecca Garrow

Kristal L. Chichlowska, **Ph.D., MPH**, is enrolled in the Colville Confederated Tribes from her father Glenn Raymond and is a descendant of the Spokane nation from her mother Charlene Teters. She received her master's of public health degree in both Epidemiology and Biostatistics at Boston University in 2005, her doctoral degree from the Department of Epidemiology at the University of North Carolina at Chapel Hill (UNC-CH) in May 2009 and is the Director of the California Tribal Epidemiology Center. Her research interests include health disparities. Beginning in September 2002, she worked at the Office of Health Disparities, National Center for HIV, STDs, and TB Prevention, Centers for Disease Control (CDC) in Atlanta, Georgia on a one-year fellowship. From 2003 through 2008, via funding on National Institute of Health Research Supplements for Underrepresented Minorities, she has engaged in research focusing on the role of discrimination in racial/ethnic health disparities and examined the effect of socioeconomic status on the metabolic syndrome. She was a Sequoyah Dissertation Fellow of the Society of Fellows at UNC-CH during her final year as a student (2008-2009) which allowed her to complete her doctoral research on heart failure and electrocardiographic risk factors. She and her husband Maciej recently relocated from North Carolina to California with their red-headed 10-month old daughter Monika Eve, and purchased their first home in Fair Oaks, CA. Her hobbies include anything outdoors, exploring Northern California, and trying to keep her crawling daughter away from major catastrophes.

Getting to know the staff...

Thomas J. Kim, MD, MPH is originally from Washington, D.C. but moved to South Korea at age seven and attended a school for international students before returning to the United States to attend Brown University. He went onto complete his medical training in Washington, D.C. at George Washington and Georgetown University. While in medical school and internal medicine residency, he worked on the Crow Creek Reservation at Fort Thompson, South Dakota for his rural medicine rotations where he experienced working in a Native community and introduced him to Native health. After receiving his Master in Public Health from Johns Hopkins University, he served as a primary care physician on the Colville Reservation IHS clinic in Eastern Washington State for four years. His experience there, particularly in the diabetes prevention program, led him to pursue further training in public health through the CDC Epidemic Intelligence Service Program where he was assigned to the California Department of Public Health. After completing this two-year fellowship, he became the first medical epidemiologist for the California Tribal Epidemiology Center, a job which marries two areas of great professional and personal interest, Native health and epidemiology. He and his wife, Teri, have two young daughters.

Virginia Q Myers, BA, is enrolled in the Yurok Tribe of California and is also of Karuk descent. She received her bachelor's of arts degree in Sociology and American Indian Studies from the University of California, Los Angeles, and has been the Epidemiology Program Coordinator for the California Tribal Epidemiology Center since July of 2007. Her interests include health disparities and risk factors among California Indian people. As the program coordinator of CTEC, Virginia has been the lead on creating and collaborating with CRIHB's Family and Community Health Services department on creating and disseminating the Injury Prevention Toolkit. Prior to her work at CTEC she worked for the Yurok Tribe Collections and Repatriation program where she focused on returning cultural and ceremonial items to the tribe. Virginia grew up along the Klamath River on the Yurok Reservation and is the youngest of 9 children. She and her partner Calvin Hedrick welcomed their son, Peygoy Yeh Seywee Hedrick, into this world October 10, 2009 at 11:10pm after 20 hours of labor. He was born 6lbs 15oz, 20 inches with a full head of hair. She has spent the last three months at home enjoying her time with Peygoy and is happy to return to work with him at her side.



Staff continued...

