Tribal Epidemiology Centers

Strengthening American Indian and Alaska Native Public Health through Data, Collaboration, and Innovation

2024

TribalEpiCenters.org

Acknowledgements

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Overview of This Publication

This publication describes the twelve Tribal Epidemiology Centers (TECs) and provides updated examples of their projects, successes, challenges, and best practices

In 2013, the TECs began documenting their efforts in "Best Practices in American Indian & Alaska Native Public Health: A Report from the Tribal Epidemiology Centers." The report described "the situation, response, and impact of Tribal Epidemiology Centers to improve American Indian and Alaska Native (AI/AN) public health surveillance, data availability, and data quality."[1] Since then, the TECs have grown exponentially in staff, capacity, and infrastructure. There are many more successes to share of how they work with Tribal Organizations, and Urban Indian Organization (T/TO/UIO) partners to advance AI/AN health.

Over 30 years of working with Tribes, T/TO/UIO partners, the 12 TECs have honed skills and developed best practices to ensure public health activities meet the needs and are culturally representative of the people they serve.

Section 1

This report provides an update to the original 2013 publication and represents a collaborative effort among the national network of TECs. It builds on the first publication and shares more examples of best practices that TECs employ when working with T/TO/UIO partners.[2]

Section 2

This section introduces the TECs, provides the history of the TEC program, and shares an overview of the TEC designation as public health authorities.

Section 3

This section provides an overview of each TEC that includes descriptions of the parent organizations. Each TEC shares examples of projects that highlight a variety of best practices in working with T/TO/UIO partners.

Section 4

This section describes significant challenges TECs face with data access and quality, which affects effective analysis and utilization. It offers a list of best practices for methods of data collection, analysis, and present data for AI/AN populations, as well as other keys to success that include prioritizing relationship and trust building. [3]

[1] Best Practices in American Indian & Alaska Native Public Health: A Report from the Tribal Epidemiology Centers (2013). Accessed from tribalepicenters.org/wp-content/uploads/2016/03/TEC-Best-Practices-Book-2013.pdf.

[2] Best Practices, 2013.

[3] Reece, J., Skelton-Wilson, S., Mitchell-Box, K., Groom, A., & Thomas, C. (2023). Building a roadmap to health equity: strengthening public health infrastructure in Indian Country. Public Health Reports, 00333549231186579.

Introduction to Tribal Epidemiology Centers

TECs were created through federal legislation to address healthcare challenges of the AI/AN population. For more than 30 years TECs have worked to identify and address health risks, support disease prevention and control, and collaborate on common priorities while tailoring public health services to meet regional and local needs.[6,7]

The AI/AN population faces multiple historical, social, economic, and health challenges. The public health infrastructure required to address these inequities is complex, under-resourced, and under-developed. It requires a systems-based approach to address gaps in data and build public health capacity to promote health and prevent disease in AI/AN communities.[3] AI/AN people are a minority population that differs from other U.S. racial and ethnic minorities. They have special rights due to a unique historic and legal government-to-government relationship that federally recognized Tribes have with the U.S. government. This relationship was established through numerous Supreme Court decisions, treaties, legislation, and Executive Orders.

Some of this legislation relates to health care challenges of the AI/AN population. The Indian Health Care Improvement Act (IHCIA) was passed in 1976 and amended in 1992. The amendment declared, "it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy."[4] IHCIA established the legal and programmatic structure for providing health care and public health services to AI/AN people.[5]

The 1992 amended IHCIA included authorization for establishing the TEC program.[6] The first three TECs were established in 1996. They included the Alaska area, the Great Lakes area, and the Phoenix area. There are now 12 unique TECs vital to the public health system supporting AI/AN communities throughout the United States. They are funded in part by the Indian Health

[4] Indian Health Amendments of 1992, Pub. L. No. 102-573, §§ 101, 106 Stat. 4526 (1992) (codified at 25 U.S.C. §§ 1601 et seq.)

[5] Hoss, A., Ransom, M., Penn, M. (2015). "Tribal Epidemiology Centers Designated as Public Health Authorities Under the Health Insurance Portability and Accountability Act." Accessed from tribalepicenters.org/wp-content/uploads/2019/06/TECs-as-public-health-authourities.pdf.

[6] Pub. L. No. 102–573, 106 Stat. 4526 § 214(a)(1)

[7] Finkbonner, J. (2019). Commentary on Tribal Epidemiology Centers From Tribal Leaders' Perspective. Journal of Public Health Management and Practice, 25, S3-S4.

[8] Groom, A., Espey, D., Allison, A., & Thomas, C. (2019). CDC partnerships with Tribal epidemiology centers to improve the health of American Indian and Alaska Native communities. Journal of Public Health Management and Practice, 25, S5-S6.

Table 1. The 12 TECs, IHS Service Area, and location of the TEC.

TRIBAL EPIDEMIOLOGY CENTER	INDIAN HEALTH SERVICE AREA	LOCATION
Alaska Native Epidemiology Center	Alaska Area	Anchorage, Alaska
Albuquerque Area Southwest Tribal Epidemiology Center	Albuquerque Area	Albuquerque, New Mexico
California Tribal Epidemiology Center	California Area	Roseville, California
Inter Tribal Council of Arizona, Inc. Tribal Epidemiology Center	Phoenix and Tucson Areas	Phoenix, Arizona
Great Lake Inter-Tribal Epidemiology Center	Bemidji Area	Lac du Flambeau, Wisconsin
Great Plains Tribal Epidemiology Center	Great Plains Area	Rapid City, South Dakota
Navajo Epidemiology Center	Navajo Area	Window Rock, Arizona
Northwest Tribal Epidemiology Center	Portland Area	Portland, Oregon
Oklahoma Area Tribal Epidemiology Center	Oklahoma City Area	Oklahoma City, Oklahoma
Rocky Mountain Tribal Epidemiology Center	Billings Area	Billings, Montana
United South and Eastern Tribes, Inc. Tribal Epidemiology Center	Nashville Area	Nashville, Tennessee
Urban Indian Health Institute	Urban Areas Nationwide	Seattle, Washington

Service (IHS). There is a TEC in each of the IHS administrative areas and another serving Urban Indian Organizations across the country.[7]

The TECs have worked for more than 30 years to identify and address health risks, support disease prevention and control, and collaborate on common priorities while tailoring public health services to meet regional and local needs.[7,8]

In consultation with Tribes, T/TO/UIOs, the IHS created the TEC program to enhance epidemiologic and public health support to AI/AN people and communities by performing seven core functions.[9,10] These seven functions have remained the core focus of TEC work and each of the 12 TECs structures its work around the following functions to best serve their areas[11]:

1. Collecting data and monitoring health
2. Evaluating data and programs
3. Identifying health priorities
4. Making recommendations for health service needs
5. Making recommendations for improving health care delivery systems
6. Providing epidemiologic technical assistance
7. Providing disease surveillance

Permanently reauthorized in March 2010 in the "Patient Protection and Affordable Care Act," IHCIA included provisions designating TECs as public health authorities.[12,13] A public health authority, or covered entity,

[9] Pub. L. No. 102–573, 106 Stat. 4526 § 214(a)(3)

[10] Neel, L. C., & McCollum, J. T. (2023). Indian Health Service Support for Tribal Epidemiology Centers. Public Health Reports, 00333549231151672.

[11] 25 U.S.C.A § 1621m(b)3

[12] Pub L. No. 111-148, 124 Stat. 119 § 10221

[13] 25 U.S.C.A. § 1621m(e)(1)

TEC Timeline

1992 — **Amendment to the Indian Health Care Improvement Act that established creation of the TEC program**

1996 — First three TECs established to serve the Alaska, Phoenix/Tucson, and Bemidji Areas

1997 — TEC established to serve the Portland Area

2000 — TECs established to serve the Nashville Area and nationwide Urban Areas

2005 — TECs established to serve the Great Plains, Oklahoma City, and Billings Areas

2006 — TECs established to serve the Albuquerque and Navajo Areas

2008 — TEC established to serve the California Area

2010 — **IHCIA permanently reauthorized**

2014 — Centers for Disease Control and Prevention funded the Good Health and Wellness in Indian Country Round 1

2017 — CDC funded TEC Public Health Infrastructure Program Round 1

2019 — **First TEC Journal Supplement published**

2020 — CDC funded GHWIC Round 2

2022 — CDC funded TECPHI Round 2
U.S. Government Accountability Office Report: Tribal Epidemiology Centers: HHS Actions Needed to Enhance Data Access

2023 — **Second TEC Journal Supplement published**

is granted authority and responsibility for public health matters as part of its official mandate and may use or disclose protected health information (PHI) without written approval by the individual.[14,15] The Act was a significant step toward achieving health equity for AI/AN people.

As public health authorities, TECs can access PHI "for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions."[16]

In addition, this Act provided TECs "access to data, data sets, monitoring systems, delivery systems, and other protected health information in the possession of the Secretary"[17] of the Department of Health and Human Services (DHHS).

TECS DESIGNATED AS PUBLIC HEALTH AUTHORITIES
25 U.S.C. Chapter 18: Indian Health Care

§1621m. Epidemiology centers

(e) Access to information

> ***(1) In general*** An epidemiology center operated by a grantee pursuant to a grant awarded under subsection (d) shall be treated as a public health authority (as defined in section 164.501 of title 45, Code of Federal Regulations (or a successor regulation)) for purposes of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 1936).
>
> ***(2) Access to information*** The Secretary shall grant to each epidemiology center described in paragraph (1) access to use of the data, datasets, monitoring systems, delivery systems, and other protected health information in the possession of the Secretary.

DEFINITIONS:
45 CFR § 160.103 & § 160.103

Health information means any information, including genetic information, whether oral or recorded in any form or medium, that:

> ***(1)*** Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
>
> ***(2)*** Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

Individual means the person who is the subject of protected health information.

Individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual, and:

> ***(1)*** Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
>
> ***(2)*** Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
>
> > ***(i)*** That identifies the individual; or
> >
> > ***(ii)*** With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

[14] 45 CFR § 164.501
[15] 45 CFR § 164.512
[16] 45 CFR § 164.512(b)(i)
[17] 25 U.S.C. § 1621m(e)(2)

TRIBAL EPIDEMIOLOGY CENTERS (TEC)

Network Coordinating Center
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TRIBAL
EPIDEMIOLOGY
CENTERS

TEC Overview & Regions

TECs share the mission of improving the health of AI/AN people by identifying and understanding health risks and inequities, strengthening public health capacity, and assisting in disease prevention and control.

The services provided by TECs enhance the knowledge and understanding of the health status or concerns of AI/AN people and provide decisionmakers, policymakers, community members, and Tribal leaders with valuable data and information they need to make informed health-based decisions for the people they serve. TECs also provide many training opportunities, contributing to workforce development for staff of Tribes, T/TO/UIOs. They implement and evaluate community-based strategies to eliminate health disparities to achieve health equity and strengthen the public health systems. Together, TECs offer services to 574 Tribes[18], 41 UIOs[19], and 9.7 million AI/AN people[20] nationwide.

Each TEC Director provides leadership and, in collaboration with T/TO/UIO partners, sets the priorities of the Center based on needs in their respective areas. The 12 TEC Directors are voting members in an informal association referred to as the TEC Consortium (TEC-C). Members of the TEC-C share lessons on public health best practices, approaches to enhancing data access and stewardship, establishing collaborations, and diversifying funding for sustainability.

Since the 2013 edition of this report, TEC-C work has strengthened in part due to the COVID-19 pandemic, when the Directors began to meet more frequently to discuss emergency response issues. The TEC-C continues to meet virtually on a bi-weekly basis. These meetings provide an opportunity for addressing issues of concern, fostering collaborations, learning from one another, and providing opportunities for other potential partners to connect with the TEC-C as problems emerge and priorities shift.

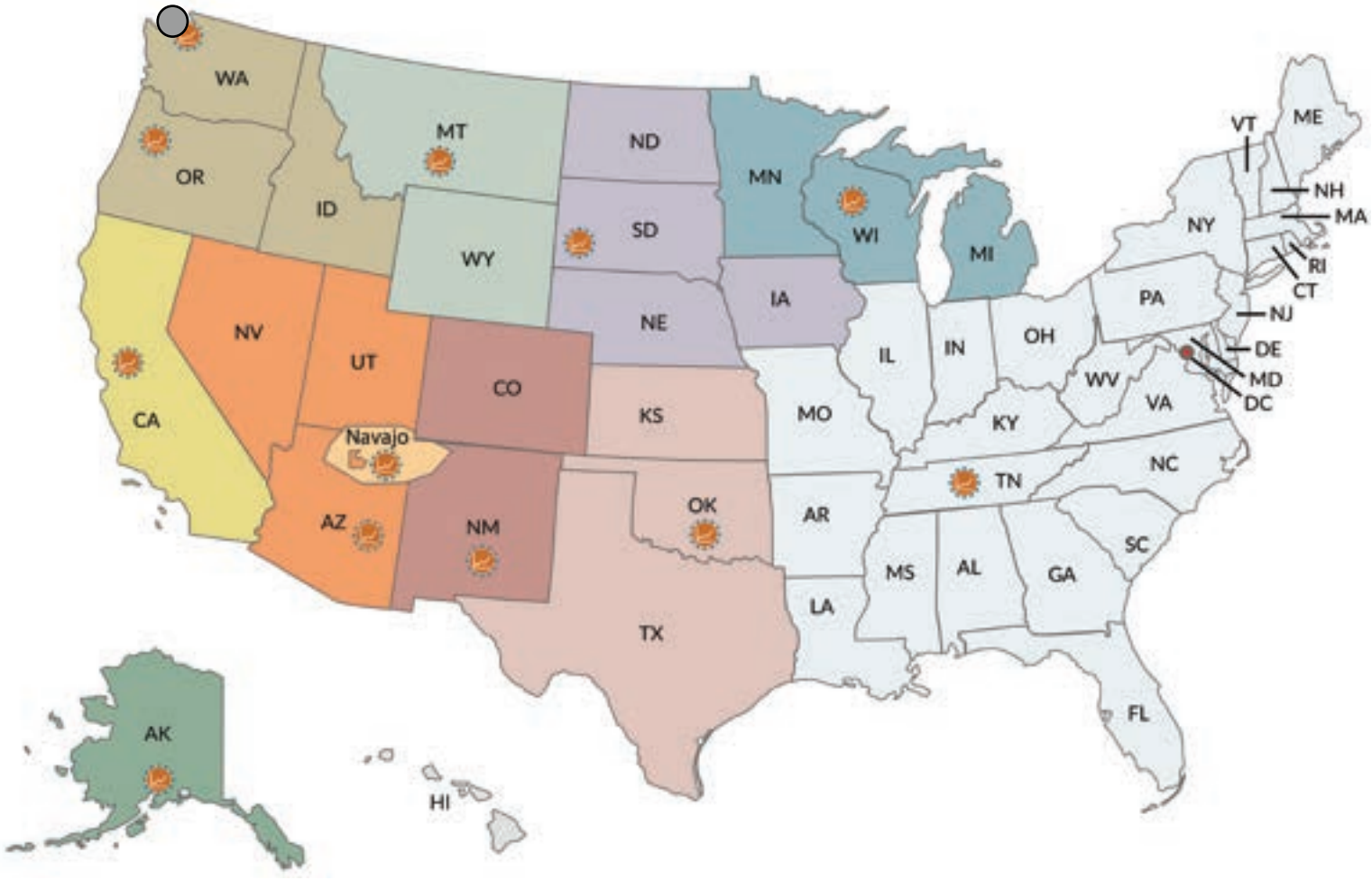
Each TEC varies in size, with unique structures, staffing, and programs. This uniqueness is an outcome of the responsibility of individual TECs to be responsive to the priority needs of the T/TO/UIOs served, their position within their parent organization, and their funders.

This section gives an overview of the 12 TECs, including information on the population they serve, parent organization, history and scope, staffing, highlights of their current work, project accomplishments, and key partnerships.

[18] The 574 Federally Recognized Indian Tribes in the United States, February 8, 2023. Retrieved from crsreports.congress.gov/product/pdf/R/R47414, August 2023.

[19] Overview of Urban Indian Organizations (UIOs). Retrieved from ncuih.org/uio-directory/, August 2023.

[20] 2020 Census Illuminates Racial and Ethnic Composition of the Country. Retrieved from census.gov/library/stories/2021/08/improved-race-ethnicity-measures-reveal-united-states-population-much-more-multiracial.html, August 2023.



ALASKA NATIVE TRIBAL EPIDEMIOLOGY CENTER	URBAN INDIAN HEALTH INSTITUTE	NORTHWEST TRIBAL EPIDEMIOLOGY CENTER	GREAT PLAINS TRIBAL EPIDEMIOLOGY CENTER
INTERTRIBAL COUNCIL OF ARIZONA, INC.	NAVAJO EPIDEMIOLOGY CENTER	ROCKY MOUNTAIN TRIBAL EPIDEMIOLOGY CENTER	GREAT LAKES INTER-TRIBAL EPIDEMIOLOGY CENTER
CALIFORNIA TRIBAL EPIDEMIOLOGY CENTER	ALBUQUERQUE AREA SOUTHWEST TRIBAL EPIDEMIOLOGY CENTER	OKLAHOMA AREA TRIBAL EPIDEMIOLOGY CENTER	UNITED SOUTH & EASTERN TRIBES

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ALASKA NATIVE
TRIBAL HEALTH
CONSORTIUM

EPIDEMIOLOGY CENTER

ANEC Region & Parent Organization

The Alaska Tribal Health System (ATHS) is a statewide hub-and-spoke network of Tribal Health Organizations (THOs) providing clinical and public health services to Alaska Native/American Indian people in 15 regions. Each THO retains autonomy with regard to health priorities, services, and policies in its service area. The ATHS network includes 178 village clinics, 57 Tribal health centers, seven regional hospital facilities, and the referral healthcare facility: the Alaska Native Medical Center (ANMC).

Village clinics are staffed by Community Health Aides or Community Health Practitioners (CHA/Ps) who are trained community health workers that provide basic primary and emergency care. CHA/Ps refer patients to their sub-regional or regional Tribal health facility providers, as appropriate. Regional facility providers (physicians, nurse practitioners, or physician's assistants) then refer patients, as needed, to ANMC. Several village communities also have Behavioral Health Aides and Dental Health Aides.

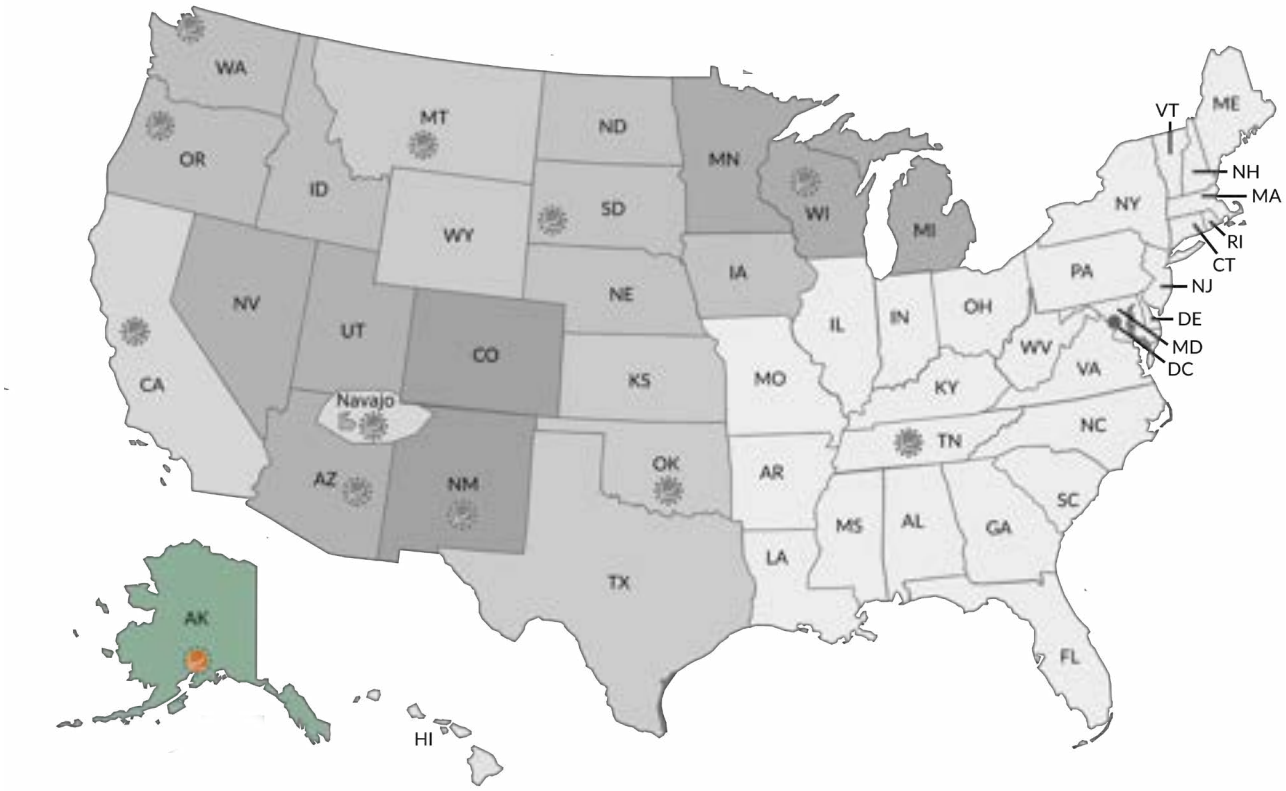
Alaska Native Tribal Health Consortium

Under the authority of the Indian Self-Determination and Education Assistance Act Public Law 93-638, the Alaska Native Tribal Health Consortium (ANTHC) entered into a Self-Governance Agreement known as the Alaska Tribal Health Compact with the Indian Health Service (IHS). ANTHC became a nonprofit 501(c)(3) organization in December 1997. It provides statewide health services formerly provided by the IHS in Alaska. ANTHC is the largest self-governance entity in the United States and supports the regional THOs that make up the ATHS. ANTHC's range of services—provided across Alaska's vast distances—includes specialty medical care, rural provider training, community and public health services, research, construction, water and sanitation services, and a broad range of health system support programs to help partner organizations successfully serve communities. ANTHC possesses the extensive management and administrative infrastructure necessary to successfully manage this broad portfolio. In 2023, ANTHC employed approximately 3,100 people, had an operating budget of more than $866 million, and managed more than $340 million in grant funds.[21]

The ANTHC vision is that "Alaska Natives are the healthiest people in the world," and the organization's mission statement is "Optimizing health and well-being through collaborative partnerships and services." This vision guides the management, employees, and work that ANTHC does to serve AN/AI people throughout the state.[22] ANTHC is a consortium of consortia, with the Board of Directors made up of Tribal leaders from

[21] Alaska Native Tribal Health Consortium 2023 Annual Report, 2023 Financial Summary. Retrieved May 2024 from anthc.org/wp-content/uploads/2023/12/ANNUAL-REPORT_2023_FINAL_sm.pdf

[22] ANTHC Overview. Retrieved July 2023 from anthc.org/who-we-are/overview/



regional THOs. They work together to collaboratively guide strategy for the Consortium.[23]

ANTHC's structure consists of four main divisions that provide services across the state:

1. ANMC is a 182-bed hospital providing comprehensive medical and referral-based specialty care.
2. The Division of Community Health Services (DCHS) provides public health and research services, wellness and disease prevention initiatives, and rural provider training programs.
3. The Division of Environmental Health and Engineering (DEHE) provides health facility construction and engineering services including the installation of wells and septic systems, and other environmental health services.
4. The Consortium Business Support Services provides infrastructure services, including Human Resources, Finance, and Information Technology.

Alaska Native and American Indian Population (AN/AI) in Alaska

Alaska is home to 229 federally recognized Tribes that are indigenous to a state that is one-fifth the geographic size of the contiguous United States. About 160,000 AN/AI people[24] reside in Alaska, making up roughly 22% of the state's total population[25]. Many AN/AI people reside in remote areas, where 86% of Alaska's 355 communities off the road system and are accessible only by airplane or boat. Most of these communities have fewer than 500 residents.

[23] ANTHC Board of Directors. Retrieved July 2023 from anthc.org/who-we-are/board-of-directors/

[24] Official 2023 Alaska Native/American Indian User Pop, v152, updated and retrieved 9/16/2024

[25] Alaska Population Estimates. Retrieved July 2024 from live.laborstats.alaska.gov/pop/index.html

ANEC Overview

The Alaska Native Epidemiology Center was created in 1996. It was one of the very first TECs to be established after the nationwide TEC program was approved by Congress in 1992.

ANEC is located within ANTHC's Division of Community Health Services (CHS) and it provides public health and epidemiologic services to THOs and their Tribal communities. ANEC also develops and implements programs, conducts program evaluation, provides technical assistance, and offers public health capacity-building training opportunities. ANEC receives funding from IHS, Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), and other federal agencies and organizations that align with the priorities of ANTHC and the ATHS.

ANEC Purpose & Functions

ANEC supports the mission and vision of ANTHC. Its core purpose is to "provide epidemiologic and other public health services to Tribal Health Organizations and the Tribal communities they serve." ANEC fulfills this purpose through four core functions:

Data Dissemination and Translation

ANEC provides data-related products to a variety of partners, including THOs, the State of Alaska, and other medical and/or public health professionals, and programs that serve AN/AI communities. The ANEC website shares aggregated data and information that provide an overview of the health status of the Alaska Native population from a variety of resources, including the US Census Bureau, Behavioral Risk Factor Surveillance System, Vital Records, Pregnancy Risk Assessment Monitoring System, and many others. ANEC also produces and distributes various comprehensive health-related reports, including the *Alaska Native Health Status Report, Alaska Native Mortality Report, Cancer in Alaska Native People: 50-Year Report, and the Alaska Native Injury Atlas*. Some staff publish manuscripts in peer-reviewed literature and present findings to Tribal leadership and audiences at the local, state, and national levels.

Technical Assistance and Training

ANEC responds to data and technical assistance requests, such as developing program evaluation plans, assisting with study and project design, survey development, qualitative and quantitative approaches to data collection, analysis, and reporting. ANEC offers training opportunities to ANTHC and ATHS staff and other partners. It provides public health capacity-building training on a variety of topics and has served as the home for two national coordinating centers: the CDC Good Health and Wellness in Indian Country (GHWIC) Program and the CDC Tribal Epidemiology Centers Public Health Infrastructure (TECPHI) Program. These coordinating centers collaborate with organizations nationwide to support chronic disease initiatives, increase public health capacity, and improve public health infrastructure for Tribes, Tribal organizations, and Urban Indian Organizations that are recipients of the GHWIC and TECPHI Programs. Finally, ANEC sponsors internships and mentorships to facilitate pathways for AN/AI students into public health.

Applied Epidemiologic Studies

ANEC studies primarily address prevention and control of cancer among AN/AI people, with many studies focusing on ways to prevent or control colorectal cancer.

Disease Surveillance

ANEC engages in the systematic and ongoing process of collecting, analyzing, and interpreting data related to the occurrence, distribution, and characteristics of diseases or health conditions within the AN/AI population. ANEC houses two disease surveillance programs:

The Alaska Native Tumor Registry (ANTR) was initiated in 1974 to investigate the unique patterns of cancer among AN/AI people. It has been a full member of the since 1999 special population registry under the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) program since 1999. Cancer is a leading cause of mortality among AN/AI people and this program works with data spanning back to 1969.

ANEC's Syndromic Surveillance (SyS) Program assists Tribal Health Organization partners throughout Alaska in the near real-time monitoring of symptoms of concern. This type of surveillance can inform operations and planning, especially concerning potential disease outbreaks.

ANEC Staff

ANEC has a Director and Lead Epidemiologist who provide leadership and direction based on ANTHC and regional priorities. Grant funding and staff numbers increase or decrease based on the needs of the programs or levels of funding. Current staff specialize in epidemiology, biostatistics, demography, analytical engineering, programming/analytics, public health, marketing, media, and program evaluation. ANEC also contracts with consultants and a variety of subject matter experts. ANEC is organized by funded program (e.g. SyS Program, Colorectal Cancer Control Program) and by function (e.g. Administrative, Marketing and Media).

