



19th Annual
Indian Health Research Conference

Multiple Perspectives on AI/AN Research Policy

June 4 - 7, 2007

Phoenix, AZ



Indian Health Service and Native Research Network, Inc



Welcome

Dear Conference Participants,

Welcome to the 19th Annual Indian Health Research Conference. Over the last 2 decades, this annual gathering of American Indian and Alaska Native (AIAN) researchers, students and their non-native colleagues has become one of the Nations' most important venues for the exchange of new information and scientific methodology central to the Indian Health Service (IHS) mission... to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. For the second year in a row, the Native Research Network (NRN) has played the central role in the planning and conduct of the Annual Research Conference program. I think you will see that role reflected in both the excellence of this year's program and it's relevance to the needs of the Tribes and Native communities. This year's theme, "Multiple Perspectives on AI/AN Research Policy" was selected by the NRN Board of Directors, based on the growing need to reconsider those multiple perspectives in the context of the Native research infrastructure now emerging across Indian Country, being developed by and for AIAN people and communities.

Evidence-based practice has come to be seen as a vital hallmark of modern medical care. The IHS Research Program is dedicated to creation of the practice-based evidence now needed for the best possible quality of care, specific to the needs of the AIAN populations served by the IHS. Toward that end, the development of Native researchers is just as important as the development of Native clinicians and development of research agendas by the Tribes, themselves, will help ensure that the concerns of the Tribes will be central to any research conducted by, for and/or about them. The IHS Research Program thanks the NRN for the key contributions made to this year's conference and for NRN's continuing commitment to the Annual Indian Health Research Conferences.

Sincerely,

Alan Trachtenberg, MD, MPH

IHS Research Director (acting)

Donald Warne, MD, MPH

NRN Co-chair



19th Annual Indian Health Research Conference

Table of Contents

Welcome from Conference Co-Chairs.....	next page
2007 Research Conference Planning Committee	1
Faculty List	2 - 4
Workshop/Poster Abstracts Faculty List	5 - 8
Conference Agenda	9 - 18
Map of Meeting Rooms	19
Educational Objectives for Plenary & Breakout Sessions.....	20 - 22
Poster Abstracts	23 - 29
Oral Abstracts	30 - 45
2007 Frank Dukepoo Research Award	46
Continuing Education Credits.....	47
Verification of Attendance & Request for CE	48 - 49
Presentation Evaluation	50 - 54
Conference Summary Evaluation	55
Participant List	56 - 59



2007 Research Conference Planning Committee

Co-Chairs

Indian Health Service

Alan Trachtenberg, MD, MPH

Native Research Network

Donald Warne, MD, MPH

Committee Members

Alison Ball, PhD

Dora Bradley, MPH, RN

Nathaniel Cobb, MD

Doris Cook, MPH

Gigi Holmes

Selina R. Keryte

Zeenat Mahal, MBBS, MS

Marla N. Pardilla, MPH

Tassy Parker, PhD, RN

Mary E. Mahsetkey

Terry Powell

Leslie L. Randall, RN, MPH

Yvette Roubideaux, MD, MPH

Delight E. Satter, MPH

Dean Seneca, MPH, MCURP

Phillip L. Smith, MD, MPH

Teshia G. Solomon, PhD

Lillian Tom-Orme, PhD, MPH, RN, FAAN

Lucie Vogel

Disclosure Statement:

All of the planning committee members for this course have completed the disclosure process and have declared that they have no significant financial relationships with any product or commercial manufacturer that would constitute a conflict of interest.



Indian Health Research Conference Faculty List

Raphael Bear, Yavapai
Fort McDowell Yavapai Nation- President
(Invited)
Fort McDowell Yavapai Nation
PO Box 17779
Fountain Hills, AZ 85269

Beverly Becenti-Pigman, Dine'
Chair, Navajo Nation Human Research
Review Board
P. O. Box 1202
Kayenta, Arizona 86033
(928) 697-2525 phone number
(928) 697-4826
bbp_pqh@yahoo.com

Eddie Brown, DSW, Tohono
O'odham/Pascua Yaqui
Director of American Indian Studies, Arizona
State University
American Indian Studies
College of Liberal Arts and Sciences
Campus Box 874603
Arizona State University
Tempe , Arizona 85287-4603
(480) 965-3634 (Office)
efbrown@asu.edu

CAPT James Cheek, MD, MPH, Cherokee
Director, IHS Division of Epidemiology and
Disease Prevention
Indian Health Service
5300 Homestead Rd, NE
Albuquerque, NM 87110
(505) 248-4132
James.cheek@ihs.gov

CAPT Nathaniel Cobb, MD
Chief of Chronic Disease Branch
IHS Division of Epidemiology and Disease
Prevention
Indian Health Service
5300 Homestead Rd, NE
Room # 3026
Albuquerque, NM 87110
(505) 248-4432
Nathaniel.cobb@ihs.gov

Doris Cook, Akwesasne Mohawk
NRN Co-Chair
kanestenhawi@yahoo.com

Philip Sam DeLoria, JD, Standing Rock
Sioux, American Indian Graduate Center
4520 Montgomery Blvd. NE Suite 1B
Albuquerque, NM 87109
Phone:(505) 881-4584
Toll Free:1-800-628-1920 Fax:(505)884-0427
sam@aigcs.org

Kathy Etz, PhD
National Institute on Drug Abuse
6001 Executive Blvd.
Room 5153 MSC 9589
Bethesda, MD 20852
301 402 1749 (P)
301 480 2543 (F)
ketz@nida.nih.gov

Joseph Frascella, PhD
Director, Division of Clinical Neuroscience and
Behavioral Research
National Institute on Drug Abuse
National Institutes of Health
Rm. 3164, MSC 9593
6001 Executive Boulevard
Bethesda, Maryland 20892-9593
301-443-4877
301-443-6814 (fax)
jf80t@nih.gov

William L. Freeman, MD, MPH, CIP
Director of Tribal Community Health
Programs; & Human Protections Administrator
Northwest Indian College
<http://www.nwic.edu>
Lummi Nation <http://lummi-nsn.gov>
2522 Kwina Road
Bellingham, WA 98226-9217
360-392-4284 fax 360-647-7084
wfreeman@nwic.edu

Joseph Gone, PhD, Gros Ventre
Department of Psychology
University of Michigan
2239 East Hall
530 Church Street
Ann Arbor, MI 48109-1043
Phone: 647-3958
jgone@umich.edu



Jennie Joe, PhD, MPH, Dine'
Director, Native American Research &
Training Center
1642 E. Helen
Tucson AZ 85719
520-621-5075
jrjoe@email.arizona.edu

Harriet Kuhnlein, PhD, RD
Professor, School of Dietetics and Human
Nutrition, Centre for Indigenous Peoples'
Nutrition and Environment (CINE)
McGill University, Macdonald Campus, 21111
Lakeshore Road
Sainte-Anne-de-Bellevue
QC H9X 3V9, Canada
Tel.: 514-398-7671 Fax: 398-1020/
harriet.kuhnlein@mcgill.ca

John Lewis, MA
Inter Tribal Council of Arizona, Inc.
2214 N Central Avenue, Suite 100
Phoenix, AZ 85004

Zeenat Mahal, MBBS, MS
Director, ITCA Epidemiology Center
Inter Tribal Council of Arizona, Inc.
2214 N Central Avenue, Suite 100
Phoenix, AZ 85004
Zeenat.Mahal@itcaonline.com

Sergio Maldonado, PhD, Arapaho,
Wind River Tribal College
education@northernarapaho.com

Violet Mitchell-Enos, Yavapai,
Director of Salt River DHHS
Salt River Pima-Maricopa Indian Community
10,005 East Osborn Rd.
Scottsdale, AZ 85256
(480) 850-8413
(480) 850-7383 Fax
violetmitchell-enos@saltriver.pima-maricopa.nsn.us

Leo Nolan, Akwesasne Mohawk
Senior Policy Analyst, External Affairs
Indian Health Services
801 Thompson Ave. Suite 400
Rockville, MD 20852
(301) 443-7261
Leo.nolan@ihs.gov

CAPT Charles Q. North, MD, MPH
Acting Chief Medical Officer
Indian Health Service
801 Thompson Ave. Suite 440
Rockville, MD 20852
(301) 443-1083

Tassy Parker, PhD, RN, Seneca
Assistant Professor of Family and Community
Medicine
Co-Director, Mental & Behavioral Health
Center for Native American Health
The University of New Mexico Health
Sciences Center
2400 Tucker NE, MSC09 5040
1 University of New Mexico
Albuquerque, NM 87131-0001

Jill Peters, MLS, Dine'
Director, Legislative Affairs and Community
Outreach
Office of Community Outreach
Translational Genomics Research Institute
(TGen) www.tgen.org
445 N. Fifth Street, Suite 600
Phoenix, AZ 85004
602-343-8474
jpeters@tgen.org

Terry Powell, Aleut
IRB Administrator and Member
Alaska Native Medical Center
4315 Diplomacy Drive –RMCC
Anchorage, Alaska 99508
ATTN: Terry J. M. Powell
907-729-3924 FAX 907-729-2082
tjpowell@anmc.org

Leslie L. Randall, RN, MPH, Nez Perce
Private Consultant
25311 Serenity Lane
Lapwai ID 83540
208-843-2818
leslie.randall@comcast.net

Jeff Reading, PhD, Tyendinaga Mohawk
Scientific Director,
Institute of Aboriginal People's Health
Canadian Institutes of Health Research
University of Victoria
PO Box 1700 STN CSC
Victoria, British Columbia, Canada V8W 2Y2
Tel: (250) 472-5451
Fax: (250) 472-5450
jreading@uvic.ca



Yvette Roubideaux, MD MPH,
Rosebud Sioux
The University of Arizona
500 N. Tucson Blvd, #110
Tucson AZ 85716
yvetter@u.arizona.edu

Delight E. Satter, MPH,
Confederated Tribes of Grand Ronde
Director, American Indian and Alaska Native
Research Program
UCLA Center for Health Policy Research
delight@ucla.edu
Direct phone (310) 794-2691
10960 Wilshire Boulevard, Suite 1550
Box 957143
Los Angeles, CA 90024
www.healthpolicy.ucla.edu

C. June Strickland, PhD, Cherokee
626-167th N.E.
Bellevue, WA 98008
Phone: 425-747-7268
jstrickl@u.washington.edu

Mary Beth Skupien, PhD, Sault Ste. Marie
Tribe of Chippewa Indians
Deputy Director
IHS Office of Public Health Support
Indian Health Service
12300 Twinbrook Pkwy. Suite 450A
Rockville, MD 20852
(301) 443-0222
MaryBeth.Skupien@ihs.gov

Phil L. Smith, MD, MPH, Dine'
Director, IHS Division of Planning, Evaluation
and Research
Indian Health Service
12300 Twinbrook Pkwy. Suite 450
Rockville, MD 20852
(301) 443-1549
Phillip.smith@ihs.gov

Teshia G. Arambula Solomon, PhD,
Choctaw
Co-Director, Native American Research and
Training Center, Associate Professor,
Department of Family and Community
Medicine
The University of Arizona
1642 E. Helen
Tucson, AZ 85719
Phone: 520-621-5075 Fax: 520-621-9802
Teshia.solomon@mac.com

Alan Trachtenberg, MD, MPH,
Research Director (acting),
Indian Health Service (IHS),
801 Thompson Ave. TMP 450
Rockville, MD 20852
phone: 301-443-0578; fax: 301-443-0114
email: alan.trachtenberg@ihs.gov

Karina Walters, MSW, PhD, Choctaw
Associate Professor
University of Washington
School of Social Work
4101 15th Ave. NE
Seattle, Washington 98105
Box 354900
(206) 543-5647
kw5@u.washington.edu

Donald Warne, MD, MPH, Oglala Lakota
Clinical Professor
Arizona State University
College of Law
McAllister & Orange Streets
P.O. Box 877906
Tempe, AZ 85287-7906
Donald.Warne@asu.edu

Faculty Disclosure Statement

The majority of the faculty for this course has completed the disclosure process and has declared that they have no significant financial relationships with any product or commercial manufacturer that would constitute a conflict of interest. Additionally, each faculty member has indicated that he or she will identify any experimental or "off-label" uses of any medications, and will use generic names or multiple trade names when discussing medications.

As of the time of the printing of this document, a few speakers had not completed the disclosure form.



Workshop/Poster Abstracts Faculty List

Alexandra Adams, MD, PhD
Department of Family Medicine
777 S. Mills St Madison, WI 53715
608-265-4671, FAX 608-263-5813
Alex.Adams@fammed.wisc.edu

Lorenda Belone, PhD Candidate
Associate Research Scientist
Masters in Public Health Program,
Department of Family and Community
Medicine, MSC09 5060
1 University of New Mexico
Albuquerque, New Mexico 87131-
0001, 505-272-3634
ljoel@salud.unm.edu

Anne Marie Bott, PharmD, BCPS
Critical Care Team Pharmacist
Alaska Native Medical Center
4315 Diplomacy Drive
Anchorage, AK 99508
907-729-2143, 907-729-2135
ambott@anmc.org

Patricia Bradley
Native Services Librarian
Health Sciences Library & Informatics
Center, University of New Mexico,
Albuquerque NM 87131
505-272-0664
pbradley@salud.unm.edu

Isaiah Brokenleg, MPH candidate
Great Lakes NARCH Student Intern and
Research Assistant, American Indian
Community Tobacco Project
1300 S 2nd Street Suite 300
Minneapolis, MN 55454
612-616-9721
brok0013@umn.edu

Bridget M. Canniff, MALD
Project Director, Tribal EpiCenter
Consortium, Northwest Portland Area
Indian Health Board
527 SW Hall, Suite 300
Portland, OR 97205
503-228-4185, fax 503-228-8182
bcanniff@npaihb.org

Jenny Chong, PhD
Research Assistant Professor
University of Arizona
1501 N Campbell, Room 7301
Tucson, AZ 85724
520-495 0421, 520-621-2111
jchong@u.arizona.edu

Diana Cournoyer, MEd
Native American Tobacco Education
Network, Southern Plains Inter-Tribal
Epidemiology Center, Oklahoma City
Area Inter-Tribal Health Board, PO Box
57377
Oklahoma City, OK 73157-7377
(405) 951-6005x107 (405) 951-
6006/3902
diana.cournoyer@ihs.gov

Ann Drobnik, MPH
STD/HIV Coordinator, Northern Plains
Tribal Epidemiology Center
1770 Rand Road
Rapid City, SD 57702
605-721-1922 x106
epidrobnik@aatchb.org

Christine Dubray, MD, MS
Epidemic Intelligence Service Officer
Indian Health Service Division of
Epidemiology and Disease Prevention
5300 Homestead Road NE
Albuquerque, NM 87110
505-248-4234, 505-248-4393
Christine.dubray@ihs.gov

Kelley Ellis
NARCH Research Assistant,
Confederated Tribes of Siletz Indians
P O Box 549/201 SE Swan Avenue
Siletz, OR 97380
541-444-8227 FAX: 541-444-9688
kelleyr@ctsi.nsn.us



Leah Frerichs, MS, Program Manager
Northern Plains Comprehensive Cancer
Control Program, Aberdeen Area Tribal
Chairmen's Health Board
1770 Rand Road
Rapid City, SD 57702
605-721-1922 ext 110, 605-721-1932
epifrerichs@aatchb.org

Karen Garcia, MPH, Epidemiologist
California Rural Indian Health Board,
California Tribal Epidemiology Center
4400 Auburn Blvd 2nd Floor
Sacramento, CA 95841
916-929-9761 ext. 1042; (fax) 916-929-
7246; karen.garcia@crihb.net

Maria R. Garcia, DC, BS
Program Manager
Alternative Medicine
Pascua Yaqui Tribe Health Programs
7490 S. Camino de Oeste
Tucson, AZ 85757

Kapuaola Gellert, MPH
Oregon Health & Science University,
Public Health & Preventive Medicine,
3181 SW Sam Jackson Park Road,
CB669
Portland, OR 97239, Phone: (503) 494-
1175, Fax: (503) 494-7536
gellertk@ohsu.edu

Jessica Goodkind, PhD
Assistant Professor
University of New Mexico Department of
Pediatrics, MSC11 6145
Albuquerque, NM 87131
505-272-0046, 505-272-4857,
jgoodkind@salud.unm.edu.

