



The EpiCenter currently provides epidemiological services to the Tribes in the Bemidji Area (Michigan, Wisconsin, and Minnesota). Funded in part by the Indian Health Service, the EpiCenter strives to be responsive to the health information and epidemiological needs of the Tribes in the region by providing training and technical assistance in many areas of public health, data management, program planning, and program evaluation.

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Traditional Use of Tobacco Among American Indian Youth GLITC Youth Tobacco Survey Results

In 1999, The Tobacco Project at Great Lakes Inter-Tribal Council conducted a survey of American Indian youth throughout the state of Wisconsin. Youth from grades 6th-8th completed the survey. The GLITC survey asked many of the same questions asked in the Wisconsin sponsored Youth Tobacco Survey.

One addition to the GLITC survey was a group of questions asking youth about cultural or traditional uses of tobacco. The questions included were:

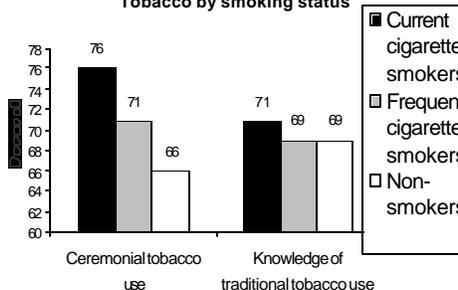
- Do you use tobacco for ceremonial uses or traditional reasons?
- How much do you know about the traditional uses of tobacco?
- Other than you, does anyone who lives in your home use tobacco traditionally?
- What type of tobacco do you use for ceremonial prayer or traditional reasons?

Overall, 70% of students said they had "a little" or "a lot" of knowledge of traditional uses of tobacco and 69% reported that they use tobacco for ceremonial or traditional reasons. Males and females knew about traditional uses of tobacco and

used tobacco for ceremonial reasons about equally. And, while 7th grade students reported the highest level of use of tobacco for ceremonial purposes or traditional reasons (72%), the 8th grade students reported the highest level of knowledge (73%). When examined by smoking status, Those students

who were non-smokers (71% frequent smokers, 76% current smokers), see Figure 1. When students were asked about other people in their home using tobacco traditionally, 47% said yes, other people in their home use tobacco traditionally. More females than males (51% and 43% respectively) and more 8th grade students than any other grade (51%) reported that other people in their home use tobacco traditionally. Approximately one quarter (25%) of students responded that they were "not sure" whether anyone in their home used tobacco traditionally. Frequent

Figure 1
 Ceremonial and Traditional Use of Tobacco by smoking status



who were frequent cigarette smokers (smoked on 20 days or more days in the past 30 days) and current cigarette smokers (at least 1 day in the past 30 days) reported higher levels of using tobacco for ceremonial uses or traditional reasons than students

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Bemidji Area Master Plan Assessment

by Victor Mosser, Bemidji Area BioMedical Officer

All Area health directors should have received a copy of the Bemidji Area Master Plan Assessment for their tribes in June of 2001. The document replaced the 1998 version of the Area Master Plan. The current version looks at all the tribes in the Bemidji Area and divides the study into three major views. It looks at the Area as a whole, then the state as a whole, and finally individual tribes. The Master Plan allows tribes to see how they compare to IHS, to other tribes in the state, and it allows them to identify individual issues relevant to them.

The study was the first of its kind in IHS and was designed to assist tribes with health care management decisions. The document provides data on the size and staffing needs as well as the health needs of each tribe. It compares the Bemidji Area to other Areas within IHS. The document identifies the needs of individual tribes and compares the health status of each tribe to combined data for other tribes within the state. Specific tribal data is only available to the individual tribes to be used by them to make management decisions. It was not the intent that it be used to compare individual tribes to on another or as a means of distributing resources.

Over the next few Great Lakes EpiCenter Newsletters, I will try to single out portions of the document and explain them and the purpose they serve in the document. The first review will be the Health System Planning (HSP) and Resource Requirement Methodology (RRM) sections.