ANEC Partnerships

Effective partnerships and collaborations are essential for developing culturally responsive programming that meet the needs of the populations served. ANEC has strong working relationships with Tribal, state, and national entities, including regional THOs, the Alaska Native Health Board, the State of Alaska, the University of Alaska, the Centers for Disease Control and Prevention, the Indian Health Service, and others. ANEC also maintains a strong collaborative relationship with the other TECs. ANEC participates in numerous national and local working groups to stay informed, provide advocacy and education, facilitate AN/AI data interests, and help raise awareness of AN/AI areas of health concern.

ANEC Highlights

Enhancing Foundational Public Health Services

Assessment and Surveillance (A&S) and Community Partnership Development (CPD).

Since 2013, ANEC has increased its capacity to better meet epidemiologic needs and offer more comprehensive foundational public health services to THOs and communities. These enhanced capabilities ensure ANEC is delivering high quality, data-driven, and culturally responsive services.

ANEC has seen substantial growth in funding and staff, leading to exponential increases in the skills, knowledge, and ability to provide high quality services. This has been especially apparent in two cross-cutting foundational public health capabilities: Assessment & Surveillance (A&S) and Community Partnerships (CPD). These recent projects demonstrate some of the best and most promising practices in performing A&S and developing and maintaining strong CPDs on behalf of AN/AI people living in Alaska:

Alaska Data Center - Launch and Expansion (A&S, CPD)

In partnership with the Alaska Department of Health, ANEC provided significant technical assistance and resources to create and launch the Alaska Behavioral Risk Factor Surveillance System (BRFSS) Data Center (alaska-dph.shinyapps.io/BRFSS), a new interactive dashboard. This publicly available dashboard provides an interactive tool to simplify access to population-based BRFSS survey results and allows users to explore the health survey results by topic and by region in Alaska. ANTHC and its partners across Alaska rely on these data for monitoring health and well-being, as well as for program planning and evaluation. The Alaska Data Center plans to expand to include other population-based surveys data, such as the Youth Risk Behavior Surveillance System and Pregnancy Risk Assessment and Monitoring System.

Syndromic Surveillance Program - Development and Implementation (A&S, CPD)

ANEC currently houses the Tribal Syndromic Surveillance (SyS) Program. Through training and technical assistance, ANEC helps Tribal health partners in Alaska use syndromic surveillance (SyS) to identify and respond to concerning trends or anomalies in the data to inform operations and planning. Syndromic surveillance is the near real-time monitoring of symptoms of concern evident in data from medical visits. monitoring for COVID-like and influenza-like illnesses as well as for disaster-related behavioral health concerns are common uses of SyS. It also offers the advantage of monitoring unstructured free-text in the medical record in addition to coded diagnoses. The powerful statistical software platform processes data to alert users to unusual activity that is impossible to track through diagnostic codes alone. THOs participating in SyS gain access to their facility-level data, and also have the potential to contribute valuable information to the Tribal health system overall. SyS traditionally involves Emergency Departments, however ANEC has also on-boarded several outpatient clinics and anticipates expanding to more clinics in the future. This is especially important in Alaska, where many communities do not have access to Emergency Departments but do have community-based clinics.

The Alaska Data Center and the SyS programs are just two of the innovative approaches ANEC has spearheaded to quickly connect Tribal leaders and others to more comprehensive data and information.

Healthy Alaskans 2030 - Technical Assistance (A&S, CPD)

The Healthy Alaskans Initiative is an ongoing collaboration co-led by the ANTHC and the Alaska Department of Health. Healthy Alaskans is the only known state health improvement plan in the nation co-led by a state and Tribal partnership. Modeled after the national Healthy People project, Healthy Alaskans provides a framework for health improvement across the state. Using data compiled and analyzed by ANEC and the state, Healthy Alaskans produces two annual scorecards: one with data for all Alaskans and the other with data that highlights progress specifically for Alaska Native peoples. These scorecards share progress toward reaching the goals of Healthy Alaskans 2030.

Publications Produced

ANEC produces and shares major reports that provide statewide and regional level data for THOs and other entities working to improve the health of Alaska Native peoples. These reports provide an overview of a variety of health status indicators, including socio-demographics, morbidity and mortality indicators for Alaska Native peoples statewide, as well as by Tribal health region. These data help demonstrate significant health improvements and areas of health opportunities among Alaska Native people.

Recent publications

- Alaska Native Health Status Report (bit.ly/AKN-HSR-3rd-Ed)
- Alaska Native Mortality Report (bit.ly/AKN-Mort-Rep) and Executive Summary (bit.ly/AKN-Mort-Rep-Exec-Sum)
- Cancer in Alaska Native People: 50-Year Report (bit.ly/Cancer-AKN-50-yr-Rep) and Executive Summary (bit.ly/Cancer-50-yr-Rep-Exec-Sum)
- Alaska Native Injury Atlas (bit.ly/3qMgkL1)

Various other reports by ANEC authors can be found at epi.anthc.org, in print, and through presentations at various Tribal, state, and national meetings.

Alaska Native Tribal Health Consortium's Colorectal Cancer Control Program

The Alaska Native Tribal Health Consortium (ANTHC) Colorectal Cancer Control Program (CRCCP) is a five-year program (2020-2025) funded by the Centers for Disease Control and Prevention. ANTHC is collaborating with regional Tribal health organizations to increase colorectal cancer screening by 10% annually at their clinics, with the ultimate goal of decreasing the incidence and mortality of colorectal cancer among Alaska Native people.

Our program focuses on increasing evidence-based interventions to improve colorectal cancer screening, including the use of client and provider reminders, provider assessment and feedback, as well as reducing structural barriers and increasing use of patient navigation and small media. The program uses a community of practice model to share best practices and provide support for screening improvements.

In the first year of funding, we established memoranda of agreement with five (5) regional THOs and their 73 primary care clinics to begin program activities. We provided technical assistance through a Community of Practice, and maintained collaborations with Tribal and non-Tribal organizations, including the ANTHC Tribal Comprehensive Cancer Program, the Alaska Cancer Partnership, and the other CRCCP grantee in Alaska, the Alaska Primary Care Association with whom ANTHC signed an memorandum of agreement to collaborate on activities to impact CRC screening.

To promote high quality screening we coordinated the 2021 update to the Alaska Native Medical Center CRC Screening Guidelines for Alaska Native People, which is used by Alaska tribal health organizations statewide. Our staff have worked to disseminate the updated guidelines at statewide provider education sessions, clinical Grand Rounds, and Community Health Aide and Behavioral Health Aide Program annual meetings.

The ANTHC CRCCP has also contributed to national screening policy efforts. The ANTHC CRCCP submitted a letter signed by the ANTHC President/Chairman to the US Preventive Services Task Force during the public comment process on the 2020 draft CRC Screening Recommendations urging the Task Force to promote screening among Tribal and other underserved populations. The CRCCP Program Director (Dr. Redwood) was also asked to participate as a subject matter expert for the President's Cancer Panel working on the issue of CRC screening during the COVID-19 pandemic and serves as the Alaska representative to the National Colorectal Cancer Roundtable.

Even with the challenges of the COVID-19 pandemic, the ANTHC CRCCP was able to increase CRC screening among participating tribal health organizations from 46% in 2020 to 62% in 2024 and continues to work to decrease the burden of this disease among the Alaska Native population.

ANTHC Epidemiology Center Research Studies

The ANTHC Epidemiology Center also conducts a number of research studies, including a randomized controlled trial of the new stool DNA test to improve CRC screening among rural/remote Alaska Native people, an evaluation of colonoscopy provision and guideline concordant CRC screening in the Alaska Tribal Health System, a CRC risk factor cohort study, and studies looking at the genetics of CRC and the gut microbiome among the Alaska Native population.

A list of CRC-related Epi-authored publications and manuscripts can be found on our webpage: epi.anthc.org/publications/.

Good Health and Wellness in Indian Country & Coordinating Center

The ANTHC Epidemiology Center was the Component 3 (C3) recipient of the Good Health and Wellness in Indian Country (GHWIC) grant (2019-2024).

As the C3, ANTHC took on the role as the National Coordinating Center for GHWIC (CCG) serving the other 27 direct recipients and over 100 subawardees. The CCG's primary services included facilitating the Community of Practice (CoP), managing the communication plan, and compiling and monitoring the national evaluation in collaboration with the GHWIC recipients and CDC Healthy Tribes. The CCG faced challenges due to the vast and diverse landscape of Indigenous communities and the COVID-19 pandemic. To address these challenges, key initiatives included monthly interactive virtual CoP meetings and network-wide All-Hands sessions, which facilitated peer-to-peer learning and collaboration during and outside of these meeting. The CCG also offered tailored capacity-building training, maintained high engagement through the TEC Connect intranet site, and hosted five impactful Gatherings, two virtual and three in-person.

Fostering evaluation capacity was a crucial goal for the GHWIC program, identified early on as essential for the national evaluation. The CCG aimed to build trusting relationships with both program evaluators and the CDC through the establishment of the Evaluation Advisory Group (EAG). The CCG facilitated monthly, virtual meetings with the EAG. These meetings provided a safe space for evaluators, who were often isolated in their work, to connect, share best practices, and address evaluation barriers with their peers and the CDC evaluators. The CCG utilized various engagement techniques and feedback mechanisms to tailor the meetings to evaluators' needs, which included providing extensive training and resources. Over time, the EAG's collaborative environment fostered strong connections and improved data collection practices, leading to more culturally responsive evaluation approaches. The group's success was evident in the quality of the national evaluation product, the Comprehensive Report, produced annually.

The GHWIC program aimed to incorporate culturally responsive evaluation methods, including storytelling, to share impactful narratives from Indigenous communities to the GHWIC network and the public. The CCG

employed strategies like leveraging technology, enhancing communication, and building Tribal partnerships to improve success story collection. Their efforts led to a substantial increase in documented stories, producing 82 stories in Year 5, with digital storytelling becoming a popular method. These efforts successfully bridged geographical and organizational divides, enhanced data collection practices, and fostered a culture of continuous improvement and mutual support, ultimately empowering Indigenous communities to advance their chronic disease prevention efforts and strengthen their collective impact.

ANEC Collaboration with ANTHC Behavioral Health

In 2024, the Alaska Native Epidemiology Center, with ANTHC Behavioral Health, is pleased to support the launch of the "Childhood Trauma and the Brain" augmented (AR) reality experience. Building on lessons learned from the "Opioids and the Brain" app developed by ANTHC in 2022, this new application helps users understand the impact of childhood trauma on brain development and its association with health conditions such as depression, behavioral dysregulation, and alcohol use disorder. Users wear a special pair of glasses to engage in a conversation with a holographic doctor and her patient, Ginew, and to complete learning tasks. The app, developed with input from tribal health physicians and behavioral health directors, runs on the Microsoft Hololens2 platform.

The app incorporates familiar Alaska Native themes and imagery. To learn about neural connectivity, a salmon fry shows the way through a network of streams and rivers. To see how childhood trauma can change how a person perceives people and situations around them, the user can look through a special glass to see the world from Ginew's perspective. In the 3D environment, brain structures and the relationships between them are presented in a simplified way that actively engages the user through gamification and conversation.

"You're Not Alone." Holographic 'Patient' Helps Adult Survivors of Childhood Trauma Learn About Behavioral Health Challenges.

An "Opioids and Medication" app was also developed. Users manipulate virtual molecules of medications to treat opioid use disorder, such as buprenorphine. By dropping the molecules into opioid receptors, users can learn about the differences between agonists and antagonists. An opioid molecule bounces off receptors shielded by naloxone, illustrating the medication's protective effects. To see recovery rates, the user their holds their hands out, palms up, and a data visualization populates over each hand.

The apps are available at no cost to tribal health clinics. By expanding to include topics such as childhood trauma, the apps aim to destigmatize behavioral health and equip users to make informed decisions about their care.

ALBUQUERQUE AREA INDIAN HEALTH BOARD, INC. (AAIHB)
ALBUQUERQUE AREA SOUTHWEST
TRIBAL EPIDEMIOLOGY CENTER (AASTEC)

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aaihb.org | aastec.net

AASTEC Region & Parent Organization

Albuquerque Area Indian Health Board, Incorporated

AASTEC is operated under the authority of its parent organization, the Albuquerque Area Indian Health Board, Incorporated (AAIHB). AAIHB was incorporated in 1980 as an Indian-owned and operated nonprofit tribally designated organization. It is composed of representatives from six consortium Tribes. AAIHB's goal is to positively impact the health and well-being of the communities it serves. To achieve that goal, AAIHB offers diverse health promotion and prevention education programs, as well as specialized public health services.

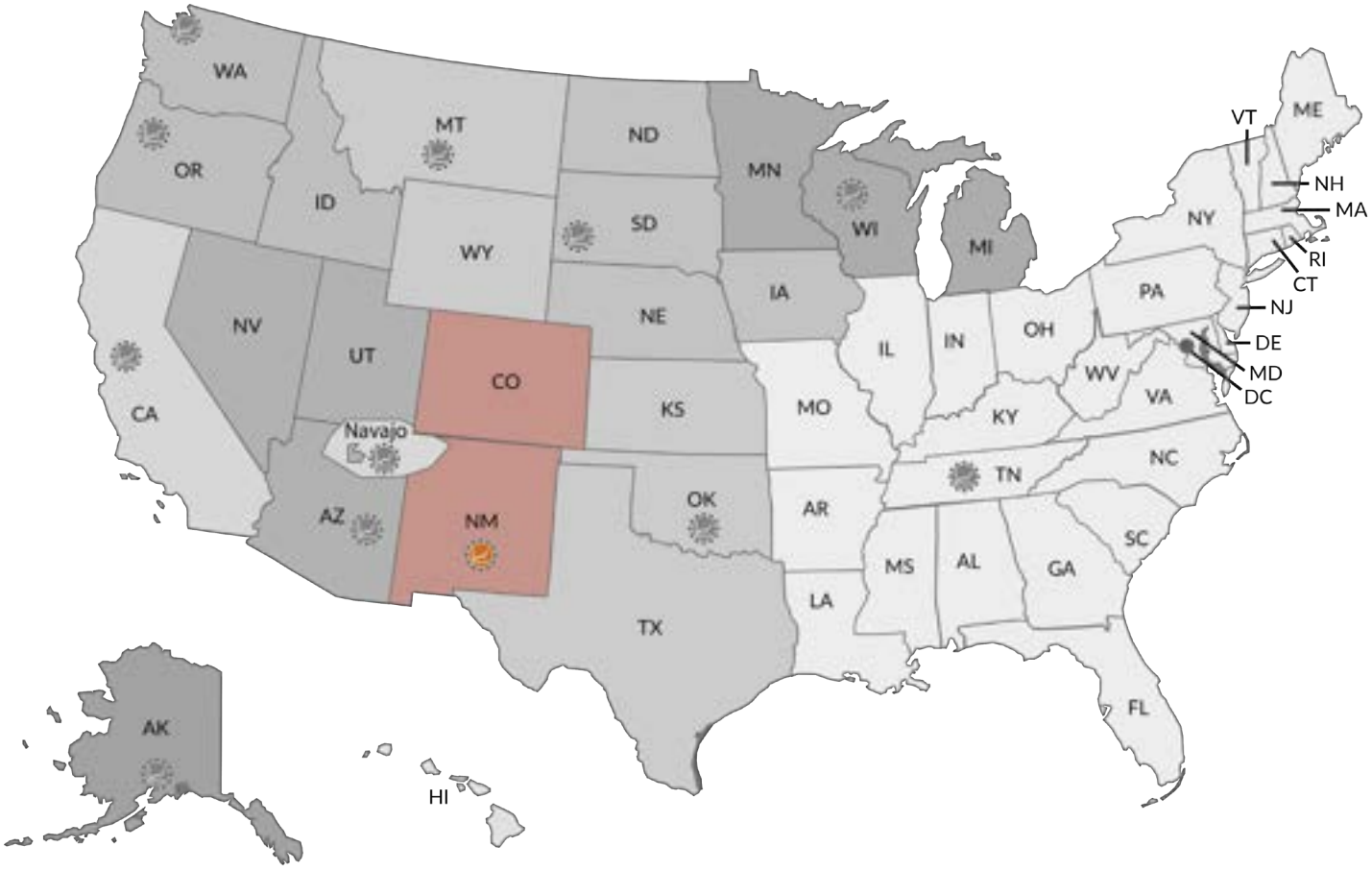
Organization officers are elected every two years from the board members representing the consortium Tribes. Officers include Chair, Vice-Chair and Secretary/Treasurer. Board members provide guidance and leadership from their own community perspective to all of the organization's activities.

AAIHB offices are in Albuquerque, which is centrally located and affords access to numerous resources, such as the Indian Health Service (IHS) Albuquerque Area Office, the University of New Mexico, and the State of New Mexico Department of Health.

In addition to AASTEC, services include audiology, public health research and capacity building, student development, a Tribal Institutional Review Board (IRB), trauma-informed and strengths based capacity building in STI/HIV prevention, opioid and substance use prevention, positive youth development, and mental health.

American Indian/Alaska Native Population in the Albuquerque Area

AASTEC currently serves the American Indian population in New Mexico, Southern Colorado, Southeastern Utah, and West Texas. According to the U.S. Census, there are approximately 104,000 American Indian/Alaska Native (AI/AN) people in the Albuquerque Service Area, including the 20 Pueblos, two Apache Nations, three Navajo Bands (not included in the IHS Navajo Area), and the Southern Ute Tribe and Ute Mountain Ute Tribe in Southern Colorado/Utah.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AASTEC Overview

AASTEC was founded in 2006 and works for all 27 Tribes in the Albuquerque Area. It is supported by an Executive Council with a representative from each community served.

The mission of AASTEC is to promote American Indian health and well-being by assisting Tribes in building public health capacity and reducing health disparities in the Albuquerque Area through the collection, management, analysis, interpretation, and reporting of epidemiologic data.

AASTEC's health priorities are determined by the Executive Council and currently include the following domains: behavioral health, chronic disease prevention and control, injury prevention, healthy aging, tribal public health preparedness, and environmental health.

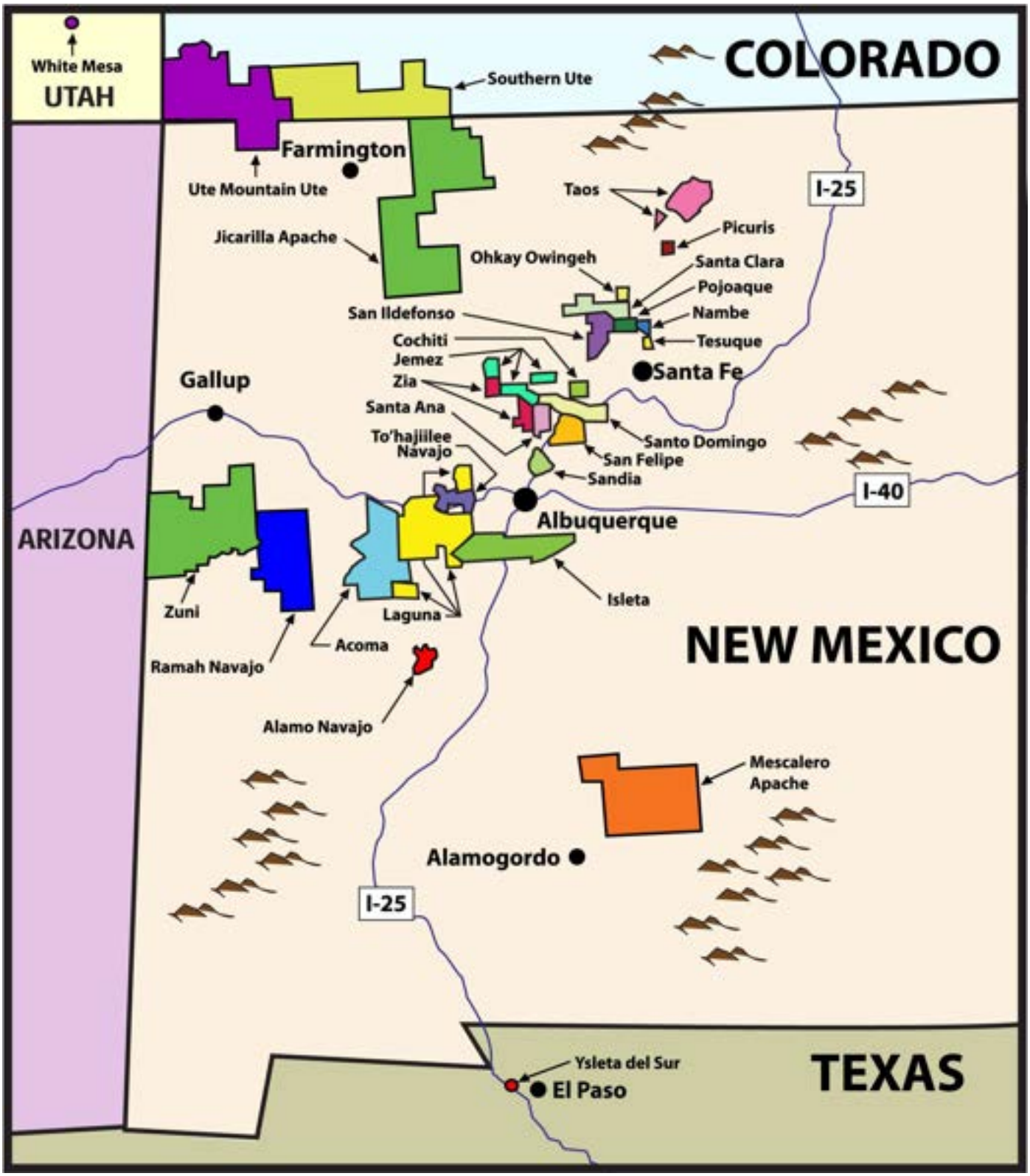
AASTEC Staff

AASTEC staff include over 40 full-time public health professionals, with the majority representing one or more of the tribal communities served.

AASTEC Projects

AASTEC is involved in a host of projects and activities in collaboration with the 27 Tribes it serves. Key project activities include public health surveillance, community health assessment, strategic action planning, health communications, program evaluation, public health preparedness & response, database development, community-based participatory research, student development, and health promotion/disease prevention intervention. Some of AASTEC's current projects include:

- Tribal BRFSS (Behavioral Risk Factor Surveillance System)
- Youth Risk Behavioral Surveillance System Oversampling Project
- Good Health & Wellness in Indian Country
- Tribal Epidemiology Center Public Health Infrastructure Program
- Tribal Overdose Prevention Program
- Tribal Injury Prevention Program
- Tribal Alcohol-Impaired Driving Prevention Program
- Sowing Seeds of Wellness (SOW) Program
- Tribal PRAMS (Pregnancy Risk Assessment and Monitoring System)
- Indigenous Healthy Homes & Healthy Communities Program
- Healthy Native Babies Program
- Southwest Indigenous Data Portal
- Tribal Toddler Survey
- Tribal Vaccine Equity Enhancement Project
- Tribal Colorectal Health Program
- Native American Research Centers for Health
- AASTEC Student Development Program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Nambe
Tesuque
Cochiti
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Santa Fe
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Santa Ana
To'hajiilee Navajo
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San Felipe
Sandia
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Albuquerque
ARIZONA
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Zuni
Laguna
Acoma
NEW MEXICO
Ramah Navajo
Alamo Navajo
Mescalero Apache
Alamogordo
I-25
Ysleta del Sur
El Paso
TEXAS

AASTEC Project Spotlight

Adolescent Health: Southwest Tribal Youth Project

Background

To produce data that are both robust and representative of AI/AN populations, AASTEC, in partnership with state and academic entities, conducts an AI/AN oversample project as a component of the New Mexico Youth Risk and Resiliency Survey (NM YRRS). The NM YRRS is an anonymous, classroom-based assessment tool that examines the health risk behaviors and resiliency (protective) factors of New Mexico high school and middle school students. This assessment is administered biennially and includes a host of topics related to youth health risk behaviors, such as substance use, unintentional injury, violence, bullying, suicidal ideation and attempts, tobacco use, sexual activity, physical activity, and nutrition. The NM YRRS is part of the national CDC Youth Risk Behavior Surveillance System (YRBSS) but is unique in that it also measures youth resiliency in terms of support and involvement in the family, school, community, and with peers. The aim of the AI/AN oversample project is to increase and improve AI/AN youth representation in the resultant NM YRRS data. This allows both complex and granular analysis to be performed for AI/AN students, and ultimately results in a better understanding of health behaviors and resiliency factors among this underserved population.

AI/AN Oversample Protocol

Schools in New Mexico are chosen to administer the NM YRRS based on a modified CDC YRBSS sampling protocol, where the probability of a school being chosen to administer the survey is proportional to the size of the school, based on student enrollment. At each school chosen to administer the survey, only students enrolled in certain randomly-chosen classescomplete the survey. As part of the AI/AN oversample protocol, AASTEC draws an additional sample of schools that enroll a high proportion of AI/AN students. These schools are ofen smaller. They are oversampled at the classroom level, meaning that every class in these schools administers the survey.

In 2007, a test sample of three high schools on Tribal lands that served exclusively AI/AN students were invited to participate in the NM YRRS AI/AN oversample project. AASTEC developed its protocol for school recruitment, teacher incentives, and data dissemination with the approval of the Southwest Tribal Institutional Review Board and its project partners. The response rate among the first three schools in 2007 was 70%. Based on this successful pilot, 23 additional middle schools and high schools with at least 75% AI/AN student enrollment were included in the 2009 NM YRRS AI/AN oversample, which resulted in a 74% response rate. For each subsequent NM YRRS survey administration cycle, all middle schools and high schools located within or adjacent to New Mexico tribal communities served by AASTEC, have been invited to participate in the AI/AN oversample project, regardless of their percentage of AI/AN student enrollment.

In 2021, a total of 54 schools were invited to administer the NM YRRS as part of the AI/AN oversample. Of these, 20 high schools and 24 middle schools opted to participate and the AI/AN oversample had an overall response rate of 65%. The 2021 NM YRRS response rate was likely impacted by the COVID-19 pandemic, as was the first time since 2009 that the response rate had been below 75%. In comparison, the 2021 response rate for schools that administered the NM YRRS under the state's standard sampling framework was

58%. Overall, 5,536 AI/AN students completed the 2021 NM YRRS. More than half of these students (2,976) were administered the survey through the AI/AN oversample project.

Community and School Engagement

With a motto "Together, we can fix things," AASTEC conducts the NM YRRS AI/AN oversample project successfully with in partnership with a number of entities. These include the University of New Mexico, the New Mexico Public Education Department, the New Mexico Department of Health, schools, and tribal communities. Several members of the AASTEC staff hold positions on the NM YRRS steering committee and contribute to the continual recalibration of the NM YRRS survey instrument to ensure its ongoing utility.

Prior to each survey administration cycle, AASTEC staff provide detailed information about the purpose, procedures, and benefits of participating in the NM YRRS survey to administrators at schools in the AI/AN oversample and leadership of tribal communities affiliated with the schools.. Survey materials are provided to schools at no cost, and AASTEC offers on-site logistical support to participating schools on the day of the survey. School supplies are also provided to honor the time commitment of the staff at participating schools.

NM YRRS Data Analysis and Reporting

Following survey administration, AASTEC disseminates results directly back to schools that participate in the AI/AN oversample. It provides a state level aggregate data report and a school-specific data report. AASTEC also offers technical and analytic support to schools, communities, and tribal partners who request in-depth data analysis, tailored data products, and/or data presentations. NM YRRS AI/AN oversample data are maintained by AASTEC. All requests to obtain school-specific data must first be approved by the principal of each school.

AASTEC staff and its partners regularly conduct comprehensive analysis of NM YRRS data to identify key risk behaviors and protective factors experienced among AI/AN youth, document health disparities witnessed among AI/AN youth in New Mexico and monitor trends over time. Topical factsheets on issues such as substance use, mental health, physical health, and violence are developed following each survey cycle and shared back to school administrators and tribal and community partners. Thisis an effort to understand and address critical health disparities observed among AI/AN youth in New Mexico.

2021 NM YRRS Key Findings

Data from the 2021 NM YRRS reveal that AI/AN students in New Mexico reported disproportionately high rates of several health risk behaviors compared to students at state and/or national levels. These rates also exceed Healthy People 2030 targets.

