

Where In The World Are We?

Just as individuals are part of a family, and the family is part of a clan or Tribal community, and the community is nestled behind reservation boundaries and the Tribal lands are sovereign nations in the United States (US), so is the US part of a continent, a hemisphere and global sphere called Earth. Many generations have preceded our unique point in time and many will follow. Our history, lands, people and politics have evolved through natural and un-natural influences resulting in either good or harm. Many “turning points” have dotted the landscape of development as a world, and I believe we are challenged by one now.

I had the privilege to receive an invitation to attend the third meeting of the “International Indigenous Health Measurement Group”, held in March bringing delegations together from the United States, Canada, New Zealand and Australia. Amid new friendships, I observed how energetically, compassionately and competently the Nations of Canada, New Zealand and Australia have legitimized the concerns of their Indigenous People, prioritized health status disparities and supported inclusive policies for better representation in health status surveys and intervention planning. Listening to their stories, I realize that the US faces several challenges:

- A small Indigenous population in relation to expanding minority populations (African, Hispanic, Asian)
- Defining the social determinants of health unique to Indigenous populations
- Establishing health equity in the absence of a universal health care program
- Competitive funding environment and resource distribution.

The World Health Organization (WHO) has recently published a report that can serve as a platform to address our challenges in the US. The report, “Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health” was produced by the WHO Commission on Social Determinants of Health. The report cites three principles of action:

1. Improve the conditions of daily life – the circumstances in which people are born, grow, live work and age
2. Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – globally, nationally and locally
3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

CSDH (2008). *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health.* Geneva, World Health Organization.

http://www.who.int/social_determinants/thecommission/finalreport/en/index.html



Program Director
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H1N1 Flu... “Time Out” for Lessons Learned...

Most community citizens are well aware of the emergence of the new (novel) virus circulating now throughout the world. The H1N1 virus (Swine Flu), seemed to have its epidemic roots in Mexico, rapidly spreading to the United States. While the news media provided stories daily, the H1N1 rooted itself in many communities. The Centers for Disease Control (CDC) has sustained daily website updates, conference calls and press conferences to coordinate outbreak investigation activities while informing the public. Staff at GLITEC have been monitoring the national and local developments in preparation for any assistance requested by our Tribal communities. So far, it has been difficult to assess what the impact of H1N1 has been on American Indians and more specifically, American Indians residing in the Bemidji Area.

Public health authorities have agreed that the H1N1 viral illness that we are experiencing now has not been as serious as previous disease outbreaks, but vigilance remains high. Viruses can mutate quickly in response to their threats to avoid extinction and, many pandemic illnesses have appeared in waves. We may face a more severe wave of H1N1 in the future, most speculating that we may see it again during fall months. The current outbreak however, has tested our national, state, local and family plans for managing a public threat. The remainder of this article will:

1. *summarize the status of the H1N1 viral outbreak*
2. *suggest evaluation questions to be used in your organization to debrief your outbreak response so far.*

H1N1 Summary

CDC’s seasonal influenza surveillance system report, *FluView*, for the week ending May 9 showed that there are higher levels of influenza-like illness in the United States than is normal for this time of year. Some of this is due to a late flu season (with currently circulating human flu viruses), but some of this activity is due to novel H1N1.

About half of all influenza viruses being detected through laboratory surveillance are novel H1N1 viruses, with the other half being regular seasonal influenza virus, including seasonal A H1N1, influenza A H3N2 and type B viruses.

Today CDC is reporting a total of 5,123 probable and confirmed cases of novel H1N1 infection. This number is thought to represent a small proportion of the number of people who have been infected with the novel H1N1 virus. Because this is a new virus, most people will not have immunity to it, and illness may be more severe and widespread as a result. In addition, currently there is no vaccine to protect against this novel H1N1 virus as we have for seasonal influenza. However, a vaccine is in development and may be available should H1N1 return for a second wave.

This virus is not “going away” as some people seem to think. It’s uncertain at this time how severe this novel H1N1 outbreak will be in terms of illness and death compared with other influenza viruses. Influenza, on the whole, is always serious – each year in the United States, seasonal influenza results in an estimated 36,000 deaths and more than 200,000 hospitalizations from flu-related causes.

People who are at high risk of serious seasonal flu-related complications include pregnant women, children younger than 5 years old, people with chronic medical conditions, and people 65 years and older. CDC believes this information from seasonal flu applies to the novel H1N1 (swine flu) viruses as well, but studies on this virus are ongoing to learn more about its characteristics and to learn what groups are at highest risk. The media spotlight may have shifted, but CDC’s response and focus has not. Now is not the time for complacency or to let down our guard. The United States is already engaged in implementing its pandemic response plan.