HSP is a computer model design to predict the space needs of a tribe given a limited number of variables. The program was designed utilizing health care facilities (both IHS and tribal) built over the last three or four years. The program looks at the national database and identifies the users for a specific tribe by county and community. It then calculates the space needed (space is listed in square meters and can be converted to square feet by multiplying

by 10.76) to provide services to that population given the health care resources available in the surrounding communities. It calculates the space needed for each department and the total space needed, including parking slots. This is extremely useful information if a tribe is planning on building or expanding. RRM will estimate the staffing levels, by position, needed to operate the facility. It is meant to serve as a guide to help plan staffing needs. The availability of professional staff will always impact the staffing of any facility.

If a tribe is planning to build or to apply for a grant, local development funds, or IHS funds, HSP will allow the tribe to identify space and staffing needs versus the existing space and staff. It will also allow a tribe to estimate construction costs for a new facility and to calculate staffing costs as part of a business plan. HSP will serve to identify the maximum Maintenance and Improvement (M&I) space a tribe is authorized under the Supportable Space Policy.

I recommend you take some time and look over this portion of the document and call the Bemidji Area staff with any questions you may have. They can be reached at 218-444-0505



Do You Have Any RPMS Training Needs?

Dina George, MIS Analyst at the Great Lakes EpiCenter may be able to help. She is able to do one-on-one on-site and group training on various RPMS packages. Please feel free to contact Dina at 1-800-472-7207.

Red Lake Diabetic Foot Program

by Charmaine Branchaud, RN, BSN, CDE

When I became involved with the Red Lake Diabetic Foot Program back in 1993, the wheels of the program were already spinning. The Diabetes Team I joined that year had already identified that Lower Extremity Amputations (LEA) were the most common major complication of diabetes on the Red Lake Indian Reservation. I became involved with the team in the development of strategies for improving access to and utilization of foot care services. We developed flow sheets and algorithms, collaborating with the International Diabetes Center which led to a process called Staged Diabetes Management (SDM). This is a systematic data based approach to practice that promotes adherence to prescribed care and local customized foot care guidelines/protocols. During 1993 I received training and education in providing palliative foot care and wound care. I was assigned as the Diabetic Foot Nurse Specialist and opened the first Diabetic Foot Clinic in January of 1994. Thus the SDM program was implemented (1994-1996) and today we operate the SDM and Outreach Program (1997-present) which means that we have added a Vascular/ Wound Healing Specialist to our team who visits our clinic on a monthly basis.

Data has been traced through different Intervention Periods (since 1986) on the average annual incidence of lower-extremity amputations, first LEAs and major LEAs at Red Lake. The data from 1986-1998 was published in *The Journal of Family Practice*, volume 47(2), 1998. Current data is also available for 1999. The Red Lake Diabetic Foot Program has seen a drastic reduction in amputation rates. The average annual incidence of any LEA was reduced by 75%, the average annual incidence of a first LEA was reduced by 83%, and the annual incidence of a major LEA was reduced by 95%. The success of this program not only included teamwork,

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Heart Disease in American Indian/ Alaska Native Men and Women

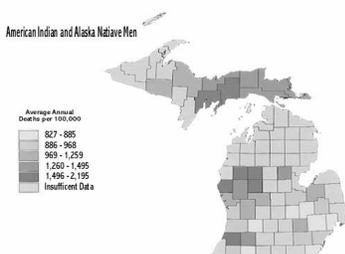
The CDC and collaborators recently produced an atlas for men and heart disease and an atlas for women and heart disease. These atlas' focus on racial and ethnic disparities in mortality due to heart disease. They report that American Indian/ Alaska Native (AI/AN) men and women both comprise about 0.6% of their respective genders above age 35 years. For the 5 year period of 1991-1995, the U.S. AI/AN heart disease mortality rate for men was 465 per 100,000 and 259 per 100,000 for women. They noted that for both AI/AN men and women, heart disease mortality rates varied considerably by geographic area. They did include a cautionary note about racial miscoding on death certificates. If miscoding in one area was more than in another, this could bias the information contained in the atlas.

The reports provide maps and ranking of heart disease mortality rates for each state by racial and ethnic group.

Michigan

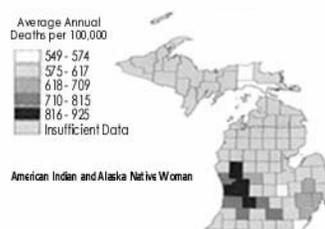
The 1991-1995 heart disease mortality rate for AI/AN men 35 years and older in Michigan was 1,067 per 100,000. This rate is about 1.5 times the rate for all men (726/100,000) and for white men (704/100,000) in Michigan. Figure 1 displays deaths per 100,000 for AI/AN men throughout the state of Michigan.