Current Tobacco Use, Past 30 Days

According to data from the 2021 NM YRRS, 25.9% of AI/AN high school students currently use at least one form of tobacco. The NM YRRS instrument does not distinguish between commercial and traditional tobacco use. The rate of current tobacco use among AI/AN high school students in NM was slightly lower than that at the NM state level across all races (27.3%), but exceeded the national rate (18.7%) and the Healthy People 2030 target of 11.3%. Among AI/AN high school students in NM, odds of current tobacco use were highest among those who also used alcohol, or experienced homelessness in the past 30 days, or who had experienced sexual violence in the previous 12 months (aOR = 4.1; 95% CI, 2.8-6.1; P < .001). Odds of current tobacco use were lowest among AI/AN high school students who had a parent or guardian who believes they will be a success, those with a parent or guardian who knows where the student is when not at home, and among those who felt there were clear rules at school about what they can and cannot do.

Current Marijuana Use, Past 30 Days

A quarter (24.8%) of NM AI/AN high school students currently use marijuana. This is significantly higher than the rate reported at the NM state level across all races (20.3%), and far exceeds the national rate (15.8%) as well as the Healthy People 2030 target of 5.8%. Among AI/AN high school students in NM, odds of current marijuana use are highest among those who also used alcohol, experienced homelessness, or were kicked out of their home, ran away or abandoned during the previous 30 days. Odds of current marijuana use were lowest among AI/AN high school students with a parent or guardian who knows where the student is (when not at home), who has an adult outside of the home who praises them when they do a good job, and among students who are involved in group activities outside of school.

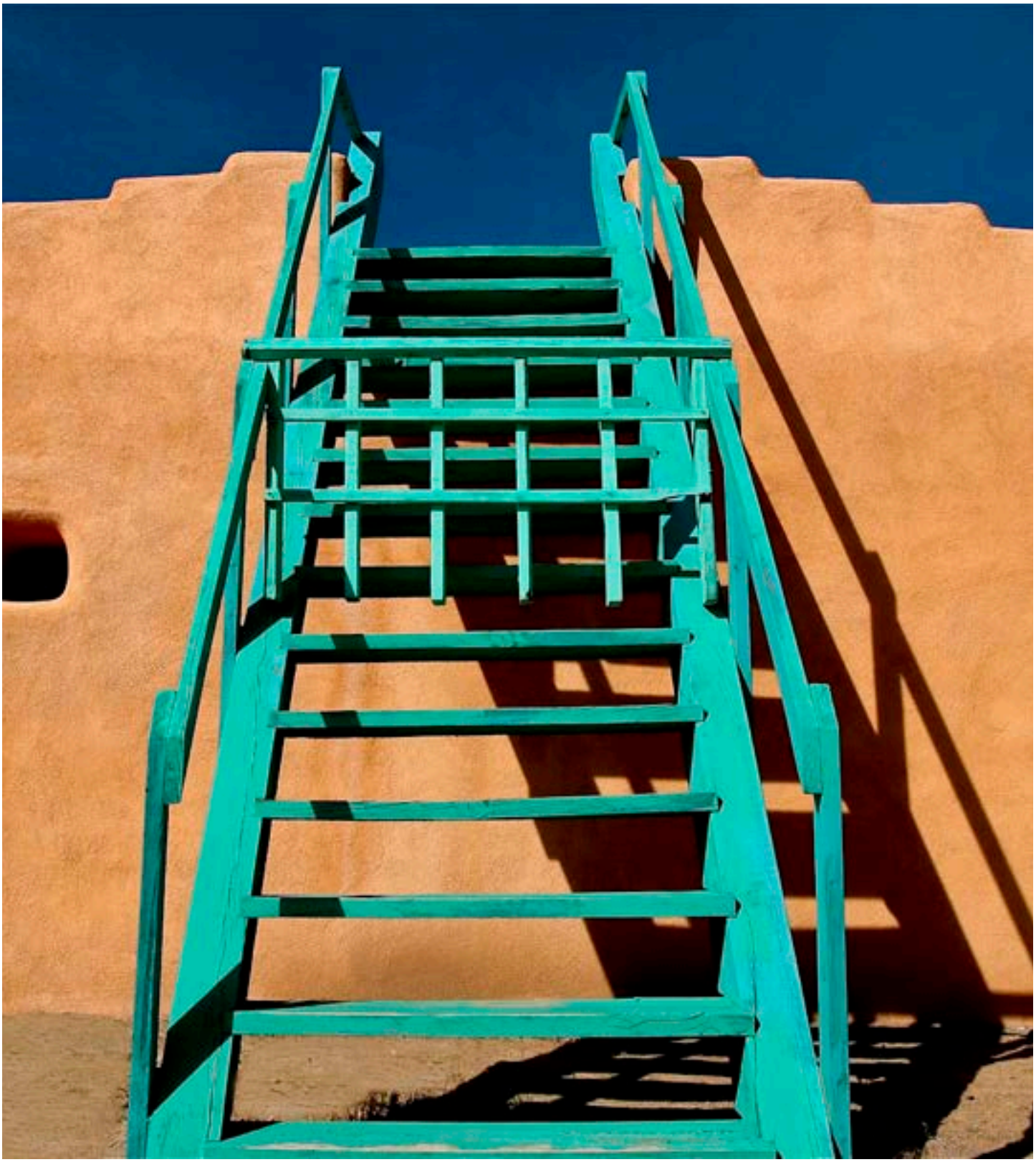
Suicide Attempt, Past 12 Months

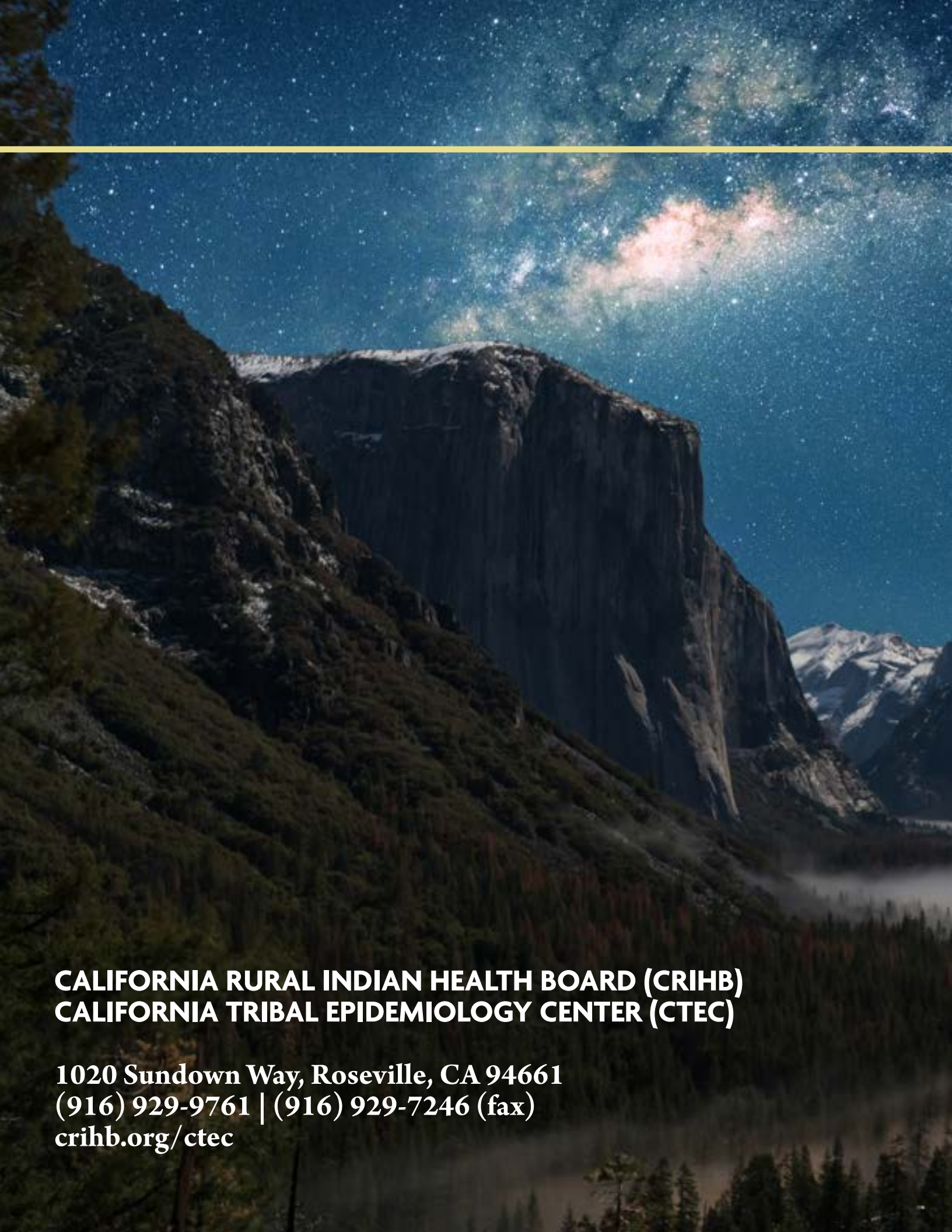
The rate of AI/AN high school students who reported one or more suicide attempts in the previous 12 months was significantly higher than the rate reported at the NM state level across all races (AI/AN: 13.6% vs NM: 10.4%) and exceeds the national rate (10.2%) as well as the Healthy People 2030 target of 1.8%. Among AI/AN high school students in NM, odds of having attempted suicide in the previous 12 months are highest among those who experienced persistent sadness and/or hopelessness orthose who carried a weapon on school property in the past 30 days, along with those who experienced sexual violence in the previous 12 months. Odds of suicide attempt were lowest among AI/AN high school students with a parent or guardian who knows where the student is when not at home, who believes they will be a success, and among students who plan to continue their education beyond high school.

While the NM YRRS data show disproportionately high rates of several health risk behaviors, they also indicate that various sources of strength and support within the lives of AI/AN youth provide protective effects against negative health behaviors and experiences.

The AASTEC NM YRRS AI/AN oversample project webpage includes access to NM YRRS data reports and topical factsheets.

www.aastec.net/services-programs/new-mexico-youth-risk-resiliency-survey-healthy-kids-colorado-survey/





CALIFORNIA RURAL INDIAN HEALTH BOARD (CRIHB)
CALIFORNIA TRIBAL EPIDEMIOLOGY CENTER (CTEC)

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(916) 929-9761 | (916) 929-7246 (fax)
crihb.org/ctec


CTEC
California Tribal Epidemiology Center

CTEC Region & Parent Organization

All of the Indian Health Service (IHS) funded facilities in California are governed by Tribes and are sanctioned by Public Law 93-638. Many AI/AN people in California utilize Indian health programs for health care.

Persons eligible to receive IHS-funded health care services in California are American Indian and Alaska Native (AI/AN) people who are enrolled members of a federally recognized Tribe or descendants of Indians documented in a survey of AI/AN people conducted by the U.S. government in California in 1852. There are 47 Indian health programs throughout California, which include Tribal, Urban, and outpatient treatment center programs.

The California Rural Indian Health Board, Inc.

The California Rural Indian Health Board, Inc. (CRIHB) is a 501 (c)3 nonprofit corporation in operation since 1969. It is a network of Tribal Health Programs (THP) controlled and sanctioned by Indian people and their Tribal governments. CRIHB is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian people of California. The organization provides advocacy, shared resources, training, and technical assistance to enhance delivery of quality comprehensive health-related services.

CRIHB is one of 12 Area Indian Health Boards in the United States and operates under the Indian Self-Determination Act (PL 93-638) as a Tribal organization.

It works closely with other IHS Area Health Boards and meets biannually with the Northwest Portland Area Indian Health Board. Tribal guidance and direction provided by its Board of Directors, the Tribal Government Consultation Committee, and the Traditional Indian Health Committee is essential to the capacity of CRIHB.

The CRIHB Board of Directors meets quarterly and consists of representatives selected by the Tribal health boards of the CRIHB member programs. The Tribal health board leaders make recommendations to the CRIHB Board of Directors, serve on state and national workgroups such as the National Congress of American Indians and the National Indian Health Board, and consult with state and federal elected officials on a government-to-government basis.

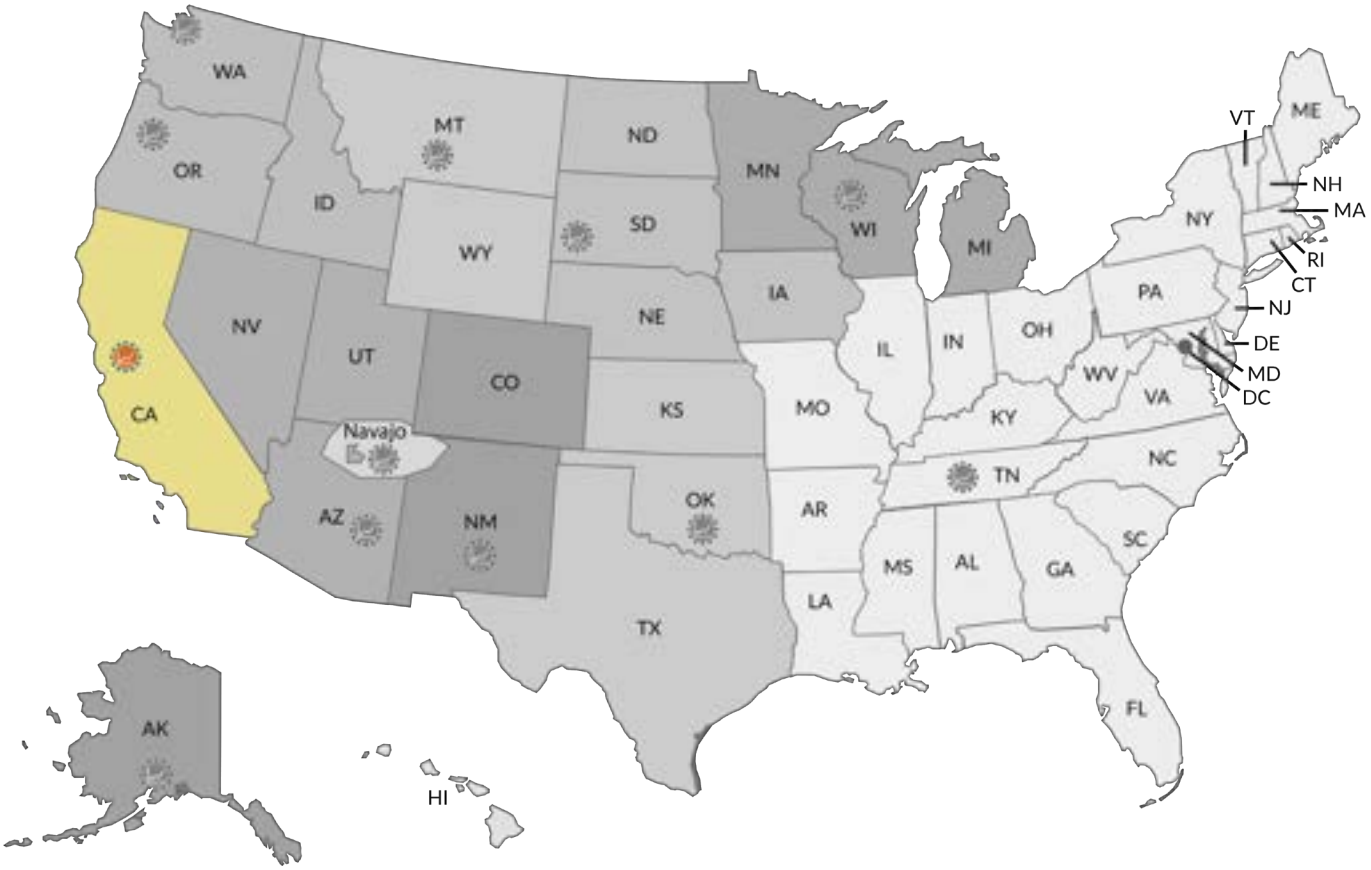
CRIHB serves as the parent organization for these programs committed to elevating the wellness of California AI/AN communities:

- California Tribal Epidemiology Center
- Tribal Opioid Overdose Prevention Program
- Department of Labor Workforce Development Rural Healthcare Grant Program, AI/AN

CRIHB is home to several other statewide programs, including:

- California Dental Support Center housed in the Health Systems Development Department
- Tribal Medication-Assisted Treatment (TMAT) Program in the Public Health Department
- Tribal Child Development Department awarded to operate the Tribal Head Start programs and Tribal childcare centers

Additionally, CRIHB successfully operates over 30 grants and contracts a year funded through federal, state, and private foundations. These support CRIHB's focus on continually supporting and elevating the well-being of California's Tribal communities.



American Indian/Alaska Native Population in the California Area

California has the largest population of AI/AN people in the nation. The 2020 U.S. Census reported that 631,016 individuals identified themselves as AI/AN in California, which represents 16.9% of the nation's AI/AN population. California has 109 federally recognized Tribes and more than 81 Tribes seeking recognition or restoration.

CTEC Overview

The CTEC mission is to improve American Indian health in California to the highest level by engaging American Indian communities in collecting and interpreting health information to establish health priorities, monitor health status, and develop effective public health services that respect cultural values and traditions of the communities. Indian people have been conducting health studies for thousands of years. Investigating and finding ways to heal is an inherent part of Indian culture. CTEC is built on those very same foundations.

CTEC was created in 2005. Since then it has worked to expand the availability of epidemiological services to AI/AN communities throughout California to establish health priorities, monitor health status, investigate health problems and health hazards, and conduct evaluation and research on programs and policies.

CTEC's ability to collect, analyze, and disseminate information to increase awareness of health disparities is strengthened by strong partnerships with 23 member THPs, representing 84 Tribes and their communities. CTEC maintains strong ties and networks with community elders, Tribal leaders, cultural specialists, youth groups, health representatives, counselors, and teachers.

An Advisory Council consisting of Tribal community members, Tribal health providers, and technical advisors makes recommendations on the operations and products of CTEC.

CTEC utilizes the network of Tribes and THPs through coordinated meetings and roundtable discussions to obtain input on data collection and analysis in research studies and presentation of findings in health reports. Ensuring that health data and information are relayed back to the Tribal communities and stakeholders is a key component to fulfilling the mission of CRIHB CTEC. CRIHB CTEC disseminates reports and presents to partner THPs and Tribal organizations, both locally and nationally, on interpreting research findings and possible implications.

CTEC Staff

CTEC staff members include a Director of Research and Evaluation, a CTEC Program Manager, a CTEC Epidemiology Manager, six MPH-level Epidemiologists, two MPH-level Evaluators, 4 Program Coordinators, an Outreach Coordinator, a Research Associate, and an Administrative Assistant.

CRIHB CTEC Partnerships

CRIHB CTEC has partnerships with the California Indian Health Service Area Office, the California Department of Public Health, the University of California at Los Angeles, and the University of California, Merced. CTEC has a Memorandum of Understanding with the University of California, Davis Comprehensive Cancer Center to partner on AI/AN cancer-related projects.

CTEC Projects

Tribal Opioid Prevention Program (TOPP)

TOPP is funded by the Centers for Disease Control and Prevention (CDC) to collaborate with California Tribes and THPs to address the opioid crisis in Indian country. TOPP staff collaborates with CRIHB's other opioid and substance use programs to provide a strategic plan and support to develop prevention and intervention programs, culturally designed for California's Tribal communities.

Tribal Epidemiology Centers Public Health Infrastructure (TECPHI)

TECPHI is a competitive grant through the CDC. TECPHI strengthens public health infrastructure and capacity. It supports a culturally informed, evidenced-based, holistic, and population-level approach to disease prevention, health promotion, and wellness of the Tribes, THPs, and Urban Indian Organizations. TECPHI supports efforts to effectively identify and address underlying social determinants of health, reduce persistent health disparities, and improve the overall health and well-being of AI/AN populations.

Infectious Disease Prevention Control

Infectious Disease Prevention Control is a project funded by the California Department of Public Health (CDPH) to create a sustainable plan to improve disease reporting from Tribal health systems to the state. This includes supporting data collection, improving electronic medical records systems, working on the COVID-19 vaccine hesitancy project, and improving data-sharing relationships between Tribes, THPs, and counties.

Disease Intervention Specialist (DIS)

DIS is another project funded by CDPH to carry out a pilot project on disease response from THPs. CRIHB is working with two THPs to pilot this project to analyze and improve communicable disease response protocols and systems, with a focus on sexually transmitted infections.

Tribal Behavioral Risk Factor Survey (TBRFS)

TBRFS is the largest survey related to health behaviors among AI/AN people in California. It provides information such as the percentage of AI/AN respondents who have been diagnosed with diabetes, the average number of hours of physical activity, and marijuana use, among many other key indicators. CRIHB is collaborating with the University of California Los Angeles (UCLA) to conduct an oversample of the Community Health Interview Survey focused on AI/AN adults via telephone interviews and an analysis of that data between 2024-2026.

STI Surveillance

STI Surveillance is a comprehensive survey to assess the burden of STIs among AI/AN population in California. The mission is aimed at providing crucial insights into the challenges faced by this community, considering factors such as limited access to healthcare, cultural barriers, and socioeconomic disparities. The online survey was conducted from July 2023 to September 2023 utilizing a convenience sampling technique. A diverse sample of 800 participants was included in the study.

Community Health Profiles

Community Health Profiles are in development for California AI/AN communities (2024-2025) using a mix of primary data and the best available secondary data sources. The profile is a resource to assist THPs, Tribal leaders, and clinic staff in:

- Further understanding how data is collected and reported for AI/AN people living in California.
- Completing grant applications that require data, facts, and figures.
- Deciding where to allocate time, money, and efforts related to health issues.

GREAT LAKES INTER-TRIBAL COUNCIL (GLITC)
GREAT LAKES INTER-TRIBAL EPIDEMIOLOGY CENTER (GLITEC)

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GREAT LAKES INTERTRIBAL
EPIDEMIOLOGY CENTER

GLITEC Region & Parent Organization

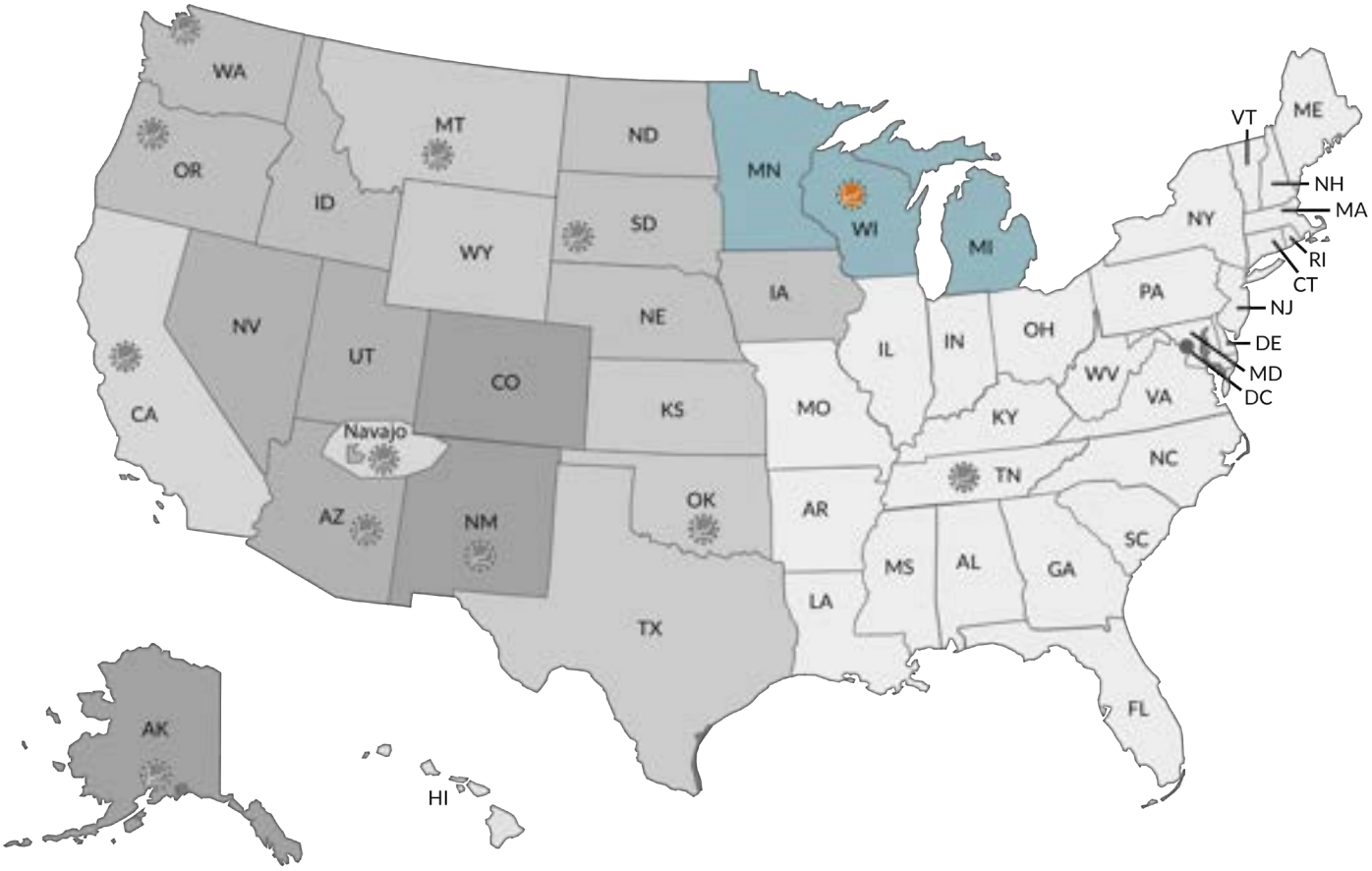
The Great Lakes Inter-Tribal Council, Inc. (GLITC), located on the Lac du Flambeau reservation, is a consortium of 12 federally recognized Indian Tribes in Wisconsin and the Upper Peninsula of Michigan. GLITC was chartered as a nonprofit corporation under Wisconsin law in 1965. It was established to provide a means by which member Tribes could unite against the threat of termination.

For more than 55 years, GLITC has used a broad range of knowledge and experience to advocate for the improvement and unity of Tribal communities and individuals. Today, the GLITC mission has evolved to support member Tribes in expanding self-determination efforts by providing services and assistance. GLITC's current goals and objectives are established by its Board of Directors, which is comprised of the Tribal chairperson or president (or his/her delegate) of each of the 12 member Tribes.

American Indian/Alaska Native Population in the Bemidji Area

The Bemidji Indian Health Service (IHS) Area includes the states of Michigan, Minnesota, and Wisconsin and the city of Chicago. Most Tribes in the Bemidji IHS Area are Chippewa (Ojibwe), though there are also Dakota, Ho-Chunk, Menominee, Mohican, Odawa, Oneida, and Potawatomi nations. In Michigan, Minnesota, and Wisconsin, according to the 2020 U.S. Census, 0.9% of the population was AI/AN alone (190,330 individuals). The figure rises to 2.5% when including AI/AN in combination with another race (548,681 people)[26].

[26] U.S. Census Bureau. (2020). Profile of General Population and Housing Characteristics. Decennial Census, DEC Demographic Profile, Table DP1. Retrieved January 19, 2024, from data.census.gov/table/DECENNIALDP2020.DP1?d=DEC Demographic Profile.



Great Lakes Inter-Tribal Epidemiology Center Central and Satellite Offices

Minnesota

A **Indian Health Board of Minneapolis**
2020 Minnehaha Ave.
Minneapolis, MN 55404

B **University of Minnesota**
1300 S. Second St., Suite 300
Minneaplois, MN 55454

Wisconsin

C **Great Lakes Inter-Tribal Council (GLITC)**
2932 Hwy 47 N., PO Box 9
Lac du Flambeau, WI 54538

D **Green Bay Office**
1566 W. Mason St.
Green Bay WI 54303

E **University of Wisconsin-Madison**
610 Walnut St.
Madison, WI 53726

Michigan

F **Grand Rapids Office**
250 Monroe Ave. NW, Suite 400
Grand Rapid, MI 49503

G **University of Michigan**
1415 Washington Heights
Ann Arbor, MI 48109

GLITEC Overview

The Great Lakes Inter-Tribal Epidemiology Center serves the 34 federally recognized Tribes, four urban Indian communities, and three IHS service units within the Bemidji Area. Established in 1996, GLITEC was one of the first four Tribal Epidemiology Centers. GLITEC staff support AI/AN communities in their efforts to improve the health of their people through partnering directly with communities; producing publicly available resources; and educating on local, state, and national levels to improve data quality.