H1N1 Flu... *“Time Out” for Lessons Learned... continued*

Response Evaluation

As the nation is settling into a pattern of flu surveillance that includes national, state and local case identification and monitoring disease severity, it's a good time to settle back for a hindsight view of how we have responded to the H1N1 public health threat. Whether your state, community, organization or family is considered, the following questions can guide you through an evaluation of your disease outbreak response:

(Rating scale: 1= poor; 5 = excellent)

Criteria	Scale	Improvement	Steps
Appropriate response team members were identified and gathered.		How can this be improved?	What action steps are needed to proceed?
A response plan was located and reviewed.			
Sequential steps are listed to provide adequate population protection.			
Information dispersed has been accurate.			
Information dispersed has been timely.			
Supplies have been available as needed.			
Community/organizational medical personnel were informed and active during the outbreak.			
Communication between state and local officials was established and ongoing.			
Critical incidents were systematically reviewed followed by appropriate operations revisions.			
Team members and operations have responded timely to changing conditions as needed.			





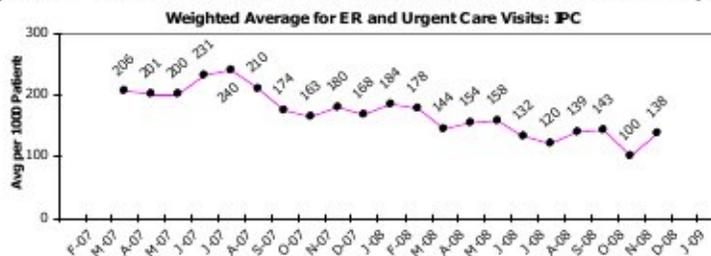
The Chronic Care Initiative

"A Path to a World-Class Quality Indian Health System"

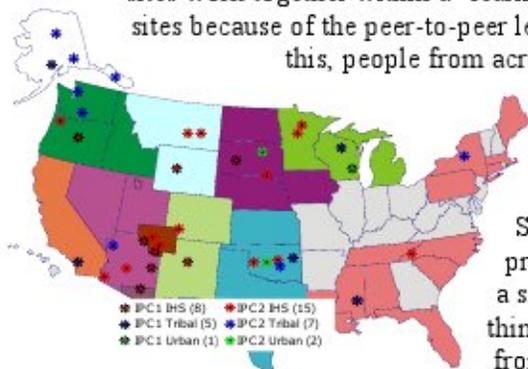


The Indian health system has a long history of addressing public health needs and caring for acute illnesses. But today, the need to treat long-term, chronic illnesses places new demands on our system and our communities. We need to improve the healthcare that we give so that patients get the care they need and want. We need to give care that uses up-to-date knowledge and we need to partner with local health programs to meet patient needs. Through the Chronic Care Initiative (CCI), the Indian health system is dealing with this important challenge. We are joining forces to build on past success and to improve the quality of our care.

Fourteen pilot sites began work in FY 2007 in the CCI. They improved work in prevention (*screening for high blood pressure, depression, intimate partner violence, alcohol misuse, tobacco abuse, and obesity*); in cancer screening (*colorectal, breast, and cervical cancer*); in chronic disease treatment (*control of blood pressure*), and in patient experience of care (*patients who would recommend their healthcare clinic to friends and relatives*), and number of emergency or urgent care visits. They were able to make these improvements in their systems of care by asking everyone to help in making changes and by sharing learning among IPC sites.



CCI work in FY 2008 added an additional 24 IHS, Tribal, and Urban Indian health programs. Together, the 38 programs provide services to over 400,000 American Indians and Alaska Natives. The CCI pilot sites work together within a "learning community". Natural teachers and leaders have emerged from CCI sites because of the peer-to-peer learning that occurs. CCI uses virtual meeting technology. Because of this, people from across the country meet using telephones and computers instead of traveling. This helps us reach many more people in a cost-effective way – and it allows us to involve community members and Tribal leaders in the work.



Some important improvements that have been used to transform our primary care system include: involving community members, identifying a small group of patients with whom to try changes and see if they make things better, developing a care team of doctors and nurses and people from community-based health programs, supporting patient and family self-empowerment for health, and using the information system as best as possible. Another very important change is setting up a medical home for each person. Creating on-going relationships in this "home" between patients and their care team helps patients to see members of their care team when needed.

"Through this collaboration, we will strive to provide comprehensive healthcare to address the "whole" patient by ensuring truly consistent continuity of care."

- Northern Cheyenne Service Unit, Lam e Deer, MT

"I was thinking that I might retire until this [Initiative] came along."

- B C, MD

The Indian health system is in many ways a model rural health care system. The CCI pilot sites are showing us a path toward becoming a world-class quality health care system. Active engagement by Tribal Leadership at the tribal and national level is crucial to the success of this work. Together we will build the system of care that can raise the health and wellness of American Indians and Alaska Natives to the highest level.



