Urban Indian Health Institute

A Division of the Seattle Indian Health Board

VISIBILITY THROUGH DATA:
Health Information for Urban American Indian and Alaska Native Communities

UIHI

The mission of the Urban Indian Health Institute is to support the health and well- being of Urban Indian communities through information, scientific inquiry and technology.

2009

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ACKNOWLEDGEMENTS

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The UIHI would like to thank the staff at the urban Indian health organizations for their input and acknowledge the excellent work they do daily on behalf of their communities.

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INTRODUCTION

HEALTH DISPARITIES AND PRIORITY ISSUES FACING URBAN AMERICAN INDIANS AND ALASKA NATIVES: WHAT WE KNOW NOW AND WHERE WE NEED TO GO FROM HERE

Over the past several years, the Urban Indian Health Institute has reported the benefits and shortcomings of data availability and analytical capacity for urban Indian health issues. This report is intended to provide all those working toward improving the health and well-being of urban American Indians and Alaska Natives (AI/AN) with a summary of our findings to serve as a resource that highlights some of the specific key health issues facing this population. It is meant to be both an end point, and a beginning for further conversations.

The report offers structure to information that has been collected from numerous sources about health issues facing AI/AN living in urban areas. We have divided the report into three sections:

Section I offers two ranked lists of health disparities affecting urban AI/AN. These were developed looking at national datasets that were not exclusively designed to track urban Indian data. Disparities on the ranked lists were measured against national data standards based on Healthy People 2010 Objectives. Also included in this section is a description of known limitations of current national data sources that are relevant when assessing the health of urban AI/AN. This description is an essential piece of creating credibility in our study findings. Since national datasets are acquired using different techniques and questions, the ability to affirmatively state our findings is limited by the demand to analyze these data through a less precise lens. Knowing this is vital to offering defensible arguments in our grants and advocacy.

Section II summarizes findings from two direct sources: (1) results from a survey sent to individuals working in urban Indian health organizations and (2) analysis of specific requests for technical assistance or data over the past year. This information provides us with guidance as to what your needs might be now and in the future.

Section III offers guidance on how you might consider using this information for advocacy, future grant writing, and program planning purposes. Also included in this section are recommendations we assert will improve national data collection for urban AI/AN analysis, and what you can do locally to advocate for better sources of available information that accurately describe the health of our communities.

We hope this report can serve as a springboard for further conversations about what those working in urban Indian health see as their primary local and national priorities. We welcome any and all comments, questions, stories, and feedback about this report and how well it aligns with your experience. We also are very interested to hear about your current activities that are showing success in combating these problems.

Please contact the Urban Indian Health Institute with your comments: info@uihi.org or 206-812-3030. You can also fill out the form on page 24 with comments or questions.

WHO ARE URBAN AMERICAN INDIANS AND ALASKA NATIVES?

American Indians and Alaska Natives (AI/AN) are a diverse and growing population. Based on the government's definition outlined in the Snyder Act, an American Indian or Alaska Native person is a member or descendent of a member of one or more tribes that may or may not be federally recognized. Additionally, individuals may or may not have historical, cultural, or religious ties to their tribal community. Over the past half-century, AI/AN have increasingly relocated from rural communities and Indian reservations into urban centers both by choice and by force, through federal policy.

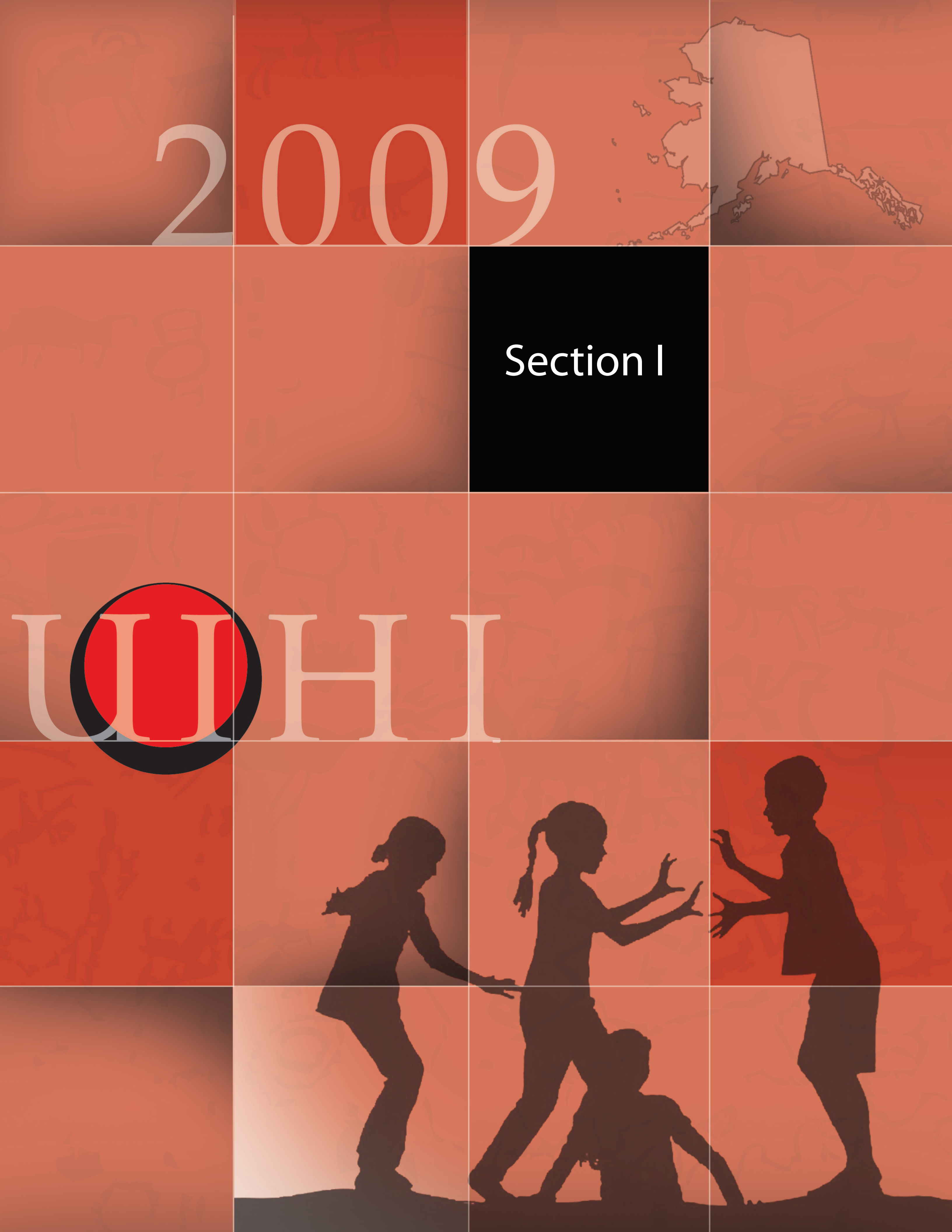
The standard definition of an urban AI/AN is any AI/AN who lives in an urban center. Individuals may travel back and forth between their tribal communities or reservations and urban centers, characterizing the population as mobile. Urban AI/AN are generally spread out within a metropolitan area instead of localized within one or two neighborhoods, thus making it difficult to be seen or recognized by the wider population. Despite this geographical shift trend, urban AI/AN are generally not included in the Indian health community, nor are they customarily listed as a minority population in local and national assessment. As a result, they remain invisible and overlooked by the larger society.

URBAN INDIAN HEALTH ORGANIZATIONS

Urban Indian health organizations (UIHO) are private, non-profit corporations that are governed by AI/AN majority Boards of Directors and serve as social and service hubs for AI/AN in select cities. Today, the network of UIHO are most often affiliated with contractual agreements with the federal Indian Health Service under Title V of the 1976 Indian Health Care Improvement Act.

UIHO range in size and services from small information and referral sites to large community health centers offering medical and dental services that are part of local safety net provider networks for the uninsured and poverty communities. UIHO serve individuals in approximately 102 counties in 19 states, and manage to provide services to more than 150,000 clients each year.

Often seen as centers for cultural activities and identity, UIHO offer AI/AN living in these urban areas a place where they can receive health information and services in a culturally appropriate manner. This report includes data from the 34 urban centers served by Title V UIHO, but we acknowledge that many AI/AN living in other urban areas are not represented. For a complete list of Title V UIHO and their service areas, see Appendix A.



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Section I

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SECTION I

USING NATIONAL DATA TO DEVELOP RANKED LISTS OF DISPARITIES FACING URBAN AMERICAN INDIANS AND ALASKA NATIVES

One of two overarching goals of Healthy People 2010 (HP 2010) is to reduce health disparities. Health inequities, or disparities, among ethnic groups result from a complex array of social, economic and historical factors that we are only beginning to understand.[1] Measuring and tracking these differences between groups is an important step in eventually finding interventions targeted to the community in need to help bring about health equity. It has only been in the past decade that a real focus on understanding the extent of health disparities affecting urban AI/AN nationwide has taken place.

For this report, we developed two ranked lists of health disparities facing urban American Indians and Alaska Natives with data primarily from three national sources: (1) Vital Statistics (birth, death, and linked birth/infant death records), (2) the Behavioral Risk Factor Surveillance System (BRFSS), and (3) the Youth Risk Behavior Survey (YRBS). Limited data from the Sexually Transmitted Disease Surveillance System is also included. More information about each of these data sources can be found in Appendix B.