GLITEC Mission statement

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.

The following principles of operation support GLITEC services:

- Respect for Tribal authority and direction in service requests
- Data confidentiality, protection, and security
- Tribal ownership of data
- Establishing transparent, trusting relationships
- Inclusion and representation

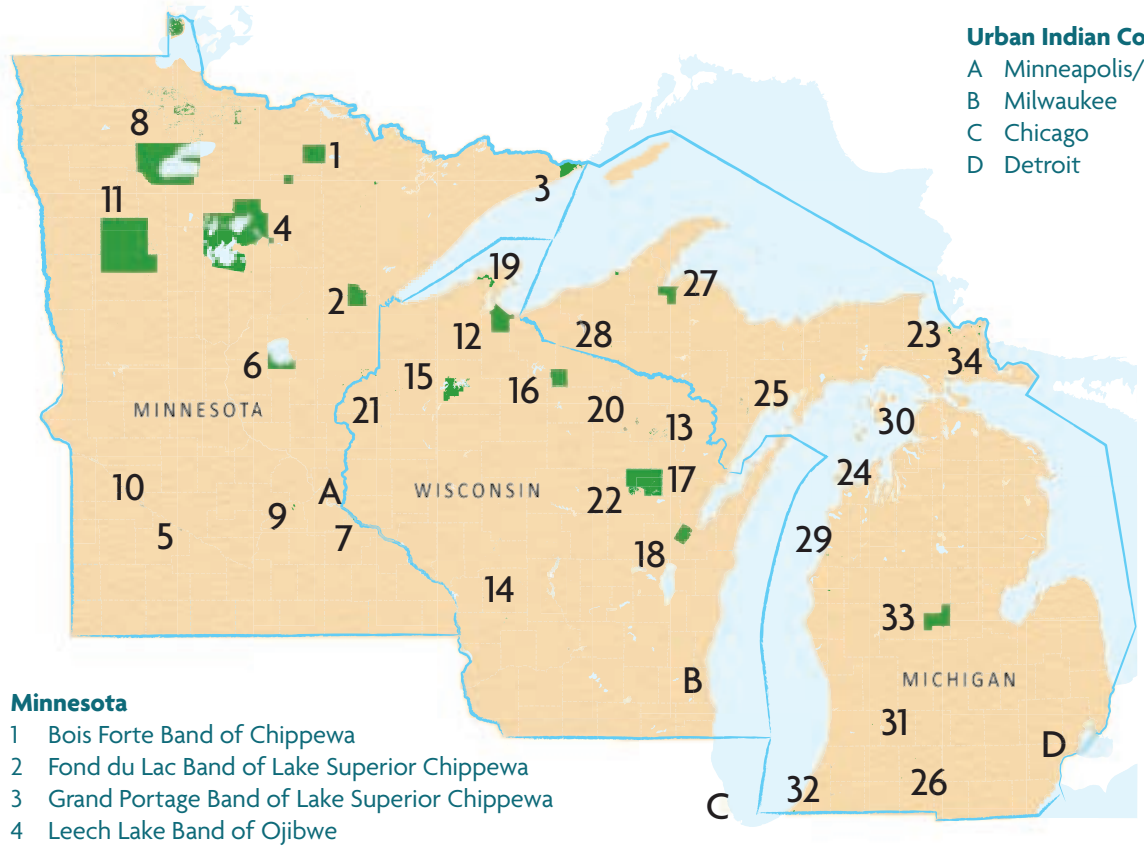
GLITEC Staff

GLITEC receives guidance from the GLITC Board of Directors, GLITC as a parent organization, and the GLITEC Director. This leadership ensures that GLITEC meets the needs of the Tribal communities and is in line with its mission statement. GLITEC is currently made up of about 20 staff with diverse skills, education, and experience. Staff titles include GLITEC Director, Program Director, Epidemiologist, Public Health Specialist, Emergency Preparedness Specialist, Communication Lead, Fiscal Assistant, Research Assistant, Program Assistant, and Graphic Designer. Staff have knowledge in biostatistics, evaluation, emergency preparedness, and other programming.

GLITEC Projects

GLITEC uses grant funds to work in partnership with Native communities in the Bemidji Area to improve the health and well-being of community members. We do this by offering culturally competent approaches that work toward eliminating health disparities faced by American Indian/Alaska Natives. Projects range in scale and scope depending on the communities' needs at the time. Some of GLITEC's projects serve only one or a few Tribal communities, while others span all 34 Tribes and four urban Indian communities across the Bemidji Area.

Great Lakes Inter-Tribal Epidemiology Center Service Area
Indian Health Service Bemidji Area



Urban Indian Communities

A Minneapolis/St Paul
B Milwaukee
C Chicago
D Detroit

Minnesota

1 Bois Forte Band of Chippewa
2 Fond du Lac Band of Lake Superior Chippewa
3 Grand Portage Band of Lake Superior Chippewa
4 Leech Lake Band of Ojibwe
5 Lower Sioux Indian Community
6 Mille Lacs Band of Ojibwe
7 Prairie Island Indian Community

Wisconsin

8 Red Lake Nation
9 Shakopee Mdewakanton Sioux Community
10 Upper Sioux Community
11 White Earth Nation
12 Bad River Band of Lake Superior Chippewa
13 Forest County Potawatomi Community
14 Ho-Chunk Nation
15 Lac Courte Oreilles Band of Lake Superior Chippewa
16 Lac du Flambeau Band of Lake Superior Chippewa
17 Menominee Nation
18 Oneida Nation
19 Red Cliff Band of Lake Superior Chippewa
20 Sokaogon Chippewa Community
21 St. Croix Chippewa Indians of Wisconsin
22 Stockbridge-Munsee Community

Michigan

23 Bay Mills Indian Community
24 Grand Traverse Band of Ottawa/Chippewa
25 Hannahville Indian Community
26 Huron Potawatomi (Nottawaseppi)
27 Keweenaw Bay Indian Community
28 Lac Vieux Desert Band of Lake Superior Chippewa
29 Little River Band of Ottawa Indians
30 Little Traverse Bay Bands of Odawa Indians
31 Match-e-be-nash-she-wish (Gun Lake) Band of Pottawatomi
32 Pokagon Band of Potawatomi Indians
33 Saginaw Chippewa Indian Community
34 Sault Ste. Marie Tribe of Chippewa Indians

GLITEC Highlights

Good Health and Wellness in Indian Country

GLITEC aims to reduce death and disability rates caused by commercial tobacco, diabetes, heart disease, and stroke and to decrease the prevalence of obesity. Through the Good Health and Wellness in Indian Country (GHWIC) grant, seven communities across the three-state region are partnered via subawards to accomplish these goals. Projects under these subawards are designed to take a multifaceted approach.

In addition to the work done by communities through the subaward, GHWIC staff have produced self-help guides, including a healthy cookbook and powwow fitness video. Materials are distributed across our service area and designed to provide culturally relevant healthy living information.

Environmental Health

GLITEC has a drinking water testing program for Tribal schools and childcare centers. This program offers free water testing for PFAS, arsenic, lead, and other heavy metals. The program also created an e-learning resource and an animated video about lead in drinking water. Both of these resources help viewers learn why lead is harmful and why lead testing is important.

Basic Screening Survey

GLITEC has partnered with both the Wisconsin and Minnesota state health departments to help conduct their Basic Screening Survey (BSS). The BSS is a national dental health survey of third graders that examines the overall level of dental care in a specific region. Traditionally, these types of surveys under-measure AI/AN youth.

GLITEC sponsors an oversample of the AI/AN population within Wisconsin to ensure enough data is collected so that the results are measurable with the population. In Minnesota, GLITEC is working to increase AI/AN school enrollment in the BSS. These schools have been selected as part of the initial random sample but generally would not be inclined to participate. GLITEC is offering a participation incentive in both states, as well as additional data protections to the communities so that the states do not receive identifiable information.

Public Health Capacity Building

Public health capacity building in Tribal communities is one of GLITEC's largest and broadest undertakings. GLITEC's grants direct resources, such as funds and materials, to capacity building.

For example, GLITEC has a data modernization project that will help communities access their own health records that are currently kept at the state level. This project involves forming agreements with each state health department to allow for easier interoperability and connection between the communities and the states. In addition to these agreements, GLITEC will provide trainings and events on infrastructure building to support the capacity building needs identified by the communities.

Another capacity building project aids in community-level overdose prevention efforts by providing subawards to 11 communities. GLITEC also offers these communities program evaluation, which may be performed by a GLITEC staff member or a partner organization.

In addition, GLITEC provides free harm reduction resources for community members and Tribal organizations including Narcan training and Narcan kits.

Trainings are conducted by certified Narcan trainers who travel to the Tribal community to provide educational information about how opioids work in the body and how to administer Narcan. The kits contain two doses of Narcan, fentanyl test strips, gloves, a barrier facemask, a CPR instruction card, a fentanyl test strip instruction card, and a Narcan instruction card.

Technical Assistance

GLITEC provides free technical assistance and there can be dozens of requests handled at one time. Requests can come in from Tribes and urban Indian communities in the Bemidji Area or their surrounding entities, including the state or state universities that are requesting assistance in conjunction with communities. Between 2018 and 2023, GLITEC was involved in technical assistance requests from over 20 Tribes and urban Indian communities. These projects frequently relate to disease surveillance, epidemiology, prevention and control of disease, injury, and disability, and program monitoring/evaluation. GLITEC often helps with survey creation, evaluation, survey administration, data entry/visualization, public health accreditation, and grant writing. Some technical assistance may involve GLITEC-led or -organized training. Common trainings include digital storytelling, data linkage, data visualization, grant writing, CPR/Narcan trainings, and epidemiology 101.

Journeying Toward Wellness Conference

GLITEC hosts an annual Journeying Toward Wellness Conference that focuses on substance use and prevention within communities. The conference takes place over two days and offers one to two days of pre-conference training directly prior to the event. Specific conference topics change annually to ensure they are relevant and address current substance use issues. The conference location rotates each year between Michigan, Minnesota, and Wisconsin and is held at Tribally owned hotels and conference centers.

Adolescent Recovery and Wellness Center

In partnership with its parent organization, GLITEC is aiding in the resource gathering and development of an Adolescent Recovery and Wellness Center. This 36-bed residential care facility will provide culturally relevant services and treatment to youth between the ages of 13 to 17 who have substance use disorder and any co-occurring mental health conditions. The vision that Culture Is Prevention will be woven into the facility's design, and the facility's healing practices will focus on treating the person, not the disease. Construction of the facility is expected to begin in 2024. Once the facility is built, GLITEC will partner with GLITC to participate in grant writing and resource gathering components necessary for the new facility's operation.

GREAT PLAINS TRIBAL LEADERS HEALTH BOARD (GPTLHB)
GREAT PLAINS TRIBAL EPIDEMIOLOGY CENTER (GPTEC)

2611 Elderberry Blvd. Rapid City, SD 57703
(605) 721-1922 | (800) 745-3466 | (605) 721-1932 (fax)
gptec@gptchb.org | gptchb.org


GREAT PLAINS
TRIBAL CHAIRMEN'S HEALTH BOARD
TRIBAL EPIDEMIOLOGY CENTER

GPTEC Region & Parent Organization

The Great Plains Tribal Leaders Health Board (GPLTHB) is a 501(c)(3) nonprofit established to provide the American Indian people of North Dakota, South Dakota, Nebraska, and Iowa with a formal representative Board as a means of communication and participation with the Great Plains Area Indian Health Service and other health agencies and organizations on health matters.

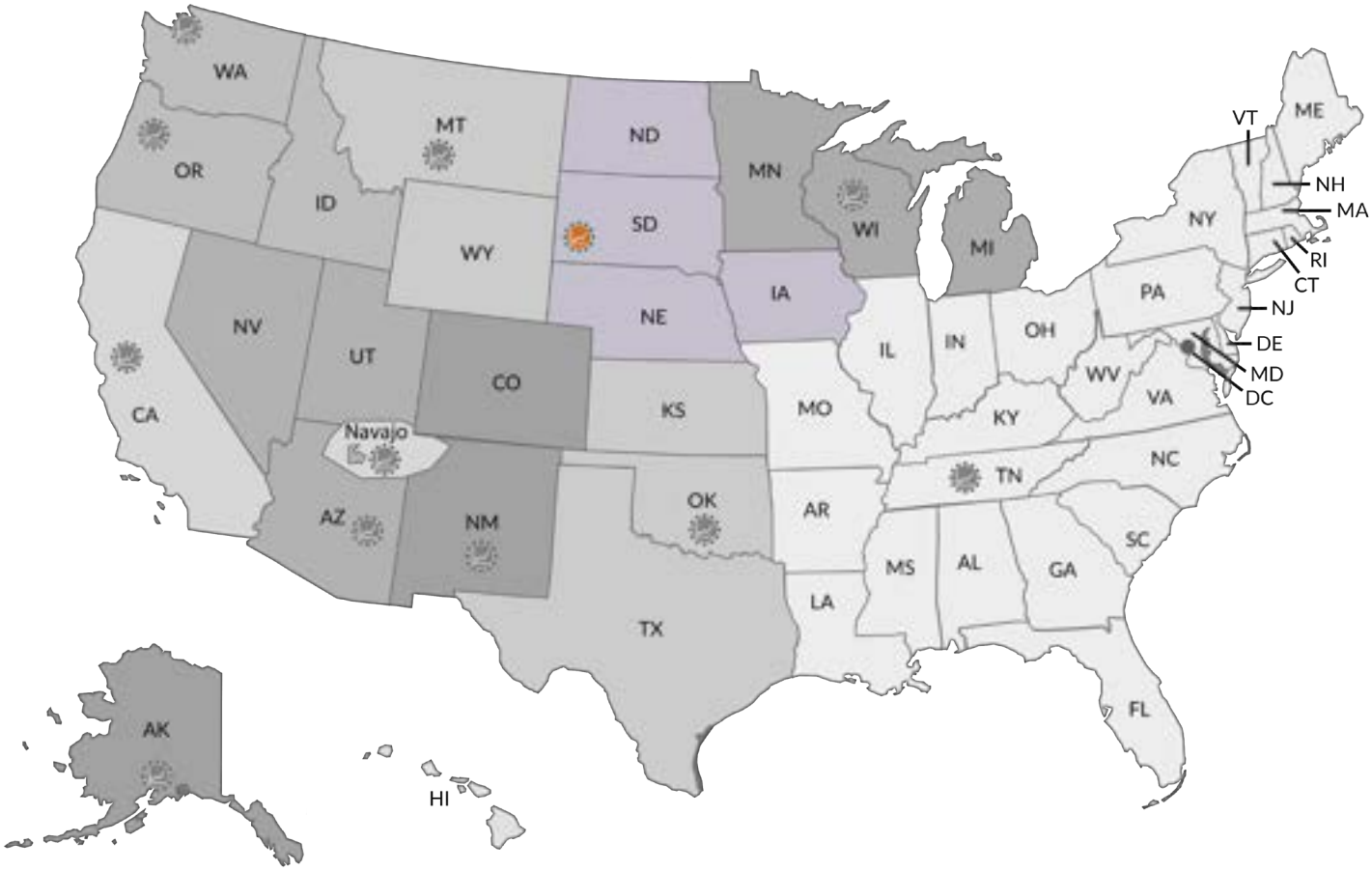
In pursuing this policy, the Board's objectives are:

- To improve the effectiveness of the Indian Health programs through responsible participation in order to improve the health status of Great Plains Tribal Communities
- To assist the Indian Health Service (IHS) in establishing program priorities and in distributing existing resources
- To advise and assist the Director, Great Plains Area Indian Health Service, in developing long-range program plans
- To represent the Indian interests and desires at all levels for health-related programs
- To assist in development of AI responsibility for community activities affecting health
- To assist member Tribes in the development of health programs that will be beneficial to the Tribes
- To establish participation in any meetings that will provide clear and concise information to the Tribes
- To represent the organization and member Tribes in the Congress of the United States at any hearings and at National Organization meetings regarding health issues and care

Great Plains Tribal Epidemiology Center (GPTEC) is a program of the Great Plains Tribal Leaders Health Board (GPTLHB) founded in 2003. Its mission is to provide leadership, technical assistance, support, and advocacy to the 18 Great Plains Area Tribal nations and communities to eliminate disparities in health that currently exist for Tribal people in the four-state region of Iowa, Nebraska, North Dakota and South Dakota.

American Indian/Alaska Native Population in the Great Plains Area

The Great Plains Indian Health Service (IHS) Area serves 18 Tribes and Tribal communities in the states of North Dakota, South Dakota, Nebraska, and Iowa. According to the 2020 US Census, 1.6% of the population in this area was AI/AN alone (106,021 individuals). The figure rises to 1.9% when including AI/AN in combination with another race (130,077)[27,28].



[27] U.S. Census Bureau. "Sex By Age For Selected Age Categories (American Indian And Alaska Native Alone)." Decennial Census, DEC Demographic and Housing Characteristics, Table P12C, 2020, Accessed on July 3, 2024.

[28] U.S. Census Bureau. "Sex By Age For Selected Age Categories (American Indian And Alaska Native Alone Or In Combination With One Or More Other Races, Not Hispanic Or Latino)." Decennial Census, DEC Demographic and Housing Characteristics, Table P12Y, 2020. Accessed on July 3, 2024.

GPTEC Overview

GPTEC Goals

- Provide Great Plains Area Tribes with reports of timely, accurate, and useful data on health priorities based on existing data sources
- Improve the ability of surveillance systems to measure and monitor the health status of American Indian populations through existing tracking or surveillance systems, and development of new surveillance activities
- Support evidence-based culturally-rooted health promotion and disease prevention initiatives in clinical and community contexts
- Build capacity to conduct health research in collaboration with academic institutions, including Tribal community colleges and Tribal schools, to ensure the benefits of well designed, culturally appropriate, and ethical health research within Great Plains AI communities
- Improve public health and epidemiologic capacity in Great Plains Tribal communities

Data and Statistical Information

- Data and statistical information are critical to the public health mission of the GPTEC:
- Epidemiology is the public health science that relies on data to understand patterns of sickness and health in Tribal communities.
- Data are used to support the public health function of assuring that persons have access to appropriate health care and for assessing the effectiveness of that care.
- Public health data may be used to inform the development and implementation of Tribal, state, regional, and national health policies.

Accessing Health Data

GPTEC is committed to helping Great Plains Area Tribes access health data in a way that is culturally appropriate and respects Tribal sovereignty. These activities advance that goal:

- Providing Great Plains Area Tribes with reports of timely, accurate, and useful data on health priorities
- Supporting the GPTEC mission, objectives, and activities across strategic focus areas
- Consulting with Tribal programs and GPLTHB staff on data management issues
- Providing leadership to other public health agencies and workgroups on data issues affecting Great Plains American Indians

GPTEC is also working to strengthen the public health infrastructure throughout the Great Plains Area to address the lack of usable data for public health planning and evaluation at local and regional levels.

GPTEC Staff

The GPTEC staff consist of a Director, Public Health Officer, Epidemiologist, Biostatistician, Data Coordinator, and multiple Program Managers, Project Coordinators and Administrative staff for eight programs.

GPTEC Partnerships & Projects

GPTEC Partnerships

GPTLHB primary partners are the 17 Tribes and one IHS (Trenton) Service Area in the Northern Plains.

- Cheyenne River Sioux Tribe
- Crow Creek Sioux Tribe
- Flandreau Santee Sioux Tribe
- Lower Brule Sioux Tribe
- Oglala Sioux Tribe
- Omaha Tribe of Nebraska
- Ponca Tribe of Nebraska
- Rosebud Sioux Tribe
- Sac & Fox Tribe of the Mississippi Indians of Iowa
- Santee Sioux Nation
- Sisseton Wahpeton Oyate
- Spirit Lake Nation
- Standing Rock Sioux Tribe
- Three Affiliated Tribe
- Turtle Mountain Band of Chippewa
- Winnebago Tribe of Nebraska
- Yankton Sioux Tribe
- Trenton Indian Service Area

GPTEC Projects

Since 2010 there has been annual Tribal engagement to evaluate, re-identify public health priorities, and to redirect GPTLHB resources to meet Tribal public health needs.

In recent years, the GPTEC has developed highly collaborative and valued partnerships with the state health departments in this region. GPTLHB/GPTEC works closely with each state health department to host annual public health meetings for the Tribal Health Directors and Tribal Leaders in the respective states. These efforts have resulted in the analysis and dissemination of the American Indian public health data to each Tribe, with available analysis of individual Tribal data upon request via Tribal resolution. Partner initiatives include:

State of South Dakota

- Annual State Meeting with South Dakota Department of Health and Tribes

State of North Dakota

- Annual State Meeting with North Dakota Department of Health and Tribes

State of Nebraska

- Annual State Meeting with Nebraska Department of Health and Human Services and Tribes

Centers for Disease Control and Prevention

- Epi Aid-Syphilis Outbreak

Colorado School of Public Health

- Resource for Tribal Epidemiology Centers

Indian Health Service

- EPI Aid
- IHS Cancer Support Leadership Training

Behavioral Health & Recovery Program

- Connecting With Our Youth (CWOY)
- Native Connections-Suicide Prevention
- Opioid Response Program

Maternal Child Health

- Great Plains Healthy Start Program (GPHS)
- Sexually Transmitted Infections and Teen Pregnancy Prevention Initiative (STI/TPPI)
- Great Plains Ride Safe (GPRS)

Health Promotion & Disease Prevention

- Great Plains HIV Capacity Building Assistance (CBA/HIV)
- Great Plains Tribal Breast and Cervical Cancer Early Detection Program (GPBCCEDP)
- Northern Plains Comprehensive Cancer Control Program (NPCCCP)

Evaluation Unit (EU) Programs

- Tribal Program Support
- Sisseton-Wahpeton-Oyate Substance Abuse Prevention Program
- Winnebago Department of Public Health
- Ogalala Sioux Tribe Wacantekiyapi Program
- GPTLHB Program Support
- Tribal Opioid Response Program (TOR)
- Circles of Care Program (CoC)
- Trauma and Violence Prevention Initiative (TVPI)
- Forensic Healthcare Program (FHC)
- Oyate Health Center (OHC)
- Good Health and Wellness in Indian Country (GHWIC)
- Epidemiology and Disease Prevention (EDP)

Emergency Operations Center (EOC)

SASP/DVP/FHC Program

HIV/STI Program

COVID-19 Vaccination Program

- Tribal Epidemiology Center Public Health Infrastructure (TECPHI)

TECPHI Opioid Program

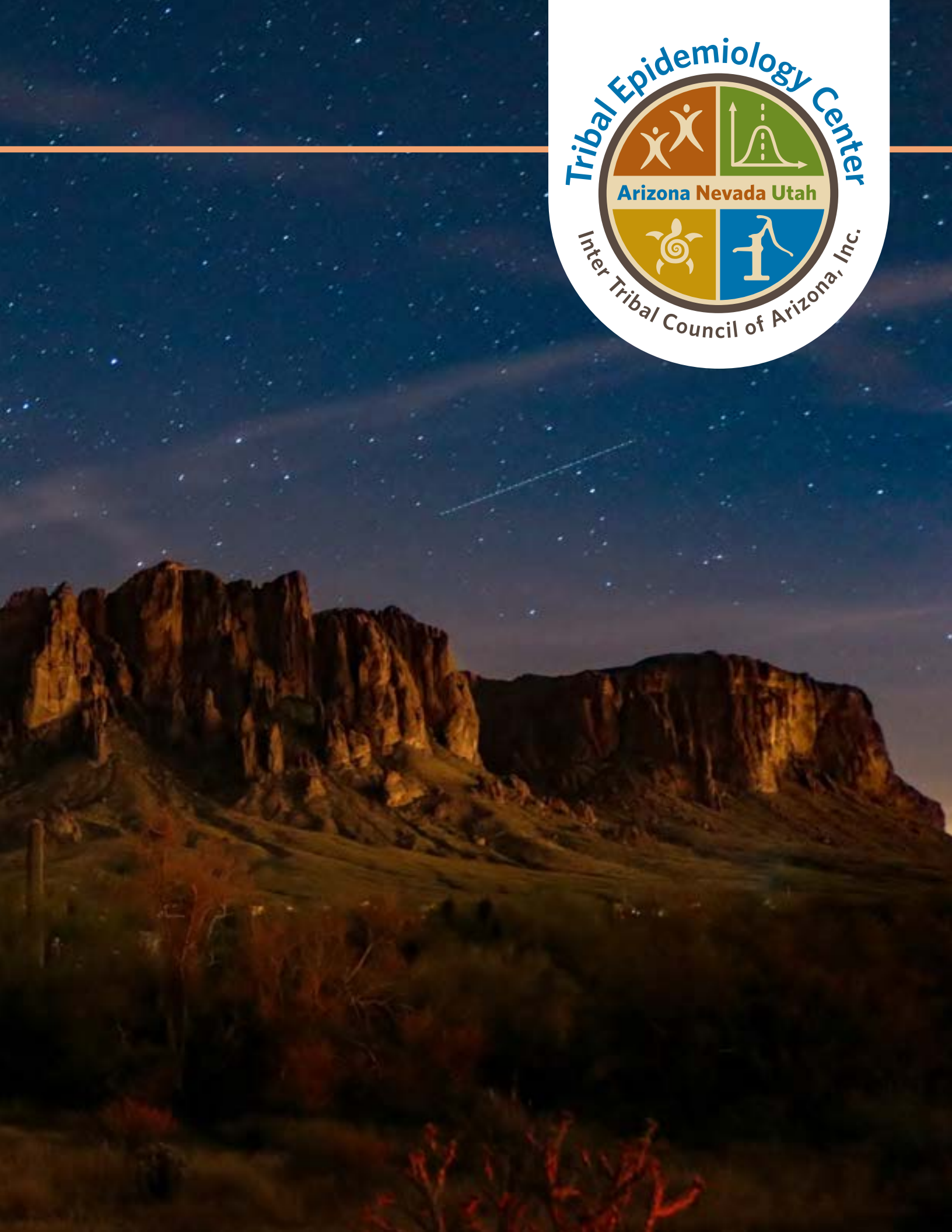
- Academic Partner Support

University of Nebraska Medical Center

Black Hills State University

INTER TRIBAL COUNCIL OF ARIZONA, INC. (ITCA)
ITCA TRIBAL EPIDEMIOLOGY CENTER (ITCA TEC)

2214 North Central Avenue, Suite 100, Phoenix, AZ 85004
(602) 258-4822 | info@itcaonline.com | itcaonline.com/tec


Tribal Epidemiology Center
Arizona Nevada Utah
Inter Tribal Council of Arizona, Inc.

ITCA TEC Region & Parent Organization

The Inter Tribal Council of Arizona, Inc. (ITCA) was established as an association of Tribal governments in 1952 to provide a united voice to address common issues of concern. The highest elected officials (Chairpersons, Presidents, or Governors) of 21 federally-recognized Tribes in Arizona represent the membership of ITCA. These leaders have a comprehensive view of the conditions and needs of the Tribal communities they represent.

