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Health Care in Indian Country: Obstacles and Opportunities

The disparities in health status between Native Americans and other Americans are nothing short of staggering.

American Indians and Alaska Natives rank at or near the bottom of nearly every social, health and economic indicator in the nation, according to a recent report from the U.S. Commission on Civil Rights. They are 670 percent more likely to die from alcoholism, 650 percent more likely to die from tuberculosis, 318 percent more likely to die from diabetes, and 204 percent more likely to suffer accidental deaths when compared with other groups.While the average lifespan of Native Americans has increased from 51 years in 1940 to 71 years today, it is still six years below that of other Americans.

There's a long tradition of the federal government working with tribes on health issues. The U.S. Constitution states that federally recognized tribes are sovereign nations with inherent rights, Charles Grim, assistant surgeon general and director of the Indian Health Service (IHS) said in a speech last year. "Health services. . .were guaranteed by treaties entered into between the federal government and sovereign nations in exchange for land, mineral rights, resources and, during certain periods of American history, some personal rights and freedoms," Grim said.

AN UNEASY ALLIANCE

But for a number of reasons, tribal nations have not always worked closely with states. It's partly that tribal nations are accustomed to turning to Washington for help. But there are also gaps in culture and knowledge.

"Most state legislators don't have a good knowledge base of who the tribes are, what our equal status is, or the unique legal, social and cultural conditions of tribal regulations. They don't know how to reach out to us or who to talk to," said W. Ron Allen, tribal chairman and executive director of the Jamestown S'Klallam Tribe, Sequim, Washington.

Often, tribes are out of sight and out of mind on the reservations, Allen added. "As a general rule in most rural communities, they are removed from mainstream society, and are often the hardest to reach."

Lawmakers may be baffled by the sovereign nation status of tribes, as well as the cultural differences and fragmentation of the 562 federally recognized tribes. Some 229 of these tribes are in Alaska; the rest are located in 36 other states.

There also is the impression among many non-Native Americans that Native Americans are nearly uniformly wealthy, due to casino gaming. "Only about 40 tribes make money on gaming, out of the 562 tribes total," said Dr. Craig Vanderwagen, chief medical officer of the IHS. The Commission notes that half the Native American population is poor or near poor, compared with 25 percent of whites.

"There is an inclination for people to think, 'This is a federal problem, we don't have to deal with it.' That's not true, and it's also short-sighted," said Jim Crouch, executive director of the California Rural Indian Health Board (CRIHB), which operates 11 tribal health programs that provide health services to some 63,000 people in rural California.

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FOCUS ON...

Voters Bring Down the Gavel on Health Measures in 8 States

On Nov. 2, voters in 34 states dispatched 164 ballot measures, 20 of which dealt with health care. The health-related issues raised most frequently concerned medical malpractice reform, medical marijuana and raising tobacco taxes.

Of the eight states that considered health-related measures, California had the most, with a total of eight initiatives. The Golden State became the first in the nation to fund stem cell research, passing a $3 billion bond to do so (see *"Highlights," page 3*). They also narrowly rejected a law that would have required employers to provide health insurance to employees.

Alaska

Voters narrowly rejected an initiative to legalize marijuana. Ballot Measure 2 would have removed civil and criminal penalties, allowing Alaskans over the age of 21 to grow, sell, use or give away marijuana and hemp products. The proposal also would have repealed existing restrictions on prescribing medical marijuana. [43% YES, 57% NO]

California

Voters approved Propositions 61, 63 and 71, while rejecting Propositions 67 and 72. Among the approved measures, Proposition 61 allows the state to sell bonds to finance children's hospitals, Proposition 63 places an additional tax on incomes over $1 million to help fund mental health services, and Proposition 71 allows the state to sell bonds to finance stem cell research. Rejected Propositions 67 and 72, respectively would have added a telephone surcharge to cover emergency medical services and uncompensated care and would have approved legislation expanding employers' responsibilities in providing health coverage to workers. [Prop. 61: 58% YES, 42% NO; Prop. 63: 53% YES, 47% NO; Prop. 67: 28% YES, 72% NO; Prop. 71: 59% YES, 41% NO; Prop. 72: 51% YES, 49% NO]