Measurements are based on Healthy People 2010, a national plan that provides a framework for prevention activities in public health. HP 2010 Objectives are action statements toward which the nation, communities, institutions and local groups can work. A complete list of HP 2010 focus areas can be found in Appendix C and more about this national endeavor can be found at http://www.healthypeople.gov.

HP 2010 Objectives that are able to be measured for one population (such as urban AI/AN) were included in this analysis. Objectives that were not included were those that target schools, states, air quality, and other non-population based institutions. A more detailed description of the development of our HP 2010 database and the indicators that were included for analysis can be found in Appendix D.

The National Center for Health Statistics has developed a framework for the measurement of health disparities that allows for comparison across indicators.[2] This framework was used throughout this analysis process when possible.

The ranked list includes all analyzed indicators where urban AI/AN show rates at least 3 times higher than the target rate.

The first ranked list of disparities offered here compares the rate for each available indicator among urban AI/AN to the HP 2010 Objective target. Targets are specific rates or measurements that were established for the nation and communities to attempt to reach by the year 2010. The ranked list that we developed includes all analyzed indicators where urban AI/AN show rates at least 3 times higher than the target rate.

The second list of ranked disparities compares the rate for each indicator among urban AI/AN to the rate among the general population in the same geographic areas. The general population includes people of all races, including AI/AN. This second ranked list includes all indicators where urban AI/AN show rates at least 1.5 times higher than the rate in the general population. Because the general population as a whole is still not meeting the HP 2010 target for most objectives, the disparities based on the general population were relatively lower than those based on the HP 2010 targets.

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1 - WHO, 2006. The Development of the Evidence Base of the Social Determinants of Health.

2 - Keppel K, Pamuk E, Lynch J., et al. Methodological issues in measuring health disparities. National Center for Health Statistics. Vital Health Stat 2(141). 2005.

SECTION 1 | *Continued on page 6*

Section I

Geographic areas for most data sources used for analysis were areas served by one of the 34 Title V urban Indian health organizations (see Introduction Section for more information). For YRBS indicators, all youth who attended school in an urban area (Census-defined Metropolitan Statistical Area) were included.

We include here both ranked lists in order to get a more complete picture of disparities facing our communities. Many indicators were common to both ranked lists.

As you look over the ranked lists provided on the following pages the following definitions and explanations below may be helpful:

HP 2010 Objectives:

These are the official HP 2010 Objectives, with the related chapter and indicator number. More about each indicator and the background of the health issues can be found here: www.healthypeople.gov.

HP 2010 Target:

This is the specific rate that has been established as a goal to reach by 2010.

Description of Measured Indicator:

This is what was actually measured in the survey or data source. It may be slightly different than the HP 2010 Objective, but it was what was available in the data source used. Some of these may have been changed to restate the measure with the opposing outcome. When disparities are measured to be compared with each other they should be stated with an adverse outcome.[4] However not all HP 2010 Objectives are written this way. Thus, the HP 2010 Objective "Increase the proportion of persons with health insurance" was changed for this disparity analysis to "Percent of the population with no health insurance." In the second ranked list of disparities, based on the rate in the general population, the measured indicators may be quite different from the HP 2010 Objective. For example, the measured indicator "Alcohol-related deaths" encompasses more than the HP 2010 Objective "Alcohol-related motor vehicle deaths," but we chose to include this indicator when looking at the rate among AI/AN compared with the general population. We did not compare the rate among AI/AN with the HP 2010 Target in these examples because of the variation of the two measurements.

Rate:

A rate is used to measure an event in a population in a specific place and within a certain time period. Rates are calculated by taking the number of "events" (for example, a birth or a student reporting current tobacco use) over the number of people in the population who could be at risk for such an event (such as women living in the county of interest, or students in a school answering a survey question). These numbers are then multiplied by a common number (such as 100, 1000, or 100,000) in order to make the final number more meaningful and comparable to other places, times, or populations.

For example, in County X:
- 7 babies between the ages of 28 days and 1 year died in 2008 (this is considered the "post-neonatal period" when examining infant deaths)
- During 2008 there were 1840 babies born alive in County X (this is the number of individuals who would be considered "at-risk" during this time period)
- Calculate: $\left(\frac{7}{1840}\right) \times 1000 = 3.8$
- So, in 2008 County X had a post-neonatality death rate of 3.8 per 1000 live births

General Population Rate: (only included in second ranked list)
This is the rate measured among everyone (including AI/AN) living in the designated urban areas.

AI/AN Rate:
This was the rate measured among urban American Indians and Alaska Natives. Details about years of data used and geography represented for each indicator are in *Appendix C*.

Disparity Ratio:
This is the actual disparity measurement and is how these lists are ranked. To calculate the disparity ratio, take the rate among urban AI/AN (labeled AI/AN Rate) and divide it by the HP 2010 Target, or the rate in the general population (not provided).

$$\text{Disparity Ratio} = \frac{\text{AI/AN Rate}}{\text{HP 2010 Measure}}$$

HP 2010 Objective 18.2 Reduce the rate of suicide attempts by adolescents:

Disparity Ratio is: $\left(\frac{10.9}{2.7}\right) = 4$

Two examples taken from the tables on the next pages are, "Urban AI/AN are 29 times more likely to be uninsured than the national target," or, as shown above, "Urban AI/AN youth are 4 times more likely to have attempted suicide than all urban youth combined."

HP 2010 Measure: (only included in first ranked list)
This is generally the same as the HP 2010 Target, but may reflect the change between an objective written with a positive outcome to one with an adverse outcome (see above).

Recommended Source and Actual Source Used:
We do not have direct access to all of the recommended sources of data, and/or urban AI/AN may not be adequately represented in those sources. In these cases, we have used another source of data to examine the health disparities. The outcome of the indicator may change depending on the source used (e.g. a rate may go up or down depending on how the question is asked, who it is asked of, and other details). This is a limitation of these ranked lists of disparities.

If a HP 2010 Objective is on both ranked lists, it is bolded in the tables below. In addition, certain HP 2010 Objectives have been designated by the Office of Minority Health (OMH) as objectives of "particular relevance" for racial/ethnic minority populations. Others have been identified as objectives that, among AI/AN as a whole, need more progress toward the target because not enough progress was shown over the first part of the decade. We call these "OMH Priority Objectives" and "OMH Limited Progress Objectives," and they are noted in each table.

As you look over these ranked lists, keep in mind that measured health disparities are only one way to look at the health of a population. These ranked lists do not include all important health indicators, and do not necessarily include the issues most detrimental to the health and well-being of urban American Indians and Alaska Natives. But they do show areas where severe inequities exist, and can point to places where interventions can and should be targeted.

These ranked lists present areas where severe inequities exist, and can point to places where interventions can and should be targeted.

Table I

RANKED LIST OF KNOWN HEALTH DISPARITIES AMONG URBAN AMERICAN INDIANS & ALASKA NATIVES, COMPARED WITH HP 2010 TARGETS

For complete description of the contents of this table, please see pages 6-7.

Legend

\# - OMH Priority Objectives (see page 7)

$ - OMH Limited Progress Objectives (see page 7)

Bold - HP 2010 Objectives are common to both disparity lists

HP 2010 Objective	HP 2010 Target	Description of Measured Indicator	HP 2010 Measure	AI/AN Rate	Disparity Ratio	Recommended Source (HP 2010)	Actual Source Used (UIHI)
26.10b Reduce the proportion of adolescents reporting use of marijuana	0.7 % in past 30 days	Used marijuana one or more times during the past 30 days	0.7%	38%	54.3	National Household Survey on Drug Abuse	Youth Risk Behavior Survey
1.1 Increase the proportion of persons with health insurance[#]	100%	Adults age 18-64 who do not have health insurance	1% (rounded to 1 from 0 in order to calculate ratio)	28.8%	28.8	National Health Interview Survey	Behavioral Risk Factor Surveillance System
26.11d Reduction in adolescents aged 12 to 17 years engaging in binge drinking	2.0 % in past month	Reported five or more drinks in a row in past 30 days	2%	32.6%	16.3	National Household Survey of Drug Abuse	Youth Risk Behavior Survey
27.2c Reduce tobacco use by adolescents: spit tobacco[#]	1.0% in past month	Reported spit tobacco use in the past 30 days	1%	15.7%	15.7	Youth Risk Behavior Survey	Youth Risk Behavior Survey
18.2 Reduce the rate of suicide attempts by adolescents[$]	12 month average of 1%	Suicide attempts in youth that required medical attention in past 12 months	1%	10.9%	10.9	Youth Risk Behavior Survey	Youth Risk Behavior Survey
26.15 Reduce the proportion of adolescents age 12-17 who use inhalants	0.7% in the last year	Sniffed glue, breathed contents of aerosal cans, or inhaled any paints or sprays to get high one or more times during last 30 days	0.7%	7.4%	10.6	National Household Survey of Drug Abuse	Youth Risk Behavior Survey
13.14 Reduce deaths from HIV infection	0.7 deaths per 100,000 persons	Death rate: HIV Disease per 100,000 persons	0.7%	4.4%	6.3	National Vital Statistics System	National Vital Statistics System
16.1h Reduce deaths from sudden infant death syndrome (SIDS)	0.25 deaths per 1000 live births	Infant death rate: sudden infant death syndrome (SIDS) per 1000 births	0.25%	1.5%	6	National Vital Statistics System	National Vital Statistics System
3.11a Increase the proportion of women age 18 years+ who ever received a Pap test	97% of women ever received Pap test	Women age 18 years and older who have NEVER had a Pap test	3%	15.2%	5.1	National Health Interview Survey	Behavioral Risk Factor Surveillance System