The Chronic Care Initiative

Questions and Answers



How did the Chronic Care Initiative (CCI) begin?

The CCI began in 2004 under the direction of the IHS Director, Dr. Charles Grim, as one of the Three Health Initiatives including Health Promotion and Disease Prevention, Behavioral Health, and Care of Chronic Conditions. The IHS had made improvements in the care of patients with diabetes, but care for other illnesses was not improved in the same way. This initiative is building on the learning of IHS and Tribal diabetes programs to improve treatment and prevention of all chronic conditions that affect the people we serve.

I have heard of Innovations in Planned Care (“IPC”). What is it?

IPC is a part of the Chronic Care Initiative that is learning creative, new ways to improve healthcare. IHS, Tribal, and Urban Indian Health programs are working together in the IPC learning community to find out how best to improve care. The first 18 months of this work (IPC 1) included 14 sites; 24 other sites joined at the end of 2008. In IPC, we are learning about changes that make a difference in the care and health of American Indians and Alaska Natives. We are also learning how to make those changes happen and are sharing what we learn with the entire Indian health system.

Who is involved in IPC?

IPC started with 8 Federal, 5 Tribal, and 1 Urban site in January 2007. These 14 sites found the work important enough to them and their communities to continue work in IPC2, when other sites joined. IPC now has 23 Federal, 12 Tribal, and 3 Urban sites working together with all 12 Areas represented, and facilities of different sizes and types. All of these sites joined IPC to learn together how to make important improvements in the way we care for our communities.

What happens after IPC2?

After IPC2, the Chronic Care Initiative will run a very large learning community called *Planned Care for All*. Building on the learning of IPC, it will be open to any facility in the Indian health system that wants to improve care for their patients and wants to join.

Is there funding for the sites that are involved in IPC?

The funds that are given to sites cover travel expenses to meetings where teams come together to learn from each other. IPC sites work with and learn from faculty who are national experts in health care delivery. The faculty is also expert in running learning communities in which sites learn from each other. If a facility chose to do this type of work outside of the Chronic Care Initiative using private sector consultants, their costs would be close to \$15,000 and travel costs would be extra.

Is there National Tribal oversight for the Chronic Care Initiative?

The Tribal Leadership Diabetes Committee is the National Tribal Oversight group for the CCI. CCI staff routinely present the work to them and seek discussion and advice.

How can I get involved in the work of the Chronic Care Initiative?

If your local program is involved in IPC, then you may already know about some of the improvements that are happening. If you haven't heard about any changes yet, please reach out to your facility leaders to learn more. To best understand what needs to be improved and to create a better healthcare system, health programs must work with Tribal leadership and with their community. If your local program is not yet involved in IPC, please encourage them to get ready to join when *Planned Care for All* is launched in 2010. Also, anyone can join the Chronic Care Initiative listserv now. It and the Readiness Call Series are designed to share the learning from IPC with the rest of the Indian health system.

Project Profile: Ain Dah Ing Halfway House for Substance Abuse

On April 6, two Epi Center epidemiologists visited the Ain Dah Ing Inc. (Ojibwa for “Our Home”) residential facility and administrative office in Spooner, Wisconsin. Ain Dah Ing is a non-profit, state of Wisconsin licensed, 15-bed community based residential facility, offering a culturally based “approach to substance abuse by integrating the ‘Indian way’ with the standard philosophies of rehabilitation.” In addition to services such as one-on-one counseling, group therapy, or aftercare planning, Ain Dah Ing incorporates culturally-specific values and activities into the recovery process. Activities such as traditional feasts, Indian arts and crafts, and attending local powwows and sweat lodges help residents connect to the heritage and history of their community. Since its establishment in 1975, Ain Dah Ing has provided direct services to over 200 American Indians each year. Though most residents are from Wisconsin, Ain Dah Ing has welcomed individuals from Tribes in Minnesota, Michigan, and even Canada.



Epidemiologist
Anne Trinh

The Great Lakes Inter-Tribal Epidemiology Center is working with Ain Dah Ing’s executive director to examine client records and summarize information about the people Ain Dah Ing has helped and the services that have been provided through the years. This data will be assembled into an aggregate quantitative report with no personal identifying information. In combination with the stories of alumni, some of whom have been sober for over 30 years, a powerful story will be told showing the value Ain Dah Ing brings to the American Indian communities of the Bemidji Indian Health Service Area.