Colorado

Amendment 35 passed safely, levying with it additional taxes for tobacco products. Effective January 1, 2005, Colorado smokers will find an extra 64 cent tax per pack of cigarettes. Other tobacco products will carry an additional tax of 20 to 40 percent of their price. The amendment designates that new revenues generated by these taxes will go towards health services and tobacco cessation education. [61% YES, 39% NO]

Florida

Floridians who went to the polls favored four constitutional amendments on health. Amendment 1 allows the legislature to pass laws requiring female minors to notify parents prior to seeking an abortion. However, the amendment allows a judge to waive the requirement. Amendment 3 addresses medical malpractice awards, specifying that claimants may receive no less than 70 percent of the first $250,000 of an award and 90 percent of any additional sum. Amendment 7 allows patients the right to review health-care facilities' and providers' records on the frequency and nature of adverse events, including injuries and fatalities. Amendment 8 is a medical malpractice "three strikes" law designed to protect patients from doctors with records of injuring patients. Three or more incidents of medical malpractice and a doctor loses licensure in Florida. A court, administrative agency or binding arbitration must find that malpractice has been commited. [Amdt. 1: 65% YES, 35% NO; Amdt. 3: 64% YES, 36% NO; Amdt. 7: 81% YES, 19% NO; Amdt. 8: 71% YES, 29% NO]

Montana

Montana became the latest state to approve medical use of marijuana with the passage of Initiative 148. The measure allows patients with debilitating conditions to produce, possess and use marijuana to alleviate the suffering caused by their illnesses. Additionally, Montanans passed I-149, the 2004 Healthy Kids, Healthy Montana Tobacco Tax Increase Act. The act raises the per-pack cigarette tax to $1.70, while increasing moist snuff taxes by 85 cents per ounce and all other tobacco products by 50 percent. Revenues generated by the taxes will fund new health insurance and Medicaid initiatives, state buildings, veterans' nursing homes and the state general fund. [I-148: 59% YES, 41% NO; I-149: 62% YES, 38% NO]

Nevada

The three health-care-related ballot measures in Nevada all addressed medical malpractice reform. (A successful court challenge blocked a marijuana legalization initiative from being placed on the ballot.) The "Keep Our Doctors in Nevada" initiative (Ballot Question 3) passed quite easily. It will limit attorneys' fees and remove the two exceptions in the Nevada law that cap non-economic damages at $350,000. The two remaining measures (Ballot Questions 4 and 5) sought to amend the state constitution and failed. The former sought to decrease medical malpractice insurance premium rates by 20 percent (with a removal of non-economic damage caps if rates had not been reduced by 10 percent within one year), while the latter would have fined lawyers who file frivolous medical malpractice lawsuits. [Q3: 59% YES, 41% NO; Q4: 34% YES, 66% NO; Q5: 36% YES, 64% NO]

Oklahoma

Question 713 passed in Oklahoma, altering income, sales and tobacco taxes. Beginning Jan. 1, 2005, tobacco taxes will increase by 4 cents per cigarette. The measure designates that the tobacco tax revenues will go toward health initiatives and provides penalties for Indian tribes that break tobacco tax compacts. [53% YES, 47% NO]

Oregon

Voters in Oregon rejected a ballot measure that would have expanded medical marijuana laws and practices (Measure 33), and another that would have capped at $500,000 non-economic damages in medical malpractice cases (Measure 35). [Measure 33: 42% YES, 58% NO; Measure 35: 49% YES, 51% NO]

Wyoming

Medical malpractice crept onto the ballot in Wyoming, through Constitutional Amendment C. Voters approved an amendment that will allow the legislature to enact laws requiring alternative dispute resolution or medical panel review before a medical malpractice suit may be filed. An additional related amendment, Amendment D, would have established caps for non-economic damages in medical malpractice cases. That measure, however, failed to pass. [Amdt. C: 52% YES, 48% NO; Amdt. D: 49% YES, 51% NO] *GM*

