

# GLITEC GAZETTE

Summer 2015

GREAT LAKES INTER-TRIBAL EPIDEMIOLOGY CENTER



## BALAC LAUNCHES

### Bemidji Area Leaders Acting for Change Initiative Now Underway

The Great Lakes Inter-Tribal Epidemiology Center (GLITEC) is pleased to announce the launch of the Bemidji Area Leaders Acting for Change (BALAC) initiative. BALAC will assist American Indian communities in Michigan, Minnesota and Wisconsin in addressing health disparities and ultimately aid in the prevention of chronic disease. GLITEC launched this initiative by funding four Indian communities in Michigan: Bay Mills Indian Community, American Indian Health and Family Services in Detroit, Keweenaw Bay Indian Community, and the Lac Vieux Desert Band of Lake Superior Chippewa Indians. GLITEC will also provide support to other communities in the form of technical support and evaluation.

The purpose of the BALAC program is to reduce chronic disease in American Indian communities through policy, systems and environmental changes. Working in collaboration with community coalitions, healthcare providers and community partners, GLITEC will encircle each community with training, tools, technical assistance and other resources to increase local capacity and empower citizens to address the burden of chronic disease. A major component of the effort will be the incorporation of community coalitions comprised of various community sectors including spiritual leaders, medical providers, mental health and AODA professionals, law enforcement, elected officials, informal leaders and others. This is crucial to developing the community buy-in required to initiate culturally acceptable changes within American Indian communities. The resource network will focus on shifting social norms while addressing the underlying issues inherent to sustainable, holistic health.

Isaiah Brokenleg, Epidemiologist and Program Director, says that a culturally sound approach will strengthen each community's ability to address public health and environmental issues. "By creating culturally acceptable curriculum and programming, we are reinforcing traditional



***"Tell me and I'll forget. Show me, and I may not remember. Involve me, and I'll understand."***



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belief systems - which are key to acknowledging and strategically countering health related problems in American Indian communities," said Brokenleg.



Funding for this project comes from the Centers for Disease Control and Prevention's (CDC) A Comprehensive Approach to Good Health and Wellness in Indian Country grant. This grant represents a substantial investment by the CDC in Indian Country. Recognizing the critical state of health in Indian Country, the CDC has, for the first time, funded such a project in the Bemidji Area and other Indian Health Service (IHS) regions nationally.

Historically, the Bemidji Area has been the most underfunded among all IHS areas - with funding equal to only 49.8 percent of need. American Indian and Alaskan Natives living in the Bemidji area, comprised of 34 Tribal Nations in the three states of Michigan, Minnesota and Wisconsin, and four urban areas including Chicago, Detroit, Milwaukee and Minneapolis, will benefit from the BALAC initiative. American Indians and Alaskan Natives historically suffer from disproportionately higher rates of cancer, respiratory disease, diabetes, heart disease, influenza and pneumonia, kidney disease, suicide and unintentional injury. IHS, in conjunction with GLITEC and the Bemidji Area Tribes, has identified a number of issues that exacerbate the health disparities between American Indian and all-races populations. GLITEC used a competitive process for the BALAC initiative to fund Indian communities in the Bemidji Area.

## BALAC KICK-OFF MEETING

Great minds with great ideas recently met in Chicago for the BALAC Kick-Off meeting. "I think the meeting went well, and I'm excited about the number of people that attended. The Epi team had the opportunity to answer questions, and I am pleased that we are all working together for a common goal. It was good to get together to discuss our hopes, concerns, dreams and plans for future," said Isaiah Brokenleg, BALAC Program Director.



Topics discussed at the Kick-Off meeting included an overview the BALAC grant, updates from each sub-awardee on their progress and their plans for the future, a discussion on policy, systems and environmental changes, allowable expenses, and work plans and evaluations.

The meeting concluded with announcements, including information on the upcoming Good Health & Wellness Resource Meeting that will be held in Detroit on August 12 and August 13, 2015.



## THE SIGNIFICANCE OF MISSING DATA....THE UNTOLD STORY

Commentary by Kristin Hill, MSHSA, Director

What if you just realized the book you are reading didn't contain the last two chapters? You won't know how the story ends....or what if the journal article you were hoping to cite omitted the "discussion" and "conclusion" sections? You would likely feel not only disappointment, but perhaps anger arising from dashed expectations and being left in the dark about how the story ends. You are left to either disregard the story or make up your own ending.

We have come to expect a lot from data use and applications in public health.