Table I - CONTINUED

RANKED LIST OF KNOWN HEALTH DISPARITIES AMONG URBAN AMERICAN INDIANS & ALASKA NATIVES, COMPARED WITH HP 2010 TARGETS

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- OMH Priority Objectives (see page 7)

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Bold - HP 2010 Objectives are common to both disparity lists

HP 2010 Objective	HP 2010 Target	Description of Measured Indicator	HP 2010 Measure	AI/AN Rate	Disparity Ratio	Recommended Source (HP 2010)	Actual Source Used (UIHI)
25.2 Reduce gonorrhea$	19 new cases per 100,000 population	Diagnosed cases per 100,000 population	19%	84.3%	4.4	STD Surveillance System	STD Surveillance System
14.29b Increase the proportion of adults who are ever vaccinated against pneumococcal disease: non-institutionalized adults aged 65 years and older#	90%	Adults age 65 years and older who have never received a pneumococcal vaccine	10%	41.6%	4.2	National Health Interview Survey	Behavioral Risk Factor Surveillance System
16.6b Increase the proportion of women that receive early and adequate prenatal care	90% of live births	Percent of live births who did not receive early and adequate prenatal care *(Kotelchuck index)*	10%	39.4%	3.9	National Vital Statistics System	National Vital Statistics System
26.11c Reduction in adults aged 18 years and older engaging in binge drinking	6% in past month	Adults age 18 and older who reported five or more drinks in one occasion in past month	6%	21.3%	3.6	National Household Survey on Drug Abvuse	National Household Survey on Drug Abvuse
16.1e Reduce post-neonatal deaths (between 28 days and 1 year)	1.2 per 1000 live birth	Infant death rate: post-neonatal deaths per 1000 live births	1.2%	4.3%	3.6	National Vital Statistics System	National Vital Statistics System
14.29a Increase the proportion of adults who are vaccinated annually against influenza: non-institutionalized adults aged 65 years and older	90%	Adults age 65 and older who did not receive influenza vaccine in past 12 months	10%	31.7%	3.2	National Health Interview Survey	National Health Interview Survey
16.6a Increase in maternal prenatal care beginning in first trimester of pregnancy#	90% of live births	Prenatal care did not begin in first trimester	10%	30.7%	3.1	National Vital Statistics System	National Vital Statistics System

Table II

RANKED LIST OF KNOWN HEALTH DISPARITIES AMONG URBAN AMERICAN INDIANS & ALASKA NATIVES, COMPARED WITH GENERAL POPULATION*

For complete description of the contents of this table, please see pages 6-7.

Legend

- OMH Priority Objectives (see page 7)
$ - OMH Limited Progress Objectives (see page 7)
Bold - HP 2010 Objectives are common to both disparity lists

HP 2010 Objective	HP 2010 Target	Description of Measured Indicator	General Population Rate	AI/AN Rate	Disparity Ratio	Recommended Source (HP 2010)	Actual Source Used (UIHI)
18.2 Reduce the rate of suicide attempts by adolescents$	12-month average of 1%	Suicide attempts in youth that required medical attention in past 12 months	2.7%	10.9%	4.0	Youth Risk Behavior Survey	Youth Risk Behavior Survey
26.1 Reduce alcohol-related motor vehicle deaths	4 per 100,000 population	Death rate: alcohol-related deaths per 100,000 population	10.1%	28.1%	2.8	Fatality Analysis Reporting System	National Vital Statistics System
16.1h Reduce deaths from sudden infant death syndrome (SIDS)	0.25 deaths per 1,000 live births	Infant death rate: sudden infant death syndrome (SIDS) per 1,000 births	0.6%	1.5%	2.5	National Vital Statistics System	National Vital Statistics System
26.2 Reduce cirrhosis deaths	3.0 deaths per 100,000 population	Death rate: chronic liver disease and cirrhosis per 100,000 population	10.3%	23.2%	2.3	National Vital Statistics System	National Vital Statistics System
27.2c Reduce tobacco use by adolescents: spit tobacco#	1% in the past month	Reported spit tobacco use in the past 30 days	7.3%	15.7%	2.2	Youth Risk Behavior Survey	Youth Risk Behavior Survey
3.11a Increase the proportion of women age 18 years+ who ever received a Pap test	97% of women ever received Pap test	Women age 18 years and older who have NEVER had a Pap test	7.0%	15.2%	2.2	National Health Interview Survey	Behavioral Risk Factor Surveillance System
15.39 Reduce weapon carrying by adolescents on school property	4.9 percent in past 30 days	Carried a weapon on school property in past 30 days	6.8%	14.4%	2.1	Youth Risk Behavior Survey	Youth Risk Behavior Survey
16.1e Reduce post-neonatal deaths (28 days to 1 year)	1.2 per 1,000 live births	Infant death rate: post neonatal deaths per 1,000 live births	2.1%	4.3%	2	National Vital Statistics System	National Vital Statistics System
9.7 Reduce pregnancies among adolescent females*	43 pregnancies per 1,000	Ever been pregnant or gotten someone pregnant *(boys and girls)*	5.7%	10.6%	1.9	Abortion Provider Survey, The Alan Guttmacher Institute	Youth Risk Behavior Survey
26.14 Reduce steriod use among adolescents	0.4% in past year	Took steriod pills or shots without doctor's prescription during lifetime	4.2%	7.9%	1.9	Monitoring the future study	Youth Risk Behavior Survey

* The general population refers to individuals of all races living in the same geographic areas, including AI/AN.

Table II - CONTINUED

RANKED LIST OF KNOWN HEALTH DISPARITIES AMONG URBAN AMERICAN INDIANS & ALASKA NATIVES, COMPARED WITH GENERAL POPULATION*

For complete description of the contents of this table, please see pages 6-7.

Legend

- \# - OMH Priority Objectives (see page 7)
- $ - OMH Limited Progress Objectives (see page 7)
- **Bold** - HP 2010 Objectives are common to both disparity lists

HP 2010 Objective	HP 2010 Target	Description of Measured Indicator	General Population Rate	AI/AN Rate	Disparity Ratio	Recommended Source (HP 2010)	Actual Source Used (UIHI)
26.15 Reduce the proportion of adolescents age 12-17 who use inhalants	0.7% in past year	Sniffed glue, breathed contents of aerosol cans, or inhaled any paints or sprays to get high one or more time during last 30 days	4.2%	7.4%	1.8	National Household Survey on Drug Abuse	Youth Risk Behavior Survey
9.8 Increase the proportion of adolescents who have never engaged in sexual intercourse before age 15 years	88%	Had sexual intercourse for the first time before age 13	7.4%	12.4%	1.7	Females: National Survey of Family Growth, Males: National Survey of Adolescent Males	Youth Risk Behavior Survey
16.6a Increase in maternal prenatal care beginning in the first trimester of pregnancy#	90% of live births	Prenatal care did not begin in first trimester	17.9%	30.5%	1.7	National Vital Statistics System	National Vital Statistics System
26.9a Increase in average age of first use in adolescents aged 12 to 17 years: marijuana	Average age in years: 17.4	Tried marijuana for the first time before age 13	10.3%	17.5%	1.7	National Household Survey on Drug Abuse	National Vital Statistics System
1.1 Increase the proportion of persons with health insurance#	100%	Adults age 18-64 who do not have health insurance	18.2%	28.8%	1.6	National Health Interview Survey	Behavioral Risk Factor Surveillance System
1.6 Reduce the proportion of families that experience difficulties or delays in obtaining health care do not receive needed care for one or more family member#	7%	Could not see a doctor because of the cost in past year	12.9%	19.8%	1.5	Medical Expenditure Panel Survey	Behavioral Risk Factor Surveillance System
19.2 Reduce the proportion of adults who are obese	15%	BMI≥30, by reported height and weight	20.5%	30.1%	1.5	National Health and Nutrition Examination Survey	Behavioral Risk Factor Surveillance System
26.10b Reduce the proportion of adolescents reporting use of marijuana	0.7% in past 30 days	Used marijuana one or more times during the past 30 days	25.2%	38%	1.5	National Household Survey on Drug Abuse	Youth Risk Behavior Survey
27.4a Increase the average age of first use of tobacco products among adolescents aged 12 to 17 years	Avergae age of first cigarette use: 14	Smoked a full cigarette for first time before age 13 *(percent of population)*	22%	33.1%	1.5	National Household Survey on Drug Abuse	Youth Risk Behavior Survey

* The general population refers to individuals of all races living in the same geographic areas, including AI/AN.

TABLE SUMMARIES

WHAT THESE RANKED LISTS TELL US AND WHERE TO GO FROM HERE

A total of 99 out of approximately 322 HP 2010 Objectives or sub-objectives have been analyzed by the UIHI, and were included in this analysis. The remaining indicators either are not analyzable due to limitations on the part of the dataset (see below for more about these limitations), or the UIHI does not have access to the source. One major limitation of this current ranked list of disparities is that it does not include a greater number of measurable indicators. We hope to increase this in the future as we pursue access to additional data sources.

As shown in Table 1, there were sixteen analyzed HP 2010 Objectives where the rate among urban AI/AN of the adverse outcome was at least three times higher than the established target rate. Four of these indicators have been identified by OMH as Priority Objectives, and one is an OMH Limited Progress Objective.