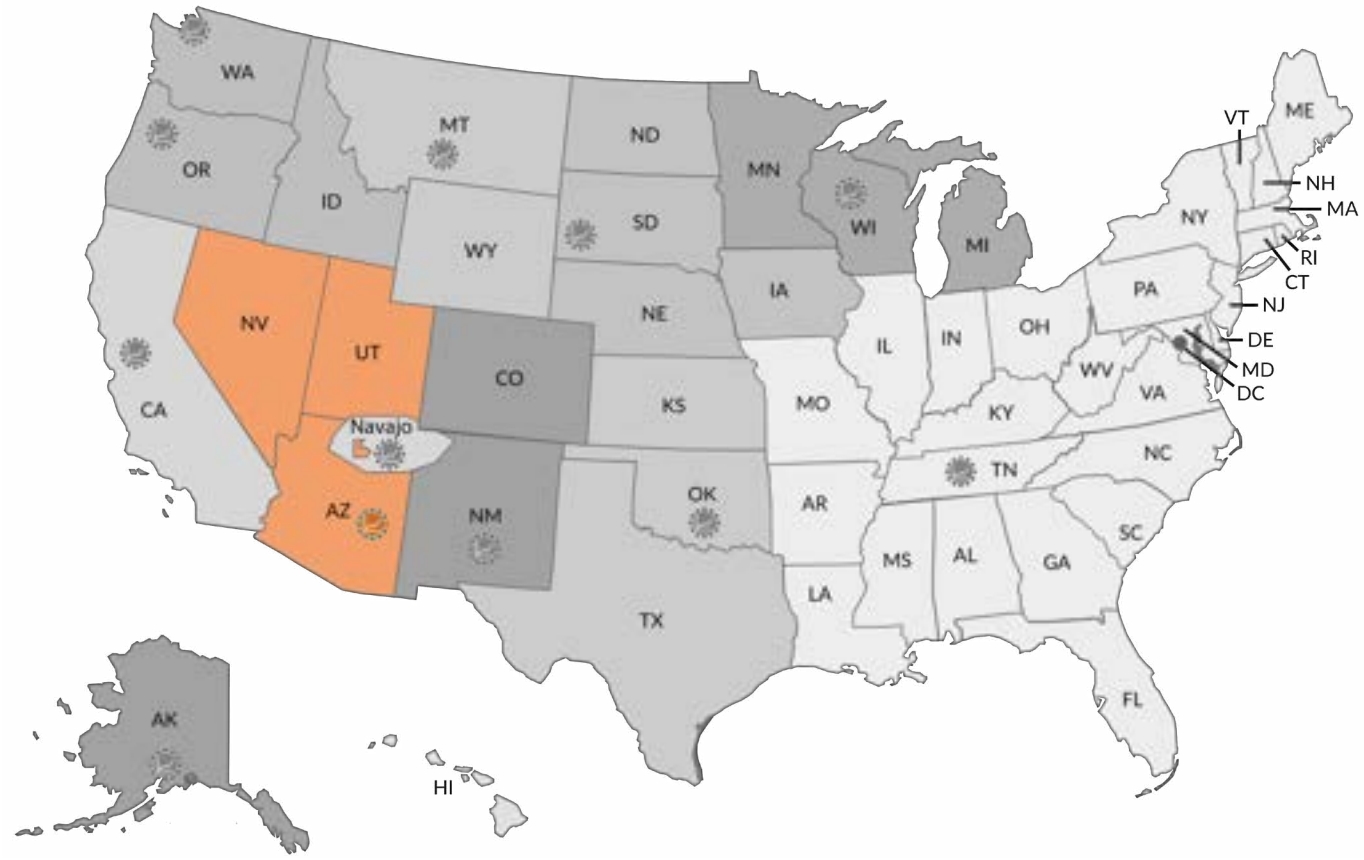
ITCA was incorporated as a 501(c)(3) nonprofit charitable organization in July 1975. The purpose of the organization is to "use any lawful means to provide its Member Tribes as sovereign nations and American Indian Tribes with a united voice, and the means for united action on matters that affect them collectively or individually." With the guidance of Tribal leadership, ITCA, Inc. was established as an accessible resource to Tribal governments on the pathway to self-determination and self-governance.

Over the past 49 years, there has been major growth in the scope of services provided by ITCA for the Tribes. This growth began with the passage of P.L. 93-638, the Indian Self- Determination and Education Act of 1974 P.L. 93-638 provided Tribal governments the lawful basis to assume responsibility for federal programs. Throughout its years of operation, ITCA, Inc. has adjusted its capacity to best meet the needs of Tribes and the evolving responsibilities of Tribal governments through policy, research, advocacy, training, technical assistance, and resource development. Tribal governments have now forged a strong intergovernmental working relationship with the federal and state governments based on their legal sovereign status, resulting in access to new resources and programs for Tribes.

Staff

ITCA, Inc. is sanctioned by its Member Tribes to administer more than 40 federal and state programs, which it achieves with a staff of 70.

At least 95% of funds received by ITCA support Tribal programs via the pass-through of funding to member Tribal governments, or through the provision of training and technical assistance services for Tribes. ITCA has a long history of addressing health-related issues, including providing capacity-building activities, as demonstrated through numerous programs and funding sources awarded to it. These include the Centers for Disease Control and Prevention, the Indian Health Service, National Institutes of Health, and the U.S. Department of Agriculture. Some of the major health issues ITCA addresses include maternal and child health, HIV/STI prevention, behavioral health, substance abuse, chronic disease, and cancer.



American Indian/Alaska Native (AI/AN) Population in the Indian Health Service Phoenix-Tucson Service Areas

The ITCA TEC has served American Indian Tribes in the Phoenix-Tucson Service Areas of the Indian Health Service (IHS) since 1996. This includes Tribes in Arizona, Nevada, and Utah, with exception to the Navajo Nation. There are 48 federally-recognized Tribes, Colonies, Bands, and Community Councils served by the ITCA TEC in the IHS Phoenix-Tucson Service Areas.

According to the 2020 U.S. Census, in the three states that make up the IHS Phoenix-Tucson Areas, there are a total of 529,298 individuals that identify as AI/AN alone or in combination with one or more races: Arizona: 405,281, Nevada: 67,377, and Utah: 56,640.

Inpatient and outpatient medical care in the IHS Phoenix Service Area is provided through ten Indian Health Service units, two Youth Regional Treatment Centers, and a network of health care facilities across the region including Phoenix Indian Medical Center and Native Health in Phoenix. IHS Phoenix Service Area estimates 180,000 users.

The IHS Tucson Service Area provides technical assistance for primary care and outreach programs and environmental health services. Two Tribal clinics, the Tucson Indian Center, and other partner providers are available for purchased and referred care.

ITCA TEC Overview, Highlights & Accomplishments

ITCA Tribal Epidemiology Center

ITCA TEC's mission is to build Tribally-driven public health and epidemiologic capacity among Tribes in the Phoenix and Tucson Indian Health Service Areas by assisting Tribes with health surveillance, prevention, and program evaluation for planning and policy decision-making in order to improve community health and wellness. The goal of ITCA TEC is to build independent Tribal capacity to collect and use community health information in directing programs, managing resources, and building relations with local, state, and federal public health systems.

ITCA TEC provides Tribal Public Health Department and Tribal Behavioral Health Department Support through:

- Tribal small grant funding
- Technical Assistance for public health, epidemiologic, and evaluation services
- Public health capacity-building training
- Health promotion and disease prevention support
- Public health studies
- Social media health campaign support

ITCA TEC Staff

ITCA TEC has a Director and Program Managers who provide leadership and direction based on Tribal priorities. Staff positions are grant-funded, and staff numbers increase and decrease based on the levels of funding. Special public health skills include epidemiology, evaluation, programming/ analytics, ArcGIS, marketing, and social media. ITCA TEC subcontracts with Tribes and a variety of subject matter experts to provide training, technical assistance, and project support as needed.

Partnerships

ITCA TEC has strong working relationships with Tribal, state, and national entities, including Tribal programs, Arizona Department of Health Services, Utah Department of Health, Nevada Department of Health and Human Services, Northern Arizona University, University of Arizona, Arizona State University, Centers for Disease Control and Prevention, and Indian Health Service. ITCA TEC maintains strong collaborative relationships with the other 11 TECs. ITCA TEC participates in a number of committees and working groups across the region and holds an epidemiology working group twice annually to better serve Tribes in the region.

ITCA TEC Projects

Tribal Community Health Profile Programming

The main objective of this project is to assist American Indian Tribes in Arizona, Nevada, and Utah by identifying and addressing important health issues that impact their community members and residents. This project brings together the main data sources available in the region to examine health and wellness and describes the strengths and limitations of the information.

The project seeks to address issues with health information for American Indian and Alaska Native people (AI/ANs), which is often not available, is scattered among different data sources, or is often characterized by poor data quality. Additionally, reliable

health information is often not available at the Tribal or community level.

The ITCA TEC Community Health Profile Project aims to increase Tribal capacity for using data for Tribal health decision-making. A Regional Report and Tribal-specific reports are provided on a five-year cycle. Tribal-specific reports are not available to the public. Regional reports are available at:

- Regional Community Health Profile of American Indian and Alaska Native people in Arizona, Nevada, and Utah 2014-2019, located at: https://itcaonline.com/wp-content/uploads/2022/03/Regional-CHP-2021-Final.pdf
- Regional Community Health Profile 2009-2014, located at: https://itcaonline.com/wp-content/uploads/2013/05/Regional.pdf

Human Immunodeficiency Virus (HIV), Sexually Transmitted Infections (STI), and Hepatitis C (HCV) Prevention Programming

The main objective of this project is to assist American Indian Tribes in Arizona, Nevada, and Utah with HIV/STI/HCV prevention by providing small grants, training, technical assistance, and working group support. As part of this work, ITCA TEC has provided six Tribes with small grants, and continues to provide programmatic funding and support as of 2023-2024.

- From 2020-2022, ITCA TEC housed a CDC Public Health Associate to provide hands-on training for new HIV program leaders.
- During the same time period, it partnered with Johns Hopkins University (JHU) and the Alaska Native Tribal Health Consortium (ANTHC) for the Iwantthekit pilot project. This pilot provided STI and HIV web-based screening and information for American Indians in response to the HIV epidemic in Arizona. The project was so successful in the area that IHS decided to take it over and nationalize the screening services.
- ITCA TEC partnered with the ITCA Women, Infant, and Children (WIC) program to pilot the new mom bag programming, which provided over 250 new moms with health information, prenatal vitamins, STI screening coupon, and FitBits for health tracking and heart health information awareness.
- ITCA social media ran several campaigns providing HIV and STI prevention, screening, and treatment information.
- An Area-wide Strategic Plan and Roadmap were in development in 2024.

ITCA TEC Provided Health Data Reports

- Human Immunodeficiency Virus, Sexually Transmitted Infections, and Hepatitis C Virus Surveillance among American Indians/Alaska Natives in Arizona, Nevada, and Utah, 2000 – 2020, located at: itcaonline.com/wp-content/uploads/2023/07/HIV_STI_HCV-Surveillance-Report-DRAFT-FINAL-6.9.23.pdf
- Sexually Transmitted Disease (STD), Human Immunodeficiency Virus (HIV) and Tuberculosis (TB) Surveillance among American Indians in Arizona, Nevada, and Utah 2014, located at: itcaonline.com/wp-content/uploads/2014/03/STD_HIV_TB_FINAL.pdf

Behavioral Health & Substance Abuse Prevention Programming

The main objective of this project is to assist American Indian Tribes in the IHS Phoenix-Tucson Service Area with prevention and response to substance abuse epidemics in the region by providing small grants, training, technical assistance, and working group support.

ITCA TEC provides technical assistance for IHS Tribal grantees under the Substance Abuse and Suicide Prevention and Domestic Violence Prevention programs. Under the Centers for Disease Control and Prevention, Tribal Public Health Infrastructure Program, opioid supplement, and planning support was a large focus in 2018. Strategic planning continues to be an important priority area. From 2020-2023, the ITCA TEC supported five Tribal programs in their efforts for COVID-19 related suicide, adverse childhood experiences, and intimate partner violence prevention specialized programming

with Seven Directions. ITCA TEC also convened COVID After Action Review Planning with a Behavioral Health Focus with Blue Stone Strategy Group.

As part of this work, we have produced several tools, reports, and co-authored publications.

- **Strategic Planning Toolkit.** Link: Tribalepicenters.org/wp-content/uploads/2019/01/FINAL-Jan-2019-ITCA-Strategic-Planning-Toolkit.pdf
- **The Risk Communication Toolkit.** Link: https://assets.website-files.com/5d68735d677c2aa989f0317b/6307dd5a4214be2fbebff3af_Risk Communication_072922_Final-compressed.pdf
- **After Action Review (AAR) Toolkit – Behavioral Health Edition.** Link: itcaonline.com/wp-content/uploads/2023/02/ITCA_BH_AAR_Toolkit_02.14.23-djf.pdf
- **Behavioral Health and Substance Abuse Surveillance among American Indians in Arizona, Nevada, and Utah, 2018.** Link: https://itcaonline.com/wp-content/uploads/2023/02/ITCA_BH_AAR_Toolkit_02.14.23-djf.pdf
- **The Opioid Epidemic in Indian Country, What Tribal Leaders Need to Know, 2018.** Link: itcaonline.com/wp-content/uploads/2018/10/ITCA-TEC-Opioid-Report-2018.pdf. In 2023, ITCA TEC received funding from the CDC to work with Tribes to prevent overdose. Program activities were planned for 2024.

Vaccination Programming

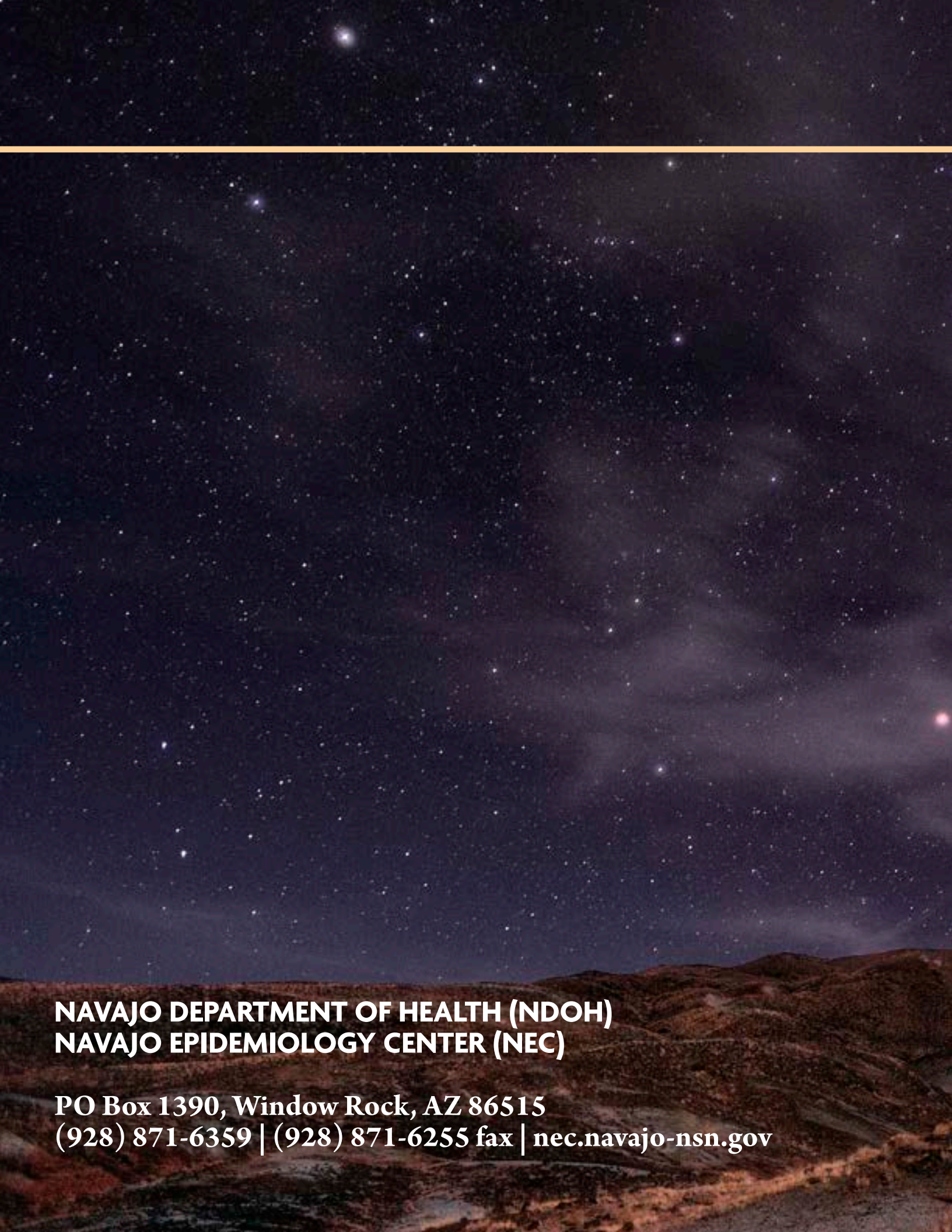
The main objective of this project is to assist American Indian Tribes in the IHS Phoenix-Tucson Service Area with vaccination promotion and vaccine point-of-delivery support by providing small grants, training, technical assistance, and working group support.

Programming for Tribes has included promotion on ITCA's social media of vaccinations for influenza, back-to-school immunizations, Human Papilloma virus (HPV), shingles, and hepatitis A and B.

ITCA TEC partnered with the Northwest TEC and the ITCA Area Agency on Aging (AAA) Region 8 to provide over 250 ITCA AAA program elders in Arizona with summer health supplies and shingles vaccination information. ITCA TEC is currently partnering with two Tribes to provide the man bag project, which provides a FitBit, stress reduction supplies and health information, including information regarding hepatitis A and B vaccination and hepatitis C treatment. ITCA TEC partnered with ITCA social media to create a Vaccine Promotion Toolkit, available at: itcaonline.com/wp-content/uploads/2023/02/ToolkitPostersSample.png

Tribal Public Health Department Infrastructure Development & Enhancement Programming

The main objective of this programming, funded through IHS and CDC, is to assist American Indian Tribes in the IHS Phoenix-Tucson Service Area with starting a health department, or enhancing existing Tribal Health Department programs and services. ITCA TEC has provided small contracts, strategic planning, community health assessment, community health improvement planning, evaluation support, and other specialized technical assistance to support Tribal goals. Tribes are working in a number of public health areas to provide culturally-centered prevention programming in areas such as substance abuse, COVID-19, Rocky Mountain spotted fever, and speech and hearing.



NAVAJO DEPARTMENT OF HEALTH (NDOH)
NAVAJO EPIDEMIOLOGY CENTER (NEC)

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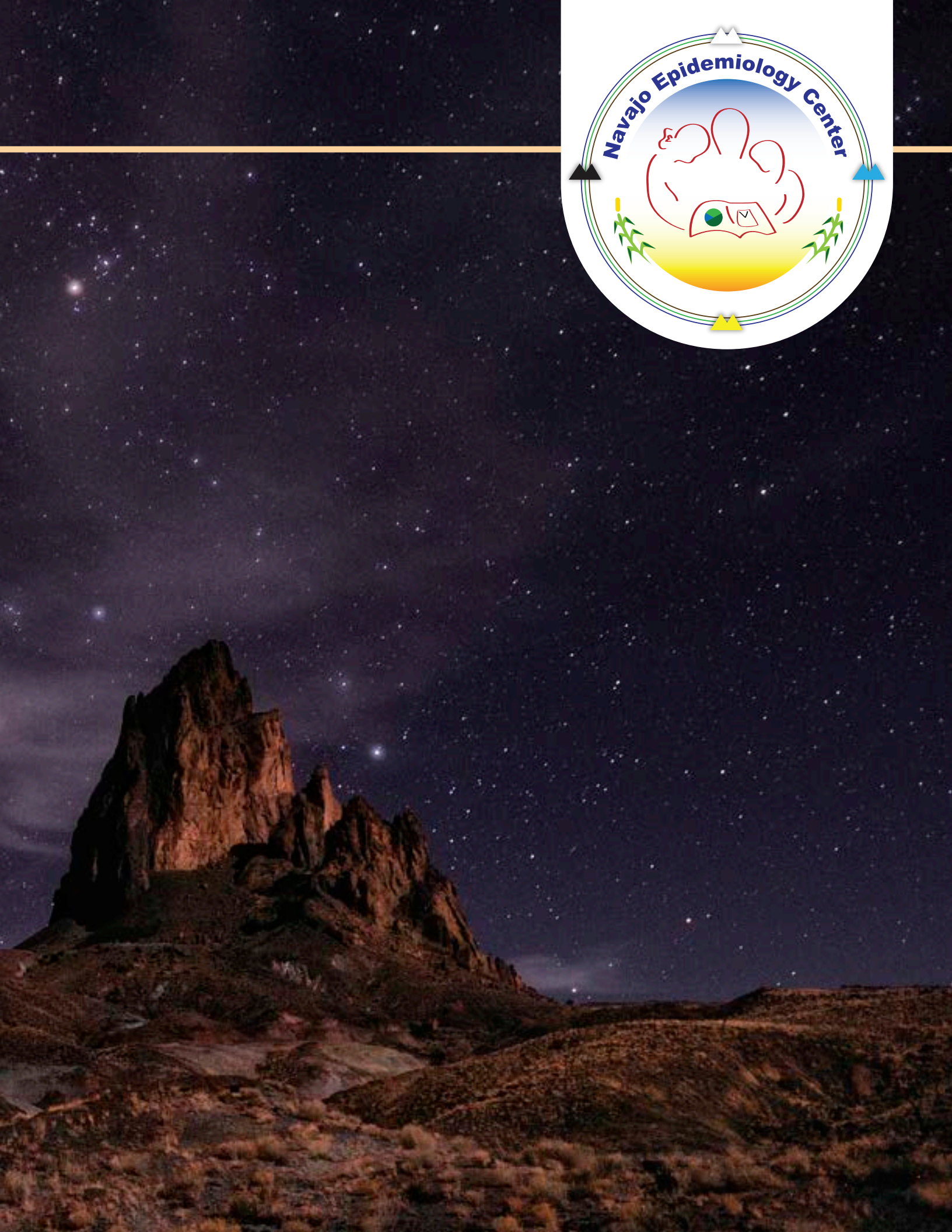

Navajo Epidemiology Center

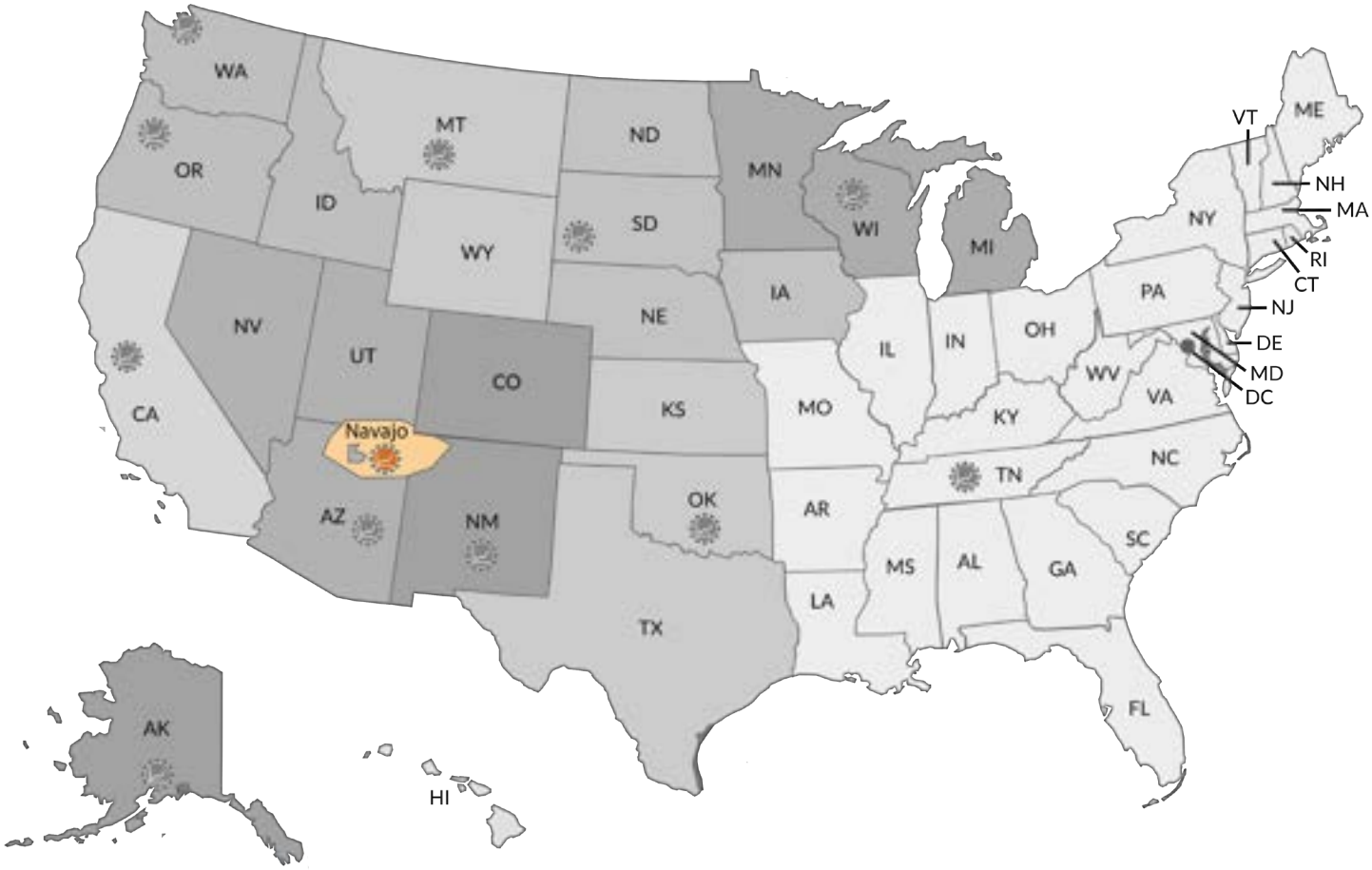
NEC Region & Parent Organization

The Navajo Nation is a three-branch (executive, legislative, judicial) government with the Executive Branch led by the Navajo Nation President and Vice President. The Legislative Branch is led by the Navajo Nation Speaker and Council members, and the Judicial Branch is led by the Chief Justice of the Navajo Nation. The Navajo Department of Health and its Navajo Epidemiology Center sits within the Executive Branch. The Navajo Epidemiology Center is one of fifteen programs within the Navajo Department of Health.

American Indian/Alaska Native (AI/AN) Population in the Navajo Area

The Navajo (Diné) people live in the largest American Indian reservation in the US. The reservation covers more than 27,000 square miles, extending into Arizona, Colorado, New Mexico, and Utah. The Navajo Nation consists of five regions (also known as agencies), and across these regions are small communities (also known as Chapters) that have an average population of approximately 1,700 residents.

Chapters function as the smallest level of government, where governance and planning are conducted by local elected officials. By population, Navajo is now estimated to be the largest American Indian Tribe in the United States. It has nearly 400,000 enrolled Tribal members, of whom nearly half live on the Navajo reservation.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NEC Overview, Highlights, & Accomplishments

Established in 2005, the Navajo Epidemiology Center (NEC) is the only Tribal Epidemiology Center located on Tribal lands. The NEC manages the Navajo Nation's public health information systems, investigates diseases and injuries, provides data and reports to help health program management, conducts health research, responds to public health emergencies, and coordinates these activities with other public health authorities. The NEC has developed important collaborations to enhance its data reporting infrastructure, with a focus on providing health data relevant to the Navajo people.

Expectations of the NEC are to:

- Identify the Navajo health status priorities for the Navajo Nation.
- Develop/disseminate Navajo health reports.
- Develop disease surveillance/prevention/control, including notifiable condition reporting, and conduct a Navajo Behavioral Risk Factor Surveillance System (also known as the Navajo Nation Health Survey – NNHS).
- Assist in public health emergencies – outbreak response.

To accomplish these expectations, NEC launched the NNHS, assisted in generating Navajo Community Health Profiles, built upon the Navajo Area IHS data sharing agreement, developed and obtained data sharing agreements with other health care providers on the Navajo Nation, such as P.L. 93-638 Tribal corporations and private health providers, identified and accessed high-quality health data, and disseminated epidemiological Navajo specific health reports.

NEC Accomplishments

Worked with key partners (Tribal programs, IHS, Tribal health organizations, state health departments, academic institutions, and nonprofit organizations) to conduct COVID-19 disease surveillance, including hospitalization and vaccination coverage.

Worked with key partners (Tribal programs, IHS, Tribal health organizations, state health departments, academic institutions, nonprofit programs, and the Centers for Disease Control and Prevention), to conduct disease surveillance and manage the data to help with data visualization.