**Statistical significance** is a recognized term used to imply that inferences from the data are "probably true." Numbers, percentages, correlations and rates displayed in various visual formats such as charts and graphs help us understand population health trends, improve services and acquire needed funding. We rely on the accuracy of data to objectively inform policy makers. The United States constitution requires the population to be counted every ten years. The American Community Survey samples U.S. households in between the decennial census to obtain population estimates for every level of geography in the U.S. and guides over \$400 billion dollars in annual federal aid annually used by states and local governments.<sup>1</sup>



"The numbers tell the story" is a frequent mantra used by many trying to advocate for public health, yet the larger story rests in data that *isn't* there more than data that is....especially for small populations such as American Indian/Alaska Native. Why is American Indian/Alaska Native data often missing from local, state, regional and national vital statistics, various data registries such as a state cancer registry and routinely administered population health surveys? Here are some common reasons.

1. Data access: Public data such as vital records (birth and death certificates) remain largely inaccessible. State health departments and federal agencies who store data are often under staffed to respond to requests for information services to integrate, analyze and interpret data into useful information.
2. Racial identification: Data collection systems collect racial identity inconsistently or not at all. Often insufficient number of racial or ethnic categories for respondent selection limit the identification of American Indian/Alaska Native people when small population numbers are collapsed together for reporting purposes.
3. Racial misclassification: Incorrect identification of race causes poor data quality. Studies have shown that American Indian/Alaska Natives are more likely to be misclassified than individuals of other races.<sup>2</sup>
4. Small population size: American Indians/Alaska Natives comprises approximately 2% of the overall population of the United States (2010 Census). Common survey sampling methods typically result in undercounting of American Indians or stretching the sampling timeframe to achieve sufficient sample size which reduces data quality.

So, why is missing or inaccurate data significant? Health inequity and health disparities are evident in small, vulnerable and hard to reach populations, based on special studies that attempt to utilize data collection and analysis procedures that adjust for small population size and racial misclassification. American Indian/Alaska Natives often carry the highest burden of disease or adverse health conditions. Information needed for the development of ongoing and comprehensive strategies to address the high burden of disease requires consistently collected and monitored accurate data. Fundamental limitations to uniform and accurate data collection result in under-representation of American Indian/Alaska Natives which structurally omits disparities from view. An inability to "see" data eliminates any possibility of competent service delivery decisions and appropriate funding allocation. Data counts....missing data does not.

1. Porter, Meghan. Eroding the Foundation of U.S. Data: Imminent Threats to the Decennial Census and American Community Survey: An Urgent Call to Action for Tribal Leaders and Health Directors. December 4, 2014. Great Lakes Inter-Tribal Epidemiology Center, Great Lakes Inter-Tribal Council, Inc.

2. Best Practices in American Indian and Alaska Native Public Health. A Report from the Tribal Epidemiology Centers, 2013.

## BICYCLING THROUGH SMART OBJECTIVES

By Meghan Porter

When GLITEC's Director, Kristin, told me that she was assigning me to write a newsletter about bicycling, goals, and epidemiology, my first thought was that it would not work. Despite it appearing to her that I must be an excellent goal setter because of how frequently I rode my bike, the truth is that I break all the conventional wisdom of goal setting (at least as it's used in public health). Sometimes, though, examining mistakes other people make can be very educational- so let's break down my actual bicycling goals and objectives for 2014 along with what I *could* have done.

In public health, a **goal** is usually thought of as a broad, overarching statement of where a community hopes to be or would like to do.

How well did I follow this? Well, I didn't. In fact, I had no overreaching goal whatsoever. In retrospect, a good goal may have been: *Meghan will participate in a variety of bicycling experiences.*

While a goal is broad, an objective is very precise. Public Health favors use of the SMART (**S**pecific, **M**easurabe, **A**ttainable, **R**elevant, and **T**ime-bound) objective framework to provide more detail about what goes into making a goal.

As it turns out, I also lacked solid objectives. Let's look:

1. Bike at least 2,000 miles in 2014.

This one isn't so bad: it meets all the criteria. Hidden behind this number of 2,000 miles, though, is the fact that because of my unpredictable work schedule with sometimes frequent travel, I can't accurately plan how many days a year I will be at home. 2,000 was a deliberately low estimate; in reality I biked over 3,000 miles and if I had a job with no travel during the bike-friendliest months, I likely would have had over 4,000. So, it raises the question: what is *actually* realistic?

