

Personal Story

The Power of Organ Donation

By Nuvia Enriquez



Rosa Estrada standing by a Donate Life poster. Donate Life is the national campaign to promote organ and tissue donation.

Rosa Estrada, 59, was diagnosed with hypertension in 1990, and the condition caused her kidneys to fail. She needed a transplant, and while she got one, she was on dialysis, a procedure that performs some of the duties of kidneys like removing waste products from the body.

Every night before she went to bed, she hooked herself to the dialysis machine for six to eight hours. She did this for four years, the time it took to receive the miraculous call that would give her a second chance at life.

And it was a miracle indeed. Tired of a procedure that drained her energy, caused her to lose her appetite and made meat and other foods taste like cardboard, one night she said "No more." "As I went to bed I thought, 'I can't do this anymore,'" she says. When her husband got home from work and asked why she wasn't hooked to the machine, she said "If God wants to take me he can take me. I can't do this." And they began to pray. That night around 4 a.m. Rosa received a call from Banner Good Samaritan Hospital. A kidney had become available to her.

"I couldn't believe it!" she says. "I thought someone was playing a joke on me." They were at the hospital in less than an hour, and Rosa received the gift of life from a generous organ donor.

After the transplant Rosa ate her favorite foods again and actually enjoyed them. While on dialysis she was prohibited from eating fruits and vegetables. Fruit had been part of her daily breakfast, and that's exactly what she ordered when she went out for dinner the first time. "I couldn't believe food was so good!" says Rosa. She also had energy to walk two miles after work with her husband.

Rosa lived healthy with her transplanted kidney for seven years, after which she went into rejection and her kidney failed once more. She waited six months to be placed on the waiting list again and another year and a half to receive a kidney from her younger sister.

"Now when I'm out talking to people about how important it is to be an organ donor, I tell them, 'What more can I show you so you make the decision to register but me and my health?'" *Continued on page 5*

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Increasing American Indian Access to Behavioral Health Care

By Lydia Hubbard-Pourier

Community Story

The State of Arizona is home to twenty-one Federally recognized tribes. The Arizona American Indian population comprises approximately 6.2% of the 4.1 million US American Indian population as of April 1, 2000. The Arizona American Indian population per the 2000 US Census was 255,879, or 5% of Arizona's total population. This population with a myriad of individual tribal cultures and languages and status as sovereign nations presents unique challenges for access to the state's behavioral health services and managed care system.

The State of Arizona's behavioral health services are "carved out" from its managed care system and administered by the Arizona Department of Health Services Division of Behavioral Health Services (ADHS/DBHS) through Regional Behavioral Health Authorities (RBHAs). Arizona is unique in that there are five Intergovernmental Agreements (IGAs) with tribes. Three of the IGAs are with tribes to function as Tribal RBHAs. The other tribal members in the state were assigned to the RBHAs by service areas for provision of behavioral health services until 2010. Although the Arizona tribal members who are not members of a Tribal RBHA and are assigned to RBHAs access the limited behavioral health services provided by the federal Indian Health Service (IHS) and the tribal behavioral health programs on tribal reservations, there has been limited use of the state managed care behavioral health services as provided by the RBHAs prior to 2008.



The RBHA Tribal Liaisons were happy together. From left to right: Julia Chavez, Cheri Wells and Sheina Yellowhair. D'arcy Roybal was absent.

The RBHAs are a state-wide system of professionally administered networks that provide integrated managed behavioral health care to members in specified geographic service areas (GSAs). Generally, RBHA staff and providers are non-Indian and not familiar with the tribes, their cultures or the tribal government structures, nor are they at ease going to tribal settings and initiating working relationships with the tribes in their GSAs. For this reason, ADHS/DBHS initiated a contractual requirement that the RBHAs employ an individual to be a Tribal Liaison. This Tribal Liaison position would have the following two main functions: A. to work with the sovereign tribal governments in the GSA to identify and coordinate the development of behavioral health services to meet the needs of the tribal communities, and B. to address individual coordination of care issues related to American Indian clients attempting to access RBHA services. By the end of 2008, all RBHAs had hired a Tribal Liaison.

Since 2008, there have been major accomplishments in increasing access to behavioral health services for tribal members. There have been eight letters of agreement between RBHAs and tribes granting permission for the RBHAs to provide services on tribal lands. The first outpatient behavioral health clinic operated by a RBHA provider on an Indian reservation in Arizona was opened in 2010 on the Tohono O'odham reservation. Crisis services have been planned and developed on the San Carlos Apache, the Hualapai, Ft. Mohave, Tohono O'odham, and Ft. McDowell Indian reservations by all of the RBHAs.

