Tribal Epidemiology Center, Tribal, State, & Federal Partnering:

To Improve Public Health Data for American Indians/Alaska Natives (AI/AN)

An Overview

April, 2014

LEARNING OBJECTIVES

- **American Indians and Alaska Natives (AI/AN)**
  - Unique health care entitlement
  - Health disparities
  - Data needs
- **Tribal Epidemiology Centers (TECs)**
  - History
  - Purpose & Function
  - Activities
- **Benefits of partnering with TECs**

Health care entitlement, health disparities, data needs

AMERICAN INDIANS AND ALASKA NATIVES (AI/AN)

American Indians and Alaska Natives

UNIQUE HEALTH CARE ENTITLEMENT

- **Based on Supreme Court decisions, treaties, legislation, and Executive Orders**

- **Federally recognized Tribal members have a unique entitlement to federally funded services for:**
  - **heath care**
  - **public health services**

- **Indian Health Service (IHS) is responsible for fulfilling this federal trust responsibility**
  - **1.9 million AI/AN receiving IHS services**

American Indians and Alaska Natives

RELATIONSHIP WITH FEDERAL US GOVERNMENT & RECOGNIZED TRIBES

- Government-to-government
- Treaties ratified with Indian Nations did not *create* tribal governments
  - US recognized Tribal governments as sovereign entities
  - Tribes are domestic sovereign nations not states or local counties
  - Federal laws apply, but Tribal nations construct all other laws and codes

American Indians and Alaska Natives

U.S. CENSUS DATA

- 565 Federally Recognized Tribes in 35 States
  - Nearly 2.5 million people enrolled

- 2010 Total AI/AN population
  - 5.2 million AI/AN Alone or in combination

- Since 2000, AI/AN pop grew by 26.7% vs. overall US growth of 9.7%

Source: US Census Bureau: CB12-FF.22 ; Oct 25, 2012

American Indians and Alaska Natives

NATIONAL SOCIAL DETERMINANTS OF HEALTH

- **EDUCATION**
  - 79% with a High School education vs. US 86%
  - 13% with Bachelor's degree vs. US 28%
- **INCOME**
  - $35,192 median income vs. US $50,502
  - 29.5% live in poverty vs. US15.9%
- **HEALTH INSURANCE**
  - 27.6% lack insurance vs. US15.1%

American Indians and Alaska Natives

AI/AN NATIONAL MORTALITY RATE DISPARITIES, 2000-2007

MORTALITY	AI/AN RATE	NHW RATE	RATE RATIO [c]
INFANT	8.3[a]	5.6[a]	**1.5**
MOTOR VEHICLE CRASHES	29.1[b]	15.0[b]	**1.9**
SUICIDE	14.6[b]	14.4[b]	1.0
DRUG INDUCED	12.1[b]	13.6[b]	0.9
CORNOARY HEART DISEASE	97.4[b]	134.2[b]	0.7
HOMICIDES	11.8[b]	3.7[b]	**3.2**

[a] RATES Per 1,000 [b] RATES Per 100,000 [c] Disparities for AI/AN are RR >1.0

Source: CDC Morbidly and Weekly Report Supplement 2011,Vol 60 Health Disparities and Inequalities Report.

History, Purpose & Function, and Activities

TRIBAL EPIDEMIOLOGY CENTERS (TECS)