Kyla Hagan, MPH, Epidemiologist
ANTHC – EpiCenter
4000 Ambassador Drive, C-DCHS,
Epidemiology Center
Anchorage, AK 99508
907-729-4568
kdhagan@anmc.org

Irina V. Haller, PhD, MS
Senior Research Scientist,
SMDC Health System Division of
Education & Research
503 East Third Street, Ste 200
Duluth, MN, 55805
Ph: 218-786-8185, Fax 218-786-3835
IHaller@smdc.org

Laurie Helzer, MPH, Senior Researcher
Southcentral Foundation
4501 Diplomacy Drive
Anchorage, AK 99508
907-729-5489, 907-729-5464
lhelzer@SouthcentralFoundation.com

Adeola O. Jaiyeola, MD, MHSc
Director, Northern Plains Tribal
Epidemiology Center (NPTEC),
AATCHB 1770 Rand Rd
Rapid City, SD 57702
605-721-1922 ext. 115, 1-800-746-3466
drajaiyeola@aatchb.org

Stacey Jolly, MD
UCSF General Internal Medicine
Clinical Research Fellow
Box 1364
San Francisco, CA 94143-1364
ph 415-206-5135, fax 415-206-5586
sjolly@medsfgh.ucsf.edu

Xenia T. King, PhD
Research Associate
Native American Research and
Training Center UA
1642 E Helen St
Tucson, AZ 85719
520-229-9969, 520-621-9802
xnkn@email.arizona.edu

Carol Korenbrot, PhD
Research Director,
California Rural Indian Health Board
4400 Auburn Blvd
Sacramento CA 95841
(916) 929-9761
carol.korenbrot@crihb.net

Rochelle Lacapa, MPH Candidate
Johns Hopkins Bloomberg School of
Public Health Center for American Indian
Health
621 N Washington St
Baltimore, MD 21205
(410) 955-6931
rlacapa@jhsph.edu

Luisa P. Machuca, MS
Research Associate
1104 Hillcrests Drive
Anchorage, Alaska 99508
907-729-5491, 907-729-5464
aslpm@uaa.alaska.edu



David Mark, MD, Chief Medical Officer
Crow-Northern Cheyenne IHS Hospital
P.O. Box 9
Crow Agency, MT 59022
406.638.3309, 406.638.3572
david.mark@ihs.gov

Archana Minnal
4825 Hazel Ave. #73
Fair Oaks, CA 95628
archana_minnal@hotmail.com

Cynthia Naha
Environmental Programs Coordinator
Inter Tribal Council of Arizona, Inc
2214 N Central Ave , Suite 100
Phoenix, AZ 85004
602-258-4822, 602-258-4825
Cynthia.Naha@itcaonline.com

Ann Nicometo
Mayo Clinic Cancer Center
Native American Programs
200 First Street SW
Rochester, MN 55905
507-266-9755, 507-266-2478
MayoIHSpartnership@mayo.edu

Natalia T. Orosco
16152 Kumeyaay Way
Valley Center, CA 92082
(760) 560-7200
nataliao@sanpasqualtribe.org

Tassy Parker, PhD, RN, Assistant
Professor Co-Director, Mental and
Behavioral Health, UNM HSC Center for
Native American Health,
1001 Medical Arts NE
Albuquerque, NM 87102
(505)272-9873
taparker@salud.unm.edu

Kathleen E Perkins, MPA, Director
Population Health Programs, Medical
Care Development, Inc
11 Parkwood Drive
Augusta, ME 04330
Ph 207-622.7566 x225
KPerkins@mcd.org

Wesley Petersen, PhD, Mayo Clinic
Cancer Center Native American
Programs
200 First Street SW
Rochester, MN 55905
507-266-2204, 507-266-2478
peterw@mayo.edu

V. Lynn Peterson, MPH,
Epidemiologist, ANTHC – EpiCenter
4000 Ambassador Drive, C-DCHS,
Epidemiology Center
Anchorage, AK 99508
907-729-4562
vlpeterson@anmc.org

Kimmine Pierce
Chronic Disease Epidemiologist, Great
Lakes Inter-Tribal Council Epidemiology
Center
P O Box 9, 2932 Hwy 47
Lac du Flambeau, WI 54538
tel:715-588-3324 ext 229 fax:715-588-
3607 kpierce@qlitc.org

Ellen M. Provost, DO, MPH, Director
Alaska Native Epidemiology Center
4000 Ambassador Drive, C-DCHS,
Anchorage, AK 99508
Phone: 907-729-2923, Fax: 907-729-
4569 emprovost@anmc.org

David Quincy, MPH-HA
Health Systems Specialist
Bemidji Area IHS
522 Minnesota Ave NW
Bemidji, MN 56601 Tel (218) 444-0471
David.Quincy@ihs.gov

Christine Rinki, MPH
Northern Plains Tribal Epidemiology
Center
1770 Rand Road
Rapid City, SD 57702
605-721-1922 x120
epirinki@aatchb.org

Susan Jill Roskopf
Assistant Researcher
University of Wisconsin – Milwaukee,
College of Health Sciences, PO Box 413
Milwaukee, WI 53201
414-229-3121, 414-229-2619
sroskopf@uwm.edu



Cleora B. Scott, BS, Project Specialist
Data into Action, Northwest Portland
Area Indian Health Board
527 SW Hall, Suite 300
Portland, Oregon 97201
501-228-4185
cscott@npaihb.org

Louise Shavings, MSW
Research Associate
900 Jayme Court
Anchorage, AK 99518
(907) 770-8994
lshavings@yahoo.com

Kristen Speakman, MA, MPH
Program Manager, Johns Hopkins
Center for American Indian Health
8205 Spain Rd NE Suite 110
Albuquerque NM 87109
505-323-4065, 404-400-6174
kspeakma@jhsph.edu

Maile Taulii, MPH, Associate Director
Urban Indian Health Institute, Seattle
Indian Health Board, PO Box 3364
Seattle, Washington 98114-3364
Phone (206) 812-3030, Fax (206) 812-3044
Mailet@uihi.org

Lisa R. Thomas, PhD
Research Scientist
Alcohol and Drug Abuse Institute,
University of Washington, 1107 NE 45th
St, Suite 120, Seattle, WA, 98105 206
897-1413, 206 543-5473
lrthomas@u.washington.edu

Matthew Town, MPH
Navigator Project Director, Northwest
Portland Area Indian Health Board
527 SW Hall, Suite 300
Portland, OR 97201
503-228-4185, 503-228-1472
mtown@npaihb.org



19th Annual Indian Health Research Conference

Multiple Perspectives on AI/AN Research Policy

June 4 - 7, 2007

AGENDA

Monday, June 4 Pre-Conference Sessions

1:00 - 4:00 pm

Workshops

Crescent III

Research Participant Protection-Town Hall and Training Workshop

Leslie Randall, RN, MPH, *Nez Perce*
NRN Past Co-Chair, NRN Secretary

Doris Cook, *Akwesasne Mohawk*
NRN Co-Chair

Alan Trachtenberg, MD, MPH
IHS Research Director (acting) and Human Research Protection Administrator

Crescent A

NIH Grant Applicant Training

Joseph Frascella, PhD
Director, Division of Clinical Neuroscience and Behavioral Research
National Institute on Drug Abuse, National Institutes of Health

Kathleen Etz, PhD
Division of Epidemiology, Services and Prevention Research
National Institute on Drug Abuse, National Institutes of Health

1:00 - 5:00 pm

Invited Session

Phoenix A

Tribal Epidemiology Centers Directors Meeting - Invitation only

CAPT James Cheek, MD, MPH, *Cherokee*
Director, IHS Division of Epidemiology and Disease Prevention

4:00 - 5:00 pm

Invited Session

Crescent II

IRB Chairs Meeting

Phil Smith, MD, MPH, *Dine'*
Director, IHS Division of Planning, Evaluation & Research

Alan Trachtenberg, MD, MPH
IHS Research Director (acting) and Human Research Protection Administrator

6:00 - 8:00 pm

Welcome Reception - Heard Museum

Sponsored by the Inter Tribal Council of Arizona, Inc.



Tuesday, June 5

Plenary Session: Policy Issues

8:00 - 8:20 am	Opening Session
Crescent Ballroom A/B	Blessing – Dino Haley (Dine') Marc Harrison Remembrance – Donald Warne, MD, MPH
8:20 - 9:00 am	Opening Remarks Phil Smith, MD, MPH, <i>Dine'</i> <i>Director, IHS Division of Planning, Evaluation & Research</i> Donald Warne, MD, MPH, <i>Oglala Lakota, NRN Co-Chair</i> <i>Arizona State University</i> Raphael Bear, <i>Yavapai</i> <i>Fort McDowell Yavapai Nation- President (Invited)</i>
9:00 - 9:20 am	Welcome from the IHS CAPT Charles Q. North, MD, MPH <i>Acting Chief Medical Officer, Indian Health Service</i>
9:20 - 10:20 am	The Community's Role in Research Jennie Joe, PhD, <i>Dine'</i> <i>Native American Research & Training Center,</i> <i>University of Arizona</i>
10:20 - 10:40 am	Refreshment Break Sponsored by Arizona State University
10:40 - 11:40 am	US and Canadian Research Policies Moderator: Dr. Donald Warne Jeff Reading, PhD, <i>Tyendinaga Mohawk, Scientific Director</i> <i>Institute of Aboriginal People's Health</i> <i>Canadian Institutes of Health Research</i> Leo Nolan, Akwesasne Mohawk Senior Policy Analyst, External Affairs, <i>Indian Health Services</i>
11:40 am - 12:00 pm	Frank Dukepoo Award Presentation Presenters - Donald Warne & Doris Cook, <i>NRN Co-Chairs</i> Recipient - Dr. Jennie Joe IHS Research Awards – Dr. Phil Smith, Presenter Introduction of Scholar/Scribes Doreen Bird, BA, <i>Santo Domingo Pueblo</i>
12:00 pm - 1:00 pm	Lunch on your own



1:00 - 1:30 pm

Poster Session

Crescent C

1. **Northwest Tribal Cancer Navigator Program: Addressing Barriers To Care In Indian Country.** Victoria Warren-Mears, *Matthew Town, Jenine Dankovchik, Christine Merenda, Sandra Hahn, Leah Hardy, Mary Loy
2. **Effects Of Acculturation On Substance Abuse Among Siletz Tribal Members.** *Kelley Ellis, Delina John, Claire Wood
3. **Developing And Piloting A Historical Trauma Mental Health Program In Indian Country: A Community-Based Participatory Research Approach.** Jessica Goodkind, *Eugene Tsinajinnie, *Lance Freeland, Christopher Lee.
4. **Building A Regional Coalition For A Native American Cancer Control Program: Lessons Learned.** Leah Frerichs*, Shinobu Watanabe-Galloway, Tinka Duran.
5. **Finding Culturally Competent Health Care Literature About American Indians: Which Database Is Best?** Patricia Bradley, Patricia Auflick.
6. **A Feasibility Study Of An Electronic Record And Tracking System For Use By Nurses Who Perform Breast & Cervix Cancer Screening Exams In Indian Health Service And Tribal Clinics.** *Wesley Petersen, Ann Nicometo, Mary Alice Trapp, Piet De Groen, Judith Kaur
7. **Developing An Alliance: The Indian Health Service And Mayo Clinic Partnership.** *Ann Nicometo, Wesley Petersen, Lisa Baethke, Mary Alice Trapp, Piet De Groen, Cynthia Claus, Judith Kaur
8. **Community Characteristic Effects On Health Outcomes Of Aian Relying On Tribally-Operated Health Programs.** Carol Korenbrot, Chi Kao And James Crouch.
9. **American Indian Science Scholars Program At The University Of Wisconsin – Milwaukee.** *Susan J. Roskopf, *Brian J. Jackson, Mary K. Madsen.
10. **Exploitation Of Native American Culture: Dissemination Of Project Titan Findings.** *Jillian Doss, Mph, *Diana Cournoyer, Vicki Tall Chief, Edd, Laura Beebe, Phd.
11. **Self-Rated Health Status Of Isleta Pueblo Elderly.** Natalia T. Orosco
12. **Determinations Of The Extent Of Unmet Health Needs For Natives In California.** *Karen Garcia, Chi Kao, Carol Korenbrot, James Crouch..

1:30 - 2:45 pm

Invited Speaker Sessions

Crescent A

Human Subjects Protections and Community Protections

Eddie Brown, DSW, *Tohono O'odham/Pascua Yaqui*
Director of American Indian Studies, Arizona State University

Philip Sam DeLoria, JD, *Standing Rock Sioux*
American Indian Graduate Center



Crescent B	Principles of Community Based Participatory Research Harriet Kuhnlein, PhD, RD <i>Centre for Indigenous Nutrition and Environments</i> <i>McGill University</i>
	June Strickland, PhD, RN, <i>Cherokee</i> <i>University of Washington School of Nursing</i>
Phoenix C	Research Design and Small Populations Zeenat Mahal, MBBS, MS <i>Director, ITCA Epidemiology Center</i>
2:45 - 3:00 pm	Refreshment Break
3:00 - 4:15 pm	Invited Speaker Sessions
Crescent A	Tribal IRB Processes Beverly Pigman, <i>Dine'</i> <i>Navajo Nation IRB</i>
	Terry Powell, <i>Aleut</i> <i>Alaska Native Medical Center IRB Member</i>
Crescent B	Conducting Research in Urban Indian Communities Karina Walters, MSW, PhD, <i>Choctaw</i> <i>University of Washington</i>
	Delight Satter, MPH, <i>Umpqua/Klickitat</i> <i>UCLA – Center for Health Policy Research</i>
Phoenix C	Tribal and University Partnerships Yvette Roubideaux, MD MPH, <i>Rosebud Sioux</i> <i>University of Arizona</i>
	John Lewis, <i>Mohave</i> <i>Inter Tribal Council of Arizona</i>
	William Freeman, MD, MPH <i>Tribal Community Health Programs, Northwest Indian College</i>
Crestview	Cultural Competence and Investigator Training Donald Warne, MD, <i>Oglala Lakota</i> <i>Arizona State University</i>
	Leslie Randall, RN, MPH, <i>Nez Perce</i> <i>Private Consultant</i>
4:20-5:00 pm	Breakout Summaries and Door Prizes
5:30 - 7:30 pm	Native Research Network, Inc. Annual Membership Meeting
Crestview	



Wednesday, June 6

Plenary Session: Emerging Research Issues

Crescent Ballroom A/B

8:30 - 9:00 am

Blessing - Sergio Maldonado, *Arapaho*
Opening Remarks

Doris Cook, *Akwesasne Mohawk*,
NRN, Co-Chair

Mary Beth Skupien, PhD, *Sault Ste. Marie Tribe of Chippewa Indians*
Deputy Director, IHS Office of Public Health Support

9:00 - 10:30 am

Intellectual, Spiritual, and Cultural Property

Joseph Gone, PhD, *Gros Ventre*
University of Michigan

Philip Sam DeLoria, JD, *Standing Rock Sioux*
American Indian Graduate Center

Sergio Maldonado, PhD, *Arapaho*,
Wind River Tribal College

10:30 - 10:45 am

Refreshment Break

Sponsored by the Translational Genomics Research Institute

10:45 - 11:30 am

Genetics Research Issues

Donald Warne, MD, MPH, *Oglala Lakota*
Arizona State University

11:30 - 11:45 am

A Collaborative Research Partnership Between The Salt River Pima-Maricopa Indian Community and the Translational Genomics Research Institute

Violet Mitchell-Enos, *Yavapai*
Executive Director of Salt River Health and Human Services

Jill Peters, MS, *Dine'*
Director, Community Outreach, Translational Genomics Research Institute

11:45 - 12:00 pm

Announcements

Tassy Parker/Alan Trachtenberg

12:00 - 1:00 pm

Lunch on your own

1:00 - 1:30 pm

Poster Sessions

Crescent C



1:30 - 2:45 pm

Breakout sessions

Crescent A

Session 1

Using Collaborative Research To Address Health Disparities: Two Examples.

*Jennie R. Joe, Kris Olsen-Garewal, Maria R. Garcia.

Negotiating Community Participatory Evaluation In One Tribal Community.

*Xenia T. King.

Using Data To Create Positive Change In Tribal Communities: The Tribal Epicenter Consortium. *Bridget M. Canniff, Robin Kinnard, Karen Garcia.