HIGHLIGHTS

BIOTECHNOLOGY

California Charges Ahead

Thanks to Proposition 71, California could become the West Coast version of the NIH, according to an article in the San Francisco Chronicle. Passed by voters Nov. 2, the initiative directs the state to issue $295 million in bonds annually for 10 years for human embryonic stem cell research. The new California Institute for Regenerative Medicine will give grants and loans to organizations that conduct research with stem cells derived from human embryos that are less than two weeks old. "This dwarfs what any other political entity in the world is spending," David Greenwood, executive vice president of Geron, which owns 15 U.S. stem cell patents and has filled for 200 more, told the San Diego Union-Tribune. Advanced Cell Technology, a Massachusetss company that has been conducting stem cell research, plans to open a branch in California. However, Massachusetts researchers say they're not going to "take this lying down." In April, Harvard University launched a stem cell research institute, with a fundraising goal of about $100 million, which includes research not funded by the federal government. A response to the perceived inadequacy of federal funding, the California money dwarfs other U.S. sources of funding for stem cell research, notes the publication Medicine & Health. Since Aug.10, 2001, when President Bush authorized federal funding for research based on stem cell lines created before that date, the federal government has spent only about $25 million annually on such research. From 1994 and 2004, when a total of $30 billion in venture capital flowed into biotechnology, only $300 million went into stem cell research, and most of that financed adult stem cell research, American Enterprise Institute fellow Scott Gottlieb, MD, wrote Nov. 1 in Forbes.

HEALTH INSURANCE

"Heading for a Crisis"

In a major new initiative, Kansas Gov. Kathleen Sebelius is joining with Insurance Commissioner Sandy Praeger to expand coverage to at least 70,000 of the state's 300,000 uninsured residents. The $50 million "HealthyKansas" initiative seeks to reduce the administrative costs of health care, provide access to cheaper prescription drugs, reduce the incidence of obesity and other chronic, preventable conditions, expand the State Children's Health Insurance Program, and create a new affordable private insurance product that would allow small businesses to pool their insurance risks. HealthyKansas would be paid for by raising the state's ciga-

To Tax or Not to Tax Snacks

In an effort to fight obesity, state legislators are weighing whether to raise taxes on snack foods. There's precendent in that higher taxes helped to quell smoking.

In 2004, 14 states considered legislation that would have raised taxes on foods such as potato and corn chips. None of the bills passed, according to NCSL's Health Policy Tracking Service.

A recent report from the U.S. Department of Agriculture's Economic Research Service (ERS) notes that three variations on such a tax have emerged, each with a different goal. One version would impose a tax in an effort to price snack foods beyond many consumers' reach. Another would target a tax at foods that are particularly unhealthy because, for example, they contain saturated fat. This might encourage food manufacturers to reformulate their products and offer more healthful alternatives. The third variation would earmark tax revenue to fund information programs promoting healthy diets and lifestyles.

The ERS found that a small tax on salty snack foods would not at least immediately affect consumer buying habits. And it might not get manufacturers to make their products more healthy. But a small tax could produce significant revenues, and those revenues could be used to pay for campaigns that would educate consumers about the effect of unhealthy snack foods on their waistline and health.

A relatively low tax of 1 cent per pound would raise about $40 million annually, while a tax of 1 percent of value would generate some $100 million in tax revenues, the ERS said.

Ninety-nine percent of U.S. households purchased some salty snacks, such as potato chips, corn chips, tortilla chips or microwave popcorn, in 1999. On average, each U.S. household spent $76 on 32 pounds of salty snacks. — CK

"Taxing Snack Foods: What to Expect for Diet and Tax Revenues" is at www.ers.usda.gov/

Nearly all households purchase salty snacks

Snacks	Share of households that purchased snacks	Average yearly quantity purchased by households that did purchase		Yearly expenditure by households that did purchase
	Percent	*Pounds per household*	*Pounds per capita*	*Dollars*
Potato chips	91.3	9.8	4.2	26.14
All chips	95.5	16.3	7.0	41.43
Other salty snacks [1]	96.8	16.5	7.9	37.41
All salty snacks	99.2	31.8	14.5	76.39

[1] Includes pretzels, microwave popcorn, cheese puffs, and nuts.
Source: Tabulations from ACNielsen Homescan panel, 1999.

rette tax by 50 cents a pack, to $1.29. "Double-digit increases in the cost of health insurance and prescription drugs have made them unaffordable for too many working parents and small businesses," Praeger said. "We have a moral responsibility to partner with the business community to address the crisis in health-care costs." Sebelius noted that about 30 percent ($3.5 billion) of the $12 billion that Kansans spend on health care each year goes to cover administration, such as claims processing and paperwork. To streamline the health care bureaucracies, Sebelius plans has ordered that all of the state's major health care programs be moved into a new business division called the Kansas Health Care Authority. The governor also plans to establish a Kansas Health Care Cost Containment Commission, which will work to cut unnecessary administrative costs, improve patient care and help providers expand the use of health-care information technology. Commissioner Praeger will head a committee responsible for developing a state-subsidized private insurance product for some 30,000 to 40,000 low-wage workers in small businesses that don't currently offer coverage to their employees. "We're really heading for a crisis, so I think we've got to take some very aggressive action and do it now," Sebelius, who was previously the insurance commissioner of Kansas, told the AP.