Rebecca L Garrow, **MPH**, received her master's of public health degree in Health Promotion and Behavioral Sciences at San Diego State University in 2007, and is a Research Associate for the California Tribal Epidemiology Center. Her research interests include the built environment, geographic influences on health behavior, and public health marketing. Beginning in September 2005, she worked at the SDSU Center for Behavioral and Community Health Studies as a Project Coordinator for a nation-wide skin cancer prevention study. Prior to moving to San Diego to pursue her master's degree, she was a PE teacher in the Sacramento area. She grew up on the California coast about an hour north of Santa Barbara, and spent her childhood years surfing and playing a multitude of sports. She is currently captaining a winter indoor league for her soccer team, and can often be found playing pickup basketball twice a week in Davis. She and her partner Doug purchased their first home together in 2008, and plan to marry in June of 2010. They spend many an evening discussing successes and mishaps from their last soccer game, strategizing for the new softball season (which Rebecca captains in the sunnier months of Sacramento), and riding their bicycles to downtown Sacramento to attend concerts in the park and Saturday art walks.

Richelle Harklerode, **MPH**, is the Associate Epidemiologist for CTEC. She has a bachelor of science degree in Microbiology from the University of California Davis, and completed her master's of public health with a dual emphasis in Epidemiology and Global Health at Loma Linda University in 2006. Due to her interests in improving health equality, Richelle has sought out various international volunteer and work opportunities. She surveyed communities on their health needs in Ecuador, reviewed community development projects in Peru, performed data analysis for sexual health improvement in Papua New Guinea, and this past year researched trends in malaria and bed net usage for the College of Medicine in Malawi. Richelle is a certified health education specialist (CHES) and in the past has enjoyed instructing various groups of children and adults on health issues. In her spare time, she volunteers for Sacramento County and the surrounding area in emergency preparedness and response events. She enjoys outdoor activities, especially exploring the hiking trails throughout California. Many at CRIHB are thankful of her delight in baking, as she often shares the homemade goodies. Since she has traveled to six out of the seven continents, for her next vacation, Richelle is trying to find a research project that will take her to the last continent, Antarctica.

Staff continued...

Jared Michael Dunlap, **BA**, is enrolled in the Fond-du-Lac Band of Lake Superior Chippewa. He received his bachelor's of arts degree in American Indian Studies with a Pre-Medicine/Health concentration from the University of California, Los Angeles, and has been the Epidemiology Assistant for the California Tribal Epidemiology Center since November 2009. He would like to further his education with plans to receive his master's in public health and go on to complete medical school. His interests include reducing health disparities and improving socioeconomic conditions for Natives. Before joining CTEC, Jared worked on developing a burn clinic in Chiapas, Mexico, and has conducted research on the effects of USDA commodity foods in American Indian/ Alaska Native communities. Native Health Initiative is a project that he and others continue to lead, striving to improve the overall health and wellness of Native communities. Jared is the youngest of 5 siblings and has an identical twin brother, born just 2 minutes earlier. Although he relocated to California in 2004, he was raised on the Fond-du-Lac Reservation in northern Minnesota and can often be found with his head in the office freezer, reminiscing the cold, sub zero temperatures of past years. In his free time, Jared can be found taking long public transportation adventures to and from work, perusing the isles at a bookstore, exploring new coffee houses, dominating on the tennis court, strolling down a street, attending a culture or music event, making plans to travel, or keeping himself plenty busy with his nieces and nephews, so they can continue to think of him as their favorite Uncle.

Here are some of things we are working on...

H1N1: *Riding and Remembering the Pandemic Roller Coaster*

As of the writing of this article, we are on the down slope of a second "peak" of the 2009 A/H1N1 influenza pandemic. That is, we are finishing the second surge of the number of people infected in the U.S. after our initial surge in April 2009 when the virus was first recognized. What tells us that we have passed through this peak? Aside from tracking actual influenza hospitalizations and deaths, one type of illness that public health official's measure is called, "influenza-like-illness" or "ILI" for short. Typically this is fever with either cough or sore throat. Although, it is not necessarily the flu, it serves as a reliable measure of how many people have the flu in a given community, state or country. In the past six weeks, we have seen both in the U.S. and in California, consecutive drops in the percentage of patients with ILI after four weeks of very steep increases. Hospitalization has also followed this pattern. So, having gone through these two peaks of the H1N1 Pandemic, what should we do in light of this experience?