Crescent B

Session 2

Innovative Strategies For Increasing Colorectal Cancer Screening Among Alaska Native People. *V. Peterson, E. Provost, D. Espey, C. Christensen, F. Sacco.

Improving American Indian Cancer Surveillance And Data Reporting In Wisconsin: A Community Based Participatory Research Process. *Kimmie Pierce, Jackie Matloub, Laura Stephenson, Rick Strickland.

Do Records Of Breast Cancer Cases Seen At PIMC Appear In The ACR?

*Archana Minnal, Tim Flood, Kathleen Evans, Shannon Myers, Charlton Wilson.

Phoenix C

Session 3

Bone Health And Vitamin D Status In American Indian Women. *Irina V. Haller, Julia (Bunny) Jaakola, Neil Binkley.

Disparities in Use of Cardiac Procedures for Heart Disease among American Indian/Alaskan Natives (AI/AN) and Whites in California. *Stacey Jolly, Chi Kao, Andrew Bindman, Carol Korenbrot.

Risk Factors For Hearing Loss And Tinnitus Among Northwest American Indians. Kapuaola Gellert*, Jodi Lapidus, William H. Martin, Thomas Becker.

Crestview

Session 4

Legal, Social, Educational, And Mental And Behavioral Health Characteristics Of New Mexico Native American Youth Detainees. Tassy Parker, *Billie Kipp, Gayle Dine'Chacon, Rebecca Ballantine, Bernie Teba.

A Model For Program Sustainability: The Transfer Of The Family Spirit Home-Visiting Program For Adolescent American Indian Parents To Tribal Public Health Nursing Programs. Kristen Speakman, Allison Barlow, Tennille Marley, *Louise Yazzie, Wilpita Bia, Elena Varipatis-Baker, Jill Moses.

Low Prevalence Of Pediatric Asthma Among American Indian Youth In Southeastern Montana. *David Mark and Melissa Roberts.

2:45 - 3:00 pm

Break



3:00 - 4:15 pm

Breakout Sessions

Crescent A

Session 1

Using The Circle Of Strength To Promote Family Participation. Jenny Chong*, Yvonne Fortier, Dino Haley, Amberly Atene and Sheryl Caponera.

Healing Of The Canoe: The Community Pulling Together To Prevent Youth Substance Abuse And Promote Cultural Identity And Belonging. *Lisa R Thomas, *Robin Sigo, Dennis M Donovan, Gidget Lincoln, Lisette Austin.

Exploring The Unraveling Hoop: Tobacco Use, Abuse, And Tobacco Abuse Predictive Factors Among Urban American Indian Youth In Minnesota. *Isaiah Brokenleg, Kris Rhodes, Jean Forster, Cynthia Davey, for the American Indian Community Tobacco Project Steering Council.

Crescent B

Session 2

Native American Family Intervention Project: Community Based Participatory Research Process Involving A University And Two Southwest American Indian Tribes. *Lorenda Belone, Nina Wallerstein, Bonnie Duran, John Oetzel, Greg Tafoya, Rebecca Rae, Erica Rodriguez. Tribal Organizers Jemez: Harriet Yepa-Waquie, Anita Toya, Willie Waquie, Carol Gachupin, *Dominic Gachupin, *Leah H. Stevenson; Ramah Navajo: Jennifer Henio, *Ira Burbank, Phoebe Maria, *Lula Kelhoyouma Yin-Mai Lee & Carolyn Finster.

Lessons Learned In Tribal Consultation In Meeting The Needs Of American Indian/Alaska Native Communities. Matthew Town, *Cleora Scott.

Changing Epidemiology Of Invasive Pneumococcal Disease Among White Mountain Apache Persons In The Era Of Pneumococcal Conjugate Vaccine. *Rochelle Lacapa, Sandra J. Bliss, Francene Larzelere-Hinton, Kathryn J. Eagle, Debra J. McGinty, Alan Parkinson, Mathuram Santosham, Mariddie J. Craig, Katherine L. O'Brien.

Phoenix C

Session 3

Using The State Behavioral Risk Factor Surveillance System (BRFSS) Data To Assess The Behavioral Health Risks Of American Indian Adults In Nebraska. *Shinobu Watanabe-Galloway, Francine Romero, Liyan Xu, Sayaka Kanade, *Adeola O. Jaiyeola

Alaska Native Mortality Update: 1999 – 2003. Gretchen Day, * Ellen Provost, Lanier, Anne.

Non-Fatal Hospitalized Suicide Attempts Among Alaska Native People From 1991-2004. *Laurie J. Helzer, Ryan Hill, Martha Moore, Ruth A. Etzel.



Crestview

Session 4

Healthy Children, Strong Families: Baseline Data. Alexandra Adams, Kate Cronin, SuAnne Vannatter, Tara LaRowe, *Ron Prince.

South Dakota Tribal PRAMS: Adapting The CDC Pregnancy Risk Assessment Monitoring System Surveillance Protocol To Serve South Dakota American Indian Communities. *Christine Rinki, *Glenn Drapeau, Ssu Weng

Trends In Antimicrobial Prescribing Rates For Alaska Native Children And Adolescents. Anne Marie Bott*, Michael G Bruce, Tom W Hennessy, Lisa Bulkow.

7:30 - 9:00 pm

Crescent A

National Heart, Lung and Blood Institute (NHLBI) Grantee Meeting: Projects on Community-responsive Interventions to Reduce Cardiovascular Risk in AI/AN. Jared Jobe, PhD, Program Official, NHLBI



Thursday, June 7

**Plenary Session:
NARCH Programs and Epidemiology Centers**

Crescent Ballroom A/B

8:00 - 8:30 am **Blessing** - Joseph Enos (Tohono O'odham)

Welcome

Teshia Solomon, PhD, *Choctaw*
Native American Research and Training Center, University of Arizona

CAPT Nathaniel Cobb, MD
Chief of Chronic Disease Branch
IHS Division of Epidemiology and Disease Prevention

8:30 - 9:30 am **Differences Among Evaluation, Public Health Practice and Research**

Phil Smith, MD, MPH, *Dine'*
Director, IHS Division of Planning, Evaluation & Research

9:30 - 9:45 am **NARCH Program Overview**

Alan Trachtenberg, MD, MPH
IHS Research Director (acting) and
Human Research Protection Administrator

9:45 - 10:00 am **Epi Centers Overview**

CAPT Nathaniel Cobb, MD
Chief of Chronic Disease Branch
IHS Division of Epidemiology and Disease Prevention

10:00 - 10:15 am **Break**

10:15 - 12:00 pm **Breakout Sessions**

Crescent A
Session 1

Methamphetamines And The Environment. Cynthia Naha and Jerome Clark

Working With A Regional Coalition To Improve STD And HIV/AIDS Prevention And Control In Northern Plains Tribal Communities. *Ann M. Drobnik.

Hepatitis C Virus Infection Among American Indian Women Seeking Prenatal Care — Northern Plains, 2005–2006. *Christine Dubray, John T. Redd, Kathy Byrd, Supriya Janakiraman, Cecile M. Town, James E. Cheek.

Crescent B
Session 2

Creating An Alaska Tribal Regional Health Profile. *Kyla Hagan, Ellen Provost.

Bemidji Area Urban American Indian/Alaska Native Health Assessment Pilot Project. David Quincy, Kristin Hill, Alice Park.

Exemplifying Community Based Participatory Research; Envisioned, Designed, And Conducted Entirely By An Urban Indian Community. *Maile Taualii, Ursula Tsosie, Alice Park, * Mei Castor, Ralph Forquera.



12:00 pm **Closing Blessing - Dino Haley (Dine')**

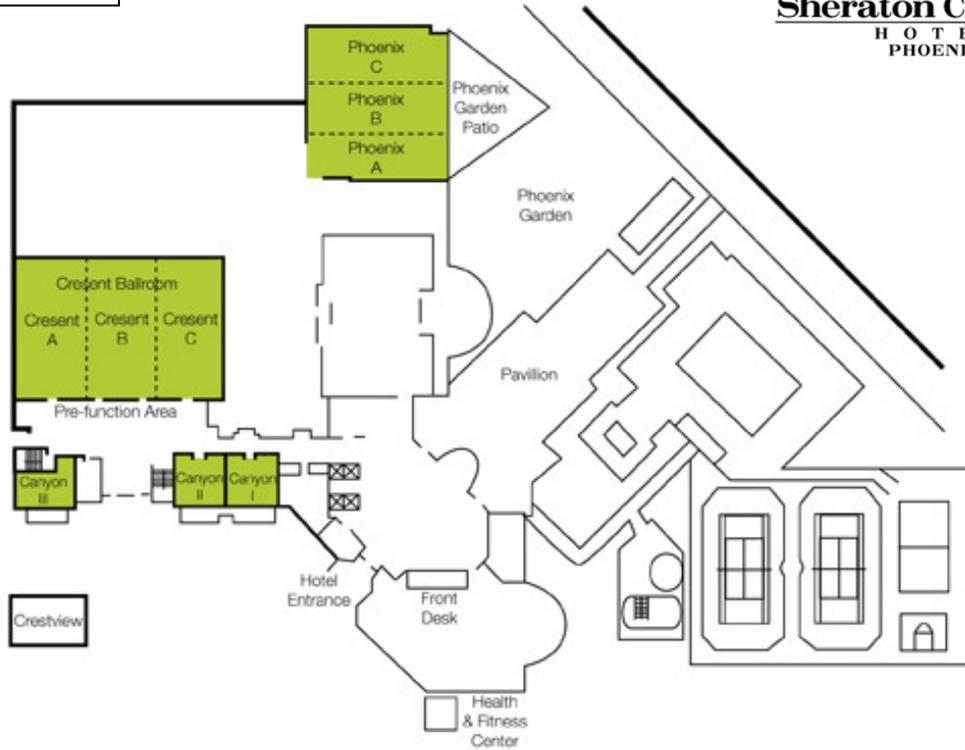
1:00 - 4:00 pm **NARCH Investigators' Town Hall Meeting**

Crescent C

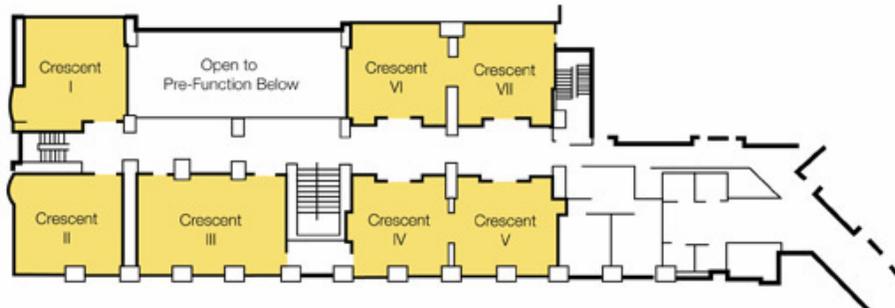


Map of Meeting Rooms

First Floor



Second Floor





Educational Objectives for Plenary & Breakout Sessions

Tuesday, June 5, 2007

The Community's Role in Research

1. Describe the importance of community participation in research and the impact it has on improving clinical care.
2. Describe effective approaches that facilitate community involvement in research.

US and Canadian Research Policies

1. Identify similarities and differences in policies and how they affect research and clinical care of native people and communities.
2. Describe different approaches to community and Tribal participation in the research planning process.

Human Subjects Protections and Community Protections

1. Identify issues related to protection of individuals and communities from research-related harms.
2. Review important features of community input into protection from research-related harms.

Principles of Community Based Participatory Research

1. List at least two major differences between CBPR and community organization.
2. List and discuss at least two challenges for research in conducting CBPR.
3. List at least two reasons why CBPR is preferred in tribal communities.

Research Design and Small Populations

1. Describe how research design is affected by the size of the population to be studied.
2. Discuss how small populations can be handled safely and scientifically.

Tribal IRB Processes

1. Describe how Tribal IRBs are formed and operated.
2. Describe successful partnerships with Tribal IRBs that facilitate the overall health and wellbeing of AI/AN people.

Conducting Research in Urban Indian Communities

1. Describe how health is affected in Urban Indian Communities.
2. Identify successful approaches with Urban Indian Communities related to conducting research.

Tribal and University Partnerships

1. Create and sustain successful partnerships between Tribes and universities to promote and enhance the health and the health research of Tribes and Tribal organizations.
2. Identify pitfalls, problems and potential solutions in the partnership process.

Cultural Competence and Investigator Training

1. Explore issues of cultural competence to conduct health research with AI/AN communities.
2. Articulate cultural competence training needs for new and experienced investigators.

Wednesday, June 6, 2007

Intellectual, Spiritual, and Cultural Property

1. Identify proprietary issues in the use, generation, collection and exploitation of Intellectual, Spiritual, and Cultural knowledge.
2. Explore approaches to resolution of these issues.

Genetics Research Issues

1. Identify issues in genetics research, especially as they apply to AI/AN subjects.
2. Review and critique current problems and approaches related to genetics research.



A Collaborative Research Partnership Between The Salt River Pima-Maricopa Indian Community and the Translational Genomics Research Institute

1. Identify the issues raised by Tribal partnership and ownership in translational genomics.
2. Describe a successful Tribal collaborative approach to address certain issues in genetics research.

1:30 - 2:45 pm - Breakout Sessions

Crescent A Session 1

1. Assess research needs in partnership with various kinds of Native communities.
2. Describe the issues surrounding data-sharing with regard to technological availability and acceptance, integration across tribal units, willingness to share intra-tribally, and concerns regarding internal and external use.
3. Describe the mechanisms needed to undertake and coordinate joint health research projects between different kinds of partners.

Crescent B Session 2

1. Develop a better understanding of the disparities in mortality that exist for Alaska Native people.
2. Describe how cancer profiles and an aggregate profile were developed through the use of community based participatory research methodology.
3. Describe the process of analyzing data from the ACR to determine completeness for American Indian/Alaska Native (AI/AN) female breast cancer cases.

Phoenix C Session 3

1. Describe the bone health and vitamin D status in indigenous populations of North America.
2. Describe access to life-saving cardiac procedures for AI/AN with ischemia-related heart disease (IHD).
3. Identify the predictors of hearing loss among AIAN.

Crestview Session 4

1. Identify potential risk factors of New Mexico Native American Youth Detainees.
2. Describe the process for transferring an evidence-based home visiting program for American Indian parents to promote maternal and child.
3. Describe the occurrence and prevalence of asthma in certain AIAN youth.

3:00 - 4:15 pm - Breakout Sessions

Crescent A Session 1

1. Discuss how to adapt outcome measures and measure the quality of the collaborative research relationship.
2. Describe the factors associated with youth substance use and abuse.

Crescent B Session 2

1. Review various approaches to defining research needs and opportunities
2. Describe the epidemiology of invasive Pneumococcal Disease among White Mountain Apache persons.

Phoenix C Session 3

1. Describe how existing data can be used to describe and interpret health risks of AIAN populations.
2. Recognize the leading causes of mortality among Alaska Native people from 1999-2003.

Crestview Session 4

1. Examine the benefits to tribes of implementing a population-based maternal and infant health risk surveillance project.
2. Describe the patterns of antimicrobial prescriptions to Native youth in the Anchorage region from 1992 to 2004.



Thursday, June 7, 2007

Differences Among Evaluation, Public Health Practice and Research

1. Differentiate between the various kinds of activities that may or may not be seen as health research in different contexts.
2. Describe available approaches, within current regulations, for determination of the type of activity a new project may represent and the appropriate regulatory requirements for that project.

10:15 - 12:00 pm - Breakout Sessions

Crescent A Session 1

1. Address areas of health disparity including STDs and HIV/AIDS and beyond by increasing collaboration and communication between health agencies involved.
2. Describe the epidemiology of HCV infection among American Indian women in the Northern Plains.

Crescent B Session 2

1. Describe how a health profile for a region can be compiled and utilized while learning the strengths and weaknesses of accessing and using regional level data.
2. Describe approaches, methodologies and types of data that may be used to better understand the health issues of the target population.