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Arizona Health Disparities Center

Mission:

To promote and protect the health and well being of the minority and vulnerable populations of Arizona by enhancing the capacity of the public health system to effectively serve minority populations and reduce health disparities.

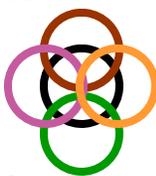
Vision:

Health equity for all

We envision a state where each person has equal opportunity to prevent and overcome disease and live a longer, healthier life.

Contact:

Arizona Health Disparities Center
Bureau of Health System Development
Arizona Department of Health Services
1740 West Adams Suite 205
Phoenix, AZ 85007
602-542-1219
602-542-2011 fax



<http://www.azminorityhealth.gov>

What Is Essential for Basic Health Access? My Experience in Japan

By Robert C. Bowman, M.D.

Physician's Perspective

The U.S. has developed a healthcare system that does not place a priority on the basic healthcare services needed by nearly all Americans, nearly all the years of their lives, in nearly all locations. To determine what could be improved, it helps to see what happens in other nations.

I recently visited medical schools, clinics and hospitals to help understand healthcare differences in Japan. One big difference relevant to those in most need of care is that Japan has invested in 1,000 new physicians graduating each year who are obligated to serve for 6 years in rural and underserved areas in their prefectures (47 prefectures that are like the 50 states of the U.S.). This is the equivalent of 2,400 obligated physicians in the US, given greater population here (310 million versus 128 million). These 1,000 are admitted and trained to serve where needed. This is backed by commitment as 95% of these graduates serve their six year obligation. Not surprisingly, with 15 years of training and obligation and connection to those they serve, they continue to serve where needed in their prefectures at four times the level of other physicians in Japan, even at retirement. The U.S. efforts rearrange the health workforce, but do not facilitate a larger primary care workforce or a greater workforce for all in need of care.

What was more impressive in Japan was the way that primary care nurses and physicians worked together. If you think that the U.S. has continuity in primary care homes, think again. The U.S. does not have continuity in insurance coverage, appointments, personnel at primary care clinics and care locations (urgent, ER, hospitalist) or reasonable financial support that even focuses on continuity. Continuity is the design in the clinic in Japan that I visited.

In the rural clinic in Japan, patients entering were greeted by the front desk. They did not wait long as the appointments stayed on schedule. There were few in the waiting room, and they knew one another and their nurses and physicians. People with more emergent needs were inserted into care. There was no other care in the town. The office meeting run by the chief medical officer was at 8:30 a.m. sharp, and all were there. After brief information sharing by key personnel, all resumed their activities.

Patients knew up front to pay the 30% co-pay. Since Japan has had universal health care coverage for some time, there is no hassle about the source of coverage. The focus is on care. The office does not need to have additional personnel to do billing or collections or explanations; the focus is on physicians and nurses delivering care throughout the community. There are dental health, mental health and community health education classes and space to use for all ages. There is also respite care to minimize long-term care costs. The nursing home that I visited was spotless and did not smell like a nursing home. The care was fully integrated and coordinated.

Software worked for primary care and took a minimal amount of time and effort to update between patients. The information was present on the computer, and messages and prescriptions were linked out. There were no pieces of paper passed around for approvals, prescriptions or referrals. There was direct patient care facilitated by people and software. The nurses and physicians did the ultrasounds, endoscopies and simple x-ray procedures.

The clinic was run by the town and time and effort were not spent on application after application for grants, foundation



Inside and outside of a Japanese clinic. The man in both pictures is a doctor and the woman a nurse.



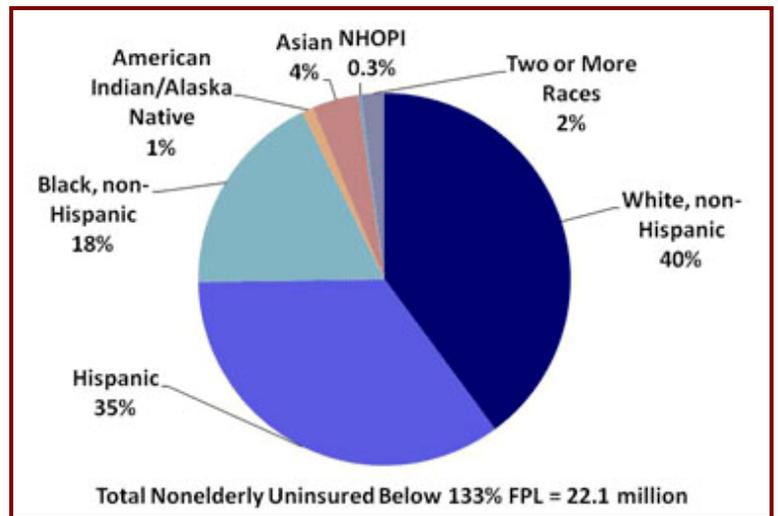
support or donations. There was no small fortune spent for memberships or for political activity to secure or keep funding. The clinic just delivered health care services. There was not a local board as in the Community Health Center of the U.S. The elected leaders dealt with health care and focused on the long-term care of the community. There was no federal or state government dependency. There was just a national finance plan to facilitate health care services. *Continued on page 4*