As shown in Table 2, nineteen analyzed HP 2010 Objectives showed at least a 50% higher rate among urban AI/AN of the adverse outcome than among the general population (a ratio of at least 1.5). Again, four of the objectives are OMH Priority Objectives and four are OMH Limited Progress Objectives.

These two ranked lists of relative health disparities share nine indicators in common. These nine indicators are cases where there can be no doubt regarding the severity of health inequities faced by urban AI/AN. The nine common indicators are:

1.1 Increase the proportion of persons with health insurance (OMH priority)
3.11 Increase the proportion of women who ever received a Pap test (OMH Limited Progress)
16.1 Reduce post-neonatal deaths (between 28 days and 1 year)
16.1 Reduce deaths from sudden infant death syndrome (SIDS)
16.6 Increase in maternal prenatal care beginning in first trimester of pregnancy (OMH priority)
18.2 Reduce the rate of suicide attempts by adolescents (OMH Limited Progress)
26.10 Reduce the proportion of adolescents reporting use of marijuana
26.15 Reduce the proportion of adolescents who use inhalants
27.2 Reduce tobacco use by adolescents (spit tobacco) (OMH Limited Progress)

See Appendix E for a list of all indicators by HP 2010 Focus Area.

Next steps for the UIHI

While this information is valuable and can be immediately utilized, this process also offered an opportunity to learn how best to continue these activities in order to give a more complete picture of health disparities facing urban AI/AN. It also provides an opportunity to outline some of the major problems with the current data sources and methods of data collection.

We see this current process as providing initial information on which we hope to build. During this analysis, we reviewed the list of measurable HP 2010 Objectives for the most frequently cited recommended resources. Doing this, we found that the National Health Interview Survey is the most recommended data source for 37 of the remaining un-analyzed indicators. Other recommended sources included: the National Health and Nutrition Examination Survey (28 indicators), National Hospital Discharge Survey (11 indicators), National Vital Statistics Survey (11 indicators), National Notifiable Disease Surveillance System (10 indicators), and the National Survey of Family Growth (7 indicators). A brief description of these data sources, along with some known limitations, can be found in Appendix F.

LIMITATIONS IN NATIONAL DATA

Some common limitations related to national data sources that are found when assessing the health of urban American Indians and Alaska Natives include the following:

How race is designated:

National surveys done face-to-face or on the phone now generally contain one or more questions asking the respondent to state how they define their own race. Some (such as BRFSS and the National Health Interview Survey) allow individuals to report more than one race, and then to specify which is their preferred race. While phone and in-person surveys usually allow for the individual to self-identify as a particular race, death certificates, disease registries, hospital discharge records, and other data sources that allow for others to specify an individual's race are known to contain numerous errors. Racial misclassification is a known and well-described problem for AI/AN, especially for those living in urban areas. Researchers at the National Centers for Health Statistics (NCHS) found that between 1990 and 1998 only 55% of death certificates of known AI/AN accurately reported their race. The percentage of those correctly identified for race was even lower for those living in urban areas.[3] This inaccuracy can give a distorted picture of the health of AI/AN, and results in lower published rates of cancer, mortality, and other health issues that rely on such race data. Even when race is self-identified, not all sources collect and report the minimum standards that were mandated in 1997 by the Office of Management and Budget (OMB). These minimum categories are: American Indian and Alaska Native, Native Hawaiian or Other Pacific Islander, Asian, Black or African American, and White. Minimum ethnicity categories are Hispanic or Latino and Not Hispanic or Latino.

Data sampling and small populations:

American Indians and Alaska Natives make up less than 2% of the total population nationwide. When national and local surveys are developed, the intent is often to approximate this percentage among respondents. This can result in respondent numbers that are too small to analyze with scientific validity. While small numbers of AI/AN participants may be included in surveys, data on the population may not be released to the public, continuing the invisibility of urban Indian communities. Oversampling – when specific attempts are made to include a higher percentage of individuals from small sub-populations – can help address this problem. However, cost issues often prevent this from occurring. Oversampling also may not completely solve the problem. The concept of "equal explanatory power" has been recently proposed to address this issue.[4] This concept originated with Maori advocates in New Zealand. Equal explanatory power entails including an adequate number of respondents from the sub-population – however many that may be - to assure enough statistical power to make scientifically valid conclusions.

Researchers at the National Center for Health Statistics (NCHS) found that between 1990 and 1998 only 55% of death certificates of known AI/AN accurately reported their race.

Public access to geographical information:

Concerns for the confidentiality of survey respondents and other individuals represented in national datasets continue to rise. Decisions regarding release of public use data take confidentiality concerns into account, and it has become increasingly difficult to access data at smaller geographic levels than state or even large regions. For example, Vital Statistics data prior to 1989 are available to the public for all counties.[5] In 1990, restrictions were made to limit availability to those counties with populations of either 100,000 (birth and death records) or 250,000 (linked birth/infant death records).

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[3] - Arias E, Schauman WS, Eschbach K, Sorlie PD, Backlund E. The validity of race and Hispanic origin reporting on death certificates in the United States. National Center for Health Statistics. Vital Health Stat 2(148). 2008.

[4] - Te Röpü Rangahau Hauora a Eru Pömare. Mana Whakamärama - Equal Explanatory Power: Mäori and non-Mäori sample size in national health surveys. Whiringa-ä-Rangi. 2002.

[5] - For more information see: www.cdc.gov/nchs/about/major/dvs/NCHS_DataRelease.htm

Starting with the 2005 data release, no data with state or county-identifiers are available without an accepted research proposal. Another example are large national surveys such as the Youth Risk Behavior Survey (YRBS) and the National Health Interview Survey (NHIS), which no longer provide urban/non-urban geographic designators in their public use files. While confidentiality of participants is extremely important, accessing public data for a group such as urban AI/AN becomes difficult, if not impossible, without these geographic designations.

Distrust of government and medical research:

Termination and relocation efforts of American Indian and Alaska Native people have resulted in a deep seeded mistrust of the U.S. government within many AI/AN communities. Unethical medical research practices that have been imposed in the past have made many AI/AN communities reluctant to participate in national surveys or studies and weary of partnering with research and other health agencies. This distrust results in limited AI/AN participation in national studies and bias due to inadequate representation of the AI/AN population.

National data may not represent local issues:

Not in itself a limitation of national data, but looking at a combined picture of urban AI/AN nationwide does not necessarily give insight into local community needs. What is recognized as a critical issue in Phoenix, for example, does not necessarily turn up in studies of the nation as a whole. Especially when combining information about such a diverse population as urban AI/AN, local health workers may not recognize their community's needs in a national report. However, national data can be a useful starting point and local leaders should continue to work with local groups and public health institutions to improve access to community-level information.

While all national data sources have limitations, especially when attempting to describe the health of such a diverse and dispersed population as urban AI/AN, we recognize that these can be a source of common language among the public health community. Because of this, we hope to continue this work by accessing other data sources such as the National Health Interview Survey for analysis. We are also currently in the process of looking at sexual and reproductive health behaviors and experiences found within the National Survey of Family Growth. Future projects related to this analysis of national health disparities will be available soon.

This information can be combined with your own stories, experiences, and local community data in order to paint a picture necessary to communicate your specific need. See the final section of this report for some ideas of how to use this information in your work.

National data can be a useful starting point and local leaders should continue to work with local groups and public health institutions to improve access to community-level information.

2009

Section II

UIHI

SECTION II

LOCAL HEALTH PRIORITIES BASED ON INPUT FROM URBAN INDIAN HEALTH ORGANIZATIONS

Two primary sources of information were used to uncover the most pressing health issues facing urban AI/AN, based on those involved with directly serving the community. These findings should be considered preliminary, and we hope to hear more from those working and living in urban Indian communities about their perceived health priorities.

The first source, described below, is an informal survey given to Executive Directors and other staff of the UIHO, asking them to rank the top three health issues facing their communities.

The second source is an analysis of the UIHI's technical assistance activities in the past year, and data requests received from UIHO staff. Most data requests are related to grant applications, and thus can give us an indication of what needs exist in terms of program planning and future activities.

A. Survey – methods and results

The survey was first introduced at the annual Urban Indian Health Conference in Seattle in July 2008. Individuals working in urban Indian healthcare were asked to respond to a one-page survey about health priorities in their communities. In August, representatives of the California Consortium for Urban Indian Health were asked to fill out the survey as well. In September 2008, the same survey was sent to the Executive Directors of the 34 urban Indian health organizations. They were asked to respond and forward the survey on to staff that would be interested in giving input regarding health priorities among their clients. Follow-up surveys were sent to non-responders.