Figure 1
Michigan AI/AN Men
Smoothed County Heart Disease Death Rates, 1991-1995



The 1991-1995 heart disease mortality rate for AI/AN women 35 years and older in Michigan was 617 per 100,000. This rate is 1.3 times the rate for all women (442/100,000) throughout the state of Michigan. Figure 2 shows deaths per 100,000 for AI/AN women throughout Michigan.

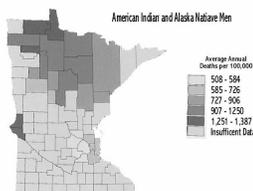
Figure 2
Michigan AI/AN Women
Smoothed County Heart Disease Death Rates, 1991-1995



Minnesota

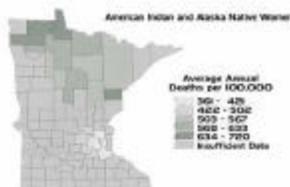
The 1991-1995 heart disease mortality rate for AI/AN men 35 years and older in Minnesota was 693 per 100,000. This rate is about 1.2 times the rate for all men (554/100,000) and white men (554/100,000) throughout the state of Minnesota. Figure 3 displays deaths per 100,000 for AI/AN men in Minnesota.

Figure 3
Minnesota AI/AN Men
Smoothed County Heart Disease Death Rates, 1991-1995



The 1991-1995 heart disease mortality rate for AI/AN women 35 years and older in Minnesota was 472 per 100,000. This rate is 1.6 times the rate for all women (284/100,000) throughout the state of Minnesota. Figure 4 shows deaths per 100,000 for AI/AN women in Minnesota.

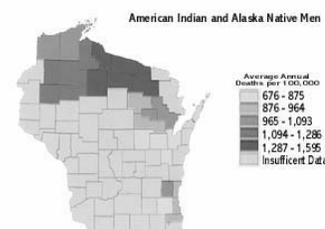
Figure 4
Minnesota AI/AN Women
Smoothed County Heart Disease Death Rates, 1991-1995



Wisconsin

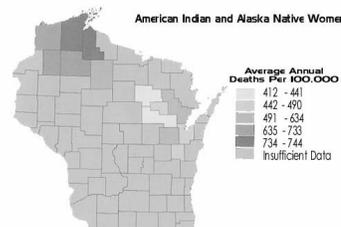
The 1991-1995 heart disease mortality rate for AI/AN men 35 years and older in Wisconsin was 915 per 100,000. This rate is about 1.4 times the rate for all men (634/100,000) in Wisconsin. Figure 5 displays deaths per 100,000 for AI/AN men throughout the state of Wisconsin. Figure 6 displays deaths per 100,000 for AI/AN men in Wisconsin.

Figure 5
Wisconsin AI/AN Men
Smoothed County Heart Disease Death Rates, 1991-1995



The 1991-1995 heart disease mortality rate for AI/AN women 35 years and older in Wisconsin was 445 per 100,000. This rate is 1.2 times the rate for all women (354/100,000) in Wisconsin. Figure 6 displays deaths per 100,000 for AI/AN women throughout the state of Wisconsin. Figure 6 shows deaths per 100,000 for AI/AN women in Wisconsin.

Figure 6
Wisconsin AI/AN Women
Smoothed County Heart Disease Death Rates, 1991-1995



The state rankings of heart disease deaths puts Michigan, Minnesota, and Wisconsin among the states with the highest rates of death due to heart disease for both AI/AN men and women. The state of Michigan ranked

(Continued on page 4)

Northern Wisconsin Tribal Dental Needs Assessment Project

The Northern Wisconsin Tribal Dental Needs Assessment which began in Spring of 1998 was recently completed. A total of five Tribes in Wisconsin participated in the project. A report aggregating data from all participants and tribal specific reports were produced and distributed to participating Tribes. Overall, 556 people were assessed using the World Health Organization Dental Assessment Form (1986). About half of participants were males and half females. About 39% of participants were under 18 years of age and 9% were over 60 years of age. The assessment included examination for periodontal and dentition status. Pre-existing conditions were also recorded but the reliability of this data is not clear. If you are interested in this report or project, please contact the EpiCenter for more details.