PUBLIC HEALTH

Vaccine Tracking

If the Food and Drug Administration gives its approval, Illinois, New Mexico and New York City will be able to import enough influenza vaccine to vaccinate their highest risk residents. When it was announced last month that the U.S. would get only about half the 100,000 required doses of flu vaccine, Illinois Gov. Gov. Rod Blagojevich started started looking to Europe for help. He managed to purchase 300,000 doses from Aventis Pasteur, which is the same company that has manufactured the vaccine already purchased by the U.S. When New Mexico, which has about 500,000 high-risk residents, expressed concern about its shortage, Blagojevich agreed to allow New Mexico to purchase 150,000 of its 300,000 doses. The vaccine is packaged and ready to be shipped within hours of approval by the FDA, New Mexico Gov. Bill Richardson said. On Nov. 10, New York City Mayor Michael Bloomberg announced that NYC is purchasing an additional 200,000 doses of vaccine from Europe. This additional vaccine is made by GlaxoSmithKline in Germany and Aventis in France. These vaccines are considered investigational new drugs, but have been approved by European regulatory bodies. Given the track record of these products, the manufacturers and their approval by the European regulatory authorities, it is expected that FDA approval will be granted expeditiously, Bloomberg said. There have been two nursing home outbreaks in NYC so far this season. In one of them, four people died.

Adult Smoking Declines

A new Centers for Disease Control and Prevention Study finds that on average, slightly fewer U.S. adults are smoking, but the rate varies widely from state to state. In 2003, smoking prevalence was highest for men and women in Kentucky (where a median 30.8 percent of adults smoked), and lowest in Utah (where a median 12 percent of adults smoked). Utah was the first and only state, and the U.S. Virgin Island was the only territory, to meet the federal government's goal of reducing smoking rates to 12 percent by 2010. Nationally, the median prevalence of smoking among adults was 22.1 percent in the 50 states and the District of Columbia. That rate represents a 1 percent decline from 2002. The CDC noted that the more states spend on tobacco control programs, the greater the reduction in smoking. However, the amount of money that states spent on tobacco control decreased by 28 percent during 2002-2003 to $541.1 million, which is less than 3 percent of the estimated $19 billion that states are epected to receive from tobacco excise taxes and tobacco settlment money. For FY 2004, only four states -- Arkansas, Delaware, Maine and Mississippi -- invested at least the minimum per capita amount that CDC recommends for tobacco control programs. For more, go to www.cdc.gov/mmwr/

Women Unaware of Screening

Many uninsured California women are unaware of a state program that provides treatment for breast and cervical cancer at no cost, according to a new report from The Kaiser Family Foundation and George Washington University. In 2000, Congress passed a law giving states the option to establish access to Medicaid for any uninsured woman under age 65 who has been screened and diagnosed with breast and/or cervical cancer through state screening programs funded by the Centers for Disease Control and Prevention. In 2001, California expanded Medi-Cal to cover such treatment, and launched a program that uses state funds to cover cancer treatment for uninsured women who have been diagnosed with breast or cervical cancer but do not meet the eligibility criteria for the Medi-Cal program. Focus groups conducted by Kaiser and George Washington researchers found that:

- Women who received treatment through the Medi-Cal program were consistently grateful and said the coverage was critical in their ability to seek and obtain screening as well as treatment.
- Uninsured women and providers both would benefit from increased education and outreach about the Medi-Cal and state-only programs.
- Enrollment in the Medi-Cal and state-only program was easy for women due in large part to assistance from health-care provider staff.
- Cultural traditions play a major role in women's receptivity to screening and decisions about treatment. Translation services were crucial.
- There was significant confusion about what services were covered and for how long.

