DATA SHARING AGREEMENT

Hot of the press...

Tribal Epidemiology Center’s (TECs) across the Indian Health Service Areas have been systematically increasing local capacity to collect and use primary data for local Tribal health care providers and leaders to accurately assess health status, determine local policy, seek additional resources and engage in quality improvement activities. Yet, data access and data quality issues remain. Over the last ten years, efforts on behalf of Tribal leaders and Indian Health Service staff has now lead to an approved “Data Sharing Agreement” that will open the door for TECs to access the Indian Health Service Data Warehouse to add epidemiologic tools to the array of data services and products requested by our Tribal communities.

Consequently, on October 2nd, GLITEC staff met with the Bemidji Area staff to officially sign the Data Sharing Agreement for the Bemidji Area. GLITEC staff plan to actively engage Tribal Health Director’s throughout the Bemidji Area to determine data priorities, establish options for data products and methods to evaluate data utilization to better meet local Tribal community needs.

For more information about GLITEC’s data sharing policy, please contact Kristin Hill, Program Director.

A FOND FAREWELL FROM NANCY BENNETT

After 7 years at the Great Lakes Inter-Tribal Epidemiology Center as their MIS Analyst and 14 years of living in the Northwood’s of Wisconsin, I am moving on. I have accepted a newly created position at the Portland Area Epidemiology Center as their Biostatistician in Portland, Oregon. Although I will miss everyone here I am very excited to begin a new chapter of my life in an amazing area of the country. I will be here until mid-December and available remotely after the New Year to make the transition as smooth as possible. I always love visitors, so if you are in the Portland area, give me a call!
For many years, through multiple iterations using phrases such as “standards of practice”, “best practices”, “model programs” and “comparative effectiveness research”, the idea that there is one best way to provide and receive medical/social services across the country has proliferated. In addition to the language of uniformity, grant funding and financial reimbursement strategies have called for documentation of providing tested “evidence-based interventions” in order to receive and sustain funding. In fact, authors R. Dale Walker, MD and Douglas A Bigelow, Ph.D., in their article, “A Constructive Indian Country Response to the Evidence-Based Program Mandate”, 2011 cite an Etzioni, 1968 term “remunerative coercion” as a tactic common in funding circles. Remunerative coercion is the strong suggestion and even requirement to implement evidence-based interventions written into important government policies and requests for funding.

There are, no doubt, benefits in proving that a program can work in all settings and in all population groups. However, Walker and Bigelow describe challenges for Tribes subjected to a model program mandate such as:

- They are not always adaptable to Indian communities
- Developer training and fidelity testing are often alien processes, not often available to Tribes
- Loss of familiar and accepted practices and programs that further subject the Tribe to trauma
- The very mandate is in conflict with principles of sovereignty, consultation policy and government to government relations

In addition, a failure to recognize “indigenous ways of knowing” in program, study and evaluation design has been described as a barrier among Tribal leaders, Health Directors and Program Directors. In response to increasing pressure for Tribes to engage in implementation of ill-suited practices, the Oregon Tribal Best Practices (TBP) initiative began when the state of Oregon legislated an evidence-based model program mandate (Oregon Revised Statute 669, 2003) that became problematic for Oregon’s nine Tribes. Through a process described as constructive engagement, Tribes were invited to produce a culturally appropriate approach to identifying best practices.

The TBP model incorporated logic model process and outcome development that acknowledges Tribal communities as “dynamically complex, emergent systems” that includes local context and culture. It was essential for TBP to develop indicators and measures to effectively evaluate Tribal best practices on equal footing with generally disseminated evidence based model programs. At the time of the author’s submission for publication, more than twelve TBP programs were reviewed and approved. The approach used in the TBP initiative is labeled “evidence-informed” to distinguish it from “evidence-based programs.”

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EVIDENCE BASED PRACTICE

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In summary, the evidence-informed approach weaves efficacy, effectiveness, basic research, data, principles, theory, local community cultural context and stakeholder preferences into programming and evaluation activities. As GLITEC moves forward in working with our state and federal funding partners, we pledge to continue diligently supporting the acceptance and use of “evidence-informed” practices to more successfully address health disparities in Bemidji Area Tribal communities.

Full article citation:

BEMIDJI AREA TRIBAL ENVIRONMENTAL HEALTH ASSESSMENT

Over the summer I spent most of my time at GLITEC working on an assessment of environmental health priorities and resources among the 34 Tribes in the Bemidji area. This is part of a larger effort by GLITEC to start addressing environmental health in addition to the established focus areas of behavioral health, maternal and child health, and chronic disease.