Poster Abstracts

Northwest Tribal Cancer Navigator Program: Addressing Barriers To Care In Indian Country. Victoria Warren-Mears, *Matthew Town, Jenine Dankovchik, Christine Merenda, Sandra Hahn, Leah Hardy, Mary Loy

Background: For many cancer sites, AI/ANs have worse outcomes and lower survival than other racial/ethnic groups. Lack of access to adequate cancer screening and treatment remains a major cause of higher cancer morbidity in tribal communities. Additionally, funding limitations and cultural, social and geographic barriers to cancer care are further challenges specific to tribal communities. While the cancer navigator model has been shown to be effective in reducing barriers to care in other underserved communities, it has not been widely implemented in Indian communities. **Methods:** Four intervention tribes and four comparison tribes have been recruited to participate in the study. The intervention tribes will have Navigators employed at the clinics that will see all cancer patients wishing to be involved, and will collect data on those with abnormal screenings for breast, colorectal, prostate or cervical cancer. Comparison sites will be recruited and will receive stipends and documentation of their cancer patient populations. **Conclusions:** This project is one of the first of its kind and is designed to provide a map for those wishing to establish patient navigator programs in other AI/AN communities. If proven effective, the findings of Northwest Tribal Cancer Navigator Program will provide policy-makers solid evidence on which to base funding decisions regarding use of this method of reducing the burden of cancer among American Indians and Alaska Natives.

For Further information: Matthew Town, MPH. Navigator Project Director, Northwest Portland Area Indian Health Board, 527 SW Hall, Suite 300, Portland, OR 97201. 503-228-4185, 503-228-1472. mtown@npaih.org

Effects Of Acculturation On Substance Abuse Among Siletz Tribal Members. *Kelley Ellis, Delina John, Claire Wood

Background: Research among Native Americans in the Pacific Northwest has found that the “traditional worldview” increases resilience and decreases use of mood altering substances. The Confederated Tribes of Siletz Indians conducted a research study by administering a series of surveys to investigate and identify cultural attitudes, beliefs and substance use. **Methods:** The study was conducted in two phases. In phase 1, 1000 adult Siletz tribal members were randomly selected from the rolls to receive a mailed out survey. In phase 2 personal interviews were conducted with volunteer participants from phase 1. Both phases included surveys with tribal members self-reporting on demographics, cultural attitudes and beliefs, and substance abuse. **Results:** We received 108 completed phase 1 surveys. Of the 108 respondents 59% were women. Although 91% had a high school diploma or GED or higher education, 47% earned less than \$20,000 annually. More men and women self identified as culturally contemporary rather than traditional. 69% of the respondents were in the normal range of alcohol consumption, 19% were at risk, and 12% were potential alcoholics. Alcohol abuse appeared more frequently in the men; 65% of the at-risk or potential alcoholic respondents were male. We interviewed 32 volunteers in phase 2, 59% were men. **Conclusions:** The results of the study indicate that traditional activities should be presented to youth as a preventative measure. Self identified substance abusers are more likely within the contemporary generation and therefore rehabilitation should focus on contemporary factors to assist in their recovery.

For Further information: Kelley Ellis, NARCH Research Assistant, Confederated Tribes of Siletz Indians, P.O. Box 549/201 SE Swan Avenue, Siletz, OR 97380. 541-444-8227, 541-444-9688. kelleyr@ctsi.nsn.us



Developing And Piloting A Historical Trauma Mental Health Program In Indian Country: A Community-Based Participatory Research Approach. Jessica Goodkind, *Eugene Tsinajinnie, *Lance Freeland, Christopher Lee.

Background: Native American communities have endured 500 years of genocide and oppression, which has resulted in historical trauma. To interrupt the intergenerational transmission of trauma, it is important to identify its root causes and to create community-wide methods for healing and reconnecting to traditional culture. **Methods:** To accomplish these goals, a university-community research partnership was established to develop an innovative community-based mental health program, called “Our Life.” This 6-month program involves a psycho-educational group format, with emphases on strengthening parent-child relationships, reconnecting to traditional culture, and healing and trust-building through equine and experiential activities. The program was piloted with 12 families (children ages 7-16 and their parents/guardians). Adult and children participants are interviewed five times (pre, mid, post, and two follow-up time points) to assess the effectiveness of the program. **Results:** An outline of the 6-month program, as well as our community-based participatory research process and preliminary results from the first three interviews will be presented. **Conclusions:** In order to establish an evidence-base for mental health interventions that are culturally-grounded and developed in partnership with Native communities, rigorous community-based participatory research is important.

For further information: Jessica Goodkind, PhD. Assistant Professor, University of New Mexico Department of Pediatrics, MSC11 6145, Albuquerque, NM 87131, 505-272-0046, 505-272-4857, jgoodkind@salud.unm.edu.

Building A Regional Coalition For A Native American Cancer Control Program: Lessons Learned. Leah Frerichs*, Shinobu Watanabe-Galloway, Tinka Duran.

Background: A key to success for comprehensive cancer control (CCC) programs is developing a diverse network of partners to work together to reduce the cancer burden. This can be a challenging task for a regional CCC program such as the Northern Plains Comprehensive Cancer Control Program (NPCCCP), which works with 18 distinct tribal communities in four states. However NPCCCP has built and strengthened a regional coalition in the past two years. **Methods:** During its planning phase, NPCCCP established partnership leaders, identified and invited potential partners, and created workgroups to draft portions of a cancer plan. NPCCCP also tailored activities to address the unique needs of tribes, such as fielding a tribal needs and priorities assessment with key tribal health leaders and conducting multiple in-person visits. **Results:** NPCCCP has built a regional coalition that represents stakeholders and partners from diverse groups. Together this network of partners hosted a successful cancer summit and completed a Northern Plains American Indian Cancer Plan. However, NPCCCP met challenges in the process such as tribal partner’s lack of access to computers, lack of time for active involvement from tribal leaders, and limited cancer data. **Conclusions:** Regional tribal health coalitions can be built successfully if appropriate methods are followed. Additional time may be needed in order to address challenges and ensure the regional effort still recognizes the unique situations of each tribe involved.

For Further information: Leah Frerichs, MS. Program Manager, Northern Plains Comprehensive Cancer Control Program, Aberdeen Area Tribal Chairmen’s Health Board, 1770 Rand Road, Rapid City, SD 57702. 605-721-1922 ext. 110, 605-721-1932. epifrerichs@aatchb.org



Finding Culturally Competent Health Care Literature About American Indians: Which Database Is Best? Patricia Bradley, Patricia Auflick.

Background: In 2003 a Tribal Connections Four Corners survey indicated that there was a significant need for culture, language and race appropriate patient information. As a follow-up to the survey, team members searched three health databases to determine which provides access to the most information on culturally appropriate health care information about American Indians. **Methods:** Pub Med, the Cumulated Index to Nursing and Allied Health Literature, and the Native Health Databases were searched using terms for culturally appropriate health care and American Indians. **Results:** Pub Med retrieved 2410 records, CINAHL found 877 citations, and the Native Health Databases identified 742 documents. References were grouped by decade to determine when culturally competent health care became a major concern in the health care field. Nursing literature was compared with all other articles published to see if it had the strongest record of culturally appropriate literature about American Indians. **Conclusions:** The Native Health Databases provide the best option when obtaining a historical perspective on cultural competence; however, PubMed should be the first choice when trying to identify current culturally appropriate literature pertaining to American Indian health care. Although nurses are on the front lines in providing culturally appropriate health care, their published literature does not adequately document that contribution.

For Further information: Patricia Bradley, Native Services Librarian, Health Sciences Library & Informatics Center, University of New Mexico, Albuquerque NM 87131, 505-272-0664, pbradley@salud.unm.edu

A Feasibility Study Of An Electronic Record And Tracking System For Use By Nurses Who Perform Breast & Cervix Cancer Screening Exams In Indian Health Service And Tribal Clinics.

*Wesley Petersen, Ann Nicometo, Mary Alice Trapp, Piet de Groen, Judith Kaur

Background. Native WEB-trained IHS/tribal clinic nurses have limited time to perform breast and cervix cancer screening exams. Nurses' traditional handwritten documentation, during and after screening exams, may reduce actual available screening time and introduce error into records. Nurses Online for Well Women (NOW²) was developed to increase documentation speed and accuracy. **Methods.** Four nurses participated in two tests comparing NOW² to handwritten entry. 1) Nurses entered information from seven matched pairs of scripts, with pairs split between entry formats. 2) They documented ten (minimum) actual patient visits using each entry format with half the patients. Activities were observed, recorded, and timed. Errors in each screening record were identified, summed and recorded to a spread sheet. The time required to document each exam was noted and also recorded to the spread sheet. Errors and times were summed by session and cumulatively. Differences between formats were analyzed using T-tests. Nurses' comments about NOW² also were analyzed. **Results.** 1) Neither entry format has a significant time advantage, but NOW² produces a permanent record with one entry of patient data compared to multiple handwritten entries. 2) NOW² is significantly more accurate than hand entry. For scripted patient records and actual patients, error rates were significantly (P=.0007 and P=.006, respectively) lower. 3) Nurses liked NOW² and would use it. **Conclusions.** NOW² warrants further development. IHS and tribal clinic use would require an interface to allow communication between NOW² and existing systems.

For further information: Wesley Petersen, PhD, Mayo Clinic Cancer Center Native American Programs, 200 First Street SW, Rochester, MN 55905. 507-266-2204, 507-266-2478. peterw@mayo.edu



Developing An Alliance: The Indian Health Service And Mayo Clinic Partnership. *Ann Nicometo, Wesley Petersen, Lisa Baethke, Mary Alice Trapp, Piet de Groen, Cynthia Claus, Judith Kaur

Background: Mayo Clinic has a 14-year history of working with Native populations and the Indian Health Service (IHS) to reduce cancer and increase screening. We sought to develop a collaborative alliance between the IHS and Mayo that would capitalize on our individual and combined strengths to improve health through cost-effective health care, research, education, grants and funding, and career opportunities. **Methods:** Beginning in 2002, we followed a process to determine the potential for a productive relationship between Mayo and the IHS. We: 1) compared our missions, values and goals as characterized in our strategic plans; 2) met with appropriate program, department, and division representatives in each organization; 3) reported our findings to the directors of the IHS and the Mayo Cancer Center; 4) scheduled face-to-face meetings for the directors with other leaders, including Native American Programs' leaders. This process led to a recommendation to pursue partnership. **Results:** A draft MOU was produced. The Mayo Foundation reviewed and provisionally approved the draft. Following an endorsement by Mayo staff members who have worked with the IHS and Native populations, the draft was approved. It was forwarded to the IHS/Department of Health and Human Services where it also was approved. A public signing ceremony on July 10, 2006 formalized the partnership. **Conclusions:** The process leading to this partnership was systematic and serves as a model for others interested in developing mutually beneficial relationships with the IHS and tribal communities. The authors encourage potential collaborators to contact Mayo Clinic or the Indian Health Service.

For further information: Ann Nicometo, Mayo Clinic Cancer Center Native American Programs, 200 First Street SW, Rochester, MN 55905, 507-266-9755, 507-266-2478. MayoIHSpartnership@mayo.edu

Community Characteristic Effects On Health Outcomes Of AIAN Relying On Tribally-Operated Health Programs. Carol Korenbrot, Chi Kao and James Crouch

Objective: To determine whether characteristics of AIAN communities served by Tribally-Operated Health Programs (TOHP) had any effect on health outcomes of AIAN who use them. The dependence of preventable hospitalization outcomes on IHS funding in TOHP in the California area has been established in our prior analyses, but it remains to be determined whether the characteristics of communities served by the TOHP contributed to the outcomes as well. **Methods:** We conducted secondary data analysis of 3,181 preventable hospitalizations of AIAN users of 20 TOHP in California using multivariate Poisson regression analysis models. Characteristics of the rural AIAN communities, their demand for TOHP services, Indian Gaming revenues, and disparities with Whites in education, income, employment, transportation, telephone service and household size were analyzed. **Findings:** Community factors that had direct, independent effects on the outcomes were Median Household Income, Percent of AIAN Households with No Vehicle, and Disparities in Percent of Households with No Vehicles and No Telephone Service ($P < 0.05$). The direction of the effects, however, was opposite of that expected. The higher the socioeconomic characteristics of AIAN communities of TOHP in California, the worse the preventable health outcomes of the AIAN that use them. **Conclusions:** These results are consistent with a tendency for AIAN with lower socioeconomic status to use TOHP in communities with higher socioeconomic status in California. The implications of these findings are important in explaining the need for the TOHP in AIAN communities in California.

For Further information: Carol Korenbrot, PhD. Research Director, California Rural Indian Health Board, 4400 Auburn Blvd, Sacramento CA 95841. (916) 929-9761. carol.korenbrot@crihb.net



American Indian Science Scholars Program At The University Of Wisconsin – Milwaukee Sponsored By GLNARCH. *Susan J. Roskopf, *Brian J. Jackson, Mary K. Madsen.

Background: As part of the Student Development Component of the NARCH funding, the American Indian Science Scholars Program is a one week summer program providing American Indian high school students with hands on science and lab experiences intermixed with traditional teachings. **Methods:** For the 2006 program, 15 students were hosted at The University of Wisconsin – Milwaukee from July 23-29. With three students from Arizona, three from Michigan and nine from Wisconsin, ages ranging from 15-20, there was a great representation and diversity among participants. The combination of scientific and cultural activities kept the students motivated, engaged and enthused. Scientific activities ranged from growing bacteria to blood typing, extracting their own DNA to tracking the spread of disease, from hiking through the Cedarburg Bog to forensically analyzing a mock crime scene. Students went to the UWM planetarium, Milwaukee County Zoo, Milwaukee Public Museum, and Indian Community School. At ICS, students learned about traditional medicines, some participated in a sweat lodge, and many made their own dream catchers. Community activities included an evening of basketball, a trip to a local mall, a waterski show, and the week concluded with tailgating and a Brewers baseball game. **Results:** Students were introduced to a variety of scientific and cultural experiences, making a real and personal impact on each participant, opening their minds to a greater array of future possibilities and endeavors. **Conclusions:** As their feedback reflects, participating in this program gave students an invaluable experience that has dramatically excited and motivated them for their futures.

For further information: Susan Jill Roskopf, Assistant Researcher, University of Wisconsin – Milwaukee, College of Health Sciences, PO Box 413, Milwaukee, WI 53201. 414-229-3121, 414-229-2619. sroskopf@uwm.edu

Parental Alienation Syndrome Attributed To Parental Attitudes And Behaviors. *Luisa P. Machuca, Robert J. Boeckmann, & Bruno M. Kappes.

Background: Children afflicted by contentious divorces may indirectly be manipulated to align with one parent and alienate the other. Extreme exposure to such conditioning during custody battles could result in Parental Alienation Syndrome, a cluster of eight co-occurring characteristics within the context of parent/child relationship dynamics. With the accumulation of reports that PAS exists, researchers and clinicians lack reliable and validated psychometric tests to assess PAS. **Methods:** This research reports on the development and validation of a tool that assesses PAS (Parental Alienation Syndrome Questionnaire) using adult college students (N=329) who report parental relationship status of divorced and non-divorced. Participants also completed a measure of Parental Alienation Questionnaire, the Personal Attribute Inventory and the Love/Hate Scale for each parent. **Results:** Four factors were retained when mothers were reported as the alienating parent and three factors were retained when fathers were reported as the alienating parent. Predicted differences were confirmed when comparing Parental Alienation Syndrome Scores between the divorced and non-divorced groups when the mother was reported as the alienating parent $t(210) = 4.13, p < .0$, no differences were detected between the groups when the father was reported as the alienating parent. Significant relationships between Parental Alienation Syndrome scores and the Parental Alienation, negative Personal Attribute Inventory and Love/Hate measures further supported the Parental Alienation Syndrome Questionnaire as a valid measure. **Conclusions:** Further research is necessary to conclude PAS is a true syndrome. Suggestions for future research include refining the questionnaire and including more participants from both groups.

For Further information: Luisa P. Machuca, MS. Research Associate, 1104 Hillcrests Drive, Anchorage, Alaska 99508. 907-729-5491, 907-729-5464. aslpm@uaa.alaska.edu



Exploitation Of Native American Culture: Dissemination Of Project TITAN Findings. Jillian Doss, MPH, Diana Cournoyer, MEd, Vicki Tall Chief, EdD, Laura Beebe, PhD

Problem/Objective: Native Americans have the highest smoking prevalence rates of any racial/ethnic group. Tobacco use by Native Americans is complicated by the traditional role of tobacco for some tribes. Few culturally relevant materials exist to combat tobacco addiction in this disparate group. In partnership with the Oklahoma Native American Tobacco Education Network (NATEN) we are addressing tobacco industry tactics used to manipulate and exploit Native Americans. **Methods:** Project TITAN explored industry use of imagery, youth smoking prevention programs, and sponsorship using previously secret tobacco industry documents, key informant interviews, and other public documents. Interpretation and translation of findings were facilitated by our advisory council and NATEN. **Results:** As early as the 18th century, tobacco companies began exploiting Native Americans through the use of imagery solely for the purpose of selling and promoting commercial tobacco. From the cigar store Indian to the American Spirit brand, tobacco companies have attempted to capitalize on the traditional use of tobacco by Native Americans. In an effort to promote corporate image, the tobacco companies have sponsored ineffective youth smoking prevention campaigns and other community programs for Native Americans. These findings have been shared through presentations, print materials, and online with our community partners. **Conclusions:** Through our partnership with NATEN we have translated and disseminated our research findings, which provide strategies to assist communities in countering tobacco industry exploitation of Native Americans to sell tobacco products.