Shared its reports with leaders, stakeholders, and the public to help with making informed decisions. The reports can be found on the NEC website: nec.navajo-nsn.gov.

Received two awards from Navajo Area Indian Health Service for excellence in COVID-19 disease surveillance (2021 and 2022), data analysis and data sharing for the Navajo Nation.

Produced Cancer Among the Navajo, 2014-2018, report. As of 2024, it's the only Tribal-specific cancer report in the United States. The report covers cancer incidence, mortality, screening, and stage of diagnosis.

Produced the first-ever Navajo Nation's Active Bacterial Surveillance (ABS) report. The ABS provides population-based estimates of disease burden for the Navajo Nation as a whole. It is modeled after the Centers for Disease Control and Prevention's Active Bacterial Core surveillance, which provides disease burden estimates for the general United States. By monitoring invasive bacterial infections over time, ABS allows for evaluation of the impact of interventions, like vaccines, and guides vaccine recommendations that are most beneficial to Indigenous communities.

Produced Navajo Nation's Mortality Report 2017, and Hospitalization and Emergency Room Rates Report 2021. The purpose of the report is to further describe which diseases, health conditions, and types of injury are contributing to the mortality and morbidity burden of the Navajo Nation. The data can be used by programs, projects, departments, divisions, and organizations to understand where resources can and should be allocated.

Conducted second-round of the Navajo Nation Health Survey (also known as Behavioral Risk Factor Surveillance System).

Evaluated the Navajo Nation Healthy Diné Nation Act Policy: A Two Percent Tax on Foods of Minimal-to-No Nutritious Value, 2015–2019. It summarizes tax revenue and disbursements from the Navajo Nation Healthy Diné Nation Act of 2014, which included a 2% tax on foods of minimal-to-no nutritional value (junk food), the first in the United States and in any sovereign Tribal nation.

NEC Aims

- Build epidemiology workforce capacity and training opportunities.
- Strengthen existing partnerships and forge new ones.
- Conduct disease surveillance and survey activities.
- Build capacity to respond to disease outbreaks by creating data use agreements, protocols for data sharing and analytics, development of models for forecasting and scenario projection, expansion of models to arboviruses and sexually transmitted infections (STIs), and expansion of models to higher spatial and social resolution. The aim is to be able to use these models in populations like the Navajo Nation, county level estimates (instead of just state or national), subpopulations, etc.
- Support easy access to COVID-19 testing for Elders and other key groups by training and empowering community health workers to assist with distribution and administration of self-tests.
- Promote strong confidence in vaccines by understanding facilitators and barriers to uptake of recommended vaccines, and providing evidence-based training and education to optimize vaccine uptake.
- Adapt and evaluate an evidence-based culturally congruent, home-based intervention to support Navajo adults living with Long COVID by promoting knowledge, coping resources, and responses that lead to improved holistic health.
- Develop a cloud-based computing system to house data in a more secure environment with analytics and reporting capability.

COVID-19 Pandemic – Closing Gaps and Strengthening Disease Surveillance

The Navajo Epidemiology Center (NEC) played a critical role in assisting with making data-driven decisions by collecting and analyzing data and using them to develop appropriate strategies and activities for COVID-19 response on the Navajo Nation. NEC worked with partners (Tribal programs, Indian Health Service, Tribal health organizations, state health departments, academic institutions, nonprofit programs, and the Centers for Disease Control and Prevention), to conduct COVID-19

disease surveillance, perform contact tracing, and manage the data to help with data visualization. NEC also shared its daily COVID-19 situational reports with leaders, partners, and the public to help with making informed decisions.

Sustainable COVID-19 disease surveillance thrived at the intersection of epidemiology and public health science, data sharing, community connection, strong partnerships, and the shared belief that we are stronger together. Through such partnerships, the Navajo Nation COVID-19 epidemiology team was better able to detect public health risks as early as possible on the Navajo Nation. COVID-19 disease surveillance quickly captured information from a variety of sources about unusual or unexpected health events. In addition to monitoring events, NEC and its partners were able to measure how many illnesses and deaths were caused by COVID-19 and other infectious pathogens. This provided vital information to help public health officials and Navajo Nation leadership when designing programs to control future outbreaks.

Active Bacterial Surveillance (ABS)

With approval from the Navajo Nation Human Research Review Board and in collaboration with the Johns Hopkins Center for Indigenous Health, Arizona and New Mexico Departments of Health, and 21 Indian Health Service, Tribal, and private health facilities serving the Navajo Nation, the surveillance team conducts active, laboratory-based surveillance for invasive bacterial disease caused by Streptococcus pneumoniae, Haemophilus influenzae, Neisseria meningitidis, Staphylococcus aureus, and group A Streptococcus. Cases of invasive disease caused by these bacteria are included if the individual is an Indigenous person living in or near the Navajo Nation and receiving care at a participating facility. ABS is laboratory-based with no contact with patients. It provides population-wide estimates of disease burden for the Navajo Nation as a whole. It is modeled after the Centers for Disease Control and Prevention's Active Bacterial Core surveillance, which provides disease burden estimates for the general United States. By monitoring invasive bacterial infections over time, ABS allows for evaluation of the impact of interventions, like vaccines, and guides vaccine recommendations that are most beneficial to Indigenous communities.

Cancer Among the Navajo

In response to professional and community concerns about cancer being a major health issue among Navajo residents of the Navajo Nation, the Navajo Epidemiology Center and its Navajo Cancer Workgroup published its latest report, Cancer Among the Navajo, 2014-2018. The report was produced to update the findings of previous reports, Cancer Among the Navajo, 2005-2013, and Cancer Among the Navajo, 1995-2004, and to increase the current understanding of cancer among the Navajo people. The latest report presents cancer data among people of the Navajo Nation, a large Tribal nation both geographically and by population in the United States. It examines cancer incidence (new cases), stage of diagnosis, mortality, trends, and cancer screening behaviors among the Navajo people for the years 2014-2018. In addition, the report provides recommendations and resources to improve cancer prevention and care for the Navajo Nation. Patients, family members, medical and public health professionals, educators, community members, policy makers, Tribal program administrators and staff are encouraged to use all the reports to improve cancer prevention, education, and treatment.

The Navajo Cancer Workgroup was formed to support the efforts of Navajo Nation leaders to improve cancer prevention and care by utilizing and improving cancer data. The workgroup aims to:

- Evaluate and improve cancer data quality and monitoring.
- Empower and engage communities around cancer prevention.

- Support and improve Navajo Area health programs.
- Produce Navajo specific cancer reports to inform and educate Tribal leaders, community members, public health professionals, medical providers, Navajo Nation health programs, and local, state, and federal agencies.

Members of the Navajo Cancer Workgroup are recognized and commended for their contribution to this report in the following table.

Table 1. Navajo Cancer Workgroup Members

Name	Organization
Monique Adakai	Navajo Area Indian Health Service
Curtis Briscoe	Navajo Breast and Cervical Prevention Program
Shawnell Damon	Navajo Area Indian Health Service
Dirk De Heer	Northern Arizona University
Dana Doyle	Arizona Cancer Registry/ADHS
Marc Emerson	University of North Carolina at Chapel Hill
Timothy Flood	Arizona Cancer Registry/ADHS
Carol Goldtooth	Northern Arizona University
Melissa Jim	Centers for Disease Control and Prevention
Chesleigh Keene	Northern Arizona University
Chelsea Kettering	Navajo Area Indian Health Service
Peter Lance	University of Arizona Cancer Center
Angela Meisner	New Mexico Tumor Registry
Chris Newton	Arizona Cancer Registry/ADHS
Dornell Pete	Fred Hutchinson Cancer Center
Priscilla R. Sanderson	Northern Arizona University
Hannah Sehn	Community Outreach and Patient Empowerment
Melinda Smith	Northern Arizona University
Sheldwin Yazzie	Albuquerque Area Southwest Tribal Epidemiology Center
Charles Wiggins	New Mexico Tumor Registry
Del Yazzie	Navajo Epidemiology Center
Georgia Yee	Arizona Cancer Registry/ADHA

Hospitalization & Emergency Room Report

Through a partnership with the Indian Health Services (IHS), the Navajo Epidemiology Center (NEC) creates an annual hospitalization and emergency room report. The data is provided by IHS through their Epi Data Mart (EDM). The EDM includes millions of records of clinical data from all providers that provide health care services on the Navajo Nation (e.g. IHS, compacted Tribal health centers, private clinics). From these records, the NEC organizes health conditions and treatments into the 113 select causes created by the National Center of Health Statistics (NCHS), along with additional categories of interest to the Navajo Nation (e.g. hantavirus). Rates are then calculated using U.S. Census data and age-adjusted to the 2000 U.S. population. The Hospitalization report helps to identify key causes of morbidity on the Navajo Nation and to establish trends across time. The report can inform policy makers and program planners in advocating for funds for the Navajo Nation, evaluating current efforts to address leading causes of morbidity, and to identify emerging public health focus areas.

Navajo Nation Mortality Report

The Navajo Epidemiology Center has data sharing agreements with the three states that overlap the Navajo Nation. Each state provided death record data for all Navajo people with a place of residence found on the Navajo Nation or within one of its border towns. Three years of data (2015-2017) were compiled to smooth the data and allow for stable rates, since the count for many rare causes of death are low on the Navajo Nation. Causes of death were classified according to the International Classification of Diseases, 10th Revision and reported by underlying cause of death in similar fashion to the National Vital Statistics Reports Volume 68, Number 9. Deaths were also organized according to the National Center for Health Statistics 113 select causes of death.

Deaths were organized by 10-year age groups and age-adjusted rates were calculated using the 2000 U.S. population as the standard population. Some causes of death that are of unique importance to the Navajo Nation but not at the state and national level are also included in this report (e.g. cold exposure, alcohol dependence, animal rider).

The purpose of this mortality report is to quantify the leading causes of death among Navajos living within the borders of the Navajo Nation and its border towns. The report also highlights key mortality differences between genders and age groups. Age-adjusted rates allow comparisons between the Navajo Nation and other geographical locations, including the United States, Arizona, New Mexico, and Utah. Tracking these rates can help health programs evaluate their progress in reducing the burden of these diseases and inform decision makers in the allocation of resources. The NEC is working to update data sharing agreements with state partners to update the mortality report with more current data and to further assess the impact of Navajo COVID-19 disease mortality.

Health Policy Evaluation: Healthy Diné Nation Act (Junk Food Tax)

Navajo Tribal Council passed the Healthy Diné Nation Act (HDNA) in November 2014 to promote the health of the Navajo people. HDNA enacted a 2% tax on unhealthy or minimal-to-no nutritional value foods (junk foods). It was the first such law in the United States and in any sovereign Tribal nation. The HDNA law defines these foods as sweetened beverages, prepackaged and non-prepackaged snacks stripped of essential nutrients and high in salt, saturated fat, and sugar, including sweetened beverages, sweets, and chips and crisps. Aligned with Tribal government structures, HDNA tax revenues were allocated for disbursement directly to each of 110 Navajo Nation communities, also called Chapters, with an average of about 1,600 residents. Funds were disbursed for local wellness programming such as farming, traditional food demonstrations, exercise equipment, walking trails, and community cleanup.

The policy evaluation summarized the tax revenue and disbursements from the Healthy Diné Nation Act of 2014. Since the tax was implemented in 2015, its gross revenue has been $7.58 million, including $1,887,323 in 2016, the first full year. Revenue decreased in absolute value by 3.2% in 2017, 1.2% in 2018, and 4.6% in 2019, a significant downward trend. Revenue allocated for wellness projects averaged $13,171 annually for each local community, with over 99% successfully disbursed. More rural areas generated significantly less revenue. The results provide context on expected revenue, decreases over time, and feasibility for Tribal and rural communities considering similar policies.

Tackling Hantavirus with Healthy Homes, Healthy People Partnership

Truly impactful, sustainable public health programs are nurtured and ultimately thrive at the intersection of public health science, community connection, strong partnership, and the shared belief that, together, our impact is greater. The Healthy Homes, Healthy People (3HP) project is a unique example of such a collaboration. The program aims to reduce the risk of exposure to hantavirus among residents of the Navajo Nation by providing rodent exclusion interventions and empowering residents to repair and reinforce their homes against rodents, and to increase awareness of hantavirus and its prevention among community members.

The historical context behind this project is significant. In 1993, an outbreak of severe pulmonary disease in humans was reported on the Navajo Nation. An investigation and laboratory testing confirmed the deer mouse, abundant in many parts of North America, was the rodent host for a newly recognized virus. Transmission of hantavirus to people can occur when fresh deer mouse urine, droppings or nesting materials are stirred up through activities such as sweeping up dust materials at home. Once the infectious process has begun,

the cells lining the inside of the lung start to leak fluid into the airspaces, inhibiting breathing and, in the most severe cases, causing death.

The Centers for Disease Control and Prevention (CDC) continues to see human cases of hantavirus infection in the United States, including the severe form, called hantavirus pulmonary syndrome. Of the 728 cases reported in 36 states as of January 2017, 45% were reported in the "Four Corners" area shared by Arizona, New Mexico, Colorado and Utah—each part of, or adjacent to, the Navajo Nation. Mortality rates for cases on the Navajo Nation are approximately 44%. Given the absence of a vaccine or other medication, prevention remains the most effective public health measure. In particular, rodent exclusion efforts in homes and buildings contribute significantly to keeping deer mice away from people.

Sustainability and empowerment coexist at the heart of the 3HP project. Program activities include training local carpenters and data collectors in safe methods for detecting, assessing, reporting and repairing points of rodent entry, along with disinfecting and removal of potentially infectious materials from homes. The 3HP project also includes an education and training component aimed at homeowners to empower them with knowledge to safely and properly disinfect and dispose of rodent-infested materials.

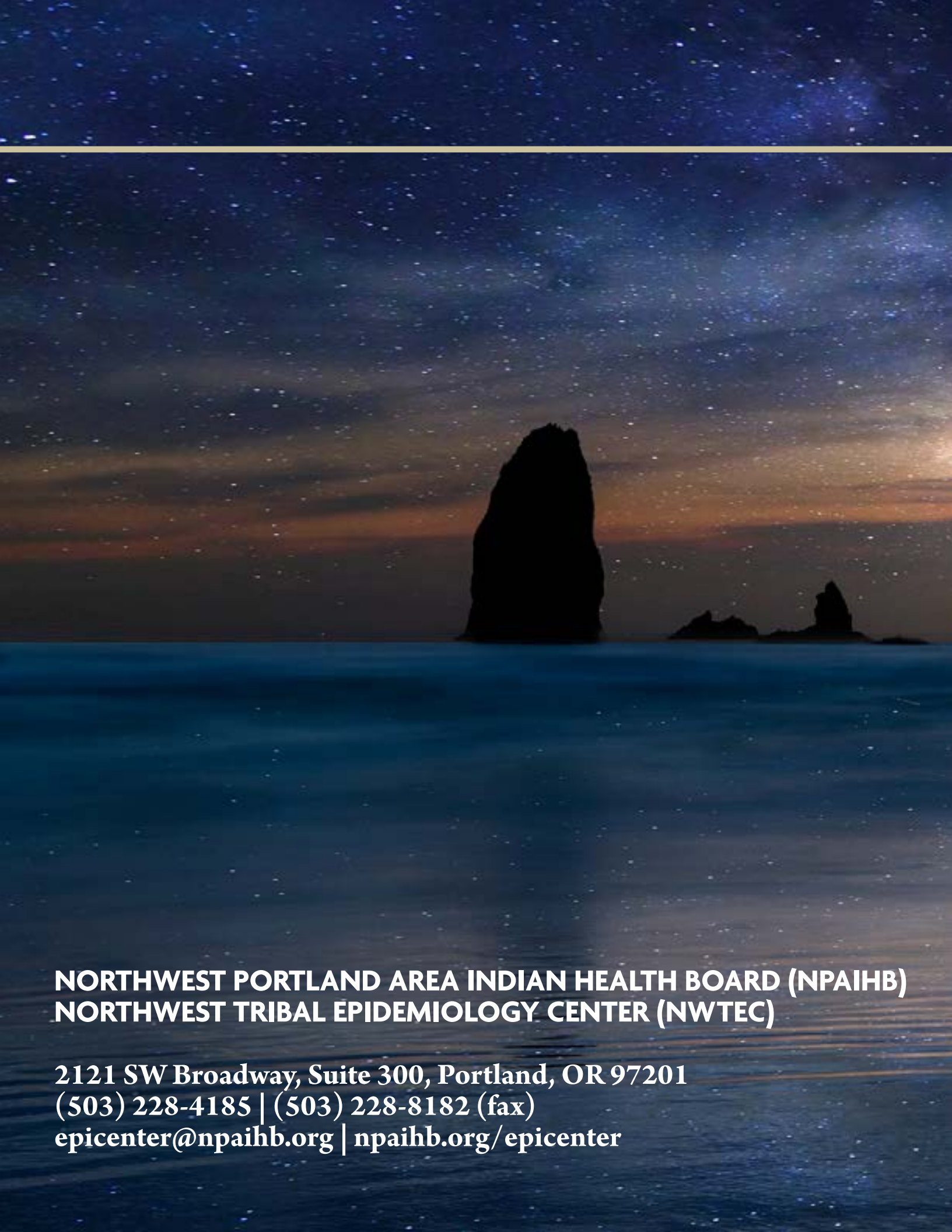
Navajo Nation Health Survey

A Tribal Behavioral Risk Factor Surveillance System

The Navajo Nation Health Survey (NNHS) is a collaborative project between NEC and Indian Health Service through a cooperative agreement grant. The objective is to develop a Behavioral Risk Factor Surveillance System (BRFSS) specific to Tribal nations to evaluate health risk behaviors of the adult population residing on the Navajo Nation. Key data findings from NNHS results provide insight toward devising health status objectives based on epidemiologic data among the adult population.

The NNHS was conducted in 2013, 2015, and 2016, and 2022 during the months of March through September. Teams of interviewers were mobilized into select Navajo Nation Chapter communities. Upon visitation to a home, one adult individual per household was chosen to participate in the NNHS. Each participant signed an informed consent form acknowledging the purpose of the health survey, procedures, risks, and benefits of their voluntary participation in the NNHS. By obtaining participant consent before interviewing, this agreement between the participant and the NEC established an entrusted responsibility to keep participants informed of the outcome of the health survey results. All interviews were conducted in person. Individuals of all races residing on the Navajo Nation were eligible to participate.

The work of the NEC to implement the NNHS has received national recognition. Simental R. Francisco, Project Manager and Principal Investigator of NNHS, submitted an abstract titled, "Initial Data Finding from Results of the Navajo Nation Health Survey: A Foundation for Development of a Navajo Behavioral Risk Factor Surveillance System" to the Council of State and Territorial Epidemiologists (CSTE) conference in 2019. The abstract was accepted and selected as a finalist for the Robert Wood Johnson Foundation Award, a national award for Outstanding Epidemiology Practice in Addressing Racial and Ethnic Disparities. There were 840 abstracts submitted for participation in the 2019 CSTE annual conference. Five finalists were chosen from those abstracts that met criteria for consideration of the award, including Mr. Francisco's abstract. This is the first national recognition the NEC has earned for its work on the Navajo Nation Health Survey project.



NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD (NPAIHB)
NORTHWEST TRIBAL EPIDEMIOLOGY CENTER (NWTEC)

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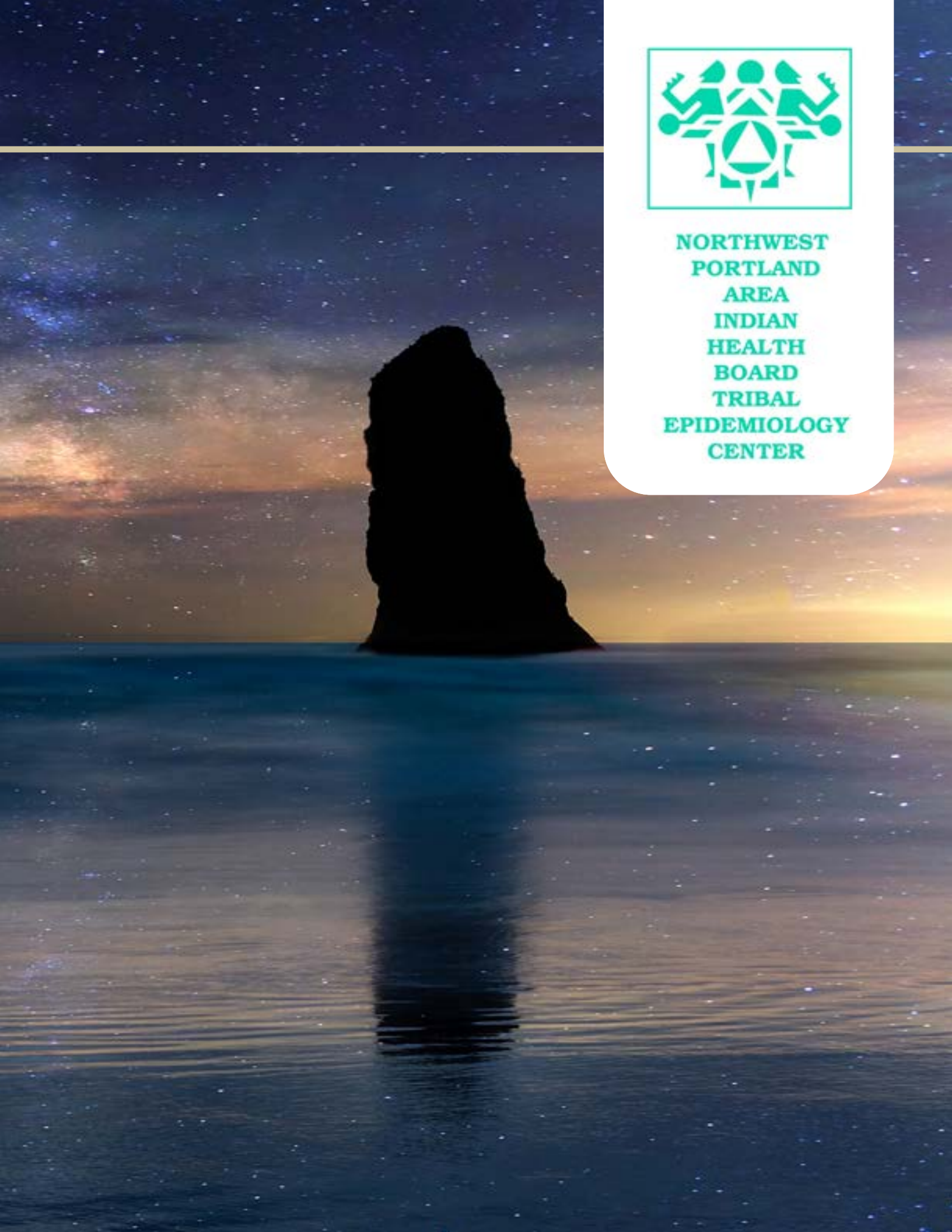


NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD TRIBAL EPIDEMIOLOGY CENTER

NWTEC Region & Parent Organization

The Northwest Tribal Epidemiology Center serves under the auspices of the Northwest Portland Area Indian Health Board (NPAIHB), a Tribal organization as defined by Public Law 93-638 and a 501(c)(3) nonprofit organization that is owned and operated by the 43 federally recognized American Indian Tribes of Idaho, Oregon, and Washington.

Established in 1972, NPAIHB's mission is to assist Northwest Tribes to improve the health status and quality of life of member Tribes and Indian people in delivering culturally appropriate and holistic health care.

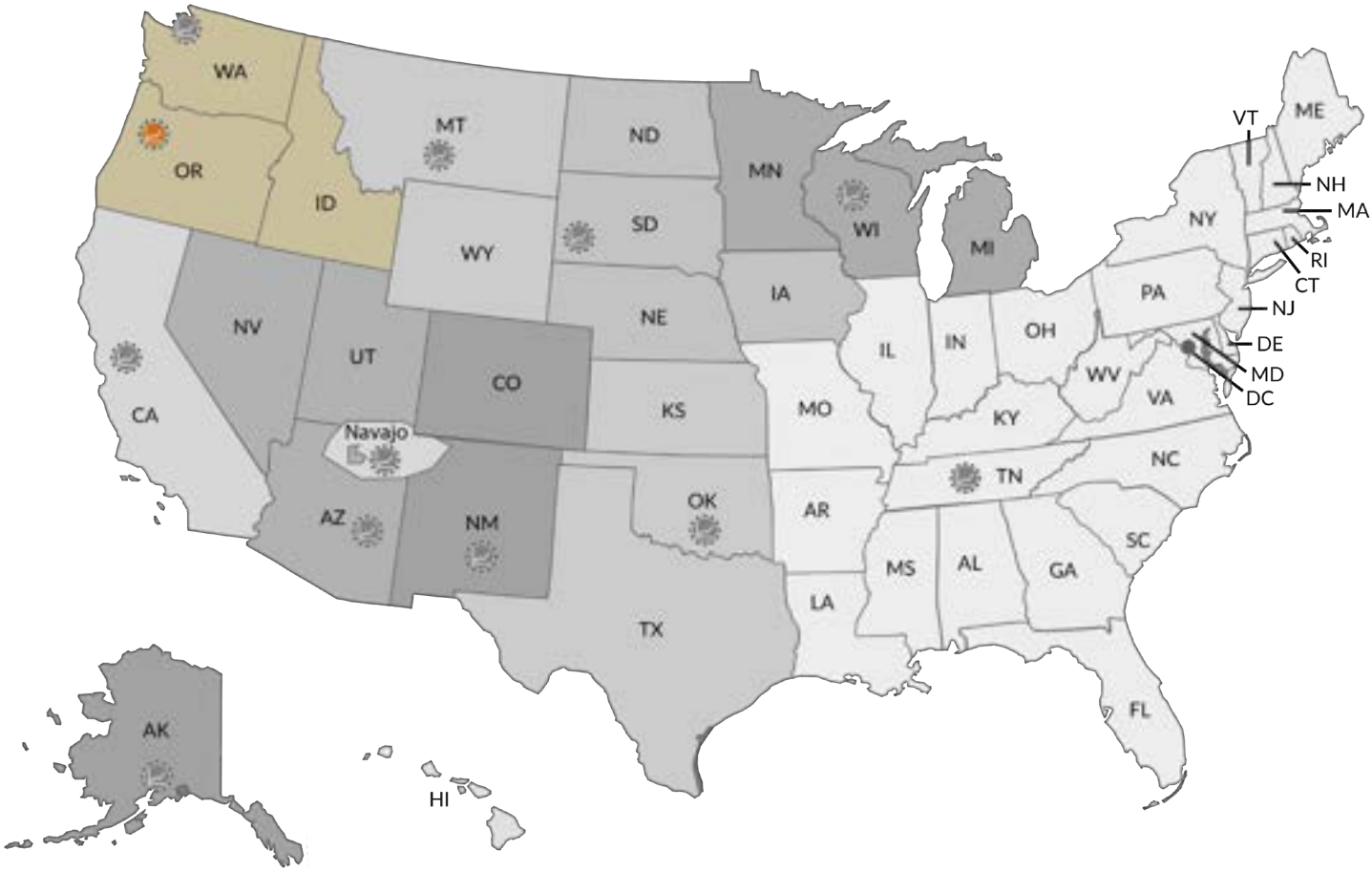
Delegates are the cornerstone of NPAIHB, providing direction and guidance on health-related legislative activities, program direction and activities, NPAIHB program operations, and the organizational strategic plan. NPAIHB is proud of the many contributions that our member Tribes have made to Indian-related health issues in the Northwest and Indian Country.

American Indian/Alaska Native (AI/AN) Population in the Portland Area

As of 2022, an estimated 444,188 AI/AN – alone or in combination with other races – lived in the Northwest region, making up 3.2% of the total population in these states[29]: Idaho (51,991 AI/AN people), Oregon (146,564 AI/AN people), and Washington (245,633 AI/AN people). There are 43 federally recognized Tribes in the Portland Area: five in Idaho, nine in Oregon, and 29 in Washington. The majority of the Indian Health Service (IHS) funded facilities in the Portland Area are governed by Tribes and sanctioned by Public Law 93-638. There are four Tribally-governed facilities in Idaho, 13 in Oregon, and 34 in Washington. The IHS operates nine service units directly, including five reservation-based facilities, four Urban Indian Organizations (including the Seattle Indian Health Board), and one school-based clinic.