"Hearing Their Voices, Lessons from the Breast and Cervical Cancer Prevention and Treatment Act" is available at www.kff.org/womenshealth/

Nevertheless, observers says that states are making progress in forging alliances with tribal nations. In some cases, they're developing models of care for Native Americans that could be used for other residents.

Alaska, for example, is "making headway toward having good relationships with the tribes," said Joyce Hughes with the Alaska Primary Care Office. "The mistrust is still there, but it's lessening." The mistrust stems in part from the fact that the health system is so complex, she added. " There are two such different systems, the funding streams are different, and the urban areas have very different issues from the rural ones."

The 49th state is divided into nine health-care delivery areas, and each area is as large as a state in the lower 48, with low population density, no road systems, extreme weather conditions and high cost of living. The cost of constructing clinics in frontier areas and of flying critically ill patients in air ambulances from remote areas to urban hospitals is enormous.

One innovative strategy that the tribes and the state have developed -- and that other states are looking at -- is the community health aide. Some 450-500 aides serve about 200 remote villages throughout the state. "They make sure there's at least some kind of health care available in remote areas," said Renee Gayhart with the Office of the Commissioner of Tribal Programs. "They can stabilize folks so they can be sent to urban areas."

The aides have differing scopes of practice, depending on the extent of their training; they're selected by their local communities to undergo training; and they're supervised by physicians based in regional hospitals. The state helps pay for training, and in 1999, Alaska got approval to pay for the services the aides provide with Medicaid funds.

The tribes want to create a similar position for dental care, and in fact, students are being trained for that purpose in New Zealand right now. (New Zealand has pioneered training for rural dental "therapists" or "nurses.") "But we've run into a lot of opposition from the American Dental Association," Gayhart said.

The U.S government first provided health-care services to Native Americans in the 1800s, when Indians who lived around U.S. Army posts were infected with diseases brought over by Europeans. To protect their soldiers, Army doctors began treating the Native Americans.

In 1921, Congress paved the way for the establishment of the IHS by passing the Snyder Act. It authorized federal funds for "the relief of distress and conservation of health" of Indian tribes throughout the U.S. In 1954, the responsibility for delivering health care to Native Americans was given to the U.S. Department of Health and Human Services (HHS), and in 1955, the IHS was established.

The IHS is the largest sole provider of health services to the Indian nations, generally serving those who live on or near reservations, or tribal or trust lands. Out of the 2.5 million Americans who identified themselves as solely Native American or Alaska Native in the 2002 U.S. Census, roughly 1.4 million use the IHS, according to Vanderwagen.

AN AMAZING JOB

Observers tend to agree that the IHS does an amazing job with the resources that it has – but they also agree that the agency's budget (which is subject to annual congressional appropriations) hasn't begun to keep up with growth in the service population or medical costs. Facilities are aged and medical equipment is often obselete, as it is used for twice the normal life span.

The IHS budget is about $2.9 billion. If Native Americans are to begin to achieve parity with other Americans, the IHS will need appropriations totaling roughly $18 billion, including a one-time appropriation of $8 billion for facility construction and $10 billion per year for health-care delivery for the next 10 years, the Commission said.

The low level of funding creates a huge disparity in what's spent on Native American health care by the IHS, and what's spent by other payers on other Americans. According to the Commission, the IHS spends $1,600 per person per year for all health services. That's about a third of the $5,775 spent by public and private payers on the average American, and half of what is spent by the federal government on federal prisoners.

"IHS doesn't even keep up with general inflation, let alone medical inflation, each year. So of course you have to end up cutting services somewhere. It's remarkable they are able to offer the services they do," said Traci L. McClellan, legislative director of the National Indian Health Board, Washington, D.C.

With the IHS so poorly funded, states and tribal nations are working to maximize all available funding for health care. One of the most useful tools is a unique Medicaid funding match that dates back to the 1976 Indian Health Care Improvement Act.

Systems vary from state to state, but in general, under the act, Medicaid will reimburse states for services provided to American Indians/Alaska Natives at 100 percent of the federal medical assistance percentage (FMAP) – if those Native Americans are enrolled in Medicaid and if the services are provided by health-care systems that are run by the IHS or tribal organizations. The state gets its regular FMAP for services provided to non-Native Americans through other providers.