For further information: Diana Cournoyer, M.Ed, Native American Tobacco Education Network, Southern Plains Inter-Tribal Epidemiology Center, Oklahoma City Area Inter-Tribal Health Board, PO Box 57377, Oklahoma City, OK 73157-7377, (405) 951-6005 x107, fax (405) 951-6006/3902, diana.cournoyer@ihs.gov

Self-Rated Health Status Of Isleta Pueblo Elderly. Natalia T. Orosco

Purpose: One of the fastest growing segments of the U.S. population is adults over the age of 65. Providing for the health care needs of this segment of the population will become a national priority. Nowhere is this more evident than among minority elders. The health status of certain Native American tribes has been declining with the increase prevalence in diseases across all age groups. This increase in disease prevalence has a drastic effect on the population 65 years and above. In order for Native Americans to be able to provide quality care for their people, there is a need to assess community needs and analyze in a format and manner that is appropriate and relevant to the tribe. **Method:** The Isleta Pueblo tribes commissioned a needs assessment in 2002 to evaluate functional impairments, socioeconomic status, and the degree to which daily care and health care is provided and received in their elders 55 and older. The current study used this needs assessment to provide a demographic overview of the elders of the Isleta Pueblo tribe of New Mexico and to determine the relationship between demographics and self-rated health status. **Results:** The results of the needs assessment indicate that income, number of reported co morbidities and the number of difficulties with activities of daily living are all significantly related to how an Isleta Pueblo elder self-rates their health status. **Conclusion:** It is essential that Isleta Pueblo address the needs of those elderly who have extremely limited incomes. Providing environmental and social resources could possibly offset limited financial resources. The other area of focus for the Isleta Pueblo is maintaining the mobility of their elders, through prevention of health conditions that affect mobility or sufficient exercise to maintain the ability to walk. Physical ability is a prominent influence on self-rated health status for the oldest old.

For further information: Natalia T. Orosco, 16152 Kumeyaay Way, Valley Center, CA 92082. (760) 560-7200 nataliao@sanpasqualtribe.org



Determinations Of The Extent Of Unmet Health Needs For Natives In California.

*Karen Garcia, Chi Kao, Carol Korenbrot, James Crouch.

Background: Determining the extent of health disparities between Natives and other populations is imperative to obtain funding for community health improvement. Using state health databases to determine health disparities is inaccurate if corrections are not made in the data for racial misclassification of Natives. We determined disparities in severe morbidity for Natives who use Tribal Health Programs (THP) in California by having the Indian Health Service (IHS) registry of Active Users for the state linked to a state database and investigating chronic and behavior-related diseases and conditions. **Methods:** Ratios of age-adjusted hospitalization rates (per 10,000 persons) were determined for Natives compared to Whites. Records for Active Users from 24 THP were linked from the IHS Registry for 1998 to 2002 (average of 42,242 records per year) with hospital discharge records and divided by the number of linked records to obtain rates. Rates for White non-Hispanics who lived in the same counties were determined by dividing records by the Census population. **Results:** Age-adjusted hospitalization rate ratios for AIAN compared to Whites were ranked. Leading causes of disparities based on rate ratios [95% CI] were: diabetes, 3.23 [2.87, 3.63]; asthma, 1.85 [1.63, 2.09]; injury and poisonings, 1.46 [1.38, 1.55]; alcohol-related, 1.36 [1.29, 1.44]; tobacco-related, 1.28 [1.25, 1.32]. **Conclusions:** High priority health issues for AIAN users of tribal clinics in California Native communities are diabetes, asthma, injury and poisonings, alcohol, and tobacco. The linkage method provided health information necessary to prioritize advocacy efforts for funding community and clinic health prevention and treatment activities.

For further information: Karen Garcia, MPH (Maidu/Pit River/Apache), Epidemiologist, California Rural Indian Health Board, California Tribal Epidemiology Center, 4400 Auburn Blvd 2nd Floor, Sacramento, CA 95841; 916-929-9761 ext. 1042; (fax) 916-929-7246; karen.garcia@crihb.net.



Oral Abstracts

Healthy Children, Strong Families: Baseline Data. Alexandra Adams, Kate Cronin, SuAnne Vannatter, Tara LaRowe,*Ron Prince

Background: Our previous studies have shown high rates of obesity in children in Wisconsin AI communities leading to adult obesity and chronic disease. Three Wisconsin tribes partnered with Great Lakes Inter-Tribal Council and University of Wisconsin researchers to develop an early childhood obesity prevention program. **Methods:** Phase I of the project is Healthy Children Strong Families, a family-based intervention that aims to decrease overweight and increase healthy behaviors among 2-5 year olds by a home based, mentor delivered skills building program for families of Head Start children. Healthy lifestyle targets include increased fruit/vegetable consumption, reduced TV time, increased physical activity and reduced candy and soda consumption. It is now in its first year and baseline data are available. Phase II is a community-based environmental assessment and intervention program that is currently being organized. **Results:** 6 month family surveys indicate good acceptance of the home-based intervention. Baseline results revealed high levels of overweight or obesity (85% of parents, mean age 31 yr, and 47% of children, mean age 48 mo), high levels (29%) of impaired glucose in participating mothers, and low fruit and vegetable intake (e.g., non-starch vegetable servings/day mean: 0.58 for children, 1.4 for adults; mean fruit (excl. juice) servings/day: .62 for children, .33 for adults). TV watching was moderate, with parents averaging 153 minutes/day and children 114 minutes/day. **Conclusions:** The Healthy Children Strong Families intervention has the potential to impact serious threats to long-term health in the participating tribes. Its favorable acceptance among participating families and their current status of health and lifestyle behaviors indicates the need for continuing intervention.

For further information: Alexandra Adams, MD., PHD. Department of Family Medicine, 777 S. Mills St. Madison, WI 53715. 608-265-4671, FAX 608-263-5813. Alex.Adams@fammed.wisc.edu

Methamphetamines and the Environment. Cynthia Naha and Jerome Clark

Background: The use, manufacturing, and disposal of methamphetamines have become an epidemic throughout Indian Country. Not only does this drug threaten our very existence, but it also has serious detrimental effects and impacts in our Native homelands. The need to understand these effects and impacts is necessary to identifying the solutions to this ever-increasing problem. **Methods:** Providing community outreach and education on the manufacturing and disposal of methamphetamines and the environment will in create informed deliberation on how our tribal communities can begin to work together to solve not only the health impacts, but also the environmental impacts. Through incorporation of Traditional Ecological Knowledge (TEK), tribal nations can recognize the importance and value our lands and their direct tie to our cultures, ceremonies, and overall...our way of life as Tribal peoples. **Results:** Due to the easy accessibility of products to manufacture methamphetamine within small "mom and pop" labs, Indian Country has become a prime target for this illegal operation. Five years ago, it was probable that meth was being produced on Indian reservations, but within the past couple of years, the likelihood has increased. Trafficking, sale, and use of the deadly drug has become prominent on Indian reservations indicating that production is on the rise and many tribal leaders are aware of the problem and are addressing the issue. As a result of education and outreach, tribes can begin to combat this ever-increasing problem through the development of task forces, coalitions, and the passing of resolutions, ordinances, and codes for their communities. Finding solutions is the first step towards healing and balancing the lives of our peoples. **Conclusions:** Working together, tribal nations can analyze the problems created by methamphetamines and develop methodologies for combating this new trickster that has taken over the lives of many of our people and contamination to our Mother Earth.

For further information: Cynthia Naha, Environmental Programs Coordinator, Inter Tribal Council of Arizona, Inc. 2214 N. Central Ave., Suite 100 Phoenix, AZ 85004. 602-258-4822, 602-258-4825.



Alaska Native Elders and Abuse: Creating Harmony by Voicing Traditions of Listening. Louise Shavings, Kathy Graves

Background: The purpose of the study was to learn from Elders how we develop respect through listening to their experiences and wisdom. Listening prevents disrespect. **Methods:** The method used individual interviews with 15 Alaska Native Elders who are Inupiat, Yup'ik/Cu'pik, Tlingit, Athabascan, and Aleut/Alutiiq. Snowball sampling occurred during April 2005-August 2005. Qualitative interview questions asked about the role of Elders and their experiences of respect, and disrespect. Interviews were analyzed using a grounded theory approach allowing the hypotheses to be drawn directly from the raw data. Atlas Ti software was used to analyze the data. **Results:** The findings indicate that, from the Alaska Native worldview, the tradition of listening and oral tradition has relevancy in the modern world. It has great significance to the future and survival of the tribe. While there is an increase in disrespect, there are culturally appropriate ways to approach it. Elders hold a central role in passing down of traditional values that create harmony and balance. The lack of it creates disconnection between others and the natural world, therefore disrespect is present. The most prevalent types of Elder disrespect mentioned were emotional disrespect and financial exploitation. **Conclusions:** In summary, Elders are traditional keepers. A role they are tasked with is orally passing on ancestral knowledge. With changes over time, Elders have encountered disrespect from others, contributed to losing the importance of listening that is believed to keep traditions and culture alive.

For Further information: Louise Shavings, MSW, Research Associate; 900 Jayme Court Anchorage, AK 99518. (907) 770-8994, lshavings@yahoo.com

Changing Epidemiology of Invasive Pneumococcal Disease among White Mountain

Apache Persons In The Era Of Pneumococcal Conjugate Vaccine., *Rochelle Lacapa, Sandra J. Bliss, Francene Larzelere-Hinton, Kathryn J. Eagle, Debra J. McGinty, Alan Parkinson, Mathuram Santosham, Mariddie J. Craig, Katherine L. O'Brien

Purpose: Invasive pneumococcal disease (IPD) is more common among White Mountain Apache (WMA) persons than among the general U.S. population. We aimed to determine if the introduction of 7-valent pneumococcal conjugate vaccine (PCV7) and programs to enhance utilization of 23-valent pneumococcal polysaccharide vaccine (PS23) impacted the incidence and serotype distribution of IPD among WMA persons. **Methods:** Active laboratory and population-based surveillance was conducted for IPD among Native Americans residing on the Fort Apache Indian reservation. **Results:** From 1991-2005, 235 cases of IPD occurred. The average annual IPD rate (cases per 100,000 person-years) dropped from 126 in 1991-1997 to 90 in 2001-2005 ($p=0.03$). However, the decline in IPD rates was limited to children; adult rates increased by 50%. The rate of IPD attributable to PCV7 serotypes declined by 91% among children < 5 years without a concomitant increase in non-vaccine type disease rates. The proportion of disease-causing isolates in PCV7 among adults was only 25% between 1991-1997, which decreased to 20% between 2000-2005, a non-significant difference. **Conclusions:** IPD rates among WMA children <5 years have decreased in the last 15 years; however rates among WMA children and adults remain higher than the general U.S. population. There is no evidence for indirect protection of adults from pediatric PCV7 use. Replacement disease among children has not been observed for any specific serotype, or for all non-vaccine serotypes taken together. Vaccines with broader serotype coverage are needed to further reduce the remaining health disparity that pneumococcal disease poses.

For further information: Rochelle Lacapa, MPH Candidate, Johns Hopkins Bloomberg School of Public Health, Center for American Indian Health, 621 N. Washington St., Baltimore, MD 21205. (410) 955-6931; rlacapa@jhsph.edu



Negotiating Community Participatory Evaluation in One Tribal Community. Xenia T. King.

Background: Community Participatory Evaluation (CPE) has not been systematically studied as a process within American Indian communities but has been supported as a promising method of program evaluation for tribes. **Methods:** A CPE was used to evaluate a demonstration program aimed at reduction of substance abuse and crime related problems with one tribe in the Northwestern United States. The process revealed three areas which should be addressed if CPE is to be truly participatory and if it is to yield positive outcomes in the aftermath of its conduct. **Results:** The areas included: Attitudes toward Tribal Data, Impact on Community Member Roles, and Use of Informal Systems Available to Tribal Members. Issues surrounding data dealt with technological availability and acceptance, integration across tribal units, willingness to share intra-tribally, and concerns regarding internal and external use. CPE also impacted tribal roles held by community members as a result of their participation in the design and conduct of the evaluation. Informal systems were found which addressed community problems but which could not be easily formalized without destroying their value. **Conclusions:** The three areas identified are not assumed to be exhaustive but merely representative of the underlying issues which evaluators should address when conducting CPEs. Attention to these issues should result in greater acceptance and implementation of recommendations by the tribe after the evaluation is complete. Hopefully more areas needing attention will be added to this list by evaluators engaged in CPE.

For further information: Xenia T. King, PHD. Research Associate, Native American Res. & Training Center, UA, 1642 E. Helen St., Tucson, AZ 85719. 520-229-9969, 520-621-9802. xnkn@email.arizona.edu

Do Records Of Breast Cancer Cases Seen At PIMC Appear In The ACR? *Archana Minnal, Tim Flood, Kathleen Evans, Shannon Myers, Charlton Wilson.

Background: Several studies of cancer registries have found data for American Indians to be incomplete or racially misclassified. In Arizona, cancer cases from Indian Health Service (IHS) hospitals are reported to the Arizona Cancer Registry (ACR) through the New Mexico Tumor Registry (NMTR). This project analyzed data from the ACR to determine its completeness for American Indian/Alaska Native (AI/AN) female breast cancer cases. **Methods:** We linked data on 99 breast cancer cases from Phoenix Indian Medical Center (PIMC) for the years 1995-2002 to the ACR. ACR identified 323 AI/AN cases. **Results:** The ACR had racially misclassified six of the PIMC cases. We identified an additional 15 cases of invasive carcinomas, three carcinomas in-situ, and three with incomplete information in PIMC records not appearing in the ACR. Thirteen of the 18 potentially missing cases and five of the six racially misclassified cases were from 2001-2002. The statewide incidence rates for AI/AN for 1995-2001 did not change significantly after adding the potentially missing invasive carcinomas. The ACR was able to locate 14 of the 15 invasive carcinomas and the three carcinomas in-situ on a list received from the NMTR, but pending registration in the ACR. The cases with incomplete information were found not to be reportable to the ACR. **Conclusions:** Only one of 96 reportable cases did not appear in the ACR. However, we noted a lag in identifying cases from recent years. Inclusion of the delayed cases is necessary to show the true rates for the two most recent years.

For Further information: Archana Minnal, MPH. Project completed while a student at the University of Arizona, College of Public Health. 602-430-8971. archana_minnal@hotmail.com



South Dakota Tribal PRAMS: Adapting the CDC pregnancy risk assessment monitoring system surveillance protocol to serve South Dakota American Indian communities. *Christine Rinki, *Glenn Drapeau, Ssu Weng.

Background: In South Dakota, the disparity in infant mortality between SD American Indian (SDAI) and white infants has been a persistent challenge. Despite a steady decline, the 2005 SDAI infant mortality rate of 11.6 per 1,000 live births was nearly two times the white rate of 6.1. The disparity was most dramatic in the post-neonatal period: 7.4 for SDAI compared to 1.6 for white infants. Sudden Infant Death Syndrome accounted for 25% of SDAI post-neonatal infant deaths. The Pregnancy Risk Assessment Monitoring System (PRAMS) sponsored by CDC and state and tribal health agencies provides state-level, population-based maternal and infant health data. **Methods:** In 2006, the Yankton Sioux Tribe became the first tribe to receive a CDC PRAMS cooperative agreement. The SDT PRAMS collaborates with all SD tribes, Northern Plains Tribal Epidemiology Center, SD Department of Health, and Indian Health Service to identify priorities for data and to develop protocols for the unique needs of SDT PRAMS. SDT PRAMS will employ a statewide census of live births to American Indian mothers or fathers to conduct small area analyses for tribe-specific estimates. Novel strategies to improve response rates include hiring tribal field staff, developing a PRAMS tribal outreach manual, hand delivering questionnaire packets, and conducting local promotion activities. A Tribal Oversight Committee governs SDT PRAMS; tribal approvals have been obtained. **Results/Conclusions:** Modifications to the CDC protocol ensure that SDT PRAMS is accepted by tribal communities and will improve response rates. SDT PRAMS will offer previously unavailable population-based statewide SDAI and tribe-specific maternal and infant health data.