Epi Info 2000 Training

As some of you are aware, there is a new version of Epi Info now available, called Epi Info 2000. Epi Info 2000 is a windows based version of Epi Info. For those people who do diabetes chart audits and enter your own data, you use Epi Info because the audit program is written in Epi Info. Others use Epi Info for registries and storing and analyzing data on various projects.

The EpiCenter has had requests for training on how to use Epi Info. We plan to offer Epi Info 2000 training in late Spring of 2002. Training will be made available to Tribes in Minnesota, Michigan, and Wisconsin. We will attempt to make the locations as geographically central as possible. As part of this training, the EpiCenter will provide each Tribe with a copy of the Epi Info 2000 manual. We plan to purchase the manuals before the training sessions, so if you would like a copy before then, please contact our office.

GLITC Youth Tobacco (cont.)

(Continued from page 1) smokers were most likely to have someone living in their home using tobacco traditionally (57%). The type of tobacco used for ceremonial purposes or prayer varied by the student's smoking status. 27% of current and non-smokers reported that they use the native tobacco plant for ceremonial uses and prayer, compared to frequent smokers who reported 22% of the time. 26% of current smokers, 21% of frequent smokers and 20% of non-smokers reported that they use commercial tobacco products for ceremonial purposes or prayer. About one quarter of students reported that they did not use tobacco for ceremonial purposes of prayer. (21% current smokers, 24% frequent smokers and 30% non-smokers).

The next Youth Tobacco Survey Report from GLITC is due out soon.

Heart Disease (con't.)

(Continued from page 3) 33rd for AI/AN men , Minnesota 23rd, and Wisconsin 31st out 35 in death rates for AI/AN men (a ranking of 1 was lowest rate and 35 highest rate).

The state ranking for heart disease death rates for AI/AN women was similar to that for men. Michigan ranked 32nd, Minnesota 27th and Wisconsin 26th out of 32 (again, a ranking of 1 was for the lowest rate and 32 was the highest rate).

Although the data presented in these reports are not Tribal specific and do not display differences, comparisons of tribal differences in heart disease death rates, the reports give an overview of heart disease death data by state, race and sex which is vital for understanding the overall burden of disease environment that tribes live within.

Maps were reproduced from Barnett E, Casper ML, Halverson JA, Elmes GA, Braham VE, Majeed ZA, Bloom AS, Stanley S. *Men and*

Heart Disease: An atlas of racial and ethnic disparities in mortality first edition. Office for Social Environment and Health Research, west Virginia University, Morgantown WV: June 2001.

Barnett E, Casper ML, Halverson JA, Elmes GA, Braham VE, Majeed ZA, Bloom AS, Stanley S. *Women and Heart Disease: An atlas of racial and ethnic disparities in mortality second edition.* Office for Social Environment and Health Research, west Virginia University, Morgantown WV: December 2000.

For copies of these reports you can send an email request to: ccdinfo@cdc.gov or call 1-888-232-2306.

Application Deadline for Injury Prevention Fellowship

Letters of interest from applicants to the Class of 2002 IHS Injury Prevention Specialist Fellowship must be received no later than November 7, 2001. Each letter must be co-signed by a local supervisor or administrator and be accompanied by a current resume.

The Fellowship was designed to accommodate a relatively large number of participants to enable the IHS to develop a highly skilled cadre of individuals in a short time. A key advantage of the Fellowship is that it only takes participants away from their duty stations for the approximately six weeks that are necessary to complete required course work and associated Fellowship activities.

For more information call Diana Kuklinski at 218.444.0503, Stewart Watson at 715.365.5112 or go to the IHS Injury Prevention Website at <http://www.ihs.gov/MedicalPrograms/InjuryPrevention/index.asp>.



Race Coding on Census 2000

Beginning with Census 2000, people have now been able to identify themselves as a member of more than one racial group on federal government documents. Over the next three years, any document used to collect racial and ethnic for the federal government, including birth and death certificates, employment surveys, and school applications, will be updated to allow this.

Before Census 2000, a person could only identify one of six racial categories: White, Black, American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, and "Some other race." Now, a person can choose up to all six, yielding 63 possible combinations to define his or her race. Hispanic or Latino is not considered a race but an ethnicity. The US Office of Management and Budget defines Hispanic or Latino as "a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture regardless of race." It should be noted that 97% of the people answering "some other race" indicated a Hispanic origin.