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One good way to evaluate where we are is to look back in history. We actually have fairly good information about the influenza pandemics in the 20th century and the current one already fits many of those same past characteristics. Mark Miller, from the National Institutes for Health, notes four characteristics of these global pandemics. **(Article Cont'd page 7)**

H1N1: *Continued…*

These characteristics include: 1) a mutating (changing and adapting) virus; 2) higher percentage of deaths in younger people; 3) successive waves of infection seen in large groups of people; and 4) an increased ability of the virus to go from one person to another compared to the regular seasonal flu virus.

Let's take a quick look at our current pandemic. Several mutations have been detected, but thankfully are not widespread. But we have come to expect this in flu viruses since they are known to spontaneously and randomly change their DNA over time and therefore possibly change how they act and harm humans. We have clearly seen that the 2009 H1N1 virus causes relatively more illness and death in younger adults and children. The Centers for Disease Control and Prevention (CDC) reports that for those aged 50 years and younger, the rate of hospitalization is about 1.5 to 3 times higher than in years past. As for waves of peaks, we can only look at the past since we are likely in the early stage of our pandemic. The 1918 Spanish Flu Pandemic lasted two years; the 1957 pandemic lasted for five years with three waves; and the 1968 pandemic lasted for three years. We have also clearly seen the effective transmission of the H1N1 virus; the CDC estimates that it has possibly infected 47 million Americans and about 4.3 million in California which are higher than expected numbers for this time of year for an average flu season.

Looking at Native Americans directly, we have seen that there has been a disproportionate effect on this group. The California EpiCenter collaborated in a study which was published in the CDC Mortality and Morbidity Weekly Review in December 2009 which looked at all those who had died due to H1N1 influenza in 12 states between April and November 2009. We found that Native Americans were four times more likely to have died than all other races and consisted of 10% of all deaths even though they are only 3% of the population. This among other findings has raised awareness nationally among Native Americans and their health care providers and has prompted further efforts to expand immunization.

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What does all this mean for us at this juncture? It means we need to keep this historical perspective in mind. Despite the encouraging trends in ILI, we need to remember that overall, the number of ILI, hospitalization and death remain higher than a typical flu season which is associated with about 30,000 deaths! The specter of mutations which change the severity of illness or cause drug resistance is ever present. This makes surveillance or a careful watch on the extent of how this virus affects communities and keeping tabs on the virus characteristics very important. As history has also shown, successive waves of peaks may possibly come. But the main defense against another peak and weapon to possibly prevent one is having the H1N1 influenza vaccine administered to as many people as possible. So even if everyone is breathing a sigh of relief, go ahead and get vaccinated if you have not already done so. It's a way to keep history in mind and protect yourself, your family and your community.

Here at the California Tribal Epidemiology Center, we continue to support the Tribal Health Programs in their pandemic influenza preparedness and response primarily through health provider education with newsletters and webinars as well as providing consultations to these clinics. If you have any questions about influenza or the vaccine, please contact us at the California Tribal Epidemiology Center or call the CA Department of Public Health Flu Hotline at 888-865-0564.

California Public Health Department Funded Tribal Asthma Survey Project (TASP)

In an effort to understand the type of housing conditions associated with asthma present among Indian people, CTEC, with funding from the California (CA) Department of Public Health, Health Investigations Branch, CA Breathing, is conducting a survey among American Indian and Alaska Native (AIAN) adults throughout CA. The ultimate goals are to improve housing conditions and to improve the health status of CA Indians. Participation by CA Indians in this project allows them to identify housing conditions that require more attention in the future to reduce the burden of asthma in our communities. Items on the survey include risk factors in housing conditions associated with allergens that may affect asthma rates, hospitalizations and missed days of work/school among AIAN who reside in CA. Understanding adverse housing conditions is important for planning, implementing, and evaluating programs and services aimed to improve the health of all tribal members.