Distribution of Nonelderly Uninsured Below 133% FPL by Race/Ethnicity, 2008

Although they represent one-third of the total U.S. population, racial/ethnic minority populations comprise more than 50% of the uninsured. By 2045, more than half of the population in the U.S. will belong to a racial/ethnic minority group. Many of them will likely benefit from the expansions to Medicaid and the financial aid being offered to some of the individuals purchasing coverage through the health exchange.

The Patient Protection and Affordable Care Act increases Medicaid eligibility to 133% of the federal poverty level (FPL), which has the potential to significantly reduce the number of uninsured. There are over 22 million nonelderly uninsured individuals in the U.S. with incomes below 133% of FPL (currently \$14,404 for an individual and \$29,327 for a family of four), and nearly 6 in 10 are racial/ethnic minorities. The Congressional Budget Office estimates that raising the eligibility level to 133% would lead to 16 million new enrollees in Medicaid and the Children's Health Insurance Program, many of them likely people of color. For more informa-

tion about how health reform might affect racial/ethnic minority communities, please see *Health Reform and Communities of Color: Implications for Racial and Ethnic Health Disparities* at <http://www.kff.org/healthreform/upload/8016-02.pdf>. ♦



What Is Essential for Basic Health Access? My Experience in Japan continued from page 3

The healthcare costs remain reasonable for Japan as compared to costs approaching 20% of the U.S. gross domestic product or costs that cripple personal finances for 40% of U.S. families (and this is increasing). Japan healthcare costs do not cripple school districts, government or business budgets, and are not passed through multiple sources. There are not separate bureaucracies for military or other special situations. The fee scales are not so confusing for different locations or insurance coverage.

The work at the clinic in Japan was specific to primary care. The physicians, nurses, patients and computer were together in the same space with ready access to lab, x-ray and injection treatments in rooms next door. The design facilitated the triangulation and the time of the physician with the patient.

In the rural clinic in Japan, the nurse was entirely with the physician and patient. She did not take the vital signs. She was not on the phone constantly doing insurance calls, approvals of care, prescription encounters or gathering fragmented information. The nurse facilitated the care at the point of care, working collaboratively with the physician. Clinic personnel dropped off notes to the nurse and to the physician, generally between en-

counters, and they dealt with the notes then or kept the notes for disposal later.

Missing in Japan are the middle men: those who take a cut of health care revenues but do not deliver health care. Businesses are prohibited from health care. There is only one insurance plan, and this one has no stockholders to support. Advertising is minimal, and the costs of care remain reasonable, as the government does not allow increases of total health spending. Suppliers cannot gouge health businesses for more profits. Health care there was local in focus, not massive and distant as in the U.S.

What is frustrating in the U.S. is that few see how primary care could be delivered, especially when the focus is about delivering primary care rather than care in other areas. It is frustrating to hear people who have closed minds when examples are used from other nations. There is often a knee jerk negative response rather than examination and objective comparison. If the U.S. hopes to recover primary care and basic health access for most Americans, it will certainly need examples from different designs rather than from the ones that have failed for the past 30 years in the primary care workforce. ♦

Refugee Health Program

Health disparities can exist in the refugee population due to their limited English proficiency (LEP), lack of knowledge regarding the western health system, illiteracy in one's native language and cultural differences in approaches and beliefs in healthcare.

The State Refugee Health Coordinator (RHC) serves as a public health liaison, health educator, community facilitator and program planner at the Arizona Department of Health Services in support of the mission for the Refugee Health Program within the Arizona Department of Economic Security Arizona Refugee Resettlement Program (RRP).