Tribal Epidemiology Centers

ESTABLISHED

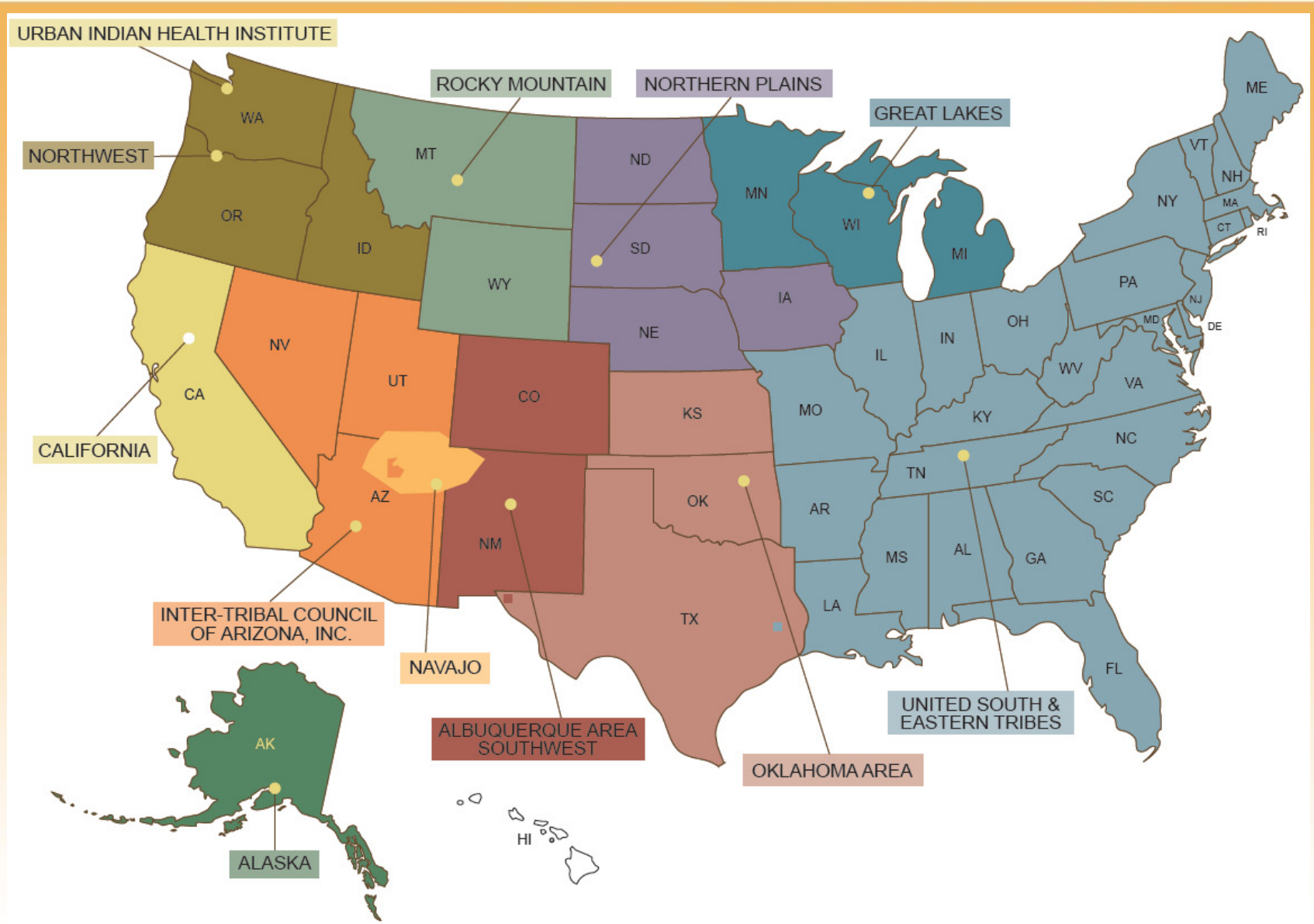
- Congress Indian Health Care improvement Act (IHCIA)
- In 1996, four TECs were started
- TECs function independently, but also as part of a national group
- Core funding: Indian Health Service Cooperative Agreement with IHS Division of Epidemiology and Disease Prevention - provides program oversight, administrative and technical support

Tribal Epidemiology Centers

2010 AFFORDABLE CARE ACT

- **Permanently reauthorized the IHCIA**
- **TECs given *"public health authority"* status**
- **Health and Human Services (HHS) directed to give TECs access to HHS data systems and protected health information**
- **Centers for Disease Control and Prevention must provide TECs technical assistance**
- **Each IHS Area must have TEC access**

Tribal Epidemiology Centers



Tribal Epidemiology Centers

SEVEN CORE FUNCTIONS

"Functions of TECs: In consultation with and on the request of Indian tribes, tribal organizations, and urban Indian organizations, each Service area epidemiology center established under this section shall, with respect to the applicable Service area" and in summary:

- Collect data
- Evaluate data and programs
- Identify health priorities with tribes
- Make recommendations for health service needs
- Make recommendations for improving health care delivery systems
- Provide epidemiologic technical assistance to tribes and tribal organizations
- Provide disease surveillance to tribes