The project is underway throughout CA; thus far we have visited the CA Rural Indian Health Board, Inc (CRIHB) Board of Directors' Meeting in Reno, NV in October, the Manchester Point Arena Tribal elections in November and the Sacramento Native American Health Center Winter banquet in December. Approximately 450 AIAN adults 18 years of age and older will be recruited to complete the survey at various events in the upcoming months. We expect to visit between 4 and 10 more tribal events between now and June 2010. Participation in the survey is voluntary and information from participants can be face-to-face or self-administered by trained interviewers and remains confidential. A gift card is given to persons who participate in the survey to compensate them for their time.

...Participation by CA Indians in this project allows them to identify housing conditions that require more attention in the future to reduce the burden of asthma in our communities...

To date completed survey questionnaires total about 200, from the three participating events. Once data collection is completed, CTEC will prepare a report summarizing the conduct of these surveys and the results of these analyses will be available on our website. A final presentation will be made to the CRIHB Board of Directors and if determined by Tribal and health leadership, with specific Tribal Health Programs. This report will be disseminated throughout the CA Area and the results shared with the CA Area Office, Indian Health Service and national organizations for use in stimulating discussion among policy makers and tribal communities and for guiding the development, targeting, and implementation of asthma prevention programs. In addition, if results from these analyses add new and important information to the general knowledge about housing conditions associated with asthma, CTEC will seek, with the participation and approval of the Internal Review Board, to publish these results in a reputable, national medical or public health journal to aid other tribal efforts throughout the United States.

For more information contact: Rebecca Garrow, MPH, Program Coordinator,
CTEC Center Tel: 916-929-9761 Email: rebecca.garrow@crihb.net

What's In A Number?

Finding Out if Our Children Are Receiving Their Vaccinations on Schedule

In the years that the Indian Health Service has been collecting information on vaccinations in children, American Indian/Alaska Native children have not been receiving their vaccinations as on-time compared to other Californian children and compared to Native children in other parts of the country. Receiving the proper schedule of vaccines for a child strongly increases the likelihood for protection against a number of infectious disease ranging from the measles, tetanus, hepatitis A and B and of course, influenza. The California Department of Public Health (CDPH), the Indian Health Service, and the California Tribal Epidemiology Center share a strong concern for these differences. We know, however, that health information presented for Native peoples in California may be incomplete due to inconsistent reporting by health providers, reporting to only the Indian Health Service but not to California State (or vice-versa), mistakenly identifying a Native person as White or Asian for example, or any number of other reasons.

...Receiving the proper schedule of vaccines for a child strongly increases the likelihood for protection against a number of infectious disease ranging from the measles, tetanus, hepatitis A and B and of course, influenza...

In order to make sure the immunization information for Native children is accurate, we will be working in Spring 2010 with the CDPH Immunization Branch to review immunization records in California schools which have the highest numbers of Native American pupils. The schools selected will provide this immunization information directly to CDPH under the authority given by the California Health and Safety and the California Code of Regulations. The identity of all children will be kept confidential, and no children will be identified in the reports which result from the review. Once we evaluate our findings, we would like to work with Tribal Health Programs to see how we may assist their efforts in improving vaccine coverage for children so that they are protected from preventable infectious diseases.

If you would like further information or a more detailed explanation of this project, please speak to Teresa Lee, MPH (at CDPH, 510-620-3737) or Thomas Kim, MD (916-929-9761, thomas.kim@crihb.net).

Winter Health Tip...

In light of the flu season and added effects by the H1N1 Flu, there is ever increasing importance to take proper steps to decrease your chances of getting the flu, by recognizing the symptoms, and consider getting the Flu/H1N1 Vaccination.