Epidemiology Definition: Herd Immunity

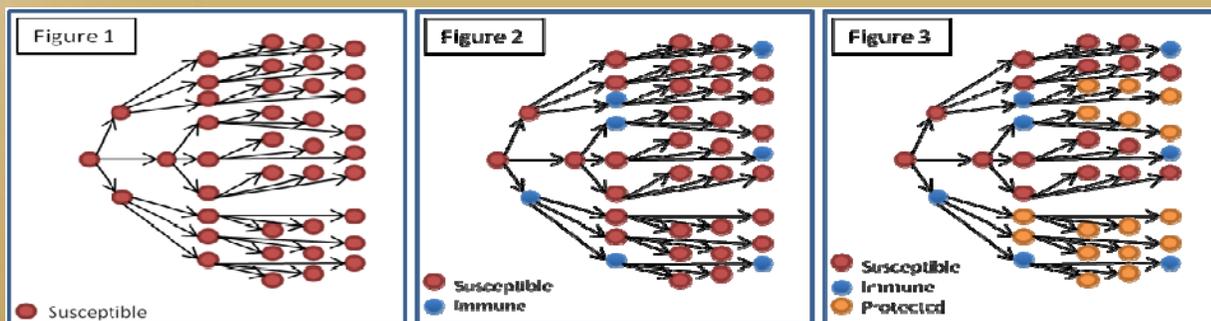
Herd immunity is an important epidemiological concept related to vaccinations. It occurs when enough people in a population are immune to a disease that even those who have not received vaccinations are unlikely to get the disease. The more people in a population that are immune to a disease, the less likely it is that an unimmunized person will come into contact with an infectious person.

Key Terms

Susceptible: At risk of becoming infected if exposed to a certain pathogen (disease-causing organism)

Infectious: Able to spread a disease

Immune: Protected against becoming infected by a certain pathogen



The figures above show a population where each person could spread a disease to three other people if he or she were infected by a virus. As seen in Figure 1, all people in this population are susceptible- they could possibly get a disease if exposed to the virus. In Figure 2, seven people are immune to the disease and so would not get sick if they were exposed. Figure 3 shows how these seven individuals indirectly protect 16 others. This protection only refers to protection from *exposure* to a virus- immunity is not passed from person to person. When a person is immune, the people he or she has contact with would not get exposed to the virus. This protects people who are unable to receive the vaccine for some reason, such as those with allergies to part of the vaccine or weak immune systems.

Childhood Vaccinations in the Bemidji Area

In the past, vaccination rates often have been higher in Indian Country than in the general population. Recently rates of childhood vaccination have been falling for American Indian/Alaska Natives in the Bemidji Indian Health Service Area. This could leave Native communities in Michigan, Minnesota, and Wisconsin vulnerable to vaccine-preventable disease outbreaks.

Graph 1 Percent of Bemidji Area American Indian/Alaska Native Children 3-27 Months Completing Vaccination Requirements, FY2004 Q1-FY2009 Q1 Rolling 4 Quarter Averages *



Graph 1 shows the percentage of Bemidji Area children who completed their vaccinations in recent years using rolling 4 quarter averages. Overall, there is a downward trend in the percent of children who have been vaccinated, from 76.5% in FY2004 quarter 1-FY2004 quarter 4 to 71.0% in FY2008 quarter 2-FY2009 quarter 1. In the Indian Health Service as a whole in the most recent four quarters, 73.8% of American Indian children received all their vaccinations. Another factor to consider is the completeness of the data that IHS receives.

Thirty four Bemidji Area sites report immunization rates to IHS. In the first quarter of 2008, 28 of these (82%) reported their rates for two year olds receiving vaccinations. This number dropped throughout the year- by the last quarter only 18 (51%) were reporting. Vaccine coverage rates also dropped over this time period from 78% to 76% (the average for the year was 77%) for two year olds. However, the number of sites reporting rose again for the first quarter of 2009- 28 sites (80%) submitted data, and 78% of eligible 2 year olds were vaccinated. If sites do not consistently submit their data, it is harder to know if the numbers received represent a true picture of immunization practices.

Why is reporting vaccination rates important?

- Reporting vaccination rates to IHS allows monitoring of who is and is not getting the recommended vaccines across the Bemidji Area and helps them respond quickly to problems.
- Maintaining high vaccination rates can reduce the frequency and severity of vaccine-preventable disease outbreaks and prevents diseases that have been eliminated from the United States from returning.
- The more people that are vaccinated, the greater the herd immunity will be- this protects those who cannot receive vaccines because they are too young or who have other health problems.

1. Indian Health Service National Immunization Reporting System Reports
<http://www.ihsps.ihs.gov/immunizations/index.cfm?module=immunizations&option=reports>

Great Lakes Inter-Tribal Epidemiology Center Mission: To support Tribal communities in their efforts to improve health by assisting with data needs through: Partnership Development, Community Based Research, Education, and Technical Assistance.

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