The Refugee Health Program is addressing the health needs of refugees in the community by serving and contributing to various workgroups and advisory boards such as the Refugee Primary Care Working Group in Tucson, the International Rescue Committee Interpreter Service Advisory Board in Phoenix, and a committee initiated and convened by RRP that is entirely comprised of former refugees who are leaders in their respective communities. All partners are committed to improving education outreach to providers and refugee communities, assessing the health needs of refugees, coordinating screening services and advocating for linguistic and culturally appropriate care. For more information, please contact Carrie Senseman at 602-364-3592, sensemcc@azdhs.gov or visit <http://www.azdhs.gov/phs/edc/refugee/index.htm>. ♦

Arizona Health Start Program

The Arizona Health Start Program is a community-based home visiting program that utilizes community health workers (CHWs) to provide education, support and advocacy services to pregnant and postpartum women and their families in targeted communities across Arizona. The program goals are to increase prenatal care services to pregnant women and reduce the incidence of low birth weight births and premature births. The CHWs reflect the ethnic culture of their communities and receive extensive training. Women and families enrolled in the program receive home visits by CHWs at least once per month during their pregnancy and regular visits after the birth of their children up to two years of age. In FY2010, the Health Start Program was provided in 100 targeted high risk communities and provided services to 2,200 women and their families. In 2009, 7.1 percent of all Arizona infants were born at a low birth weight or at less than 2,500 grams (5 pounds, 8 ounces). Low birth weight rates and shorter gestational periods (< 37 weeks) were highest for newborns of African-American mothers. In Arizona, American Indian, Hispanic or Latino, and African-American mothers were least likely to begin prenatal care in the first trimester. Health Start is effective in reducing these health disparities. Recently published research on the Health Start Program by the Arizona Department of Health Services found that Health Start participants had higher birth weight babies (above 2,500 grams) and longer gestational periods (37 weeks) than non Health Start participants. For more information please contact Sara Rumann, Health Start/FASD Program Manager, sara.rumann@azdhs.gov. ♦

The Power of Organ Donation continued from page 1

Rosa has shared her story since she became a volunteer for Donor Network of Arizona, the state's organ procurement organization, in 2003. "Especially for minority communities, it's so important that they learn what donation means for the thousands of people waiting for a transplant."

Currently in the United States there are more than 110,000 people on the waiting list for a transplant; more than half are minorities. The organ most needed by all minority patients waiting for a transplant is a kidney.

If people wish to register as organ and tissue donors, they can do so at the Motor Vehicle Division, at www.DonateLifeAZ.org or by calling 1-800-94-DONOR. ♦

When to intervene: elementary school, middle school or both? Effects of *keepin' it REAL** on substance use trajectories of Mexican heritage youth

Published by *Prevention Science*, this article presents the findings of a study exploring two questions: what age is most efficacious to expose Mexican heritage youth to drug abuse prevention interventions, and what dosage of the prevention intervention is needed? These issues are relevant to Mexican heritage youth, many from immigrant families, in particular ways due to the acculturation process and other contextual factors. The authors, Drs. Flavio F. Marsiglia, Stephen Kulis, Scott T. Yabiku, Tanya Nieri, and Elizabeth Coleman, utilized growth curve modeling to investigate the trajectory of recent substance use (alcohol, cigarettes, marijuana, inhalants) among Mexican heritage students (N=1,670) participating in the *keepin' it REAL* drug prevention program at different developmental periods: the beginning of elementary school (5th grade), in middle school (7th grade), or both. The study provided clear evidence that early intervention in elementary school alone did not lead to desired effects on substance use trajectories, and that a double dose of intervention in elementary and middle school was no more effective than middle school intervention alone. The largely consistent evidence of the effectiveness of the original *keepin' it REAL* intervention for middle school suggests that universal prevention interventions that incorporate specific drug resistance training in culturally appropriate ways continue to demonstrate great promise in preventing and reducing youth substance use.

For more information, please contact Principle Investigator, Dr. Flavio F. Marsiglia at marsiglia@asu.edu. ♦

* *keepin' it REAL* is a SAMHSA (Substance Abuse and Mental Health Services Administration) Model program developed at Southwest Interdisciplinary Research Center (SIRC), Arizona State University. *REAL* stands for the strategies that SIRC researchers found youth use most often to stay safe from alcohol and drugs: refuse, explain, avoid and leave

Data analysis was supported by the National Institutes of Health/National Center on Minority Health and Health Disparities (Grant Number P20MD002316-02) to Southwest Interdisciplinary Research Center, an Exploratory Center of Excellence on Health Disparities Research and Training. The data were collected with support from the National Institute on Drug Abuse (R-24 DA 13937-01 and R01 DA005629-09A2).

Increasing American Indian Access to Behavioral Health Care

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Work is being finalized for the co-location of Magellan providers (SMI evaluators) in the Indian Health services (IHS) Phoenix Indian Medical Center (PIMC) for better coordination of care for clients.