The **symptoms** of H1N1 flu are similar to the symptoms of seasonal flu, they include:

Fever, cough, sore throat, body aches, headache, chills and fatigue.
Some have reported diarrhea and vomiting.

If you are sick or think you have H1N1 flu infection, please contact your healthcare provider.

The **vaccinations** are available for seasonal influenza and H1N1. Ask your healthcare provider for a list of local places where the vaccinations are offered.

Cell phone users are now able to text the word "NO FLU" and their zip code to 30644 and receive vital flu-related information including alerts and the nearest vaccination location.

You can call the California Dept. of Public Health H1N1 Flu Hotline at **1-888-865-0564** M-F (9 am to 6 pm, Sat 8:30-5 pm) You can hear recorded information 24 hours a day, seven days a week.

CTEC in the News...

The December 2009 **UCLA Center for Health Policy Research** edition of their Health Policy News mentions the work we are doing here at CTEC. We are thankful for their support and hope to continue to work within our mission of improving American Indian health in California.

American Indian Health in California

INDIAN HEALTH PRIORITIES

CALIFORNIA TRIBAL EPIDEMIOLOGY CENTER

Indian Health Priorities
2008-2009

As Indian people we have been conducting our own health studies for hundreds of years. Finding ways to heal our bodies is part of our culture. The California Tribal Epidemiology Center (CTEC) goals are the same as ours. CTEC wants healthier communities and to do that together we need good health information.

CTEC has been seeking input from American Indian community members as to what they think are the most important health concerns in their community. In a survey, people were asked to rank their top 10 health concerns from a list of 27 health topics. An 'other' option was provided for people to fill in if a concern was not listed.

CTEC priorities are a combined result of the 499 surveys collected as of June 2009, at consultations with CTEC-member tribal health programs, and at various California Indian conferences and gatherings. People could choose more than one category: 204 respondents stated they were clinic staff, 97 were health board members, 59 were tribal council members, and 247 were community members.

The health issues of highest concern in the community for CTEC to focus on in the coming years:

1. Diabetes
2. Drug Abuse
3. Alcohol Abuse
4. Eating Healthy, Exercise, and Controlling Obesity
5. Mental Health
6. Heart Disease and Stroke
7. Dental Health
8. Elder Care and Support
9. Getting or Paying for Medications
10. Cancer or Tumors

Comments made by people on why the health issues are of highest concern in the community:

Alcohol abuse, because I see it even looking in the mirror.

Many of our elders suffer and die from diabetes, now it is hitting our young. We need to educate our young on caring for and respecting our bodies.

Drug abuse is killing our Native People and our young children are learning it.

Diabetes is Number One Health Concern for American Indians

Diabetes is the fourth leading cause of death for American Indians and Alaskan Natives in the U.S. but the number one concern of a group of approximately 500 American Indians surveyed recently by **The California Tribal Epidemiology Center (CTEC).** Fact sheets based on the findings of this June 2009 survey, which uses data from the California Health Interview Survey (CHIS) as a point of comparison, are now available online. Among the top 10 concerns: elder care, mental health and getting and paying for medications (the authors cite CHIS data that shows that in California, about 25% of American Indians and Alaska Natives delayed or did not obtain prescriptions because they could not afford it).

CTEC in the News...

On January 11, 2010 the **Sacramento Bee** reported a story about swine flu in American Indian/ Alaska Native communities. In the article the work of CTEC, as well as the work of California Tribal Health program, United Indian Heath Services were mentioned.

American Indians found at high risk from swine flu

The article went on to say that, "American Indians and Alaska Natives are four times more likely to die from H1N1 than all other ethnic groups combined, according to a Centers for Disease Control and Prevention study. Four American Indians in California who died of H1N1 complications accounted for 1 percent of the state's swine flu deaths between April 2009 and Jan. 2, according to the state Public Health Department. They accounted for 1 percent of the state's intensive care unit cases in the same period.