Staff were asked to identify the three most important health issues facing clients/patients at their agency. A selected list of previously identified topics were provided for participants to choose from. These included:

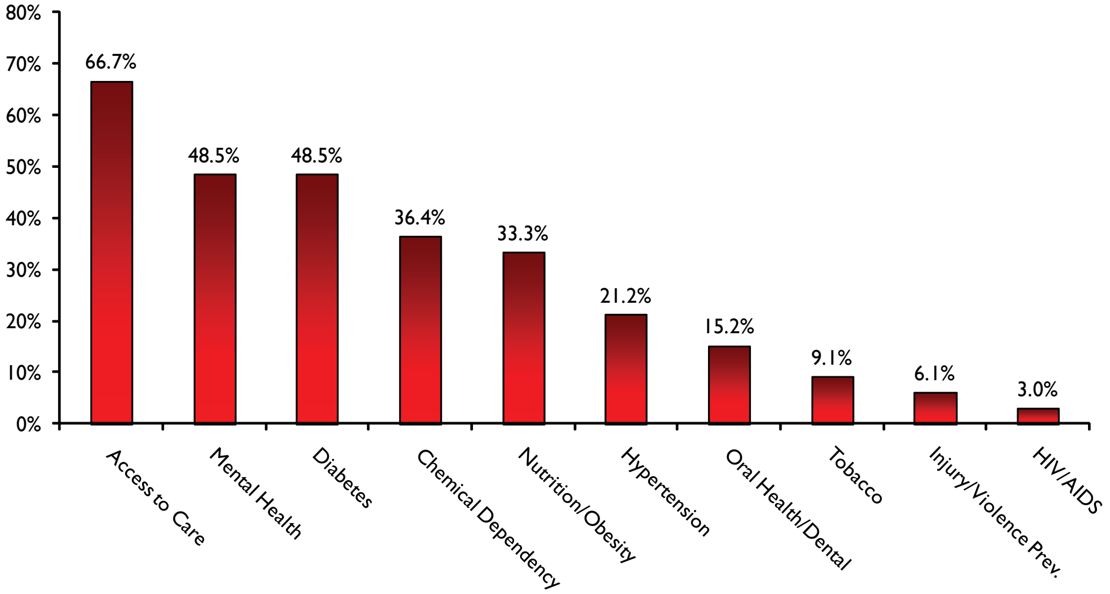
- Access to care
- Cancer prevention
- Chemical dependency/substance abuse
- Diabetes
- Family planning
- HIV/AIDS
- Hypertension
- Infant mortality
- Injury and violence prevention
- Mental health
- Nutrition and overweight/obesity
- Oral health
- Sexually transmitted infections
- Commercial tobacco use

Thirty-three individuals answered the survey, representing approximately 14 UIHO. Areas represented were: Albuquerque, Denver, Detroit, Flagstaff, Milwaukee, Portland, San Francisco, San Jose, Seattle, Tucson, and Wichita.

The top three health issues identified by the group were: access to healthcare (67%), mental health (48.5%), and diabetes (48.5%). Complete results can be found in the following graph:

The top three health issues identified by the group were access to health care, mental health, and diabetes.

Percent of Respondents that considered the Issue among the Top Three Health Priorities



B. Requests for data and technical assistance – methods and results

We examined data requests that came in between January 1 and December 31, 2008. Each request is categorized into one or more of the following: demographics, maternal and child health, sexually transmitted infections, cancer, mental health, disease (general/other), health care access, women, traditional health, substance abuse, tobacco, elders, youth, grant, and urban Indian health (general). Although we receive requests from people working in a variety of organizations, only those requests from staff at one of the 34 Title V UIHO were considered in this examination.

We found that at least 34 data requests from staff at UIHO were received during 2008. The majority were related to grant applications. The following populations were most represented in these data requests: youth, maternal and child health, and women. The non-population categories most represented were: disease (general/other), demographics, oral health, mental health, and cancer, healthcare access, substance abuse, and diabetes.

WHAT THESE SOURCES TELL US ABUT LOCAL PRIORITIES

When asked directly, two-thirds of respondents chose access to care as one of the top health issues facing their community of urban AI/AN. The UIHI receives numerous data requests, many of which are related to improving access to care for the population or a specific subset of the population. Urban Indian health organizations express great interest in utilizing data to help direct and support services. Data provided by the UIHI to UIHO, including this report, are aimed to support efforts at the local level to improve access to health care services.

Almost half of all respondents considered mental health and diabetes among the top three health issues facing their clients. Diabetes has been a well-recognized problem among AI/ANs for years, and one area that has received funding from Federal sources in the Special Diabetes Program for Indians. Because resources have been directed to this priority health issue may be one reason why the UIHI has received fewer data requests on the topic in the past year. Fewer dollars have been allocated to address the mental and behavioral health needs facing urban AI/AN communities, but clearly this is an area in need of attention.

> *Data provided by the UIHI to UIHO are aimed to support efforts at the local level to improve access to health care services.*

Other highly ranked health issues included chemical dependency and nutrition/obesity. These are closely linked to the previously mentioned issues of mental health and diabetes.

Section III

2009

SECTION III

USING INFORMATION FROM THIS REPORT

The following are offered as possible ways to use the information contained in this report in an applied way. On the final pages (page 22 - 23) there are a few visuals that we included that bring together a portion of the information in this report.

A. Grant Writing and program planning

Information in this report may be useful for you to include in background information for new or renewing grants. For example, the following statements can be used in a grant application for funding directed at mental health services for adolescents (you can cite this report as a reference):

- *Nationally, four times as many urban American Indian and Alaska Native youth have attempted suicide requiring medical attention than youth of all races combined. The rate is also more than 10 times the target for Healthy People 2010.*
- *From a recent analysis of health disparities among urban AI/AN nationwide, 6 of the top issues related to mental health or drug use among adolescents, including suicide attempts, steroid and marijuana use, and carrying a weapon on school grounds.*

Other similar statements can be pulled out, depending on your need:

- *Access to care was the top-identified issue among staff working in urban Indian health organizations in a recent survey. Data also show that the uninsured rate among urban AI/AN is 60% higher than the rate of the general population.*
- *The death rate due to HIV among urban AI/AN is 6 times higher than the target rate in Healthy People 2010.*
- *Almost twice as many urban AI/AN adolescents reported having had sex before age 13 as youth of all races, and twice as many urban AI/AN youth reported they had been pregnant or gotten someone else pregnant.*

This information will be most useful when combined with your own patient data, stories about patients or community members, and local data when available. While data describing need in your local area may be difficult to obtain, national data can still be used. For example:

- *While rates of gonorrhea among AI/AN in (your city) are difficult to gather, national data show high rates among urban AI/AN as a whole.*
- *The national rate of infant death from SIDS among urban AI/AN is 2½ times that of all races combined. While local information is not available, this is consistent with what we have seen recently in our own community with the known death of two babies from SIDS within the past year.*

The death rate due to HIV among urban AI/AN is six times higher than the target rate in Healthy People 2010.

SECTION III

B. Advocacy for urban American Indians and Alaska Natives

Advocacy on behalf of your patient population is nothing new to folks working in urban AI/AN health. You frequently use information – be it data, stories, or patient experiences – to help your community. This report can provide you with one more source of information as you prepare statements, write emails and letters, create fact sheets, talk to colleagues, friends and neighbors, and generally advocate for more focus, interest and resources to go toward your community and towards urban AI/AN nationwide. The majority of the information contained here (the ranked lists of health disparities) is based on nationally-developed public health priorities. The HP 2010 Objectives are seen by some as the optimum in methodology and are easily recognized by funding agencies, which may help in the ongoing effort to secure funding.

One issue that may be new to some of you is the need for improved access to relevant data that describes accurately the issues facing urban American Indians and Alaska Natives, both locally and nationally. Page 13 lists some known limitations with national data. A few changes that you - as leaders and experts in urban AI/AN health care - can advocate for include:

- All public and private health system entities receiving funding or reimbursement from the Federal government should be mandated to collect and publicly report data on race, ethnicity, gender, and primary language. Data should be used to assess health care access and quality as well as progress toward eliminating health disparities for urban AI/AN.

- Data collection must be standardized nationally so that all Federal, State and/or Private institutions utilize the same race and ethnicity categories. At minimum, data collection on race and ethnicity must comply with the 1997 OMB Regulations (Race: American Indian and Alaska Native, Native Hawaiian or Other Pacific Islander, Asian, Black or African American, and White; Ethnicty: Hispanic/Latino and Not Hispanic/Latino).

- Research projects should reflect the diversity of the American public by deliberately integrating participation and/or involvement of researchers and populations from all racial and ethnic backgrounds.

- Because national and/or state data may not adequately collect sample sizes needed to analyze specific subgroups, the Federal government must support data collection by ethnic subgroup, which may require small, community-based, localized efforts. The Federal government needs to fund and work with community based organizations, Tribal Governments, Tribal and Native Epidemiology Centers, and Tribal Colleges and Universities who, in tandem with underserved communities, should not only collect these data but assure adequate distribution and utilization as well as reporting back to the specific subgroup.

- Health Information Technology (HIT), Electronic Health Records and Electronic Medical Records should have the capacity to support health care providers to collect data on race, ethnicity, gender and primary language. To ensure that all communities have access to HIT, the Federal government should adequately fund local initiatives and should provide "meaningful use" incentives to providers in order to assure that data will be used by consumers, patients and advocates to improve the quality of health and health care services.

Research projects should reflect the diversity of the American public.

- Funding needs to be provided for oversampling and longitudinal studies of urban American Indians and Alaska Natives since these must be large enough to ensure "equal explanatory power", where sampling targets provide enough statistical power to make scientifically valid conclusions.

A few points you can consider at the facility and local level include:

- Include questions about race, ethnicity and primary language when collecting health information *(for example, at registration).*

- Train all staff that collects race/ethnicity information about the importance of assuring accuracy. Have policies and procedures in place for the collection of this information.

- Have clear policies and procedures in place for the reporting of notifiable diseases. Assure appropriate staff are aware of procedures and are adequately trained.

- Make multiple connections with your local health department. Advocate on behalf of AI/AN living in your area to assure data availability. AI/AN-specific data should be available at a minimum to you and the local urban AI/AN community, if not in public reports.