The assessment had three parts: a review of Tribal websites to see if there were any environmental services or resources identified, a survey completed by Tribal health directors and environmental staff, and key informant interviews. Raymond Allen, a NARCH intern and student at Ripon College, and Alex Cirillo, an MPH student at the University of Michigan, were both extremely helpful in conducting the assessment. We received 28 surveys from health directors and environmental staff and conducted 17 key informant interviews with staff from the Environmental Protection Agency (EPA), Great Lakes Indian Fish and Wildlife Commission (GLIFWC), and staff from the Department of Natural Resources and Department of Health in Minnesota, Wisconsin, and Michigan.

Highlights from the results include:

- Website Review
  - Over two-thirds (68%) of Tribes listed some type of environmental health activity on their website, e.g. water treatment, home safety, injury prevention, food safety, and hazardous material sampling

  * The EPA has identified over 125 Superfund sites in the Bemidji area. A Superfund site is an “uncontrolled or abandoned site where hazardous waste is located, possibly affecting local ecosystems or people” (see http://www.epa.gov/superfund/)

- Survey Results
  * The top five areas Tribes are working on include: water quality, air quality, chemical emergencies, home safety, and disaster health and safety
  * The top three priorities include: clean water, clean air, and food safety
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- Resources that are important to protect include: black ash and birch trees, plants and trees for traditional medicine, clan animals including fish, bear, deer, elk, moose, and wolves, traditional foods including wild rice and cranberries, and waterways

- Key Informant Interviews
  - Current activities include: mercury maps showing which lakes have fish advisories, climate change maps, air and water monitoring, flood damage control, and fish restoration
  - The top three issues projected to impact Tribes in the next ten years include: mining, climate change, and safe fish
  - Recommendations for GLITEC include: provide training and education to Tribes, assist with disease tracking and investigations, and increase collaboration

I shared the assessment results with staff at the IHS Bemidji office in October and am wrapping up the final report which will be shared at Tribal Health Director meetings and posted on the GLITEC website.

Anneke Mohr
University of Wisconsin Population Health Service Fellow

**STIGMA AND MEANING OF EPIDEMIOLOGIST**

Recently I was at a holiday party and some of the people asked me what I did for a living. When I said I was an epidemiologist one person began telling me about a recurring rash she’d been having. This story is not uncommon. I could go on a very expensive trip if I had a dollar for every time people thought I was a skin doctor. Another common problem is that once I tell people I work with health, numbers, and statistics, I get a somewhat blank stare and they suddenly find something else they have to do. Lately, I’ve taken to telling people that I sell aluminum storm doors and the conversations seem to last quite a bit longer. I understand the confusion between “epidemiologist” and “dermatologist”-- they sound relatively similar. However, I don't understand the stigma attached to people with skill in statistics or math. We aren’t all boring or uninteresting, in fact I find many people telling me I am sometimes not serious enough.

Once I did a presentation to a group of middle school students and explained epidemiology using the analogy of an eagle in Indian Country. I tell people Epidemiologists are like eagles. Eagles soar over our Indian communities watching to make sure we are okay. They see where there are problems and help us. Epidemiologists watch over the health of communities. We see where there are problems and help to solve them.

Isaiah “Shaneequa” Brokenleg
Epidemiologist, Program Director, and Part-time aluminum storm door salesman
This spring, summer and early fall was a crazy busy time for me! Not only was I working on a number of different grants and projects, but I was also traveling a lot for projects including the Youth Regional Treatment Center (YRTC) project. After receiving funding from the Indian Health Services’ (IHS) Division of Behavioral Health, Kristin Hill, Great Lakes Inter-Tribal Epidemiology Center Director, and I visited a total of eight YRTCs. There are 11 YRTCs across the United States that receive funding from IHS to provide inpatient substance abuse and mental health treatment for American Indian/Alaska Native youth. Six are operated by Tribes and five are run by IHS; only the Bemidji and Billing Areas do not have YRTCs.

During our visits, Kristin and I conducted key informant interviews with stakeholders to assess what outcome measures were currently being collected and reported. Between April and September 2012, I visited five YRTCs. Although each YRTC we visited produces an end-of-year report that summarizes their client demographics for the year, we learned each YRTC is very unique. Each uses different screening/assessment tools, different evidenced-based practices (EBPs) and different practice-based evidence practices (PBEs) to treat substance abuse and mental health issues. Some YRTCs have greater epidemiological capacity to collect and evaluate data than other YRTCs. Collection of standardized outcome data among area YRTC’s remains a challenge. One sentiment became very clear while conducting interviews……. YRTC staff in each location share a dedication and commitment to youth experiencing substance abuse and mental health issues. Their work is inspirational!