...lower [American Indian] H1N1 death rates could be racial mis-classification...

A reason that California's American Indians seem to have lower H1N1 death rates could be racial mis-classification, said Dr. Thomas Kim, a medical epidemiologist at the **California Tribal Epidemiology Center**. The state's vast ethnic diversity might lead to more racial confusion than in other states. "When you are hospitalized and being transferred straight to the intensive care unit, you're not in a position where you can answer a bunch of questions," he said. "Usually it's done by the hospital staff and often Native Americans are misclassified as white or Hispanic."

American Indian health providers across the state said they have tried to make sure patients have access to the H1N1 vaccine. Because many American Indians live in rural areas, getting the message out is difficult, said Jerome Simone, chief executive officer of **United Indian Health Services** in Arcata, near the Oregon border. His clinic used community health workers who were American Indian to educate their communities about the vaccine. "A lot of my patients don't even have telephones," he said. "But we still have to make sure they know about getting vaccinated."

Indian Health News...

The American Indian, Alaska Native and Native Hawaiian Caucus (AIANNHC) of the American Public Health Association (APHA) was established in 1981 and has focused on promoting issues that impact indigenous peoples including supportive entry of AIANNHC members into the American Public Health Association (APHA), and equal opportunity and access for indigenous peoples of North America and the Hawaiian Islands to health care, and dissemination of information addressing Native health issues and programs. The AIANNHC works with its members and the APHA to promote policies that support indigenous health and wellness.

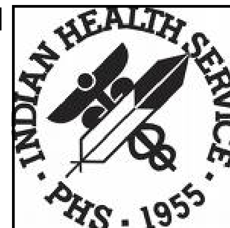
Persons who are interested in supporting the AIANNHC or considering becoming a Caucus member can do so without being a member of APHA.

Information about the Caucus is available at: <http://www.uihi.net/AIANNH-Caucus/default.aspx>
Membership forms are available online and includes:

- Access to a bi-annual newsletter.
- Opportunities to be part of a larger Native public health network.
- Opportunities to share topics of importance to Native peoples for possible dissemination.
- Leadership opportunities such as working with seasoned Native leaders to assist in the execution of AIANNHC Executive Committee tasks.

Indian Health News, continued...

In December, the Committee on Indian Affairs of the Senate enacted into law a bill to amend the Indian Health Care Improvement Act.



> ***...PART III-INDIAN HEALTH CARE IMPROVEMENT***
>
> ***SEC. 10221. INDIAN HEALTH CARE IMPROVEMENT.***
> ***(a) INGENERAL.-Except as provided in subsection (b), S. 1790 entitled "A bill to amend the Indian Health Care Improvement Act to revise and extend that Act, and for other purposes.", as reported by the Committee on Indian Affairs of the Senate in December 2009, is enacted into law...***

The Indian Health Care Improvement Act (IHCIA) has been passed through, both the House and Senate, and is now waiting to be ironed out with details.

At this past fall's meeting of tribal leaders at the White House, President Obama made it clear in his words that the health of our Native people was of great importance for his administration, stating that "Native Americans die of illnesses like tuberculosis, alcoholism at far higher rates," Mr. Obama said. "We're going to have to do more to address disparities in health care delivery." Clearly, his words have been solidified by the IHCIA continuing its way through the process of being enacted into U.S. law.

What does this mean for Indian country?...

This bill is poised to bring the *most significant improvements* to the Indian health system in decades. After months of negotiations, provisions under consideration could, over time, direct streams of money to the Indian health care system and *give Indians more treatment options*. Providing funding mechanisms and support for a variety of Indian health programs. The bill would permanently reauthorize the law, so Indian advocates don't have to find themselves going back to Congress every few years to make the case for policies that a majority [of people] agrees makes sense.

...bring the most significant improvements to Indian Health…give Indians more treatment options...

(News sources: Indian Country Today and National Indian Health Board)

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