According to the Indian Health Service, the most recent (FY2021) Indian user population estimate for the Portland Area was 114,894.

[29] Data Source: U.S. Census Bureau. "Total Population." American Community Survey, ACS 5-Year Estimates Detailed Tables, Tables B02010 and B01003, 2022. Accessed on February 5, 2024. data.census.gov/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NWTEC Overview & Highlights

NPAIHB received funding in 1997 for the development of the Northwest Tribal Epidemiology Center (NWTEC), with the goal to assist member Tribes to improve their health status and quality of life. NWTEC was one of four centers originally funded following advocacy from Tribal leaders who felt that having Tribal access to accurate data would help public health planning, advocacy and ultimately increase knowledge that can lead to the elimination of health disparities.

The mission of NWTEC is to collaborate with Northwest American Indian Tribes to provide health-related research, surveillance, and training to improve the quality of life of AI/AN people.

Goals

NPAIHB delegates identify Tribal health research and surveillance priorities on an annual basis. NWTEC's current goals include:

- Assisting communities in implementing disease surveillance systems and identifying health status priorities.
- Providing health-specific data and community health profiles for Tribal communities.
- Conducting Tribal health research and program evaluation.
- Partnering with Tribal, state, and federal agencies to improve AI/AN health data quality and accuracy.

NWTEC Staff

NWTEC along with all grant-funded projects it administers, has over 40 employees and consultants. These include a PhD level Director, two medical epidemiologists (including an IHS assignee), ten epidemiologist/biostatisticians, seven senior project directors, eight project directors, several PhD level Principal Investigators, 19 project managers, coordinators, and project specialists, and over a dozen Tribally-based or off-site staff and consultants. NWTEC also regularly offers internship opportunities to a small number of Tribal members and/or college and university students.

NWTEC Highlights

Over the years NWTEC has generated seminal reports that have allowed our member Tribes to have enhanced health information for those living in the NW.

Key among those have been the Tribal specific Behavioral Risk Factor Surveillance System (BRFSS), and data linkage projects, which began with cancer linkages, but has broadened significantly in the past five years.

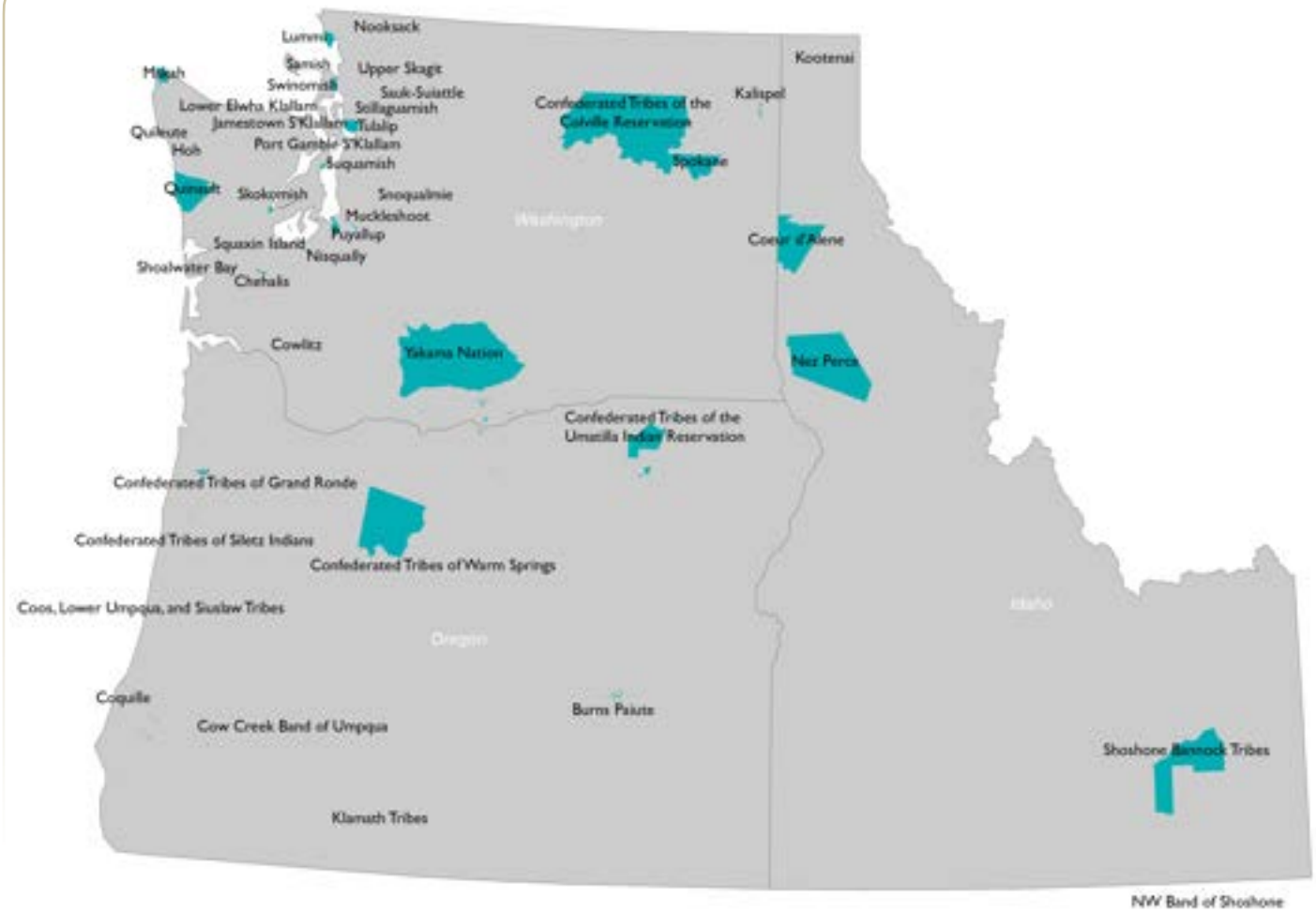
NWTEC has also developed a strong surveillance and research portfolio, which has funding from the IHS, the National Institutes of Health (NIH), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Centers for Disease Control and Prevention (CDC). Funding is also gathered from other non governmental organizations. Projects such as those described below have been an important focus for NWTEC.

Improving Data & Enhancing Access (IDEA-NW)

Health status assessment for racial/ethnic groups is often hindered by the lack of complete and accurate data on race/ethnicity in surveillance systems, and AI/AN people are more likely to be misclassified than patients of other races. Errors may be compounded when systems interact. For example, cancer and other disease registries rely on death records for demographic data.

Death certificate race data is often recorded by coroners, funeral directors, or medical examiners based on the decedent's appearance or other information. There

Tribes Served by NWTEC



may be hesitation to ask the next-of-kin questions about the decedent's race or the next-of-kin may not answer as the decedent would have.

The net result of racial misclassification for AI/ANs is the undercounting of health events and underestimated disease and mortality rates.

In response to this problem, NWTEC formed the Northwest Tribal Registry Project in 1999 to conduct record linkages with various public health datasets. This project evolved into the IDEA-NW (Improving Data & Enhancing Access) program. with funding from the Agency for Healthcare Research and Quality between 2010-2013.

Further CDC funding and movement of the Biostatistics/Epidemiology Core under IHS Core funding have allowed the staff to embark on a data modernization effort, including developing a Data Hub to serve Northwest Tribes.

IDEA-NW's goals are to improve the validity and reliability of AI/AN race data in state data systems and

increase the availability of accurate and complete health status data for Northwest Tribal communities, to inform public health decision-making and efforts to eliminate health disparities.

Improving race data in state data systems is achieved through record linkages with a list of known AI/ANs in the Northwest, the Northwest Tribal Registry (NTR). The NTR is generated from the registration data of the IIHS and Tribal clinics in the Northwest, and it includes only demographic information (no health status or diagnostic information). Through a partnership with the Seattle Indian Health Board/Urban Indian Health Institute, the data set has been augmented better to represent AI/AN people living in urban areas.

Epidemiology and Surveillance Unit

NWTEC began a unit for Epidemiology Services and Surveillance during the COVID-19 pandemic. It provided up-to-date surveillance data, hospitalization, and healthcare data on infectious disease, behavioral health, and substance use disorder healthcare visits. This group provides detailed training and technical assistance to Tribes upon request.

The Epidemiology and Surveillance Unit is responsible for developing community health profiles using existing data sets. As of 2024, the NWTEC had about 50 data sets to work with in-house.

Immunization Monitoring and Promotion Programs

Our communities have worked hard to thrive by protecting each member, including our most vulnerable. Today we can protect ourselves and others by getting vaccinated.

In October 2008, NWTEC began the Immunization initiative in the Portland Area Indian Health Service to improve the rate of immunization coverage for children from birth to young adulthood. The Immunization Program works with all IHS and Tribal clinics in Idaho, Oregon, and Washington. Services offered to all sites include gathering data quarterly through Resource and Patient Management System (RPMS) or electronic health records, evaluating clinic data, and assisting in procuring vaccine supplies as needed.

Additional vaccine promotion activities have been undertaken since 2020, including the VaccINative Initiative (indiancountryecho.org/vaccinative/) and Native Boost.

VacciNative is a national alliance of elders, clinicians, and public health professionals dedicated to sharing accurate vaccine information for Native people by Native people. This alliance includes many of our TEC partners, working on the front lines to promote vaccination.

NWTEC Partnerships

NWTEC collaborates with its member Tribes, other organizations focusing on Indian health, colleges and universities, and state health departments. It also has collaborative relationships with the other TECs. Funding partners include the IHS, the CDC, NIH, SAMHSA, the Health Resources and Services Administration (HRSA), and foundations.

We R Native

We R Native is a multimedia health resource for Native teens and young adults. It includes a website (weRnative.org), a weekly text messaging service, social media (Facebook, YouTube, X), and print marketing materials.

The goal of We R Native is to provide holistic adolescent health information, promote positive youth development, share youth-friendly health media and current events, encourage healthy behaviors, reinforce positive messages, increase cultural identity and pride, and create a safe place where Native youth feel comfortable, empowered, and connected to other Native youth. The service is funded by the President's National HIV/AIDS Strategy and the IHS.

Northwest Native American Research Center for Health (NW NARCH)

The overall goal of NW NARCH is to increase the number of well-trained AI/AN researchers capable of conducting biomedical, clinical, behavioral, or population-based research in diverse settings, especially focusing on projects relating to Tribal health.

Carefully designed and implemented health research can provide solutions to help eliminate the vast disparities in health between AI/AN and non-AI/AN people. The IHS and the National Institutes of Medicine have a joint partnership supporting the NARCH programs. NW NARCH at NPAIHB hosts the Summer Research Training Institute for AI/AN health professionals annually.

The Institute regularly provides short-term, intensive education to more than 100 Tribal members, students, and Tribal Epidemiology Center employees. Topics are broad-reaching and cover many aspects of public health, grant writing, and data management. NW NARCH also has active research projects focusing on encouraging high school youth to enter public health research careers.

NWTEC Best Practice Approaches

Data Modernization: Northwest Tribal Data Hub

Health data in the Pacific Northwest routinely leave Tribal communities through hospital, state, and federal systems, but rarely return to benefit Tribal communities, leaving them disconnected from the information generated by their own people. NWTEC has worked since it was created to access, improve, and analyze these health data on behalf of NPAIHB's 43-member Tribes. However, the ability to efficiently return these data to Tribes is hampered by disconnected data systems and manual processes that require considerable time and resources.

The solution we envision is the Northwest Tribal Data Hub (Data Hub), designed to ensure data lifecycles are cyclical and return usable data to their community of origin. This is analogous to the cyclical lifecycle of salmon, which have a deep connection with Northwest Tribes. Salmon begin and end their lifecycles in high mountain river systems of the Pacific Northwest. During the middle of the lifecycle, they live in the ocean, gaining nutrients that in turn sustain high mountain river systems. Data returning to communities will similarly strengthen those communities. Data informs health policy and systems, communities, and leadership to improve health programming, inform funding proposals, and focus interventions on the community's needs. The NWTEC hopes to utilize the Data Hub as a tool to ensure data complete their lifecycle, returning home to enrich Tribes by providing the building blocks communities need to grow and thrive for future generations.

Increasing Tribes' access to and ownership of data through modernized data systems

The Data Hub seeks to modernize the NWTEC's data systems and processes and connect Tribal nations with data for their communities. Initially, the Data Hub will utilize data obtained from state and federal agencies, including vital records, disease registries, and health surveys. In many cases, the NWTEC has improved these data through record linkages to correct the misclassification of AI/AN people as other races.

Each dataset will be migrated to a cloud-based database and updated as new data become available. NWTEC analysts will utilize the data and cloud-based analytic tools to develop dashboards that report key information on specific topic areas. The dashboards will provide aggregated data specific to each Tribe's service area, state, and the broader Northwest region, and will allow comparisons between the AI/AN population and selected reference populations to measure disparities. Tribes will access the dashboards through a secure login, and can view, interact with, and download data related to public health.

For its initial launch, the Data Hub will report data on overdose deaths, thereby addressing a priority area for Northwest Tribes. Over time, additional dashboards will be created to address Tribal health priorities, eventually resulting in a comprehensive community health profile for each Tribe.

The NWTEC will utilize a comprehensive evaluation approach to refine the data and dashboards available through the Data Hub, as well as the onboarding processes and resources to support Tribes' use of the Data Hub. As the Data Hub develops and expands, the NWTEC will collaborate with Tribes on data governance strategies to support Tribal ownership of the Data Hub.

In an era where data plays a pivotal role in public health initiatives, the Northwest Tribal Data Hub emerges as a groundbreaking initiative to support Tribal data sovereignty. The Data Hub is designed to foster

collaboration, enhance decision-making processes, and ultimately improve the well-being of Northwest Tribal communities.

Opioid Data Work: Epidemiology and Surveillance

The Epidemiology & Surveillance Unit provides routine surveillance, data analysis, and reporting to Northwest Tribes. Thanks to the record linkage project conducted by the Improving Data & Enhancing Access (IDEA-NW) Project, much of the data that is provided to Northwest Tribes is corrected for racial misclassification.

As part of the CDC opioid supplement funding, opioid and drug overdose data briefs have been created to help inform Northwest Tribes of the burden of opioid and drug overdoses in their communities.

Data Linkage

IDEA-NW project staff link death certificate data with "Northwest Tribal Registry" clinic registration data from Indian Health Service (IHS), Tribal, and urban Indian facilities. When a match is found, the race on death certificates is reclassified as American Indian/Alaska Native (AI/AN)

For opioid and drug overdose data briefs, the data source for these linkages were Washington state death certificate data, 1990-2016 (Center for Health Statistics, Washington State Department of Health); Oregon death certificate data, 1999-2020 (Center for Health Statistics, Oregon Health Authority); and Idaho death certificate data, 1999-2020 (Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare). AI/AN records used in the analysis were those indicating AI/AN race on death certificate and/or which matched with the Northwest Tribal Registry. Overdose deaths were selected using ICD-10 underlying cause of death codes and data for state and national averages were selected for comparison.

Findings

The death rate from drug overdose among AI/AN in Washington State was 43.1 per 100,000 people in 2016. This rate is almost 3 times the Washington State average and the national AI/AN rate. The rates for AI/AN overdose deaths in Washington have increased 36% since 2012 and almost 300% since 2000. Without the data linkage, the age-adjusted rate of AI/AN overdose deaths would have been underestimated by up to 24%.

In 2020, the mortality rate from drug overdoses among AI/AN in Oregon was 45.2 per 100,000 people. This rate is 2.6 times higher than the Oregon state average and 1.7 times higher than the national AI/AN rate. While national and state averages have also increased in the past five years, the rate among AI/AN populations in Oregon has increased by 158.5% compared to an increase of 59.1% in Oregon, 42.9% nationally, and 70.3% among AI/AN nationally. Without the data linkage, the age-adjusted rate of AI/AN overdose deaths would have been underestimated by up to 46%.

The death rate from drug overdose among AI/AN in Idaho (ID) was 27.0 per 100,000 people in 2020. This rate is 1.7 times higher than the Idaho average and nearly equal to the national AI/AN rate. Over time, the rate among AI/AN in Idaho tends to be higher than the state average and consistent with national trends. Without the data linkage, the age-adjusted rate of AI/AN overdose deaths would have been underestimated by up to 23%.

npaihb.org/epi-surv-unit/
Reports: npaihb.org/national-Tribal-opioid-summit/

SOUTHERN PLAINS TRIBAL HEALTH BOARD (SPTHB)
OKLAHOMA AREA TRIBAL EPIDEMIOLOGY CENTER (OKTEC)

9705 N Broadway Extension, Suite 200, Oklahoma City, OK 73114
(405) 652-9200 | (405) 840-7052 (fax) | spthb.org

OKLAHOMA AREA
Tribal Epidemiology Center

OKTEC Region & Parent Organization

The Southern Plains Tribal Health Board (SPTHB) is Tribal organization and 501(c)(3) nonprofit established in 1972. SPTHB serves 43 federally recognized American Indian Tribes in Kansas, Oklahoma, and Texas, and four urban health clinics. The SPTHB membership includes representatives from the area IHS, Tribes and Tribal Health programs, and Urban Centers. The SPTHB region is aligned as one of the 12 IHS units in the United States.

One goal of the organization is to provide a Tribal perspective toward the development of health policy and health program operations impacting Tribes. While SPTHB does not directly operate health care facilities, it serves the IHS, Tribal, and urban health care facilities (I/T/U) as an advocate by representing the interests of the area at the state and national level. SPTHB is centrally located in Oklahoma City.

Access to Care

I/T/U health care facilities are located throughout the area:

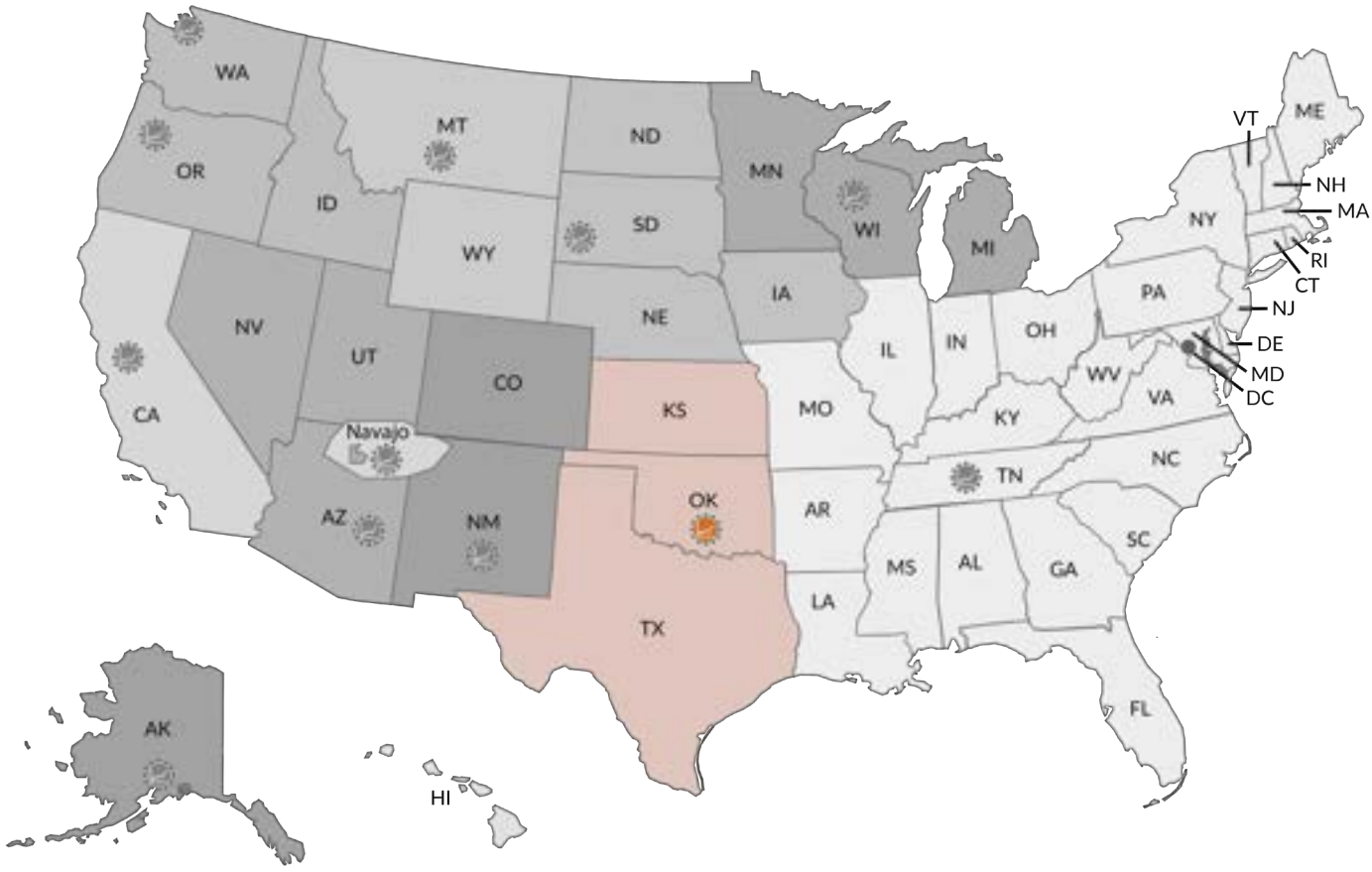
- Eight hospitals, six of which are Tribally operated, 63 outpatient care health centers, including four urban clinics, one health station, and one school health center.
- Approximately 40% of the health care delivery system is provided directly to Tribal patients by IHS. Approximately 60% of health care is provided utilizing Public Law 93-638 through contracts/compacts.

American Indian/Alaska Native (AI/AN) Population in the Oklahoma City Area

The Indian Health Service Oklahoma City Area (IHS-OCA) includes Tribal members residing in Oklahoma, Kansas, and Texas. The area is subdivided into twelve service units. The AI/AN population is estimated at 1,539,198 (U.S. Census 2020), accounting for 5.9% of the nation's AI/AN population.[30] This includes individuals identifying themselves as AI/AN alone or in combination with one or more races. IHS-OCA is home to some of the largest federally recognized Tribes in the nation – Cherokee, Choctaw, and Muscogee (Creek) – as well as Tribes whose membership total is less than 1,000. The Tribes are as diverse in culture as they are in size. Of 43 federally recognized Tribes in the IHS-OCA, 38 have Tribal headquarters in Oklahoma, four in Kansas, and one in Texas. The IHS user population of the area is 405,015.[31]

[30] U.S. Census Bureau. (2020). Profile of General Population and Housing Characteristics. Decennial Census, DEC Demographic Profile, Table DP1. Retrieved July 17, 2024, from data.census.gov/table/DECENNIALDP2020.DP1?d=DEC Demographic Profile.

[31] DHHS IHS User Population Estimates – Fiscal Year 2021 Final. Retrieved from https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/19-139ResponsiveDocuments.pdf.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OKTEC Overview

The Oklahoma Area Tribal Epidemiology Center (OKTEC) functions as a subdivision under the legal authority of SPTHB. Oversight and guidance is provided by SPTHB and the TEC Advisory Council, which is composed of SPTHB board of directors, Tribal health representatives, IHS representatives, and members of academia.

OKTEC received funding through an IHS cooperative agreement in 2004 and began operating in early 2005. It serves the largest IHS user population area in the United States.[32] The TEC's mission is to improve the health of AI/AN people in Kansas, Oklahoma, and Texas by providing public health services in epidemiology, technical assistance, data management and analysis, training, evaluation, health promotion/disease prevention and research through outreach and creative partnerships.

The TEC collaborates with Tribal health representatives and AI communities to collect, analyze, identify, and interpret health related data to prioritize health care objectives. TEC staff disseminates valuable health research and information regionally and nationally, amplifying awareness of the health disparities of AI/AN people. The TEC also apprises Tribal partners of funding sources and potential grant opportunities.

Our Approach

We address Tribal public health at its core through a multi component system, striving to improve public health issues through three key strategies: Partnerships, Advocacy, and Training & Education. We are honored to foster and support all three strategies, which come together to provide guidance and resources to our member Tribes within Kansas, Texas, and Oklahoma.

OKTEC Staff

The TEC employs 62 staff, including a Director and Deputy-Director, Epidemiologists, Biostatisticians, Evaluators, Public Health Training Coordinators and Specialists, Project Grant Coordinators, and an Administrative Assistant.

[32] IHS, 2021

OKTEC Partnerships

The TEC collaborates with a wide array of partners to implement its projects and obtain additional funding. For funding opportunities, the TEC works with IHS, Office of Minority Health (OMH), and the SAMHSA.

TEC stakeholders and technical advisors for various projects include the National Institute of Health (NIH), CDC, IHS, National Association of Public Health Statistics and Information Systems, the Oklahoma and Kansas State Department of Health, and the University of Oklahoma College of Public Health. Other collaborations include the Oklahoma Inter-Tribal Emergency Management Coalition, Methamphetamine Suicide Prevention Initiative, Native American Injury Prevention Coalition, Oklahoma Central Cancer Registry, Oklahoma Healthy Mothers Healthy Babies Advocacy Coalition, Oklahoma Healthy Mothers Healthy Babies Awareness Coalition, Oklahoma State Department of Health Infant Safe Sleep Workgroup, Oklahoma Inter-Tribal Diabetes Coalition, Oklahoma Toddler Survey Steering Committee, Oklahoma Maternal Mortality Review Board, Oklahoma Pregnancy Risk Assessment Monitoring System Steering Committee, and the Oklahoma University American Indian Diabetes Prevention Center Research Committee.

Tribes Served by OKTEC

- Absentee Shawnee
- Alabama Quassarte
- Apache Tribe
- Caddo Nation
- Cherokee Nation
- Cheyenne & Arapaho
- Chickasaw Nation
- Choctaw Nation
- Citizen Potawatomi Nation
- Comanche Nation
- Delaware Nation
- Delaware Tribe
- Eastern Shawnee
- Fort Sill Apache
- Iowa Tribe
- Kaw Nation
- Kialegee Tribal Town
- Kickapoo Tribe
- Kiowa Tribe
- Miami Tribe
- Modoc Tribe
- Muscogee (Creek) Nation
- Osage Nation
- Otoe-Missouria Tribe
- Ottawa Tribe
- Pawnee Nation
- Peoria Tribe of Indians
- Ponca Tribe
- Quapaw Tribe
- Sac and Fox Nation
- Seminole Nation
- Seneca-Cayuga Nation
- Shawnee Tribe
- Thlopthlocco Tribal Town
- Tonkawa Tribe
- United Keetoowah Band of Cherokee
- Wichita & Affiliated Tribes
- Wyandotte Nation
- Iowa Tribe of Kansas and Nebraska
- Kickapoo Tribe in Kansas
- Prairie Band Potawatomi Nation
- Sac and Fox Nation of Missouri
- Kickapoo Traditional Tribe of Texas

OKTEC Highlights & Accomplishments

AI/AN Health Disparities Project

- The Office of Minority Health AI/AN Health Disparities project aims to reduce health disparities in the AI/AN population through a number of activities.
- The TEC completed a linkage project between the Oklahoma Central Cancer Registry and the IHS.
- A similar linkage project was conducted using communicable disease data from the Oklahoma State Department of Health.
- The TEC also developed a cultural competency curriculum and hosted several trainings with the new material. An online version of the training is being developed for Tribal healthcare professionals.
- The grant award allows the TEC to sponsor a graduate internship program for students working toward obtaining a Master of Public Health degree. Eligible candidates include AI/AN students or students interested in working with AI/AN communities.

Tribal Community Health Profiles Project

The Tribal Community Health Profiles Project assists Tribal communities in determining health priorities by obtaining Tribal area-specific health information to create community health profiles (CHP). The TEC worked closely with the Oklahoma State Department of Health on the project, and created CHPs for all 43 Tribes in Oklahoma, Kansas, and Texas. The profiles indicate health status, outcomes, and trends based on county-specific data. The TEC used designated Tribal jurisdictional areas and aligned them at the county-level data to reflect a snapshot of the Tribe's health. The second phase of this project includes additional Tribal specific data for a more accurate representation of each Tribe's health.