(A 1975 law gave tribes the option of taking over the operation of IHS services. Today, tribes manage about 52 percent of the funds appropriated to IHS; they run more than 440 facilities, from full-service hospitals to clinics.)

To obtain that 100 percent match, states have been educating Native Americans about Medicaid and about the availability of tribally managed services. Tribally run services may be more sensitive to Native American culture than private institutions, so patronage of the services can be a win-win for everyone, observers said.

"The states can't delegate [to the tribes] the responsibility [for outreach], but some states may put an outstation of their own workers on a reservation [once a week or so]," said Kris Locke, an independent consultant in Sequim, Washington. But with states tightening their budgets, such programs are often the first to be cut, he warned.

Increasing enrollment in Medicaid has not been easy. The Native American community has not been accustomed to having to apply for services that are seen as a birthright, guaranteed by treaties and laws. "Many American Indians and Alaska Natives… found it humiliating to have to reveal private information about themselves in order to have access to services to which they had been promised access," attorney Myra M. Munson told Congress last summer.

Often, the lack of knowledge about how to best approach the Native American community hampers progress. And then there are complicating matters of national boundaries and treaties. "Medicare and Medicaid are tough enough, throw in tribal issues and your eyes are spinning," said an HHS staffer.

In January, the Centers for Medicare &

[Indian Health, p.6]

Indian Health, from p. 5

Medicaid Services (CMS) stepped up its efforts to reach out to the Native American community by creating a Tribal Technical Advisory Group (TTAG). The TTAG has held three meetings so far this year, to both hear the needs and concerns of tribal leaders, and to better educate them about CMS.

ALLIES IN NEED

Alaska has a great deal at stake when it comes to maximizing Medicaid reimbursement. Alaska Natives make up 16 percent of the state population, but they account for nearly 40 percent of Medicaid clients and expenditures, according to documents from the Alaska Department of Health and Social Services. Health-care costs are high because Alaska Natives are disporportionately poor, of lower health status and more likely to live in rural areas.

The state and tribes have managed to increase Medicaid payments to Alaskan tribes from $9.6 million in FY 1991, to $149 million in FY 2003, according to state documents. But state officials are worried about a looming cut in the state's general FMAP.

In 2006, the formula that determines each state's FMAP will cut Alaska's general FMAP, which will result in a funding loss of about $53 million. In the second and subsequent years, the cut will grow to $80 million or more. "It's a big hit," Gayhart said.

The tribal nations will be an important ally in the state's efforts to stave off this cut, she added. "We support each other -- the tribes for the state on FMAP, and the state for the tribes on IHS negotiations."

Another area where states and tribal nations can be allies is in improving and expanding IHS medical facilities and services. As of 2001, there was a $900 million backlog in unmet needs for IHS facilities.

The IHS has a priority list that rates the construction needs in Indian country for ambulatory care facilities, hospitals and staff quarters, Vanderwagon said. "State legislators can become knowledgeable of that list, and see whether a facility in their district may be on that priority list, and communicate with tribal leadership about where the needs are...The average age of our facilities is 36 years."

There's a great need for construction of small ambulatory clinics, Vanderwagon added. The IHS can pay for construction, and the tribes can provide the staffing. Tribes are looking to legislators to help them find short-term, start-up money, to draw up a business plan and begin paying for staff. Once the revenue streams are flowing, the clinics can be self-supporting.

+ By Therese Droste, a freelance writer in Washington, D.C.

PARTNERSHIP FOR EXERCISE

In an effort to reduce the large health disparities between Native Americans and others, tribal nations are forming partnerships with private, government and corporate entities. "We should be partnering where we can, to try to bring in revenue streams," said Dr. Craig Vanderwagen, chief medical officer of the Indian Health Service (IHS).

On Oct. 1, the National Congress of American Indians, the IHS, the Boys & Girls Clubs of America (BGCA), and NIKE Inc. launched a one-year pilot program aimed at reducing the onset of diabetes among young Native Americans. "Together Raising Awareness for Indian Life" (T.R.A.I.L.) will take place at 25 BGCA sites on reservations. Each of the 25 T.R.A.I.L. sites received a grant of about $40,000 to run the program.

The IHS reports that Native Americans develop diabetes at 2.6 times the rate of the general population. "You see diabetes type II (in children) as young as 10 or 12 years old, which is alarming, so teaching prevention is important," said Mark Piccirilli, project director of the BGCA in Indian Country.