Due to the change in how it is collected, racial data from Census 2000 is not directly comparable with those from previous censuses. The Census Bureau is currently studying methods for comparing data from Census 2000 with previous censuses.

Ninety-eight percent of the respondents to Census 2000 reported only one race. Of the 2% who indicated more than one race, 93% reported exactly two races. The four largest race combinations

(White and Black, White and Asian, White and AI/AN, and Black and AI/AN) represent 43% of the population reporting two or more races and 1% of the total population.

Approximately 2.5 million people (0.9% of the total US population) reported they were AI/AN only. An additional 1.6 million reported being AI/AN and at least one other race, of which the three most common combinations were AI/AN and White (66%), AI/AN and Black (11%), and AI/AN and White and Black (7%).

In the Bemidji Area, Minnesota and Wisconsin's AI/AN populations are very similar in multiracial breakdown (see Table). Over two-third of the population of either state who identify themselves as AI/AN at least in part, identify themselves as AI/AN only. In contrast, less than half in Michigan identify themselves exclusively as AI/AN.

Racial misclassification is a potential problem. As reported in our Winter 2001 newsletter, a study conducted with the Sault Ste. Marie Tribe found that almost a third of the Tribal members who died between 1997 and 2000 were misidentified as not being Indian racially. On death certificates where ancestral information was recorded, almost 10% lacked mention of AI/AN ancestry. Misclassifying race either way limits accurate measurements of health in the American Indian population and can seriously affect health policies and funding.

In conclusion, although the new multiracial option allows an individual to better

clarify how he or she identifies him/herself racially, it makes it harder for health researchers to clearly identify who belongs to what group. However, as with any new change, new strategies will be developed to handle it.

For more information on race and the Census, go to www.census.gov and click on Minority Links. This web page includes information about the 2000 and previous Censuses.

Red Lake Foot Clinic (*con't*)

(Continued from page 2)

but continuity and consistency of preventative foot care along with staged diabetes management. I believe that our program can be used at other IHS/ Tribal Health Programs and that RNs can be trained and utilized as Nurse Specialists.

To conclude this article, I would like to mention that I conduct two diabetic foot clinics a week and the other three days are spent in the capacity of the diabetes coordinator and diabetes educator. I see approximately 200 patients a year in the diabetic foot clinic and a total of 600 patients yearly. Our vascular/ wound healing specialist sees approximately 25 patients monthly with a total of 300 patients annually. Our service population here at Red Lake is approximately 8500 people with 642 on the diabetes registry. When I started with the program several years ago, there were over 56,000 LEAs each year nationwide. Today that figure according to the National Limb Loss Information Center has risen to 86,000. That is about 236 LEAs everyday! We at Red Lake are trying our best not to become part of that statistic.

For further information I can be contacted at 9218) 679-3912 x239, of email at Char-maine.Branchaud@mail.ihs.gov.

	Michigan	Minnesota	Wisconsin	United States
	# (%)	# (%)	# (%)	# (%)
AI/AN Alone or in Combination:	114,234 (100)	75,733 (100)	63,831 (100)	4,343,870 (100)
AI/AN Alone:	53,421 (46.76)	52,009 (68.67)	43,980 (68.90)	2,475,956 (57.00)
AI/AN and at Least One Other Race:	60,813 (53.24)	23,724 (31.33)	19,851 (31.10)	1,867,914 (43.00)
AI/AN and One Other Race:	53,688 (47.00)	20,917 (27.62)	17,667 (27.68)	1,643,345 (37.83)
AI/AN and Two Other Races:	6,507 (5.70)	2,545 (3.36)	1,983 (3.11)	189,923 (4.37)
AI/AN and Three Other Races:	418 (0.37)	197 (0.26)	126 (0.20)	25,565 (0.59)
AI/AN and Four Other Races:	190 (0.17)	60 (0.08)	66 (0.10)	8,258 (0.19)
AI/AN and All Other Races:	10 (0.01)	5 (0.01)	9 (0.01)	823 (0.02)
1990 Census Total (AI/AN Only):	58,934 (—)	49,507 (—)	39,725 (—)	1,959,234 (—)

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