The four RBHAs hired very unique individuals. They all have experience working for and with tribes and have worked and lived in tribal communities. The Tribal Liaisons, except for one, are members of an American Indian tribe. The one Tribal Liaison who is a non-tribal member has extensive experience living and working on an Indian reservation. Several Tribal Liaisons travel thousands of miles during the year in order to meet with the tribal staff in the rural and isolated tribal communities. A crucial quality of the Tribal Liaisons is their commitment and dedication to increasing access to care for American Indians.

The RBHA Tribal Liaison efforts to increase access to services for American Indians in Arizona are reflected in the increase in the Enrollment and Penetration Rates. Since July 2008, the American Indian Enrollment and Penetration Rates have doubled. Enrollment in Arizona's GSAs has increased from 2.6% to 5.0% of the American Indian Population, and Penetration Rates increased from 2.2% to 4.4% from July 2008 to July 2010.

The contact individuals for the RBHA Tribal Liaisons are Cheri Wells, L.P.C., Northern Arizona Regional Behavioral Health Authority (NARBHA) at Cheri.Wells@narbha.org or (928)-774-7128; Julia N. Chavez, Community Partnership of Southern Arizona (CPSA) at Julia.Chavez@cpsa-rbha.org or (520) 618-8863; Sheina Yellowhair, Cenpatico Behavioral Health of Arizona (CBHA) at syellowhair@centene.com or (866) 495-6738, x26192; and D'arcy Roybal, Magellan Health Services of Arizona at DJRoybal@magellanhealth.com or (602) 797-8373. ♦

(The article's contributors: Diana Kramer, Cathy Hannen and John Morrison.)

Funding Opportunities:

Pfizer Fellowship in Health Disparities

Deadline: February 11, 2011

Number and amount of award: One award of up to \$100,000, paid over 2 years at \$50,000 per year

<http://www.pfizerfellowships.com/AwardDetails.aspx?AwardID=2260>

Alzheimer's Foundation of America (AFA): Family Respite Care Grant

Deadline: May 01, 2011

Amount of funding: \$1,000 each to dozens of families

Contact: 866-232-8484 or raponte@alzfdn.org

http://www.alzfdn.org/AFAServices/family_grant.html

National Institutes of Health: Behavioral and Social Science Research on Understanding and Reducing Health Disparities

Deadline: May 11, 2013

Program Announcement (PA) Number: PAR-10-136

<http://grants.nih.gov/grants/guide/pa-files/PAR-10-136.html> ♦

Publications of Interest:

CDC Health Disparities and Inequalities Report — United States, 2011, The report details racial disparities in a broad array of health problems. <http://www.cdc.gov/mmwr/pdf/other/su6001.pdf>

Strong Medicine for a Healthier America

The supplement to the January 2011 issue of the *American Journal of Preventive Medicine*, examines what is happening in states, communities and neighborhoods to address social contributors to health.

<http://www.ajpm-online.net/issues>

New State Snapshots Demonstrate Health Disparities

The snapshots include an overview of how children in your state compare to the nation on 21 key health status and system performance measures related to: chronic conditions, complexity of health service needs, health insurance, access to care, preventive care and medical home.

http://nschdata.org/indicators/Indicator_Report.aspx?rid=4&gid=0 ♦

For more information about funding opportunities, publications of interest and events of interest, please visit www.azminorityhealth.gov. ♦

Events of Interest:

5th Annual Pathways Into Health Conference: Achieving Excellence, Harmony, and Balance – Striving to cultivate a robust American Indian and Alaska Native healthcare workforce through the 7th generation

Dates: February 23-25, 2011

Location: Westin La Paloma Resort, Tucson, AZ

www.pathwaysintohealth.org

21st Annual Art & Science of Health Promotion Conference

Date: March 21–25, 2011

Location: Colorado Springs, CO

Contact: 248-682-0707 or [confer-](mailto:conference2010@healthpromotionconference.org)

[ence2010@healthpromotionconference.org](mailto:conference2010@healthpromotionconference.org)

www.healthpromotionconference.com

Commission to End Health Care Disparities Spring 2011 Meeting

Dates: April 29-30, 2011

Location: New Orleans, LA

<http://www.ama-assn.org/ama/pub/physician-resources/public-health/eliminating-health-disparities/commission-end-health-care-disparities/meetings.shtml> ♦

Editor's Note:

The *AHDCConnection* is published quarterly on January 31, April 30, July 31 and October 31. We are looking for community stories and other leads that are related to efforts to reduce health disparities in Arizona. Because of space limitation, each community story should not be more than 500 words. Ideas for community stories are also welcome. Our deadline is the 15th of month prior to the publication date. Please email articles or ideas to the editor at

hong.chartrand@azdhs.gov. ♦