Jacob Melson
Behavioral Health Epidemiologist
At the annual meeting of the American Public Health Association, Meghan Porter presented results of an examination of the alcohol retail environment and car crashes on and near Indian reservations in Minnesota. Below is the abstract for the presentation; for a copy of the presentation, or if you are interested in exploring this topic area further, please contact Meghan.

**Examination of alcohol-related motor vehicle accidents and the alcohol retail environment on and near American Indian reservations in Minnesota**

Meghan Porter, MPH; Samantha Lucas, MPH

*Background:* American Indians in the United States face numerous health, social, and economic disparities. Though data are insufficient in quality and number, alcohol abuse may disproportionately affect this population.

*Methods:* Contract Health Service Delivery Areas (CHSDAs) were used as the level of geography for this study. CHSDAs are counties including or adjoining American Indian reservations; they are commonly used when calculating American Indian health statistics when using national or state datasets.

The number of motor vehicle accidents (MVA) in which alcohol was a factor was examined via crash report form data for non-metropolitan CHSDA and non-CHSDA counties in Minnesota for 2007-2011. The number of businesses in 2011 that sold alcohol (liquor stores and alcohol-serving establishments) and alcohol sale revenue in these areas were examined using Nielsen Company’s Prime Location Web tool.

*Results:* It was found that there were three times as many alcohol-serving establishments per capita and 50% more liquor stores in CHSDAs than in non-CHSDAs. Per capita there were 20% higher alcohol sales in CHSDAs than in non-CHSDAs.

An MVA in CHSDA counties had significantly higher odds of being alcohol-related (OR=1.43; 95% CI: 1.25, 1.64) and alcohol-related MVAs in CHSDAs had significantly higher odds of being fatal (OR=2.32; 95% CI: 1.32, 4.09) compared to non-CHSDAs.

*Conclusion:* Greater availability of alcohol in areas on and near American Indian reservations may contribute to higher rates of alcohol-related MVAs in these regions.
NEW TO THE EPI TEAM

Aloha!

My name is Megan Chock, and I am a student in the masters in public health (MPH) program at the University of Minnesota. I will be interning with GLITEC for my field experience until May 2013. I am working with Jake Melson (my preceptor), Samantha Lucas and Meghan Porter on the various projects that come through their Minneapolis office. So far, I have had a great experience – I definitely have a steep learning curve, but with the help of various activities (such as a mock “debate” about GLITEC and Tribal health, attending a Tribal health directors’ meeting, and editing reports), I am learning and appreciating what GLITEC does. The overarching goal of my field experience is to become more familiar with factors that influence Native Americans’ overall wellness including physical, mental, spiritual, social, emotional, economic, cultural, and environmental health.

For a little personal background, I was born and raised in Honolulu, Hawaii and graduated from the University of Hawaii at Manoa with degrees in biology and economics. I started at Mayo Medical School in July 2010 and completed my second year in May 2012. I am taking a year between my second and third years to do my MPH at University of Minnesota. I will finish my MPH in May 2013, after which I will return to Mayo for my final two years of medical school. I feel very lucky to be able to work with GLITEC and look forward to all I will learn in the coming year.
**Chicken Noodle Casserole**

2/3 cup chopped onion  
1 garlic clove, minced  
1 tablespoon olive oil or canola oil  
1 1/2 pounds boneless skinless chicken breasts, cut into 3/4-inch cubes  
1 can (14 1/2 ounces) chicken broth  
1 1/2 cups chopped carrots  
3 celery ribs, chopped  
3 tablespoons butter or stick margarine  
3 tablespoons all-purpose flour  
3/4 teaspoon salt  
1/8 teaspoon white pepper  
1 1/4 cups 2 percent milk  
1 1/4 cups shredded reduced-fat cheddar cheese  
8 ounces wide egg noodles, cooked and drained

**DIRECTIONS**

In a large nonstick skillet, sauté onion and garlic in oil until tender. Add chicken; cook and stir until no longer pink. Add the broth, carrots, celery and savory. Bring to a boil. Reduce heat; cover and simmer for 10-15 minutes or until vegetables are tender.

Meanwhile, in a saucepan, melt butter. Stir in the flour, salt and pepper until smooth. Gradually add milk. Bring to a boil; cook and stir for 2 minutes or until thickened. Remove from the heat; stir in cheese until melted. Pour over chicken mixture. Add noodles; mix well.

Transfer to a 3-qt. baking dish coated with nonstick cooking spray. Bake, uncovered, at 350 degrees F for 15-20 minutes or until bubbly.

Serves 8.