2. Have a fast ride of a reasonable distance.

This is a pretty poorly written objective- no parts of the SMART framework applied here at all! However, I had some unspoken criteria. For me, a ride of reasonable distance is between 15 and 25 miles. A "fast ride" for me is one in which my total average speed (including stopping for stop lights and dealing with traffic) is 15 miles per hour. A better way I could have written the objective is: *In 2014, go on a bicycle ride of 15-25 miles with an overall average speed of at least 15 mph.* Objective met.

3. Do well in a bicycle race.

Like objective 2, this does not hold up to the SMART standard. There were two races I had in mind: a spring 100 mile race on hilly, rural gravel roads, and an urban race. For the first, I just wanted to finish it; for the second, I wanted a good placing (although I'd tell people that I just wanted to do better than the previous year). I could have made this into two objectives: *Finish the 2014 Almanzo 100, and Place in the top twenty women, trans, and femme cyclists during an urban bicycle race in 2014.* When broken up this way, I didn't complete the gravel century objective (a late spring, sickness, and travel prevented me from training well, so I only finished about half the course), and I was successful for the urban race.



**BICYCLING THROUGH SMART OBJECTIVES** *(Continued from Page 4)*

Looking back, although the fact is that I had good success in achieving the objectives, the non-SMART model I used would undoubtedly lead to problems in professional settings. A key difference between these personal objectives and the kinds that are written for public health purposes as part of a strategic plan or a grant project is that I did not have to communicate with anyone. I had internal definitions, though they weren't included in the objectives I mentally wrote. Well-crafted goals and objectives are important for communication for individuals, departments, political leaders, and funding organizations. Despite the time and energy that crafting SMART objectives may take, the effort will be rewarded through the accountability and clarity of purpose that can result.

**NEW TO THE EPI TEAM**

Hello everyone! My name is **Liz Rogers** and I am interning with GLITEC over the summer. I will be located at the main office in Lac du Flambeau, and I will be working with Meghan Porter and Jake Melson. My goal for the summer is to learn more about the determinants that influence Native American health, wellness, and data quality, and to gain more experience with data collection and analysis.



I grew up in the far west suburbs of Chicago, and I attend Northern Illinois University. I hold a Bachelor of Science degree in Nutrition and Dietetics, and I am currently a graduate student studying public health with an emphasis in health promotion. I will complete my MPH in December of 2015. My goal after graduation is to earn a fellowship position, and, eventually, I would like to pursue a PhD. I feel very fortunate for the opportunity to work with GLITEC and I look forward to the learning experience!

Greetings! My name is **Kaitlyn Sykes** and I will be interning with GLITEC until August. I will be working with Jake Melson, Samantha Lucas-Pipkorn, and Meghan Porter on the projects they have this summer in Minneapolis, while being personally located in the local office in Lac du Flambeau. I have enjoyed my first few weeks getting oriented, and look forward to the remainder of my time learning more about Native American traditions, culture, and overall wellness.



I am from Ann Arbor, Michigan, where I have lived for 23 years, and am excited to explore the Northwood's during my time here. I received my undergraduate degree in Biological Psychology from the University of Michigan in 2010. I am currently studying Epidemiology at the University of Michigan, School of Public Health, and will be graduating in May 2016 with an MPH. After graduation, I hope to find a fellowship in applied public health, and be able to apply the skills I develop at GLITEC throughout my internship. I am very excited to be spending the next few months with GLITEC and am looking forward to everything I will learn and experience during my time here!

**NEW TO THE EPI TEAM**

My name is **Ashley Miller** and I am very excited to be joining the GLITEC team this summer! I will be working with Jake Melson, Samantha Lucas-Pipkorn, and Meghan Porter on a variety of projects throughout my time in Minneapolis. I hope to gain a multi-faceted understanding of Native American culture and wellness, as well as the real-world triumphs and troubles of instrument development and data collection and analysis.



I have lived in Michigan for 24 years and am excited to explore another part of the country! In 2013, I received my undergraduate degree in Health Communications and Applied Statistics from Grand Valley State University in Grand Rapids, MI. I have just finished my first year as a graduate student at the University of Michigan-School of Public Health and will be graduating next year with an MPH in Epidemiology. While I have a variety of interests in the field, I hope to work in applied public health after getting my degree and potentially pursue a PhD. With that being said I look forward to learning and working with GLITEC and supporting Tribal health!

**MEGHAN PORTER ACCEPTED TO CITYLEADERS PROGRAM**

Meghan Porter has been accepted into the 2015 CityLEADERS program. The CityLEADERS program provides leadership training for emerging and mid-level urban maternal child health leaders.



Meghan will engage in an eight month program that includes intensive training on core competencies, including one onsite meeting and a series of distance-based skills-building opportunities. Meghan will also be matched with a senior urban MCH leader in the field for a mentor/mentee relationship.