The T.R.A.I.L. pilot is actually a new, expanded version of a one-year, six-site pilot that wrapped up in September. The programs coordinate their efforts wit Hlocal IHS clinics and medical providers, which will conduct pre- and post-testing on the children's BMIs. Clinical data will be gathered over time to track results.

For a 12-week period, approximately 25 participating children at each site will work out for 45 minutes, five days a week. In addition, two days a week they will attend health classes, where they'll learn good eating habits, food preparation, and other healthy habits, said Piccirilli. When the kids 'graduate' after 12 weeks, they are encouraged to continue using the skills they've learned.

Nike has introduced a large corporate presence in the AI/AN community. As part of its Native American Diabetes Prevention Program, Nike works with approximately 60 tribes to help encourage more physical activity among children. Nike does this by both donating money and/or discounting products. The corporation also provides mentoring and coaching guidance. To encourage kids to walk and exercise, Professional Golf Association athlete and Native American Notah Begay III sponsors a "Walk with Me" campaign, challenging kids to walk the same number of miles he does each week on tour – which can be 5 to 7 miles.

And in an unusual corporate/government alliance, the IHS signed a Memorandum of Understanding (MOU) with Nike in 2003 to work together to promote healthy lifestyles among the Native American community. The goal is to help those communities gain a strong understanding of the importance of exercise, particularly for those with diabetes. In an agreement with the IHS, Nike holds workshops to train tribal leaders about good prevention habits. — *TD*

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TRACKING *TRENDS*

From NCSL's HEALTH POLICY TRACKING SERVICE

States Move to Safeguard Residents of Long-Term Care Facilities

The aging of the U.S. population is leading state lawmakers to focus more closely on long-term care. In 2004, they passed a number of laws designed to ensure the safety and health of the elderly and disabled in long-term care facilities.

Employee background checks are one way to help confirm residents' safety. According to the Health Policy Tracking Service, 41 states screen prospective employees' criminal histories. This year, 12 states enacted 15 laws that amend existing statutes; these include increased fines for background check violations in California, new requirements for administrator checks in Kentucky and South Carolina, and clarification of existing requirements in Mississippi and Arizona.

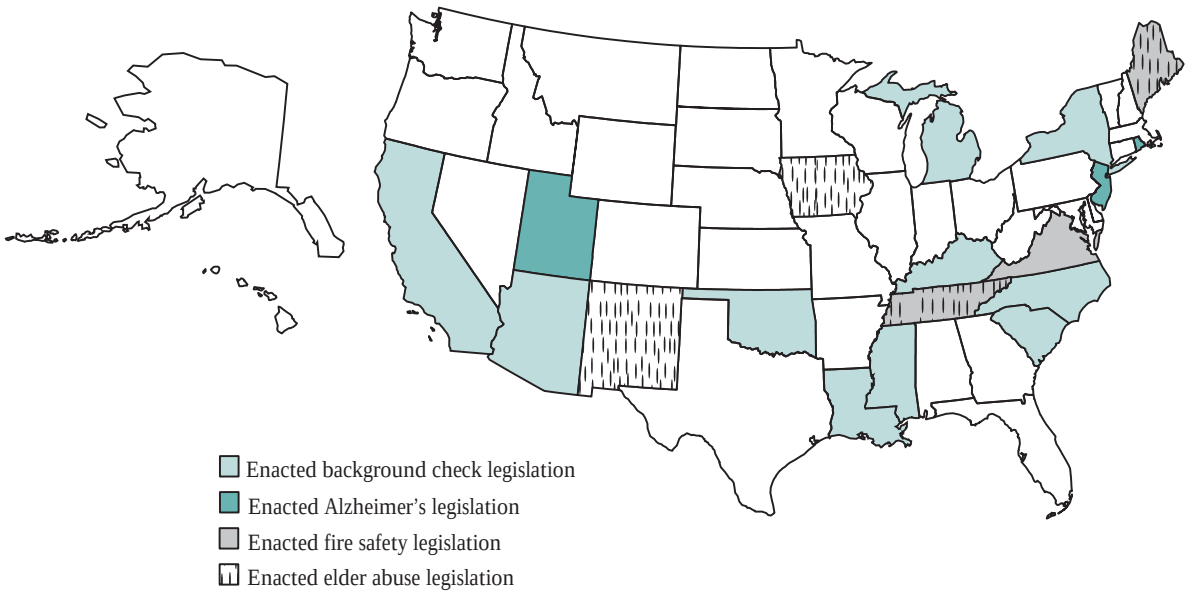
Some states enacted laws to protect individuals with Alzheimer's disease. New Jersey facilities must now maintain records of dementia-specific activities, and they also must provide specialized training for their staff. In Rhode Island, providers that house one or more individuals with Alzheimer's must employ a staffer who is licensed for dementia care. In Utah, a new law amends the Nurse Practice Act to certify licensed practical nurses who have additional training in long-term care nursing as geriatric care managers.