- Work with other local AI/AN groups to advocate for improved data quality. Consider hosting community groups to discuss priority health needs. This could be an opportunity to both present known data and to gather information about the health needs felt by community members.

C. Help to identify local health priorities

Because this report is focused nationally, the issues mentioned here may or may not reflect the need in your community. As you read through it, you can consider the following options for using it to help identify your local priorities:

- Share all or sections at a staff or team meeting and get their feedback about their perception of local health priorities.

- Discuss ways that your experience differs from what is described here.

- Identify ways to collect information about health needs of your patient population: patient surveys, examination of patient records as a whole or by specific program, new data collection system to help you better identify health priorities, etc. Please contact the UIHI if you would like assistance with ideas.

- Share results with community members and get feedback about their views of the most pressing local priorities.

- Use the information to showcase services that you are already providing that help address these identified areas of need. **We are very interested in hearing back about your programs already in place aimed at addressing these health priorities!**

We also are very interested in hearing more about how these identified national health disparities and priorities match up with your own experience. Please contact us at **206-812-3030** or **info@uihi.org** with your feedback, or fill out the form on page 25.

Consider hosting community groups to discuss priority health problems.

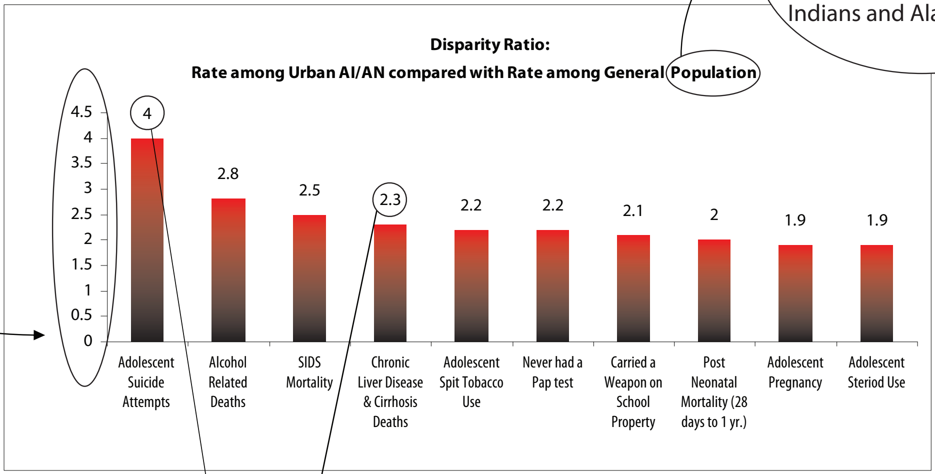
Summaries

The following pages provide some consolidated information pulled from different sections of this report.

This is a chart of the analyzed HP 2010 Objectives that had the largest measured disparity between that rate among urban AI/AN and the rate among everyone in the same geographic areas.

You'll notice that the ratios are lower when comparing AI/AN rates to the general population rather than to the HP 2010 Targets. This is because all populations are not yet meeting the targets for many HP 2010 Objectives.

When general population includes all individuals living in the select urban areas, including American Indians and Alaska Natives

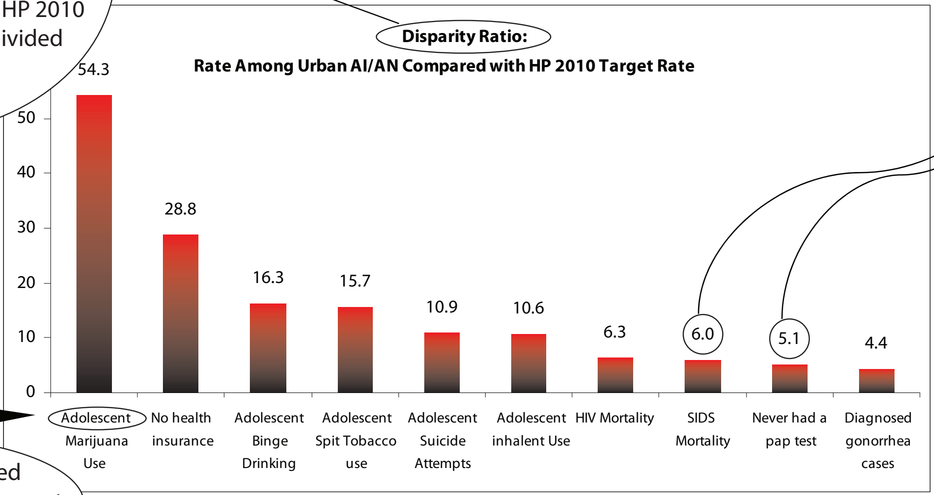


In using this information you can say "Urban AI/AN youth are 4 times more likely to have attempted suicide that required medical attention than all urban youth combined." Or, "The rate of deaths from chronic liver disease and cirrhosis among urban AI/AN nationwide is almost 2 1/2 times higher than the rate in the general population."

This is a chart of the analyzed HP 2010 Objectives that had the largest measured disparity between that rate among urban AI/AN and HP 2010 Target rate.

The disparity ratio is calculated by dividing the rate among urban AI/AN by the HP 2010 Target rate. For example, the rate of adolescent steriod use among urban AI/AN is 7.9% and HP 2010 Target rate is .4%. 7.9% divided by .4% is 19.8.

In using this information you can say, for example, that mortality rate from SIDS among urban AI/AN is 6 times higher than the HP 2010 Target rate. Or that approximately 5 times more urban AI/AN women have never had a pap test than what was called for in HP 2010



Many of the top measured disparities relate to adolescent health and substance use.

Note: The general population refers to individuals of all races living in the same geographic areas, including AI/AN.

Top Measured Health Disparities Facing Urban American Indian and Alaska Native Youth

The following is a list of the top measured health disparities facing urban AI/AN youth, when compared with rates of youth of all races living in the same urban areas.

See Tables 1 and 2 on pages 8-11 for more details about these indicators and their related HP 2010 Objectives.

- Suicide attempts in youth that required medical attention
- Sniffed glue, breathed contents of aerosol cans, or inhaled any paints/sprays to get high one/more times
- Used spit tobacco in past 30 days
- Carried a weapon on school property
- Ever been pregnant or gotten someone pregnant
- Took steroid pills or shots without doctor's prescription during their life
- Had sexual intercourse for the first time before age 13
- Tried marijuana for the first time before age 13
- Used marijuana one or more times during the past 30 days
- Smoked full cigarette for first time before age 13

UIHI
Urban Indian Health Institute
A Division of the Seattle Indian Health Board

UIHI Publication Feedback Form

We are very interested in your feedback regarding this and other UIHI publications.

Please take a moment to detach and fill out the following form with your comments, questions and suggestions. Mail to the Urban Indian Health Institute, Seattle Indian Health Board, PO Box 3364, Seattle WA 98114 or fax to 206-812-3044. You can also fill this form out on-line at www.uihi.org. Thank you very much for your time.

I am commenting on the following UIHI publication:

☐ Visibility Through Data *(2009)*
☐ Health and Health-Influencing Behaviors among Urban AI/AN *(2008)*
☐ Urban AI/AN Youth - An Analysis of Select National Data Sources *(2007)*
☐ Urban AI/AN Maternal, Infant and Child Health Capacity Needs Assessment *(2007)*
☐ Health Status Report *(2004)*
☐ Communications Broadcast *(monthly)*
☐ Other: ______________________________

I received this publication in the following way:

☐ Electronic version sent to me directly
☐ UIHI (over email)
☐ Hard copy sent to me directly from UIHI
☐ Downloaded it from the website
☐ Someone in my agency shared it with me
☐ Someone outside my agency shared it with me
☐ Other: ______________________________

Please share your thoughts, questions or comments about the publication:

____
____
____
____
____

Overall, did you consider this publication helpful? ☐ Yes ☐ No

What would have made it more helpful? ______________________________
____

Overall, did you consider this publication easy to understand and use? ☐ Yes ☐ No

What would have made it easier to understand and use? ______________________________
____

How do you intend to use this publication and the information it contains? (Check all that apply)

☐ Grants ☐ Program Planning ☐ Presentations ☐ General Background
☐ Unknown ☐ Advocacy ☐ Other: ______________________________

If you would like a staff person to respond to your questions or comments, please share your contact information: Do you prefer to be contacted by: ☐ Phone ☐ Email