For Further Information: Christine Rinki, MPH. Northern Plains Tribal Epidemiology Center, 1770 Rand Road, Rapid City, SD 57702, 605-721-1922 x120, epirinki@aatchb.org

Risk Factors for Hearing Loss and Tinnitus Among Northwest American Indians. Kapuaola Gellert*, Jodi Lapidus, William H Martin, Thomas Becker.

Background: In a 2005 national survey, American Indians and Alaska Natives (AI/AN's) were twice as likely as white adults to report hearing problems. No descriptive data on tinnitus among AI/AN's have been published. Otitis media and chronic loud noise exposure, which are considered risk factors for hearing loss and tinnitus have been reported among AI/AN's. **Methods:** We conducted a Behavioral Risk Factor Survey including 11 hearing health questions that we developed and pilot tested among one Pacific Northwest tribe. We interviewed 217 tribal members 18 years and older. **Results:** Among all participants, 18% reported hearing loss (males: 24% vs. females: 13%). Prevalence of hearing loss predictably increased with advancing age. After adjusting for age, noise exposure was a risk factor for hearing loss (OR: 8.30, 95% CI 1.84, 37.52). The overall prevalence of tinnitus was 33% (comparable among sexes). The strongest risk factors for tinnitus after adjusting for age were noise exposure (OR 2.24, 95% CI 1.28, 6.73) and otitis media history (2.82, CI 1.26, 6.30). **Conclusions:** Increasing age and noise exposure were strong predictors of hearing loss in this tribe after sex adjustment. For tinnitus, our data indicated that noise exposure and history of otitis media were the strongest predictors of this condition, even after age adjustment. We recommend that tribal members limit prolonged loud noise exposures, wear hearing protection in risky environments, and provide tribal children with the appropriate vaccines to help protect against otitis media infections which may protect against tinnitus and hearing loss later in life.

For Further information: Kapuaola Gellert, MPH. Oregon Health & Science University, Public Health & Preventive Medicine, 3181 SW Sam Jackson Park Road, CB669, Portland, OR 97239, Phone: (503) 494-1175, Fax: (503) 494-7536. Email: gellertk@ohsu.edu



Lessons Learned In Tribal Consultation In Meeting The Needs Of American Indian/Alaska Native Communities. Matthew Town, *Cleora Scott.

Background: Community based collaborative research between funders, researchers and tribal communities have proven to be complex. Perceptions, perspectives, values and self-interests make it difficult to meet the needs of AI/AN communities. Through tribal consultation, tribal communities can maintain decision making responsibilities in order to meet their needs. Tribal consultation is also important to ensure research activities are implemented in a knowledgeable sensitive manner respectful of Tribal self governance. **Methods:** This presentation will outline complexities between major funders, tribes and researchers and will offer an approach to ensure tribal consultation throughout the entire research project. This presentation will also explain how tribal self governance applies to research. **Conclusions:** Based on complexities, this presentation will enlighten tribes, funders and researchers to organize, plan and implement tribal consultation. The guiding principal of tribal consultation throughout the research process is to ensure that input is sought to effectively meet the needs of AI/AN communities.

For Further information: Cleora B. Scott, BS. Project Specialist, Data into Action, Northwest Portland Area Indian Health Board, 527 SW Hall, Suite 300 Portland, Oregon 97201 501-228-4185. cscott@npaihb.org

Using Data To Create Positive Change In Tribal Communities: The Tribal EpiCenter Consortium. Bridget M. Canniff*, Robin Kinnard, Karen Garcia.

Background: The mission of the Tribal EpiCenter Consortium is to promote the collection and dissemination of high-quality health data with the aim of eliminating health disparities facing American Indian and Alaska Native (AI/AN) communities. Over the past two years, the Consortium has built an interregional network of three tribal epidemiology centers (EpiCenters) that together serve more than 190 tribes in 7 states. The current Consortium partners are the Northwest Tribal EpiCenter (lead organization), the Southern Plains Inter-Tribal EpiCenter, and the California Tribal EpiCenter. **Methods:** The Consortium partners are collaborating to build tribal epidemiologic and public health capacity, and to promote the standardization and culturally competent use of data to improve the health of Native people. The Consortium model establishes a mechanism to undertake and coordinate joint projects, allowing each EpiCenter to benefit from the experience and expertise of the others. The latest project is a survey to assess health promotion/disease prevention capacity of Tribal and Urban Indian Health Programs. **Results:** Our short-term goal is to share the tools and experience of data collection projects and interventions in Indian Country to increase cultural competence, effectiveness and data quality. In the long term, our goal is to establish a national network among all EpiCenters, maximizing resources and expertise, and further building tribal capacity using community-based participatory methods. **Conclusions:** By working together, Consortium partners can help foster community-based and culturally appropriate data collection practices, and increase the capacity of Tribal EpiCenters to effect culturally relevant policy change.

For Further information: Bridget M. Canniff, MALD. Project Director, Tribal EpiCenter Consortium, Northwest Portland Area Indian Health Board, 527 SW Hall, Suite 300, Portland, OR 97205. 503-228-4185, fax 503-228-8182. bcanniff@npaihb.org



Using the Circle of Strength to Promote Family Participation. Jenny Chong*, Yvonne Fortier, Dino Haley, Amberly Atene and Sheryl Caponera.

Background: Support from family and friends during substance abuse treatment improves client outlook. Clients have more positive attitudes such as self esteem and self efficacy and decreased negative attributes such as hostility and depression if their family or friends participate in their treatment. We describe the Circle of Strength (COS) and how the clients' family responded to being participants. The COS is aimed at promoting the participation of family and friends in the clients' substance abuse treatment. **Methods:** Over 50 Clients and their family and friends participated in a COS weekend (2 days for Outpatient clients, 3 days for Residential clients) to learn about roles and responsibilities and to make amends. All participants were asked to complete evaluations each day that they participated in the COS weekend. **Results:** Evaluations show that participants found the COS to be very useful and reported that they gained understanding, improved their communication skills and their relationships. **Conclusions:** The impact of the COS should be further assessed to determine whether and how treatment outcomes can be improved as the relationship between clients and their family improve.

For Further information: Jenny Chong, PhD, Research Assistant Professor, University of Arizona, 1501 N. Campbell, Room 7301, Tucson, AZ 85724. 520-495 0421, 520-621-2111. jchong@u.arizona.edu

Legal, Social, Educational, and Mental and Behavioral Health Characteristics of New Mexico Native American Youth Detainees. Tassy Parker, *Billie Kipp, Gayle Dine'Chacon.

Background: New Mexico has one of the largest and fastest growing proportions of Native Americans in its youth population. While most NM Native youth demonstrate tremendous resilience in the face of adverse living conditions, it is the Native youth in the state's juvenile justice system to which we devote our investigation. Our research continues a prior study of incarcerated Native youth with a new collaboration by the NM agency responsible for the well-being of minors in its custody. Together we seek prevention, intervention, and policy strategies to "reclaim" Native detainees by systematically identifying potential risk factors. **Methods:** Chart reviews were conducted for all identifiable Native Americans detained in two state-operated facilities during 2006. Our variables of interest included: demographics; incarceration history; family/individual history of violence, mental illness, and substance use; and education considerations. Descriptive statistics were used for data analysis. **Results:** Preliminary results indicate a pattern of multiple contacts with the juvenile justice system, low educational attainment, high rates of diagnosable and co-occurring mental disorders, and family/individual substance use among the detainees. **Conclusions:** Longitudinal study is needed to illuminate temporal relationships among risk factors and to suggest surveillance strategies for prevention/intervention. Our snapshot of Native detainees suggests a need for health, social, and legal advocacy at multiple levels both outside and inside the juvenile justice system for youth with the identified characteristics. Health policy that mandates early screening, treatment, and follow-up for mental health problems among high risk Native children is needed to reduce or prevent out of home placement.

For Further information: Tassy Parker, PhD, RN, Assistant Professor, Co-Director, Mental and Behavioral Health, UNM HSC Center for Native American Health, 1001 Medical Arts NE, Albuquerque, NM 87102. (505)272-9873. taparker@salud.unm.edu. This research was supported with resources provided by NARCH and the UNM Center for Native American Health.



Disparities in Use of Cardiac Procedures for Heart Disease among American Indian/Alaskan Natives (AI/AN) and Whites in California. *Stacey Jolly, Chi Kao, Andrew Bindman, Carol Korenbrot.

Background: AI/AN have a high prevalence and rising incidence of heart disease, and heart disease has become the leading cause of death. There are effective hospital-based procedures to treat heart disease, especially ischemia-related heart disease (IHD). Yet, little is known about access to life-saving cardiac procedures for AI/AN with IHD. **Methods:** IHD hospitalizations for AI/AN and non-Hispanic Whites were determined from California patient discharge data (PDD) for years 1998-2002 using ICD-9 codes. Cardiac Procedure rates were determined using IHD Hospitalizations as the denominators and cardiac procedures for cardiac catheterization, percutaneous coronary intervention, and coronary artery bypass graft surgery as defined by ICD-9 codes as the numerators. A subgroup analysis for AI/AN Active Users of the Indian Health Service (IHS) using the National Patient Information Reporting System (NPIRS) data linked to the state PDD data was done. Linkage corrects racial misclassification and is the main source of Active User hospitalizations since there are no IHS or tribal hospitals in California. Multivariate logistic regression models are being conducted to adjust for age, gender, comorbidity, payer source and the availability of the procedures in the hospital. **Results:** Unadjusted bivariate analysis shows that AI/AN have similar rates to those of non-Hispanic Whites, however, multivariate analysis is being done to adjust for co-morbidities which are expected to be higher for AI/AN. Once adjusted for co-morbidities, the rates for AI/AN may well be significantly lower than those of AI/AN whether they are IHS Active Users or not. **Conclusions:** IHS data on AI/AN needs to be combined with state hospital data and adjusted for a number of factors to have complete information on whether there are disparities in access of AI/AN to hospital-based cardiac procedures compared to other populations.

For Further information: Stacey Jolly, MD. General Internal Medicine Clinical Research Fellow, University of California at San Francisco, Box 1364, San Francisco, CA 94143-1364. ph 415-206-5135, fax 415-206-5586, sjolly@medsfgh.ucsf.edu

Bone health and Vitamin D status in American Indian women. *Irina V. Haller, Julia (Bunny) Jaakola, Neil Binkley.

Background: Vitamin D inadequacy is common in many populations around the world and the effect of low vitamin D levels on skeletal health is established. However, very little is known about bone health and vitamin D status in indigenous populations of North America. **Methods:** We conducted a pilot project to assess heel bone mineral density (BMD), markers of bone-turnover, serum chemistries and serum 25OHD in a sample of American Indian women from the Great Lakes region. Data collection took place at the tribal clinic on March 20 and 21, 2007. **Results:** Study population included 78 women between 32 and 75 years of age, 54% were postmenopausal. There were no statistical differences between pre- and postmenopausal women for self-reported diseases and conditions known to affect bone or vitamin D metabolism, 18% of the sample reported lactose intolerance. Markers of bone turnover were elevated in postmenopausal women. Based on heel BMD, 27% of postmenopausal women had T-scores consistent with low BMD (osteopenia or osteoporosis). Serum 25OHD concentrations were low (5-46 ng/ml) and 80% of the study participants had suboptimal levels (< 30 ng/ml). **Conclusions:** Peripheral BMD measurement is convenient in rural areas, however additional skeletal sites should be evaluated, since heel BMD measurement can be confounded by BMI. Low vitamin D status was common in this sample of American Indian women. Further studies are needed to assess effects of vitamin D on skeletal and non-skeletal health in this population.

For Further information: Irina V. Haller, PhD, MS. Senior Research Scientist, SMDC Health System Division of Education & Research, 503 East Third Street, Ste. 200, Duluth, MN, 55805. Ph. 218-786-8185, Fax. 218-786-3835. IHaller@smdc.org



A Model For Program Sustainability: The Transfer Of The Family Spirit Home-Visiting Program For Adolescent American Indian Parents To Tribal Public Health Nursing Programs. Kristen Speakman, Allison Barlow, Tennille Marley, *Louise Yazzie, Wilpita Bia, Elena Varipatis-Baker, Jill Moses.

Background: The Family Spirit (FS) program has been developed and field tested by Johns Hopkins Center for American Indian Health (JHCAIH) and several southwestern American (AI) tribes since 1998. It is a 15-month home visitation program administered by Native paraprofessionals to promote maternal and child health and parent education for adolescent parents. FS has undergone a rigorous evaluation in two subsequent randomized controlled trials with a third underway. Findings suggest significant impacts in parenting knowledge and maternal and child outcomes. In an effort to disseminate the FS program to more tribal communities, JHCAIH partnered with the Indian Health Service (IHS) Chinle Service Unit, located centrally on the Navajo Nation, to design a replication process. **Methods.** Replication began in March 2006, and phases included formative design, implementation, evaluation and strategic planning for operational sustainability. **Results.** A local community advisory board has been established to guide the replication process. Two local Navajo outreach staff, trained and employed by JHCAIH, have recruited 40 parent-child dyads (45% of adolescent child-bearing population) in the first year of implementation. The replication partners have identified the IHS Public Health Nursing (PHN) Program as the most viable local platform for FS program transfer. PHN leadership from 7 IHS Service Units now participate in a planning group to design the transfer process. Results of the program transfer will be presented. **Conclusions.** This project describes the process and feasibility of replicating and transferring autonomy for a demonstrated MCH promotion model in an under-resourced and cross-cultural setting.

For Further information: Kristen Speakman, MA., MPH, Program Manager, Johns Hopkins Center for American Indian Health, 8205 Spain Rd. NE Suite 110, Albuquerque NM 87109. 505-323-4065, 404-400-6174. kspeakma@jhsph.edu.

Hepatitis C Virus Infection Among American Indian Women Seeking Prenatal Care — Northern Plains, 2005–2006. *Christine Dubray, John T. Redd, Kathy Byrd, Supriya Janakiraman, Cecile M. Town, James E. Cheek

Background: Approximately 4.1 million persons in the United States (1.6% prevalence) are positive for antibodies to hepatitis C virus (anti-HCV). However, the epidemiology of HCV infection among American Indians (AI) is not well documented. We investigated HCV epidemiology among AI women seeking prenatal care in two Northern Plains IHS facilities in which universal prenatal HCV screening was implemented in July 2005. **Methods:** We performed a retrospective review of HCV screening among AI women who received a first prenatal-care visit during July 1, 2005–July 31, 2006. A case of HCV infection was defined as presence of anti-HCV by enzyme immunoassay (EIA), verified by either recombinant immunoblot assay (RIBA[®]) for anti-HCV or nucleic acid testing (NAT) for HCV RNA. Next, we performed a case-control study to identify HCV risk factors. Four unmatched controls per case were randomly selected from women whose prenatal anti-HCV EIA was negative. **Results:** A total of 205 women were screened for HCV. Thirteen (6.3%; 95% confidence interval [CI]=3.4–10.6) had anti-HCV confirmed by RIBA[®]. In the case-control study, the strongest HCV infections risk factors were illicit drug use (odds ratio [OR] undefined (undef); [95% CI=5.6–undef]) and more than six sexual partners before pregnancy ([OR] 9.8; [95% CI=1.5–65.5]). **Conclusions:** Our results indicated a high prevalence of prenatal HCV infection. HCV infection risk factors are similar to those found in other populations, but have never been described in a rural AI population. Interventions to reduce the impact of HCV will need to include AI and rural populations.

For Further Information: Christine Dubray, M.D., M.S. Epidemic Intelligence Service Officer, Indian Health Service Division of Epidemiology and Disease Prevention, 5300 Homestead Road NE, Albuquerque, NM 87110. 505-248-4234, 505-248-4393. Christine.dubray@ihs.gov



Using the State Behavioral Risk Factor Surveillance System (BRFSS) data to assess the behavioral health risks of American Indian Adults in Nebraska. *Shinobu Watanabe-Galloway, Francine Romero, Liyun Xu, Sayaka Kanade, *Adeola O. Jaiyeola

Background: We analyzed Nebraska Behavioral Risk Factor Surveillance System (BRFSS) data to estimate the prevalence of health conditions and risk behaviors among American Indians.