After fires killed a number of residents in long-term care facilities, states began beefing up fire protection. Tennessee enacted two laws that made it the first state in the nation to require that all nursing homes have full fire-sprinkler systems. In Virginia, a new law requires that smoke-detector devices be installed in all assisted living facilities and adult day-care centers, regardless of when the building was constructed.

All providers and lawmakers want to reduce elder abuse. New Jersey enacted an innovative law allowing electronic monitoring devices, or "grannycams," in assisted living facilities to help prevent abuse. Iowa, Maine and Tennessee also toughened their elder abuse laws. *RT*

For more information on this topic call (703) 531-1213 or e-mail info@hpts.org

STATE EFFORTS



FOR YOUR *INFORMATION*

Keeping Kids Out of Foster Care by Thinking "Outside the Box"

A groundbreaking program in New York enabled that state to tackle one of the most vexing of all social service problems: how do you ensure the safety of children who are being maltreated by substance-abusing parents without putting the children into foster care? The answer: get the parents into substance abuse treatment, which, if successful, may keep the family united.

Seven out of ten children served by child welfare agencies have parents with substance abuse problems, according to Jim Little, executive director of Veritas, a non-profit substance abuses services agency in New York City.

Too often, when a child welfare case worker investigates a child abuse charge, the worker simply removes the child from the home. The case worker does not consider getting the parent into outpatient substance abuse treatment, basically because substance abuse services are typically handled by one agency, while child welfare is handled by another. Combining the two services is outside the normal protocol.

This is so, even though studies show that when parents receive substance abuse services, child abuse and neglect drop significantly, foster care case loads decline, and more birth families stay intact. The economic and social impact is immense, Little said.

Realizing this, the New York state government and more than 40 substance abuse and child welfare programs came together in 2000 to create the Temporary Assistance to Needy Families (TANF) Child Welfare and Substance Abuse Partnership Initiative.

The New York State Office of Children & Family Services (OCF) and the State Office of Alcoholism & Substance Abuse Services (OASA) funded the initiative with an original $23 million. The funds placed more than 100 skilled substance abuse therapists into more than 30 child welfare programs, where they worked with parents of abused or neglected children in foster care.

LESS NEGLECT FOUND

In September 2003, the Hite Foundation gave a grant to Veritas to study the partnership's performance in 2000-2001. The results were impressive.

In upstate rural New York, for example, the Finger Lakes Addiction Counseling & Referral Agency provides full-service case management in four county Child Protective Service offices. Substance abuse staffers provide assessments and referrals to treatment to families that are participating in preventive services or foster care. Staff attend all relevant child welfare conferences and Family Court proceedings.

Veritas found that two-thirds of all parents referred to substance abuse treatment by the Finder Lakes specialists remained in treatment. And less than 5 percent of those parents had a subsequent child abuse or neglect report filed, which contrasts greatly with the rate of over 50 percent prior to the inception of the Partnership.

Veritas also found:

- Participating child welfare programs increased by 25 percent the number of birth parents who reunited with children placed in foster care.
- Children welfare programs cut the length of stay of children in foster care by more than 25 percent.
- Two-thirds of parents referred for substance abuse treatment continued their treatment, compared to less than one-quarter prior to the partnership.

"The study illustrates that real cost savings can be achieved for New York's child welfare system," John Coppola, executive director of the Alcoholism & Substance Abuse Providers of New York State. "Not only will families be better served, but the amount of public money can be nearly cut in half simply by providing outpatient services to families." In addition, children may be released earlier from foster care or kept from entering foster care altogether. *CK*

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