**Congratulations Meghan!**



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## SIGNIFICANT PUBLIC HEALTH SURVEY - PART ONE

### THE DECENNIAL CENSUS




by Meghan Porter

**What is the Census?** The Census is the name of a survey used by public health (and many other fields) in the United States, the U.S. Census. Because it is conducted every ten years, it is known as the decennial Census.

**What is the origin of the Census?** The writers of the Constitution mandated that a census of the population be conducted every ten years. The purpose, as stated in the Constitution, is to create an “actual enumeration” so that “Representatives and direct Taxes shall be apportioned.” However, as suggested by James Madison, ever since 1790 additional questions have been added to better understand the population.

**Why is the Census so important?** Because every household in the United States must participate in the Census by law, it produces a very accurate count of the people in the country and corresponding basic facts about people and housing. It serves as a foundation for many practical and research applications. Because Census information is so accurate, professionals in many fields (like public health!) use this information to ensure that their surveys accurately reflect the populations that they work with. In addition, taxes, congressional districts, and the number of representatives in Congress’s House of Representatives are calculated based on the Census.

**What changes has the Census been through?** The Census has been through multiple changes over the years. In the past, some people were not counted well- especially slaves and American Indians. Questions and question topics have changed over the years. A major difference for the 2010 (and later decennial Censuses) compared to Censuses in recent decades is the elimination of the long form. Previously, most households received a short form Census while one out of six households received the long form. Beginning with the 2010 decennial census, only the short form was collected; a new survey, called the American Community Survey (ACS), has taken the place of the long form. The ACS will be discussed in an upcoming GLITEC Gazette.

**Who is responsible for managing the Census?** The U.S. Census Bureau is responsible for running the Census (as well as other related surveys). The U.S. Congress is responsible for giving the Census Bureau its budget.

**What data are collected?** On the 2010 Census, there were ten questions total, focusing on how many people are in a household; whether the home is rented, owned, etc., and information about each person in the household such as sex, age, Hispanic ethnicity, relationship to each other, race (including “principal tribe”), and whether they sometimes stay elsewhere. The questions for the 2020 Census are still being decided upon.

**How is the Census relevant for American Indian people?** Census participants are allowed to select multiple races, allowing multi-racial people to better report their identity- if a person is American Indian, a “principal tribe” may be selected as well. In 2010, the Census Bureau also created special geographies, called Tribal Census Tracts and Tribal Block Groups, to create more meaningful geographic areas. However, for many communities, data for these geographies are limited.

The data collected by the Census is very important for American Indian people. Having a clear understanding of population numbers- and age and sex distributions- is important to help understand who lives in a Tribal community. The information can assist with planning for programs as well as Tribal businesses, and may also be required for funding applications.

**Is there anything else I should know about the Census?** GLITEC recently released a piece on recent threats to the decennial Census and the ACS.

For more information, visit: <http://www.census.gov/2010census>.

# GREAT LAKES INTER-TRIBAL EPIDEMIOLOGY CENTER

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## ***Our 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.

[WWW.GLITC.ORG/EPICENTER](http://WWW.GLITC.ORG/EPICENTER)



## **SUMMER SISTERS STEW**

1 1/2-2 cups cooked kidney beans  
2 -2 1/2 cups rinsed chopped mushrooms  
1 -1 1/2 cup frozen corn kernels, defrosted  
2 -2 1/2 cups cut yellow squash  
1 (16 ounce) can diced tomatoes, drained  
1 large potato, diced  
1 large onion, diced  
1/2 teaspoon black pepper  
1/2 teaspoon sage  
1/4 teaspoon thyme  
1/2 teaspoon rosemary  
1/2 teaspoon cilantro or 1/2 teaspoon oregano  
2-4 bay leaves  
1/4 teaspoon salt  
1 tablespoon olive oil  
2-3 garlic cloves, minced

### ***DIRECTIONS -***

Heat half the spices, garlic, and olive oil in a large pot, Sauté the onions in the mixture for 2-4 minutes.

Add 2-4 cups of water and allow to come to a boil.

Add the potatoes and the other half of the spices, simmer for 5 minutes.

Add corn, tomatoes, and beans. Allow to simmer for 2-5 minutes.

Add squash and mushrooms. Slow to simmer for 10-30 minutes, until cooked to desired tenderness and melding of flavors.

**SERVINGS**—Four large bowls

<http://low-cholesterol.food.com/recipe/summer-sisters-stew-163108>



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