Methods: From 1995 to 2004, 57,148 adults responded to the BRFSS in Nebraska. Of those, 0.8% identified themselves as American Indian. Because of the small sample size of American Indians, data for multiple years were combined in order to have more inferential power.

Results: The American Indian BRFSS adult respondents were systematically younger, had lower education, were poorer than and had a higher unemployment rate than White respondents. The following conditions or behaviors were more common among American Indians (AI) compared to whites: diabetes (AI: 11.6% vs. White: 5.4%); obesity (AI: 32.7%; White: 20.1%); smoking (AI: 49.0% vs. White: 22.4%); and binge drinking (AI: 22.7% vs. White: 16.6%). The prevalence of immunizations and cancer screenings are similar between American Indians and Whites although they are both below HP2010 objectives.

Conclusions: These results establishes a baseline prevalence data of health risk factors which can be used by the tribes and others to plan and implement public health programs targeted towards reducing health disparities among American Indians in Nebraska. Analysis of future native-specific BRFSS data will build on this baseline to give trends and progress towards improving the health of American Indians. The paucity of data for American Indians in this yearly survey underscores the need for a native-specific BRFSS or a greater over sampling of American Indians in the regular statewide BRFSS.

For Further information: Adeola O. Jaiyeola, MD., MHSc. Director, Northern Plains Tribal Epidemiology Center (NPTEC), AATCHB 1770 Rand Rd, Rapid City, SD 57702. 6095-721-1922 ext. 115, 1-800-746-3466 drajaiyeola@aatcb.org

Bemidji Area Urban American Indian/Alaska Native Health Assessment Pilot Project. David Quincy, Kristin Hill, Alice Park.

Background: The primary goal of this project is to provide characterizing information about the health needs of urban American Indians and Alaska Natives (AI/AN) living in the Bemidji area. **Methods:** The study consisted of fourteen visits to six IHS Bemidji Area Urban Indian communities to discuss the feasibility of conducting a comprehensive assessment of urban AI/AN health. Public meetings were convened by the Health Directors of the five IHS-funded urban Indian health organizations (UIHO) located in Chicago, Detroit, Green Bay, Milwaukee, and Minneapolis, and by Phyllis Davis, Health Director of the Match-E-Be-Nash-She-Wish Band of Pottawatomi Indians in Grand Rapids, Michigan. Attendees included patients and staff of UIHO, community members, and representatives from nearby Tribes, Urban Indian agencies, and colleges. Attendees were asked to identify issues and problems that impact AI/AN health that should be included in the assessment, and to identify two representatives to serve on the Advisory Committee that would guide the proposed health assessment project. This presentation will summarize the major issues highlighted by communities. We will also describe the process for completing a comprehensive assessment of urban AI/AN health in Bemidji Area where it is anticipated that approximately 2400 interviews (400 at each of six urban sites) will be conducted.

Conclusions: The lack of data on urban AI/AN impedes the ability to support existing services or raise funds to expand services. The needs assessment seeks to measure the strengths, challenges and barriers related to urban AI/AN health.

For Further information: David Quincy, Health Systems Specialist, Bemidji Area HIS, 522 Minnesota Ave. NW, Bemidji, MN. 56601. Tel. (218) 444-0471. David.Quincy@ihs.gov



Native American Family Intervention Project: Community Based Participatory Research Process Involving A University and Two Southwest American Indian Tribes. *Lorenda Belone, Nina Wallerstein, Bonnie Duran, John Oetzel, Greg Tafoya, Rebecca Rae and Erica Rodriguez. Tribal Organizers: Jemez – Harriet Yepa-Waquie, Anita Toya, Willie Waquie, Carol Gachupin, *Dominic Gachupin and *Leah H. Stevenson; Ramah Navajo - Jennifer Henio, *Ira Burbank, Phoebe Maria, *Lula Kelhoyouma Yin-Mai Lee & Carolyn Finster

Purpose: Utilizing a community based participatory research approach the University of New Mexico Masters in Public Health Program with Tribal research teams in the Pueblo of Jemez and Ramah Navajo to adapt, modify, and implement a Native American Family Intervention Project to reduce risky behaviors in third and fourth graders. **Method:** Four year process to adapt exiting culturally specific curriculum developed by the Anishinabe (Ojibewe) people called the “Bii-Zin-Da-De-Dah” or “Listening to Each Other” prevention program. Data from the Anishinabe curriculum has showed to be successful with parents and children when there is an integration of cultural stories and traditions. First year– establish advisory boards in each tribe and adapt curriculum through focus group discussions with elders, parents, youth and service providers; second year- modify curriculum based on each tribe’s specific cultural importance, develop a community action project for participating families to be involved in and provide cameras to the youth to develop photo essays; third year-pilot curriculum in each tribe with ten families who have third or fourth graders; and fourth year-base on pilot, revise curriculum and prepare for full implementation in each tribe. **Results:** Completed first year of project, able to establish very active advisory boards and conducted monthly meetings. Conducted five Jemez and three Ramah Navajo focus group discussions, trained advisory board members to facilitate. **Conclusion:** Both tribes very much interested and excited in developing a culturally specific intervention. Will present each tribe’s and the university’s prospective on research process for the first year.

For further information: Lorenda Belone, PhD Candidate, Associate Research Scientist, Masters in Public Health Program, Department of Family and Community Medicine, MSCO9 5060, 1 University of New Mexico, Albuquerque, New Mexico 87131-0001, 505-272-3634. ljoe@salud.unm.edu

Trends In Antimicrobial Prescribing Rates For Alaska Native Children And Adolescents. Anne Marie Bott*, Michael G Bruce, Tom W Hennessy, Lisa Bulkow.

Purpose: In the US, while the number of antimicrobials prescribed in ambulatory care has declined from 1989 to 2000, antimicrobial resistance has risen. This study evaluated antimicrobial prescribing patterns from 1992 through 2004 in Alaska Native persons (AN) and American Indians (AI) <18 years of age, residing in the Anchorage region. **Methods:** Electronic medical records were used to obtain data on oral antibiotics prescribed for ambulatory and emergency-room visits. Population-based and visit-based antimicrobial prescribing rates were calculated. **Results:** The population-based rate of antimicrobial prescriptions per 1000 persons rose from 309 (1992) to 524 (2004) ($p<0.001$). The visit-based annual rate per 1000 persons remained stable from 101 (1992) to 109 (2004) ($p=0.672$). Overall, visit-based prescription rates in AN/AI were lower (range 100-150) than those previously reported in US children <15 years of age (250-340). The total number of courses of antimicrobials prescribed to AN/AI increased 94% from 4,929 (1992) to 9,561 (2004); however, the total number of ambulatory-clinic visits also increased 79% from 49,008 (1992) to 87,486 (2004) while the population of AN/AI persons <18 in the Southcentral Alaska region rose 14%. **Conclusion:** Antibiotic prescribing rates for AN/AI children have been stable over a 12-year period. Although a trend in decreased antibiotic use has been seen in the general US population, prescribing rates in our area have not decreased but remained below those in previous regional studies in the US.

For further information: Anne Marie Bott, PharmD, BCPS. Critical Care Team Pharmacist, Alaska Native Medical Center, 4315 Diplomacy Drive, Anchorage, AK 99508. 907-729-2143, 907-729-2135. ambott@anmc.org



Working With A Regional Coalition To Improve STD And HIV/AIDS Prevention And Control In Northern Plains Tribal Communities. *Ann M. Drobnik

Background: process of working with the Aberdeen Area STD/HIV Task Force to create a regional strategic plan for STDs and HIV/AIDS in Northern Plains Tribal communities. The task force is a regional coalition with representation from Indian Health Service (IHS), State Departments of Health, Tribal health programs, universities, and national partners. The strategic plan addresses clinical and community activities at the tribal, state and federal (Indian Health Service) levels. **Methods:** To create the plan, the task force worked to define a common goal and identify unmet needs and available resources. To ensure tribal participation, the task force coordinator (presenter) held individual interviews with members to solicit input on the plan, held regular coalition conference calls, and presented the plan in local meetings with tribal leaders. **Results:** The coalition has been able to address areas of health disparity beyond STDs and HIV/AIDS such as methamphetamine use and hepatitis C, is helping to increase collaboration and communication between agencies, and is working to overcome challenges presented by scarce resources at all three levels. **Conclusion:** The task force is currently working on implementing the strategic on reservations in the Aberdeen Area.

For further information: Ann Drobnik, MPH. STD/HIV Coordinator, Northern Plains Tribal Epidemiology Center, 1770 Rand Road, Rapid City, SD 57702. 605-721-1922 x106. epidrobnik@aatchb.org

Creating an Alaska Tribal Regional Health Profile. *Kyla Hagan, Ellen Provost.

Introduction: The availability of regional health data for tribal health organizations is scarce. Regional data that is available is presented with geographic divisions that do not fit the boundaries of many tribal health organizations' service areas. Tribal health organizations need region-specific health related information for the purposes of grant writing, program planning and evaluation. **Methods:** The regional health profile (RHP) is composed of demographic information, mortality and morbidity data, health promotion, health protection, preventive services and health care indicator data. The RHP is primarily composed of secondary analysis of previously collected information. It is modeled after Healthy Alaskans 2010, the Alaskan version of Healthy People 2010. Regionally-specific data was provided for most indicators. A few of the major data sources utilized were the Behavioral Risk Factor Surveillance System (BRFSS), National Patient Information Reporting System (NPIRS), and the State of Alaska's Bureau of Vital Statistics. **Results:** The RHP provides an overview of the health status of a region. It also provides an explanation of the different types of data available. **Conclusion:** Regional health profiles will be a useful tool for tribal health organizations if they can be kept up to date and made widely available.

For Further Information: Kyla Hagan, MPH. Epidemiologist, ANTHC – EpiCenter, 4000 Ambassador Drive, C-DCHS, Epidemiology Center, Anchorage, AK 99508. 907-729-4568. kdhagan@anmc.org



Innovative Strategies For Increasing Colorectal Cancer Screening Among Alaska Native People. *V. Peterson, E. Provost, D. Espey, C. Christensen, F. Sacco.

Introduction: Colorectal cancer (CRC) incidence and mortality occur at nearly twice the US White rate (102.9 vs. 51.7 and 39.4 vs 20.2 per 100,000, respectively). Delivering screening services in rural Alaska continues to be extremely challenging. The large geographic distances, the cost of travel, the capacity of regional facilities to conduct endoscopic CRC screening as well as the high prevalence of *H. pylori* infection rendering the guaiac-based fecal occult blood test not useful as a screening test are some of the barriers facing Alaska Native people. In the last decade, the Alaska Tribal Health System (ATHS) has implemented innovative strategies for increasing CRC screening throughout Alaska. This presentation will describe these strategies as well as lessons learned.

Methods: Strategies include: utilizing nurse practitioners/physician assistants (NP/PA) and Registered Nurses (RN) as endoscopists; providing flexible sigmoidoscopy training for NP/PAs; increasing screening services using itinerant endoscopists; investigating new technologies to increase options for screening; and instituting a first degree relative tracking system to identify higher risk individuals.

Results: Each strategy to increase CRC screening will be described in detail as well as lessons learned. **Conclusion:** Increasing CRC screening rates among AN people particularly in rural/remote regions continues to be a challenge. Innovative strategies for improving CRC screening in this unique health care environment are crucial for achieving CRC screening goals.

For Further Information: V. Lynn Peterson, MPH. Epidemiologist, ANTHC – EpiCenter, 4000 Ambassador Drive, C-DCHS, Epidemiology Center, Anchorage, AK 99508. 907-729-4562. vlpeterson@anmc.org

Non-Fatal Hospitalized Suicide Attempts Among Alaska Native People From 1991-2004. *Laurie J. Helzer, Ryan Hill, Martha Moore, Ruth A. Etzel.

Purpose: This project describes the frequency and geographic distribution of hospitalized suicide attempts among the Alaska Native and American Indian (AN/AI) people residing in Alaska. **Methods:** The data for this project came from the State of Alaska - Department of Health and Social Services' Alaska Trauma Registry. We analyzed non-fatal hospitalized suicide attempts among AN/AI people in Alaska during 1991 and 2004. Rates were calculated per 100,000 and the location of the event was based on the region in which the person resided. The regional analysis used census area boundaries with the exception of the Cook Inlet region. The data were analyzed using Statistical Analysis System and displayed graphically with ArcGIS. **Results:** Of the 2,729 hospitalized suicide attempts, the majority of the individuals were females (n=1719, 63.0%). Thirty one percent (n=848) were between the ages of 20 and 29. The medical record documented alcohol in more than half of the hospitalizations (n=1,560, 57.3%). The Northwest Artic, Bering Straits and Interior regions of Alaska had the highest rates of suicide hospitalization with 345.2, 334.3, 310.6 per 100,000 respectively. The Northwest Artic (196.5), the Interior (192.5), and the Cook Inlet regions (185.1) had the highest rates of alcohol-related suicide hospitalization. The majority (n=1788) of the hospitalized suicide attempts were from self-inflicted poisoning – E-code 950 (72.98%). For E-code 950, the regions with the highest rates include the following: the Northwest Artic (284.4), the Interior (280.4) and the Cook Inlet region (276.4). **Conclusions:** These data provide an indication of the magnitude of the problem of suicide attempts in Alaska Native people between 1991 and 2004. Further research is needed to help direct the efforts of suicide prevention programs.

For further information: Laurie Helzer, M.P.H. Senior Researcher, Southcentral Foundation, 4501 Diplomacy Drive, Anchorage, AK 99508. 907-729-5489, 907-729-5464. lhelzer@SouthcentralFoundation.com



Using Collaborative Research to Address Health Disparities: Two Examples. Jennie R. Joe, Kris Olsen-Garewal, Maria R. Garcia.

Background: National attention on a number of key health disparities calls for the active involvement of tribal health programs to help decrease these health disparities. **Methods:** In many instances, the funding agencies try to ensure active involvement of communities by requiring researchers to implement community-based participatory research, an approach that gives equal partnership to the researchers and to the tribal communities in all phases of development, implementation, and evaluation of the research project. **Expected Results:** The expected outcome is that this researcher/tribal community collaboration not only will empower the community partners, but also will help assure sustainability of programs or interventions initiated by the partnership after funding has ceased. **Conclusion:** These collaborative efforts, however, continue to challenge the notion of partnership where researchers are still viewed by tribal communities either as outsiders and/or as being in control of the project. This presentation will provide two examples of how partnerships can be formalized: 1) through an establish memorandums of agreement and 2) a model utilizing participatory evaluation.

For further information: Jennie Joe, PhD, MPH, 1642 E. Helen, Tucson, AZ 85719. Work: (520) 621-5075, Fax: (520) 621-9802, E-mail: jrjoe@u.arizona.edu

Developing A Model Process And Successful Structure For A Collaborative HIV Education, Testing And Outreach Program Among Local And Migrant Native American Women. *Sharon Tomah, Donna Augustine, Miigam'agan, Patty Neptune, Barbara Ginley, Kathleen E Perkins

Background: The number of HIV+ women in Maine Indian communities is disproportionate to the relative size of the population. However, these numbers are not well documented. **Methods:** Our program combined several components to increase HIV/AIDS awareness among local and migrant Native American Women. A) Women from the tribes were recruited to participate and received basic training using the American Red Cross curriculum. Additional training was provided on the Be Proud Be Responsible curriculum and Social Networks. B) Participants were asked to facilitate sharing of HIV information at three levels of project participation: informal "Champions," paid part time (3 hours a week) "Community Health Educators," and part-time traditionalists (8-16 hours a week) "Outreach Workers." C) Educators and Outreach workers were also trained to conduct HIV rapid testing. D) Structured activities were conducted with individuals and groups, on two reservations, at multi-tribe events, and at migrant camps during the blueberry raking season. E) Informal contacts were expected to take place through-out the fabric of daily life. F) Prevention education was woven into cultural events such as the Rites of Passage ceremonies for youth and traditional women's gatherings. **Results:** The Maine Indian women have been remarkably open to the HIV education messages and the messengers have become the "go to" people in their communities. Women from the tribes who are living with HIV report feeling less stigmatized. **Conclusions:** HHS should consider supporting a replication and evaluation project to determine if this is a model program that should be made available to other tribes.