Name: ______________________________ Agency: ______________________________

Phone: ______________________________ Email: ______________________________

APPENDIX A

URBAN INDIAN HEALTH ORGANIZATIONS AND THEIR SERVICE AREAS

Program Name	City	State	Service Area Counties
Native American Community Health Center	Phoenix	Arizona	Maricopa
Tucson Indian Center	Tucson	Arizona	Pima
Native Americans for Community Action	Flagstaff	Arizona	Coconino
United American Indian Involvement, Inc.	Los Angeles	California	Los Angeles
San Diego American Indian Health Center	San Diego	California	San Diego
Am. Indian Health & Services Corporation	Santa Barbara	California	San Luis Obispo, Santa Barbara, Ventura
American Indian Health Project Bakersfield	Bakersfield	California	Kern
Fresno Native American Health Center	Fresno	California	Fresno, Tulare
Native American Health Center	Oakland	California	Alameda, Contra Costa, Marin, San Francisco, San Mateo
Indian Health Center of Santa Clara Valley, Inc	San Jose	California	Santa Clara
Sacramento Native American Health Center	Sacramento	California	Sacramento
Denver Indian Health and Family Service	Denver	Colorado	Adams, Arapahoe, Boulder, Denver, Douglas, Jefferson, Broomfield
Am. Indian Health Services of Chicago, Inc.	Chicago	Illinois	Cook
Hunter Health Clinic	Wichita	Kansas	Butler, Reno, Sedgwick, Sumner
N. American Indian Center of Boston, Inc.	Jamaica Plains	Massachusetts	Suffolk, Middlesex, Norfolk, Plymouth,
American Indian Health and Family Services of Southeast Michigan	Dearborn	Michigan	Genesee, Livingston Macomb, Monroe, Oakley, Washtenaw, Wayne
Indian Health Board of Minneapolis	Minneapolis	Minnesota	Hennepin, Ramsey
Indian Health Board of Billings	Billings	Montana	Big Horn, Yellowstone
Indian Family Health Center	Great Falls	Montana	Cascade
Helena Indian Alliance	Helena	Montana	Jefferson, Lewis & Clark
North American Indian Alliance	Butte	Montana	Silver Bow
Missoula Indian Center	Missoula	Montana	Missoula
Nebraska Urban Indian Health Coalition	Lincoln	Nebraska	Douglas, Lancaster, Sarpy, Washington, Woodbury (IA)
First Nations Community Health Source	Albuquerque	New Mexico	Bernalillo
Nevada Urban Indian, Inc.	Reno	Nevada	Churchill, Douglas, Washoe, Carson City
American Indian Community House, Inc.	New York	New York	Bronx, Kings, Nassau, New York, Queens, Richmond, Westchester
Native Am. Rehabilitation Association of the NW	Portland	Oregon	Clackamas, Multnomah, Washington, Clark (WA)
South Dakota Urban Indian Health, Inc.	Pierre	South Dakota	Brown, Hughes, Minnehaha, Stanley
Urban Inter-Tribal Center of Texas	Dallas	Texas	Collin, Dallas, Denton, Tarrant
Indian Walk-In Center	Salt Lake City	Utah	Davis, Salt Lake, Tooele, Utah, Weber
Seattle Indian Health Board	Seattle	Washington	King
N.A.T.I.V.E Project	Spokane	Washington	Spokane
Gerald L. Ignace Indian Health Center, Inc.	Milwaukee	Wisconsin	Milwaukee, Waukesha
United Amerindian Health Center, Inc.	Green Bay	Wisconsin	Brown

APPENDIX B

DATA SOURCES AND RELATED INFORMATION

Data Source: Vital Statistics: Birth Records

Description of Data Source	Years Used in Analysis	Geographic Areas Used in Analysis
Data are based on birth certificates filed in all states. The data are provided by states to the National Center for Health Statistics (NCHS) through the Vital Statistics Cooperative Program (VSCP).	1995-2002	Counties served by a Title V urban Indian health organization

HP 2010 Objectives	Measured Indicator in VS – Birth Records
16.6a Increase in Maternal Prenatal Care beginning in first trimester of pregnancy	Prenatal care did not begin in first trimester
16.6b Increase the proportion of women that receive early and adequate prenatal care	Percent of live births who did not receive early and adequate prenatal care (Kotelchuck Index)

Data Source: Vital Statistics: Linked Birth-Infant Death Records

Description of Data Source	Years Used in Analysis	Geographic Areas Used in Analysis
In the linked birth/infant death data set, information from the birth certificate is linked to information from the death certificate for each infant less than 1 year of age who dies in the United States. The data are provided by states to the National Center for Health Statistics (NCHS) through the Vital Statistics Cooperative Program (VSCP).	1995-2003	Counties served by a Title V urban Indian health organization

HP 2010 Objectives	Measured Indicator in VS – Infant Deaths
16.1e Reduce post-neonatal deaths (between 28 days and 1 year)	Infant death rate: post-neonatal deaths per 1000 live births
16.1h Reduce deaths from sudden infant death syndrome (SIDS)	Infant death rate: sudden infant death syndrome (SIDS) per 1000 live births

Data Source: Vital Statistics: Mortality (Death) Records

Description of Data Source	Years Used in Analysis	Geographic Areas Used in Analysis
Mortality statistics are based on information coded by the states and provided by states to NCHS through the Vital Statistics Cooperative Program and from copies of the original death certificates received by NCHS from the state registration offices.	1995-2004	Counties served by a Title V urban Indian health organization

HP 2010 Objectives	Measured Indicator in VS - Mortality
13.14 Reduce deaths from HIV infection	Death rate: HIV disease per 100,000 population
26.1 Reduce alcohol-related motor vehicle deaths	Death rate: alcohol-related deaths per 100,000 population
26.2 Reduce cirrhosis deaths	Death rate: chronic liver disease and cirrhosis per 100,000 population

Data Source: Sexually Transmitted Disease Surveillance System

Description of Data Source	Years Used in Analysis	Geographic Areas Used in Analysis
States report to the Centers for Disease Control and Prevention (CDC) data of nationally notifiable STDs (including chlamydia, gonorrhea, and syphilis). Detailed data are usually collected at the local level. Areas generally adhere to the national STD case definitions collaboratively developed by the Council of State and Territorial Epidemiologists (CSTE) and CDC. More can be found here: www.cdc.gov/std/stats07/app-interpret.htm	2004	Counties served by a Title V urban Indian health organization

HP 2010 Objectives	Measured Indicator in STD Surveillance System
25.2 Reduce gonorrhea	Diagnosed cases per 100,000 population

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Description of Data Source	Years Used in Analysis	Geographic Areas Used in Analysis
BRFSS is a national phone-based survey administered annually by states and territories with the assistance of the Centers for Disease Control and Prevention (CDC). The survey includes a series of questions about health and health-related behaviors that are asked nation-wide. States also have the option to include additional questions on certain topics that may change each year. BRFSS uses a system of random digit dialing, and interviews non-institutionalized adults age 18 and older. More can be found here: www.cdc.gov/brfss.	2003-2007	Counties served by a Title V urban Indian health organization

HP 2010 Objectives	Measured Indicator in BRFSS
1.1 Increase the proportion of persons with health insurance	- Adults age 18-64 who do not have health insurance
1.6 Reduce the proportion of families that experience; difficulties or delays in obtaining health care or do not receive needed care for one or more family member	- Could not see a doctor because of the cost in past year
3.11a Increase the proportion of women age 18 years and older who ever receive a Pap test	- Women age 18 years and older who have never had a Pap test
14.29a Increase the proportion of adults who are vaccinated annually against influenza: non-institutionalized adults aged 65 years and older	- Adults age 65 years and older who did not receive influenza vaccine in past 12 months
14.29b Increase the proportion of adults who are ever vaccinated against pneumococcal disease: non-institutionalize adults aged 65 years and older	- Adults age 65 years and older who have never received a pneumococcal vaccine
19.2 Reduce the proportion of adults who are obese	- BMI≥30, by reported height and weight
26.11c Reduction in adults age 18 years and older engaging in binge drinking	- Adults age 18 years and older who reported five or more drinks in one occasion in past month

Data Source: Youth Risk Behavior Survey (YRBS)

Description of Data Source	Years Used in Analysis	Geographic Areas Used in Analysis
The Youth Risk Behavior Survey (YRBS) is a self-report questionnaire administered by the Centers for Disease Control and Prevention (CDC) designed to monitor the health risk behaviors of the nation's high school students. The YRBS includes surveys of students in grades 9–12. The YRBS is a self-administered questionnaire. Student participation in the survey is both voluntary and anonymous. National surveys have been conducted biennially since 1991. They employ a three-stage cluster sample design to produce a nationally representative sample of public and private high school students. More information can be found here: www.cdc.gov/HealthyYouth/yrbs/index.htm	1997-2003	Youth attending schools in an "urban" area. An urban area is defined as one within a Metropolitan Statistical Area (MSA)

HP 2010 Objectives	Measured Indicator in YRBS
9.7 Reduce pregnancies among adolescent females	Ever been pregnant or gotten someone pregnant
9.8 Increase the proportion of adolescents who have never engaged in sexual intercourse before age 15	Had sexual intercourse for the first time before age 13
15.39 Reduce weapon carrying by adolescents on school property	Carried a weapon on school property in past 30 days
18.2 Reduce the rate of suicide attempts by adolescents	Suicide attempts in youth that required medical attention in past 12 months
26.9a Increase in average age of first use in adolescents aged 12 to 17 years: Marijuana	Tried marijuana for the first time before age 13
26.10b Reduce the proportion of adolescents reporting use of marijuana	Used marijuana one or more times during the past 30 days
26.11d Reduction in adolescents aged 12 to 17 years engaging in binge drinking	Reported five or more drinks in a row within past 30 days
26.14 Reduce steroid use among adolescents	Took steroid pills or shots without doctor's prescription during their lifetime
26.15 Reduce the proportion of adolescents aged 12-17 who use inhalants	Sniffed glue, breathed contents of aerosol cans, or inhaled any paints or sprays to get high one or more times during last 30 days
27.2c Reduce tobacco use by adolescents: spit tobacco	Reported spit tobacco use in the past 30 days
27.4a Increase the average age of first use of tobacco products by dolescents aged 12 to 17 years	Smoked full cigarette for first time before age 13 (percent of population)

APPENDIX C

COMPLETE LIST OF HEALTHY PEOPLE 2010 FOCUS AREA

1. Access to Quality Health Services
2. Arthritis, Osteoporosis, and Chronic Back Conditions
3. Cancer
4. Chronic Kidney Disease
5. Diabetes
6. Disability and Secondary Conditions
7. Educational and Community-Based Programs
8. Environmental Health
9. Family Planning
10. Food Safety
11. Health Communication
12. Heart Disease and Stroke
13. HIV
14. Immunization and Infectious Diseases
15. Injury and Violence Prevention
16. Maternal, Infant, and Child Health
17. Medical Product Safety
18. Mental Health and Mental Disorders
19. Nutrition and Overweight
20. Occupational Safety and Health
21. Oral Health
22. Physical Activity and Fitness
23. Public Health Infrastructure
24. Respiratory Diseases
25. Sexually Transmitted Diseases
26. Substance Abuse

APPENDIX D

DESCRIPTION OF DEVELOPMENT OF HP 2010 DATABASE

All original HP 2010 measurable objectives were examined, although only those that could be measured at a single population level (i.e. urban AI/AN) were considered in this analysis. Thus, all objectives that target states, schools, air quality, etc. were not included. "Measurable objectives" are ones for which data were available when the objectives were established, and national baselines were available for each. "Developmental objectives", which did not originally have a known source of national data, were not considered in this analysis.