States & Federal Government, TEC & Tribes, All

BENEFITS OF PARTNERING

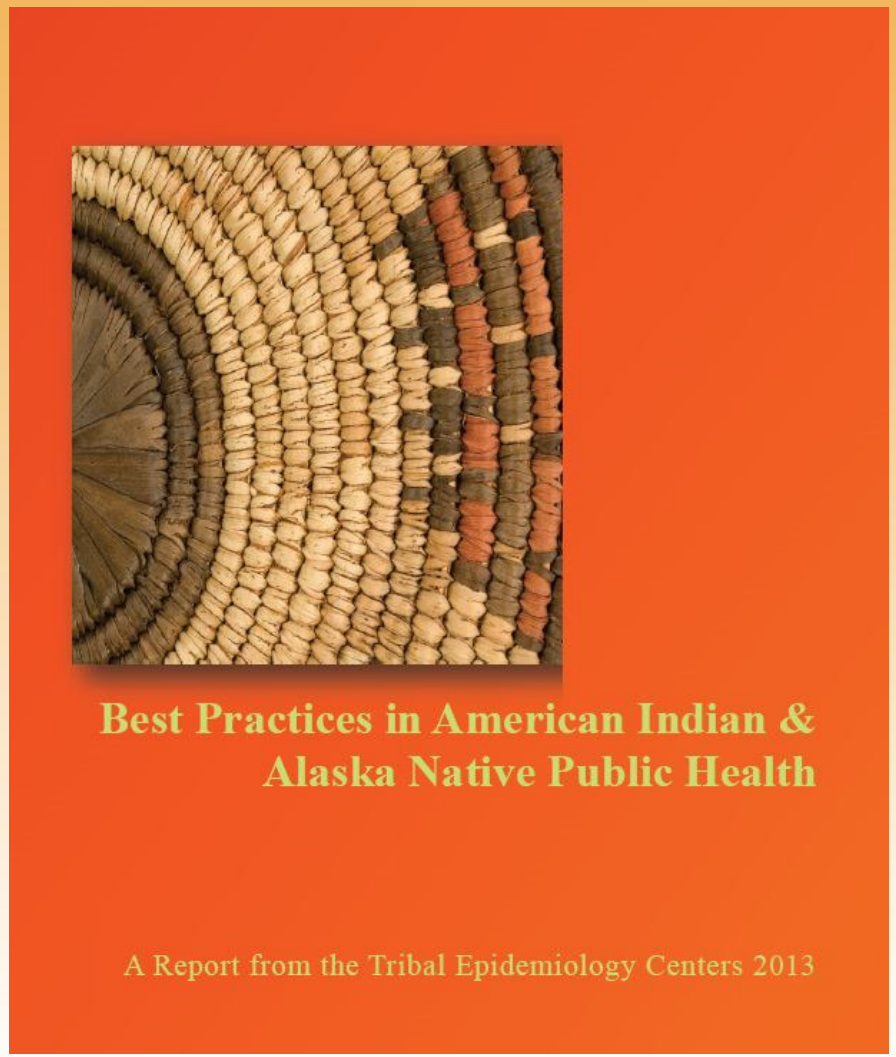
Benefits of Partnering

- **Benefit to States & Federal Governments:**
  - Contribute on solving AI/AN health disparities
  - Ensure data is accurate and reliable
  - Gain guidance with an AI/AN perspective

- **Benefit to TEC & Tribes:**
  - Data needed for AI/AN health assessments
  - Increase utility/quality of data and reports
  - Gain expert guidance

- **Benefit to All:**
  - Makes efficient use of limited resources
  - Increased capacity to serve AI/AN populations
  - Improve AI/AN health outcomes

TEC Best Practices Report



- Published Jan. 2014
- All 12 TECs included
- Electronic and limited paper copies available
  - TEC websites
  - Vendor booth

Contents

- Executive Summary
- Overview of Tribal Epidemiology Centers
- Brief Profile of Each TEC
- 19 Featured Best Practices
- Data Challenges and Strategies
- Future Directions/Next Steps

Featured Best Practices

- Adolescent Health
- Behavioral Health
  - Suicide
  - Substance Abuse
  - Mental Health
- Chronic Disease
  - Asthma
  - Cancer
  - Diabetes

Featured Best Practices - Continued

- Obesity
- Immunizations
- Sexually Transmitted Diseases
- Injury and Injury Prevention
- Maternal and Child Health
- Vital Statistics

Featured Best Practices – Continued

AASTEC YRRS/YRBS Oversample 2007-2013

Survey Year	Additional Schools	Additional Students	Response Rate	Total Students
2007	**3** All High Schools	**594 AI/AN**	**70%**	**2,366 AI/AN** 11,328 ALL
2009	**23** High schools = 13 Mid schools = 10	**1,985 AI/AN** 3,794 ALL	**74%**	**8,274 AI/AN** 45,877 ALL
2011	**33** High schools = 15 Mid schools = 18	**3,471 AI/AN** 7,392 ALL	**79%**	**10,600 AI/AN** 29,404 ALL
2013	**46** High schools = 21 Mid schools = 25	***Pending***	**78%**	***Pending***

TEC Success Stories

- **Ability to Practice Public Health:**
  - Among over 560 different Tribes with varying health believes, cultures and traditions
  - In RURAL communities and sometimes SUPER FRONTIER communities
  - Among communities with limited public health infrastructure/foundation
  - With very little funds for great public health needs/gaps
  - With very little technical support help
  - With very willing communities who volunteer at the drop of a hat and with direction, are willing to get the work done.

TEC Challenges

- **Affordable Care Act (ACA) Support**
  - **Fully funded TEC based on PUBLIC HEALTH CAPACITY BUILDING need not population**
- **DHHS Agencies Support**
  - **Qualified Public Health Practitioner Assignments**
  - **Project Technical Support**
- **Data**
  - **Access**
  - **Race/Ethnicity Measures/Misclassification**
  - **Small Population Size**
  - **Data Quality**

Future Directions/Next Steps

- **Incorporate TEC Surveillance into larger surveillance systems**
- **CBPR Approaches**
- **Collaboration with other public health entities**
  - **Tribal**
  - **County**
  - **State**
  - **Federal**

Questions?

Contact Information

•Tom Anderson, MPH

Oklahoma Area TEC (OKTEC)

tom.anderson@ihs.gov

•Kevin English, DrPH

Albuquerque Area TEC (AASTEC)

kenglish@aaihb.org

•Dr. Folorunso Akintan, MD MPH

Rocky Mountain TEC (MTWYTLC)

fakintan@mtwytlc.com