For Further Information: Kathleen E Perkins, MPA. Director, Population Health Programs, Medical Care Development, Inc. 11 Parkwood Drive, Augusta, ME 04330. Ph. 207-622.7566 x225. KPerkins@mcd.org



Healing Of The Canoe: The Community Pulling Together To Prevent Youth Substance Abuse And Promote Cultural Identity And Belonging. *Lisa R Thomas, *Robin Sigo, Dennis M Donovan, Gidget Lincoln, Lisette Austin

Background: American Indians/Alaska Natives experience unacceptable health disparities. At the same time, little is known about the strengths, resources and resilience factors that exist at Tribal and community levels. **Methods:** *Healing of the Canoe: the Community Pulling Together* is a three-year collaborative project funded by NIH/NCMHD. A Community Based Participatory Research (CBPR) method was used in which the Suquamish Tribe fully partnered with the University of Washington to: a) identify issues of greatest concern to the community; b) identify community resources; c) adapt a life skills curriculum for youth to incorporate Tribal beliefs, practices, customs, stories and traditions; d) adapt outcome measures; and e) measure the quality of the collaborative relationship. **Results:** The Suquamish Tribe identified youth substance abuse and lack of cultural identity, meaning and belonging as the issues of greatest concern. The Tribe identified Tribal Elders, Tribal youth and Suquamish teachings and traditions as their greatest resources. A draft Life Skills curriculum has been developed that incorporates Tribal teachings and stories and will be piloted with Tribal youth in Summer 2007. In addition, preliminary results of the measures of the quality of the collaborative relationship indicate that the partnership between the Tribe and the research institution is respectful and successful. **Conclusions:** This project demonstrates that true CBPR is a scientifically sound, culturally appropriate and effective method to use for research in partnership with Tribal communities.

For Further information: Lisa R Thomas, PhD. Research Scientist, Alcohol and Drug Abuse Institute, University of Washington, 1107 NE 45th St, Suite 120, Seattle, WA, 98105. 206 897-1413, 206 543-5473. lrthomas@u.washington.edu

Exploring the Unraveling Hoop: Tobacco Use, Abuse, and Tobacco Abuse Predictive Factors Among Urban American Indian Youth in Minnesota. *Isaiah Brokenleg, Kris Rhodes, Jean Forster, Cynthia Davey, for the American Indian Community Tobacco Project Steering Council

Background: American Indians smoke at higher rates and begin smoking cigarettes at an earlier age compared to other populations. American Indians have a unique relationship with tobacco that is often not considered. Research conducted in partnership with the American Indian community is necessary for the findings to be relevant and applicable for American Indians. **Methods:** American Indian youth, ages 11-17 years, were recruited through schools and American Indian youth programs in Minneapolis and St. Paul, Minnesota for a self-administered paper and pencil survey. Survey participants answered questions regarding demographics, traditional tobacco use, cigarette smoking, access to cigarettes, participants' thoughts about smoking, parent's rules on smoking, and smokers within their social network (friends and family). Analyses included frequency distributions and tests of association. **Results:** Of the 342 youth who participated: 66% used tobacco traditionally, 67% have tried smoking cigarettes at least once, 37% have smoked within the past 30 days, and 13% smoked all of the past 30 days. There are several factors associated with youth smoking. As expected, increased age is associated with increased smoking. Having smokers in one's social network (siblings, parents, friends, etc.) is also associated with increased smoking. Homes with a smoking ban and having parents and friends who think smoking is not okay are protective factors. **Conclusions:** These results provide one of very few studies of urban American Indian youth and tobacco use/abuse. The results of this study will be useful in shaping further research and in the development of empirically sound culturally appropriate interventions.

For Further Information: Isaiah Brokenleg, MPH candidate. Great Lakes NARCH Student Intern and Research Assistant, American Indian Community Tobacco Project, 1300 S. 2nd Street Suite 300, Minneapolis, MN 55454. 612-616-9721. brok0013@umn.edu



Exemplifying Community Based Participatory Research; Envisioned, Designed, And Conducted Entirely By An Urban Indian Community. *Tualii Maile, Tsosie Ursula, Park Alice, *Castor Mei, Forquera Ralph

Background: The Urban Indian Health Institute (UIHI) is one of ten Indian Health Service-funded epidemiology centers nationwide and it serves a network of 34 urban Indian health organizations. The UIHI mission is to provide centralized nationwide management of health surveillance, research, and policy considerations regarding the health status deficiencies affecting urban Indians. The UIHI fulfills its mission is by responding to the needs identified by its network and therefore exemplifies the community-based participatory research model. **Methods/Results:** The UIHI is fully engaged in a collaborative approach to research, where community representatives are researchers. This model engages community members, employs local knowledge in the understanding of health problems and the design of interventions, and invests community members in the processes and products of research. Community members are invested in the dissemination and use of research findings and ultimately in the reduction of health disparities. This presentation will describe a number of research projects conducted by an urban Indian community and will present a model for community research. Projects to be described include a family history study aimed to bridge the gap between the medical history record and AI/AN oral tradition; a community designed needs assessment; and analyses of public health data sets to identify and report disparities in the population. **Conclusions:** Various approaches, methodologies and types of data may be used to better understand the health issues of the target population. A community-based participatory approach helps to ensure community buy-in and support.

For further information: Maile Tualii, Associate Director, Urban Indian Health Institute, Seattle Indian Health Board, PO Box 3364, Seattle, Washington 98114-3364, Telephone (206) 812-3030, Fax (206) 812-3044, Email Mailet@uihi.org

Improving American Indian Cancer Surveillance and Data Reporting in Wisconsin: A Community Based Participatory Research Process.* Kimmie Pierce, Jackie Matloub, Laura Stephenson, Rick Strickland.

Background: American Indian/Alaska Native (AI/AN) cancer data has typically resulted in undercounting of cases. A pilot study showed undercounting in WI to be 50%. The (AI/AN) cancer burden in the Northern Plains is significantly greater than other regions. Accurate data is essential to reduce this cancer burden. **Methods:** Community based participatory research methodology was used for this project. Ten Tribal/Urban clinics in WI partnered with the Wisconsin Cancer Reporting System (WCRS), Great Lakes Inter-Tribal Council (GLITC), and the University of Wisconsin Paul P. Carbone Comprehensive Cancer Center to conduct this project. A retrospective cancer case study of the medical records from the participating tribal and urban clinics was conducted. Cancer cases identified in the retrospective study were matched with WCRS data. A mechanism for voluntary reporting of Tribal/urban center cancer cases directly to WCRS was established. **Results:** Trustful working partnerships were established with participating Tribes/Urban Center, and training in community based participatory research was provided for students, faculty, health professionals, and Tribal leaders. Tribal/Urban Center cancer profiles and an aggregate profile were developed. American Indian state data was improved for completeness and racial classification; this improved accuracy being successfully sustained. **Conclusions:** Community based participatory methodology was successfully used to improve AI/AN cancer data in Wisconsin and provide an educational opportunity for all parties.

For Further information: Kimmie Pierce. Chronic Disease Epidemiologist, Great Lakes Inter-Tribal Council Epidemiology Center, P O Box 9, 2932 Hwy 47, Lac du Flambeau, WI 54538 tel:715-588-3324 ext 229 fax:715-588-3607 e mail kpierce@glitc.org



Low Prevalence of Pediatric Asthma Among American Indian Youth in Southeastern Montana.
*David Mark and Melissa Roberts.

Purpose: To determine the period prevalence of current asthma in youth accessing care at the Crow Service Unit in southeastern Montana from 1987-2006. **Methods:** Retrospective electronic and manual chart review to identify patients aged 0-20 years, stratified by age and gender, with a diagnosis of asthma (ICD-9-CM, code 493) who had at least one clinic visit during the given calendar year. **Results:** Overall asthma prevalence among 0-20 year old children increased during the period 1987 to 2006, from 3.4 per 100 children in 1987 to 7.1 per 100 children in 2006. Average annual prevalence during 1987-1991 of 4.9 (SE \pm 1.6) per 100 children was not significantly different than that observed from 1992-1996, 6.1 (SE \pm 0.6) per 100 children. Average annual prevalence during 1997-2001 increased by 25% ($p = 0.03$) to 7.6 (SE \pm 1.1) per 100 children, a figure not significantly different than the average prevalence during 2002-2006, 7.5 (SE \pm 0.6) per 100 children. Among all children aged 0-20 years, overall asthma prevalence rates were significantly higher in boys than in girls. Average annual asthma prevalence was highest among children aged 0-4 years. **Conclusions:** Contrary to published data, the asthma prevalence rate in our population is lower than previously cited rates for all races and for AI/AN populations, likely due to environmental factors. Future research should include focused analysis of elements of the social and environmental microclimate to determine which factors predispose and protect against the development of asthma in our population.

For Further Information: David Mark, MD. Chief Medical Officer, Crow-Northern Cheyenne IHS Hospital, P.O. Box 9, Crow Agency, MT 59022. 406.638.3309, 406.638.3572. david.mark@ihs.gov

Alaska Native Mortality Update: 1979 – 2003. Day, Gretchen, *Provost, Ellen, Lanier, Anne.

Background: Monitoring trends in mortality are essential to understanding the health status of a population. This report will report on mortality rates among Alaska Native people (AN); compare rates with US Whites (USW); and examine trends from 1979 – 2003. **Methods:** The on-line SEERStat software available on-line through the National Cancer Institute's Surveillance Epidemiology and End Results (SEER) Program was utilized to calculate age-adjusted mortality rates for AN and USW. **Results:** For the period, 1999-2003, the three leading causes of death for AN were: cancer, heart disease, and unintentional injuries. The AN all-cause mortality rate was 40% higher than USW. The largest disparities with USW were unintentional injuries (RR=3.0), suicide (RR=3.1) and homicide (RR=4.0). Rates for heart disease (RR=0.8) were significantly lower than for USW. There was a significant decline in AN all-cause mortality rates between 1979 and 2003, similar to the USW decline (15% vs. 16%). However, this was not the case for most of the leading causes of death. Marked increases occurred for deaths due to chronic pulmonary disease (192%) and diabetes (194%) compared to USW (54% and 40%, respectively). **Conclusions:** Disparities persist in most of the leading causes of mortality for Alaska Native people when compared to the US White population. Excess rates exist for nearly all causes of death, but the largest relative differences are found in unintentional and intentional injuries. In 1950, nearly half of all deaths among AN were due to infectious diseases. There has been a significant shift in the leading causes of death toward chronic disease and injuries.

For further information: Ellen M. Provost, DO., MPH. Director, Alaska Native Epidemiology Center, 4000 Ambassador Drive, C-DCHS, Anchorage, AK 99508. Phone: 907-729-2923, Fax: 907-729-4569. emprovost@anmc.org



2007 Frank Dukepoo Research Award

Jennie R. Joe, PhD, MPH, MA

2007 Award Recipient

Dr. Jennie R. Joe is a member of the Navajo Nation. She is on faculty in the Department of Family and Community Medicine (DFCM), College of Medicine at the University of Arizona. Since 1987, Dr. Joe has also been the Director of the Native American Research and Training Center (NARTC) in the DFCM. Dr. Joe is a medical anthropologist who has been engaged in a number of community-based research projects with American Indian/Alaska Native Communities.

She has over 20 years of experience in administration, teaching, and research. She has and continues to conduct training and research projects collaboratively with a number of tribal and native communities. Some of her research endeavors have been with the White Mountain Apache Tribe, Navajo Nation, and groups such as the American Indian Wildland firefighters, the Intertribal Council of Arizona, California Rural Indian Health Board, Battelle Memorial, and the Institute for Scientific Analysis. In addition to a number of research reports, book reviews, and monographs, Dr. Joe also has over 20 chapters published in edited books and 26 articles in refereed journals with a number of other articles in press. She serves on a number of national and international boards. Some of the courses taught by Dr. Joe have included Women and Culture, Indians of North America, Living in the Place of the Sacred, Research Methods in Community based Research, and Health Policies. Dr. Joe is presently a principal investigator on four research projects and has, over the years, received other multiple sources of research funding and has conducted numerous community-based studies.

Dr. Joe served as a member on the Institute of Medicine's Committee to Assess Racial and Ethnic Disparities in Healthcare and on the National Human Research Protections Advisory Committee to the U.S Secretary of Health and Human Services. She is also a longtime member of the federal Indian Health Service's International Review Board. In her research and teaching, the thrust of her work is in the area of chronic diseases, disabilities, gender, and the socio-cultural context of these issues. Dr. Joe received her doctorate from the University of California Berkeley.

The Native Research Network is proud to present Dr. Jennie Joe the Frank C. Dukepoo Award for promoting integrity, respect, and excellence in research.



Continuing Education Credits

The IHS Clinical Support Center is the accredited sponsor for this meeting. To receive continuing education credits, please complete the Presentation and Conference Summary Evaluations and complete and sign the CE Request Form found on the next page. We need to know which sessions you attended and which credits to award. Without this form, we cannot provide the appropriate credits. Your feedback is needed to assist with the future planning of this meeting. Let us know what we can do better next time. Return/drop all forms in the boxes labeled "Evaluations" at the registration desk.

Accreditation

The Indian Health Service (IHS) Clinical Support Center is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The IHS Clinical Support Center designates this continuing education for up to 12.50 hours of Category 1 credit toward the Physician's Recognition Award of the American Medical Association. Each physician should claim only those hours of credit he or she actually spent in the educational activity.

This Category 1 credit is accepted by the American Academy of Physician Assistants and the American College of Nurse Midwives.

The Indian Health Service Clinical Support Center is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity is designated up to 12.50 contact hours for nurses.



19th Annual Indian Health Research Conference
 "Multiple Perspectives on AI/AN Research Policy"
 Phoenix, Arizona
 June 4-7, 2007

REQUEST FOR CE CERTIFICATE

PLEASE NOTE: Continuing Education Credits are available for physicians and nurses. Please **PRINT** your name and address **LEGIBLY**, and indicate below which sessions you attended. Turn in this completed form at the registration desk or place it in one of the labeled collection boxes before you leave the conference on **Thursday, June 7th. No certificate of hours attended can be issued unless you complete and return this document.**

PRINT LEGIBLY

Full Name: _____ Last Four SS#: _____

Business Address: _____

P.O. Box/Street: _____ City/State/Zip: _____

Check One:
PROFESSIONAL CATEGORY (✓): Nurse ___ Physician ___ Other: _____
Please Specify

PLEASE INDICATE THE SESSIONS YOU ATTENDED BY PLACING an "X" or "✓" IN ALL APPROPRIATE SPACES.

Tuesday, June 5, 2007

Plenary Sessions:

- _____ The Community's Role in Research
- _____ US and Canadian Research Policies

Concurrent Breakout Session (1:30 - 2:45 pm) – Check One:

- _____ Human Subjects Protections and Community Protections
- _____ Principles of Community Based Participatory Research
- _____ Research Design and Small Populations

Concurrent Breakout Session (3:00 - 4:15 pm) – Check One:

- _____ Tribal IRB Processes
- _____ Conducting Research in Urban Indian Communities
- _____ Tribal and University Partnerships
- _____ Cultural Competence and Investigator Training

Wednesday, June 6, 2007

Plenary Sessions:

- _____ Intellectual, Spiritual, & Cultural Property
- _____ Genetics Research Issues
- _____ A Collaborative Research Partnership

Concurrent Breakout Session (1:30 – 2:45 pm) – Check One:

- _____ Session 1
- _____ Session 2
- _____ Session 3
- _____ Session 4



Wednesday, June 6, 2007
(continued)

Concurrent Breakout Session (3:00 – 4:15 pm) – Check One:

- Session 1
- Session 2
- Session 3
- Session 4

Thursday, June 7, 2007

Plenary Session:

- Differences Among Evaluations, Public Health Practice

Concurrent Breakout Session (10:15 – 12:00 pm) – Check One:

- Session 1
- Session 2

I certify that I attended the sessions indicated above.

Signature of Attendee

Date

CSC USE ONLY

Total Hours Awarded: _____

Approved By: _____

IHS Clinical Support Center
Two Renaissance Square
40 North Central Avenue, Suite 780
Phoenix, AZ 85004
Phone: (602) 364-7777 Fax: (602) 364-7788