Analyzed data were drawn primarily from the following data sources: Vital Statistics (death, birth, and linked birth/infant death records), the Behavioral Risk Factor Surveillance System (BRFSS), and the Youth Risk Behavioral Survey (YRBS). Limited data from the Sexually Transmitted Disease Surveillance System is also included. These are data sources to which UIHI currently has access. Some analyzed data have been released by UIHI in reports or publications, but many have not. All available data were included in this analysis. There was no attempt to omit indicators that were not significantly different between urban AI/AN and the general population.

Data were entered into an Access database that had been built for this purpose. This database was updated with new available data up to January 2009. Updated data that were available after this time period were not included in this analysis. This Access database will be updated periodically as new data are available.

Following the direction of the National Centers for Health Statistics, all indicators were measured in terms of adverse events. For example, while HP 2010 objective 3.11 is to "increase the proportion of women who receive Pap tests", we used the "proportion of women who never received a Pap test" as the entered measure. Certain indicators that have been analyzed by UIHI differ slightly from the specific HP 2010 objective. These differences were noted.

In developing the ranked list of disparities, two separate reference points were used: (1) the HP 2010 target and (2) the rate in the general population (all races combined). Disparities were measured both in relative terms (as a ratio and as the percent difference), and in absolute terms (rate among AI/AN minus the reference rate). Only the relative difference as a ratio is included in this publication.

The indicators were ranked by the disparity ratio. For the first list of disparities based on HP 2010 targets, those with a ratio greater than three (i.e. the rate among AI/AN was at least three times the HP 2010 target rate) were separated out for further study. For the ranked list of disparities based on the general population, all those with a ratio of at least 1.5 were selected. Because the general population as a whole is still not meeting the HP 2010 target for many objectives, the disparities based on the general population were relatively lower than those based on the HP 2010 targets.

Additional ranked lists were also compiled, including (1) list of the top recommended data sources based on the number of unanalyzed indicators and (2) list of OMH priority indicators that have not been analyzed for urban AI/AN, including the recommended data sources. These will be used to direct UIHI activities in the future.

APPENDIX E

TOP MEASURED HEALTH DISPARITIES BY HP 2010 FOCUS AREA

HP 2010 Focus Area	HP 2010 Objective	Measured Indicator	Disparity Ratio (HP 2010 Target)	Disparity Ratio (General population)
(1) Access to Quality Health Services	1.1 Increase the proportion of persons with health insurance	Adults age 18-64 who do not have health insurance	28.8	1.6
	1.6 Reduce the proportion of families that experience difficulties or delays in obtaining health care or do not receive needed care for one or more family member	Could not see a doctor because of the cost in past year		1.5
(3) Cancer	3.11a Increase the proportion of women age 18 years and older who ever received a pap test	Women who have never received a pap test	5.1	2.2
(9) Family Planning	9.7 Reduce pregnancies among adolescent females	Ever been pregnant or gotten someone pregnant		1.9
	9.8 Increase the proportion of adolescents who have never engaged in sexual intercourse before age 15 years	Had sexual intercourse for the first time before age 13		1.7
(13) HIV	13.14 Reduce deaths from HIV infection	Death rate: HIV disease per 100,000 persons	6.3	
(14) Immunization and Infectious Disease	14.29a Increase the proportion of adults who are vaccinated annually against influenze: non-institutionalized adults age 65 years and older	Adults age 65 and older who did not receive influenze vaccine in past 12 months	3.2	
	14.29b Increase the proportion of adults who are ever vaccinated against pneumococcal disease: non-institutionalized adults aged 65 years and older	Adults age 65 and older who have never received a pneumococcal vaccine	4.2	
(15) Injury and Violence Prevention	15.39 Reduce weapon carrying by adolescents on school property	Carried a weapon on school property in past 30 days		2.1
(16) Maternal, Infant, and Child Health	16.1e Reduce post-neonatal deaths (between 28 days and 1 year)	Infant death rate: post-neonatal deaths per 1000 live births	3.6	2
	16.1h Reduce deaths from sudden infant death syndrome (SIDS)	Infant death rate: sudden infant death syndrome (SIDS) per 1000 births	6	2.5
	16.6a Increase in maternal prenatal care beginning in first trimester of pregnancy	Prenatal care did not begin in first trimester	3.1	1.7

APPENDIX E | *Continued on page 32*

Continued from page 31

TOP MEASURED HEALTH DISPARITIES BY HP 2010 FOCUS AREA

HP 2010 Focus Area	HP 2010 Objective	Measured Indicator	Disparity Ratio (HP 2010 Target)	Disparity Ratio (General population)
(16) Maternal, Infant, and Child Health *(continued)*	16.6b Increase the proportion of women that receive early and adequate prenatal care	Percent of live births who did not receive early and adequate prenatal care (Kotelchuck index)	3.9	
(18) Mental Health and Mental Disorders	18.2 Reduce the rate of suicide attempts by adolescents	Suicide attempts in youth that required medical attention in past 12 months	10.9	4
(19) Nutrition and Overweight	19.2 Reduce the proportion of adults who are obese	BMI≥30, by reported height and weight		1.5
(25) Sexually Transmitted Diseases	25.2 Reduce gonorrhea$	Diagnosed cases per 100,000 population	4.4	
(26) Substance Abuse	26.1 Reduce alcohol-related motor vehicle deaths	Death rate: alcohol-related deaths per 100,000 population		2.8
	26.2 Reduce cirrhosis deaths	Death rate: chronic liver disease and cirrhosis per 100,000 population		2.3
	26.9a Increase in average age of first use in adolescents aged 12 to 17 years: marijuana	Tried marijuana for the first time before age 13		1.7
	26.10b Reduce the proportion of adolescents reporting use of marijuana	Used marijuana one or more times during the past 30 days	54.3	1.5
	26.11c Reduction in adults aged 18 years and older engaging in binge drinking$	Adults age 18 and older who reported five or more drinks in one occasion in past month	3.6	
	26.11d Reduction in adolescents aged 12 to 17 years engaging in binge drinking	Reported five or more drinks on one occasion in past 30 days	16.3	
	26.14 Reduce steroid use among adolescents	Took steroid pills or shots without doctor's prescription during lifetime		1.9
	26.15 Reduce the proportion of adolescents age 12 – 17 who use inhalants	Sniffed glue, breathed contents of aerosol cans, or inhaled any paints or sprays to get high one or more times during last 30 days	10.6	1.8
(27) Tobacco Use	27.2c Reduce tobacco use by adolescents: spit tobacco#	Reported spit tobacco use in the past 30 days	15.7	2.2
	27.4a Increase the average age of first use of tobacco products among adolescents aged 12 to 17 years	Smoked full cigarette for first time before age 13 *(percent population)*		1.5

Legend

- OMH Priority Objectives (see page 7) $ - OMH Limited Progress Objectives (see page 7)

APPENDIX F

ADDITIONAL DATA SOURCES AND KNOWN LIMITATIONS

The recommended data sources from HP 2010, while adequate for certain populations or for the U.S. as a whole, often have major limitations which make analyses for urban AI/AN impossible. A few of these limitations of some of the more prominent recommended data sources under HP 2010 are:

National Health and Nutrition Examination Survey:

Includes an in-depth survey and physical examination of adults and children in the U.S. While AI/AN individuals are included, they are not oversampled, resulting in a very small number of participants. No separate data exist for AI/AN respondents, and they are grouped under the "other" category. Geographic detail is not available.

National Hospital Discharge Survey:

Survey of non-federal short-stay hospitals nationwide that produces information from in-patient hospital discharges. Geographic detail is not available, and the number of AI/AN patients overall in the sample is very small.

National Notifiable Disease Surveillance System:

Reported cases of infectious diseases of public health significance are sent to the Centers for Disease Control and Prevention by the states. Race information is collected, however states may collect it differently from each other, and records may be incomplete. Data cannot be accessed by outside researchers at a geographic level smaller than a state.

National Survey of Family Growth:

While the sample size of AI/AN respondents is small, the UIHI is currently in the process of analyzing NSFG data for AI/AN nationally and those living in urban areas. "Urban" is defined by Metropolitan Statistical Area (MSA) status, and not by the specific county of residence.