CDC-Good Health and Wellness in Indian Country (GHWIC)

Through this CDC-funded initiative, SPTHB/OKTEC staff work with multiple Tribal partners across several domains to deliver education, resources, training, tools and support with projects identified by the Tribe's priorities to address opportunities to improve health in Tribal communities. The OKTEC helps structure, develop and support projects to enhance and improve health and wellness across a broad spectrum of projects, targeting specific areas of interest including: increasing/improving physical activities, exercise, nutrition, obesity, weight-loss, tobacco and smoking cessation, heart disease, and elevated blood pressure. Additionally, the GHWIC serves area Tribes through projects that dovetail into multi-sectional everyday life that Tribes find meaningful.

Tribal Epidemiology Center Consortium (TEC-C)

Previous collaborative efforts between the NWTEC, OKTEC and CTEC, resulted in creation of a Tribal Injury Prevention Toolkit. Kit material included current trends, fact sheets of the more common types of injury for the AI/AN population, social media that can be duplicated for dissemination, and printed material identifying specific ways to avoid and prevent injuries. Toolkits were distributed in hard copy and on CDs. The collaboration also provided car seat safety events that offered education,

installation instructions, car seat safety inspections and car seats for families in need. Smoke and carbon monoxide detectors were also distributed to any AI/AN with a need.

Methamphetamine and Suicide Prevention Initiative (MSPI)

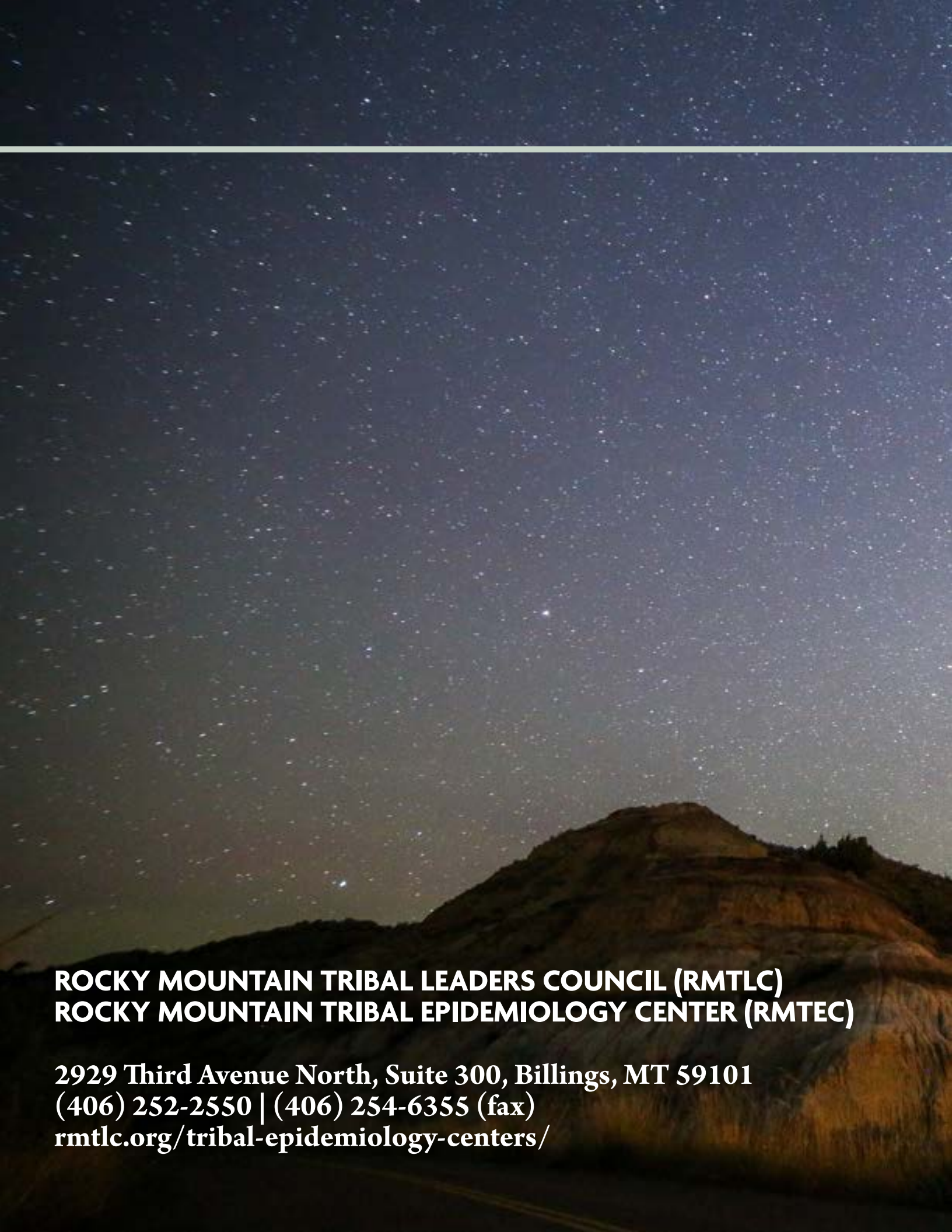
The SPTHB's role in the Methamphetamine and Suicide Prevention Initiative (MSPI) is to provide training and technical assistance on implementation and data collection, as well as to assist MSPI programs with program evaluation in the IHS-OCA. The TEC gives oversight to 23 different Tribal programs in the Oklahoma City Area.

Strategic Prevention Framework State Incentive Grant (SPF SIG)

The SPTHB TEC partnered with four area Tribes to form the Oklahoma Inter-Tribal Consortium (ITC) to apply for and receive a substance abuse prevention grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). Objectives of the SPF SIG were to:

- Prevent the onset and reduce the progression of substance abuse, including underage drinking.
- Reduce substance abuse-related problems.
- Build prevention capacity and infrastructure at the Tribal and community levels.

Since there are no Tribal reservations in Oklahoma, 15 Oklahoma counties were selected to be targeted with the cooperative agreement, correlating somewhat with original Tribal jurisdiction boundary areas. After successful execution of the SPF SIG projects, SPTHB continued partnerships with area Tribes and now provide SAMHSA's next generation program projects with SPF-PFS 2.0 and SPF Rx and Native Connections and Tribal Opioid Response (TOR) programs.



ROCKY MOUNTAIN TRIBAL LEADERS COUNCIL (RMTLC)
ROCKY MOUNTAIN TRIBAL EPIDEMIOLOGY CENTER (RMTEC)

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rmtlc.org/tribal-epidemiology-centers/


Rocky Mountain
Tribal Epidemiology Center

RMTEC Region & Parent Organization

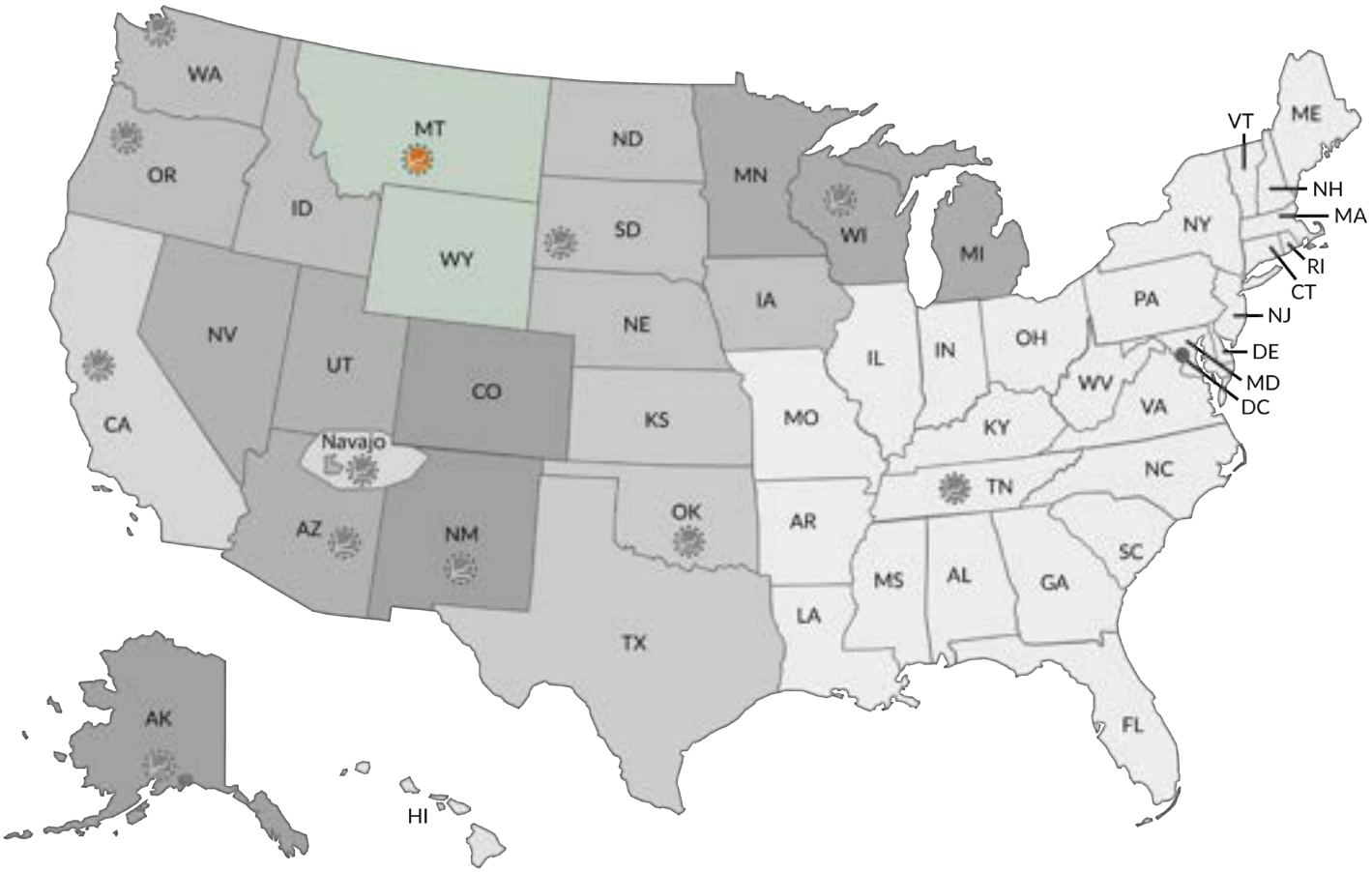
The Rocky Mountain Tribal Leaders Council (RMTLC), the parent organization of Rocky Mountain Tribal Epidemiology Center (RMTEC), has been in operation for more than 30 years. It was known as the Tribal Chairman's Association and then the Montana-Wyoming Tribal Leaders Council until 2015.

The RMTLC is governed by a consortium of Tribes in Montana, Wyoming, the Shoshone Bannock of Idaho, and the Piikani Nation of Canada. Its mission is "to preserve the homelands, defend rights of the Indian Treaties with the United States, speak in a unified voice, offer support to our people, offer a forum in which to consult each other and enlighten each other about our peoples, and to otherwise promote the common welfare of all of the Indian Peoples of Montana, Wyoming, and Idaho." To serve Tribal Priority Areas, the RMTLC has more than 30 full-time employees within more than ten departments, including the RMTEC.

American Indian/Alaska Native (AI/AN) Population in the Billings Area

The Billings Area, also referred to as the Rocky Mountain region, includes the Montana and Wyoming Tribes, with an AI population of approximately 75,852.[33] Tribes are located on eight reservations, with one urban-based Tribe in Great Falls, Montana. AI/AN populations roughly account for 10% of Montana's total population and 6% of Wyoming's total population. Each Tribal community is unique and highly diverse where there are between 3,000 to more than 10,000 enrolled members who reside on/off reservations.

[33] US Census, Table B02001. ACS 5 year estimates, 2018-2022.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RMTEC Overview

RMTEC was established in the fall of 2005 in collaboration with multiple stakeholders as part of a 5-year cooperative agreement with Indian Health Services (IHS). RMTEC continues to receive IHS core funding for RMTEC activities. All RMTEC projects were developed through a Community Based Participatory Research (CBPR) approach, with Community Health Priorities presented by RMTEC's advisory group.

The group includes Montana and Wyoming Tribal leaders and Tribal health directors, who represent Tribes and reservations served by Billings Area Office – Indian Health Service (BAO-IHS). The advisory group provides guidance and assistance to RMTEC, where Tribal Health Directors serve on the RMTLC Health Sub-Committee on Health. The RMTEC mission is to empower American Indian residents of Montana and Wyoming in the development of Public Health services, systems and epidemiological capacities to address their public health concerns.

RMTEC staff members travel several times a year for various projects/programs and as a team (RMTEC Round Trip) at least once a year to present reservation-specific Community Health Profile data, provide updates on projects/programs and emerging projects to each Tribal Health Director (the Community Health Gate Keeper of the reservations) and their staff on each reservation.

RMTEC Goals

- Public Health Promotion: Collect health status, disease surveillance, and assist Tribes to promote public health.
- Recommendations: Assist Indian Tribes, Tribal organizations, and Urban Indian Organizations (UIOs) in identifying highest priority health status objectives and the services needed to achieve those objectives, based on epidemiologic data.
- Evaluation: Evaluate existing delivery systems, data systems, and other systems that impact the improvement of Indian Health.
- Technical Assistance: Provide technical assistance to Tribes in Montana and Wyoming in the development of local health service priorities and to determine incidence and prevalence rates of disease and other illnesses in the community.

RMTEC Focus Areas

- Strengthening Tribal Governments, Systems, and Leadership
- Promoting Health Tribal Communities, Families, and Children
- Conducting Epidemiological Research to Support Health Policy
- Advocating for Justice and Equality, Protecting our Tribal Sovereignty

RMTEC Staff

RMTEC has a staffing capacity of 16, which includes a TEC Director, Epidemiologists, Project/Program Coordinators, a Program Manager, Training Coordinator, Communication Specialist, TEC Public Health

Infrastructure (PHI) Program Director, Monitoring and Evaluation Specialist, and Biostatistician.

RMTEC Partnerships

RMTEC partners with several institutions – including academic institutions and research organizations – to implement its projects and seek supplemental funding opportunities and grants. RMTEC's relationships with academic and other research organizations are fostered in part by the partnerships that the parent organization, RMTLC, has in place. RMTEC also partners with Montana Department of Public Health and Human Services (DPHHS) and State of Wyoming Department of Health (DOH), and county health departments including the Yellowstone County Health Department (also known as Riverstone). RMTEC partners with Tribes, Tribal Health Departments, and Tribal Chemical Dependency programs. RMTEC stakeholders and team of technical advisors for various projects include the National Institute of Health (NIH), Centers for Disease Control (CDC), and IHS.

RMTEC is able to address tribal/community health priorities through a variety of funders. RMTEC's parent owner, RMTLC, pursued other sources of funding to augment its core funding from IHS. Additional RMTEC funding agencies include the CDC Foundation, Montana State University, and IHS.

Some Cancer stakeholders and partners include: Tribal Nations; Montana Department of Health and Human Services, Montana Tumor Cancer Registry(MTRC); Participating Montana Cancer Control Programs; Montana Cancer Institute Foundation, American Cancer Society; American Indian Tobacco Prevention Specialists; Benefis-Sletten; Cancer Institute; Billings Clinic; Bozeman Deaconess; Indian Family Health Clinic; Montana American Indian Women's Health Coalition (MAIWHC); Montana Family Planning Clinics; Montana Tobacco Use Prevention Program (MTUPP); Northwest Healthcare; Planned Parenthood; Respecting the Tobacco Way; Shodair; St. Peters Hospital; St. Vincents Hospital and Susan Komen for the Cure Foundation.

Notice: The results presented in this report may not be referenced or duplicated without permission from the Rocky Mountain Tribal Leaders Council. For clarifications, please contact Eleanor GunShows at RMTLC/RMTEC, 2929 Third Avenue North, Suite 300, Billings MT 59101, or call (406) 252-2550; e-mail: eleanor.gunshows@rmtlc.org

RMTEC Highlights & Accomplishments

Community Health Profiles and Regional Health Profiles

Data are needed for all populations to address health and public health disparities. This includes data for under-engaged populations, such as AIs living on rural reservations. Building public health infrastructure remains a key Healthy People[34] objective. This includes public health data that is essential to provide effective public health services for data for all population groups, data for leading health indicators, health status indicators, and priority data needs at Tribal, state, and local levels and national tracking of Healthy People 2030 objectives.

RMTEC works with many partners to develop Tribal-specific Community Health Profiles for each reservation in the Billing IHS Area based on county, state, and national American Indian data. Partners include the Wyoming Department of Health, Montana Department of Public Health and Human Services, IHS, and others In addition, RMTEC has developed a larger Regional Health Profile for the Billings Area region. RMTEC incorporates Indigenous data sovereignty initiatives and values feedback and input from Tribal partners. By collaborating closely, RMTEC ensures data is meaningful and aligns with Tribal health priorities for each of the Montana and Wyoming Tribal Nations.

Child Health Measures (CHM)

Among North American youth, AI/AN populations have one of the highest prevalences of obesity. Overweight and obesity among youth is associated with an increased risk for pre-diabetes, metabolic syndrome, type 2 diabetes with insulin resistance, and heart disease. The CHM project was funded between 2006 and 2018 to help inform participating Tribes on health measures associated with the risks for childhood obesity, diabetes, and heart disease among children of the participating Tribes. The project annually screens children in kindergarten through high school for: weight/height (body mass index), blood pressure, presence of acanthosis, asthma diagnosis, and family history of disease. More than 50 trained Tribal field workers and schoolteachers/nurses from participating reservations volunteer in project data collection efforts (measurements and survey administration). A summary of measures is available and provided to Tribal Health Directors to implement Tribal public health activities/interventions. As a 10-year project (2008-2018), seven of the eight Tribal reservations participated annually with more than 13,000+ measurements.

With support from Colorado School of Public Health, Centers for American Indian & Alaska Native Health (Resource Center for Tribal Epidemiology Centers funding), the CHM project was revived with another five-year funding span beginning in 2023. Based on evaluation and feedback, the RMTEC is working with Tribal partners to revise and update study methodologies and include the addition of traditional foods questions. This project will provide continued monitoring and surveillance for Rocky Mountain Tribal reservation youth for pre-diabetes, metabolic syndrome, type 2 diabetes, and heart disease. Seven of the eight Tribal reservations receive funding, technical assistance, and training through the CHM project. By incorporating culturally relevant strategies, RMTEC envisions a reduction in health outcomes associated with overweight/obese in youth.

Tribal Maternal Mortality Review Committee (a Feasibility Study)

AI/AN women in the United States are more than twice as likely to die of pregnancy or birth-related complications

[34] health.gov/healthypeople

than non-Hispanic White women (29.7 deaths per 100,000 live births compared to 12.7). [35]

It is important to identify factors that increase women's risk and prevent maternal mortality, especially among AI/AN women. Existing Maternal Mortality Review Committees (MMRCs) are convened at the State level and are multidisciplinary. The goal of MMRC review processes is to "identify and implement recommendations to inform public health and clinical improvements to both reduce deaths and improve wellness." At this time, there are no Tribal/Tribally led MMRCs.

With support from the CDC Foundation, the RMTEC is collaboratively working with an external contractor to determine the feasibility of establishing a Tribally-led MMRC for the Rocky Mountain region. A literature review and environmental scan was conducted to understand practices, approaches, and considerations of Tribal MMRC and lay the groundwork for the feasibility study. A survey was conducted to identify challenges or needs and understand the overall awareness of and interest for a Tribal MMRC. Findings showed interest in developing a regional Tribal MMRC, but the concept of MMRC is limited. Of the identified considerations, and as a next step, the project has been expanded to further incorporate Tribal elders' perceptions of Tribal MMRC. For more information on feasibility study findings, recommendations, and proposed models, please contact the TECPHI Director.

Injury Prevention Program (IPP)

Accidents (unintentional injuries) are the fourth leading cause of death in the United States. Among AI/AN people between 1-44 years old, unintentional injuries are the leading cause of death. In collaboration with IHS, the RMTEC Injury Prevention Program's goal is to increase overall injury prevention awareness, implement targeted strategies to prevent injury, and develop/maintain collaborative partnerships to reduce the burden of injury within Tribal Nations. Collaborating with Tribal partners, the RMTEC focuses are elder falls prevention, unintentional falls, and car seat safety. Approximately 218 car seats (infant, toddler, and booster) have been distributed among the majority of Montana and Wyoming Tribes. In addition, the program engages local Tribal communities at community events, conducts trainings/webinars, and meetings with injury prevention professionals. Currently, nine Montana and Wyoming Tribes participate in this program.

Coronavirus Disease 2019 (COVID-19) Efforts

The COVID-19 pandemic had a worldwide impact. However, AI/AN populations were disproportionately impacted; there were increased rates of COVID-19 incidence, hospitalizations, and mortality. AI/AN people are resilient and COVID-19 mitigation efforts were multidisciplinary.

With support from Montana State University-Bozeman, the RMTEC worked individually with six regional Tribal Community Colleges to support COVID-19 prevention efforts (small projects) and provide introductory public health courses to increase overall public health interest. Individual small projects focused on providing COVID-19 education, sexually transmitted infections awareness, the importance of mental health, and supporting wastewater surveillance.

With support from the NPAIHB, the RMTEC worked with nine of ten Tribes in Montana and Wyoming to develop culturally relevant vaccination information specifically for COVID-19 and influenza, for Tribal elders. Over multiple years, the RMTEC focused on developing and adapting existing health information for specific age groups, increasing awareness of COVID-19 variants, compared and contrasted COVID-19 and flu signs and symptoms, and researched natural homeopathic remedies to increase immune system. In addition, the RMTEC conducted focus groups to understand additional challenges associated with vaccine promotion, long COVID-19 symptoms, and misinformation.

[35] CDC MMWR, 2017

UNITED SOUTH AND EASTERN TRIBES, INC. (USET)
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UNITED SOUTH AND EASTERN TRIBES, INC.
Established 1969

OTPH Region & Parent Organization

The United South and Eastern Tribes, Inc (USET) is a non-profit, intertribal organization comprised of 33 federally recognized Tribal Nations in 13 eastern and southern states.

USET is dedicated to enhancing the development of Tribal Nations, improving the capabilities of Tribal governments, and improving the quality of life for Indian people through a variety of technical and supportive programmatic services.

USET serves AI/AN people in the 22-state region known as the Indian Health Service (IHS) Nashville Area, which spans from the Northeast Woodlands to the Everglades, and across the Gulf of Mexico. Within this region, there are two Urban Indian Health Organizations and 28 Tribes. Twenty-six of these Tribes comprise the USET organization. Within this region, there are two Indian Health Organizations and 29 Tribes. Twenty-seven of these Tribes comprise the USET organization.

Three of the USET Tribes receive services at healthcare facilities operated by the IHS and most of the remaining Tribes operate their own healthcare facilities. Because USET's guiding principle, 'Strength in Unity," it plays a major role in the self-determination of the member Tribal Nations in promoting better Tribal health. Through USET's Office of Tribal Public Health (OTPH), a designated TEC through the Indian Health Care Improvement Act (IHCIA), structure for multiple AI/AN public health activities is provided under its nine core competencies: Epidemiology, Data Improvement, Integrated Community Health, Public Health Planning and Infrastructure, Workforce Development, Chronic Disease Prevention, Behavioral Health, Diabetes Support Center, and Dental Support Center.

American Indian/Alaska Native (AI/AN) Population in the Nashville Area

As of 2024, AI/AN population in the service area is approximately 100,00 with 60,000 residing on or near reservations.

USET Tribal Nations & Locations

1. **Eastern Band of Cherokee Indians**
   Cherokee, North Carolina
2. **Miccosukee Tribe of Indians of Florida**
   Miami, Florida
3. **Mississippi Band of Choctaw Indians**
   Choctaw, Mississippi
4. **Seminole Tribe of Florida**
   Hollywood, Florida
5. **Chitimacha Tribe of Louisiana**
   Charenton, Louisiana
6. **Seneca Nation of Indians**
   Salamanca, New York
7. **Coushatta Tribe of Louisiana**
   Elton, Louisiana
8. **Saint Regis Mohawk Tribe**
   Akwesasne, New York
9. **Penobscot Indian Nation**
   Indian Island, Maine
10. **Passamaquoddy Tribe – Pleasant Point**
    Perry, Maine
11. **Passamaquoddy Tribe – Indian Township**
    Princeton, Maine
12. **Houlton Band of Maliseet Indians**
    Littleton, Maine
13. **Tunica-Biloxi Tribe of Louisiana**
    Marksville, Louisiana
14. **Poarch Band of Creek Indians**
    Atmore, Alabama
15. **Narragansett Indian Tribe**
    Charlestown, Rhode Island
16. **Mashantucket Pequot Tribal Nation**
    Mashantucket, Connecticut
17. **Wampanoag Tribe of Gay Head (Aquinnah)**
    Aquinnah, Massachusetts
18. **Alabama-Coushatta Tribe of Texas**
    Livingston, Texas
19. **Oneida Indian Nation**
    Verona, New York
20. **Aroostook Band of Micmacs**
    Presque Isle, Maine
21. **Catawba Indian Nation**
    Rock Hill, South Carolina
22. **Jena Band of Choctaw Indians**
    Jena, Louisiana
23. **The Mohegan Tribe**
    Uncasville, Connecticut
24. **Cayuga Nation**
    Seneca Falls, New York
25. **Mashpee Wampanoag Tribe**
    Mashpee, Massachusetts
26. **Shinnecock Indian Nation**
    Southampton, New York
27. **Pamunkey Indian Tribe**
    King William, Virginia
28. **Rappahannock Tribe**
    Indian Neck, Virginia
29. **Chickahominy Indian Tribe**
    Providence Forge, Virginia
30. **Chickahominy Indian Tribe Eastern Division**
    Providence Forge, Virginia
31. **USET Headquarters**
    Nashville, Tennessee
32. **USET SPF Office**
    Washington, DC

OTPH Overview

Since its establishment, Office of Tribal Public Health (OTPH), which is one of the 12 designated Tribal Epidemiology Centers, has been pivotal in advancing public health within Tribal communities. Operating from its headquarters in Nashville, OTPH plays a crucial role in addressing diverse and complex health needs across a broad spectrum. Through a commitment to data-driven, culturally responsive services, OTPH has significantly expanded its capabilities and outreach.

Its efforts span a wide range of activities, from providing Tribal Nation specific data and reports, enhancing diabetes and dental care within the health clinics, providing clinical and public health related webinars, building public health infrastructure, and offering support with community-based interventions. The scope of OTPH's work is marked by their comprehensive approach to public health, addressing both immediate needs and long-term health improvements for Tribal populations.

OTPH Competencies

OTPH has grown to include almost 60 positions, including public health and clinical health specialists, in addition to support staff.

Epidemiology and Data Improvement Competency

These two competencies work hand in hand in improving and providing Tribal-Nation specific data and reports, as well as to offer tailored-technical assistance to all member-Nations. Funding for these two teams comes from the funding mechanism that is prescribed in IHCIA.

OTPH Epidemiology and Data Improvement Projects

Tribal Public Health Preparedness and Resilience Task Force

This task force is crucial for enhancing public health preparedness across Tribal communities. It aims to improve Tribal capacity to respond to public health emergencies by providing cross-sectorial technical assistance to Tribal Nations. The task force brings together Tribal leaders, public health professionals, and community stakeholders to coordinate efforts, share best practices, and address gaps in preparedness and resilience. By fostering collaboration and strategic planning, this initiative ensures that Tribal communities are better equipped to handle public health emergencies and build long-term resilience against evolving health challenges.

Reports and Data Summaries

OTPH epidemiology and data improvement staff recently completed Clinical Reporting System (CRS) reports to assist Tribal Nation health staff in improving selected clinical health measures by identifying gaps in clinical

screening, care, and treatment within the health clinic. These reports are created annually, which allow Tribal Nations to review changes in clinical quality. Additionally, during cold and flu season, staff generate weekly reports of respiratory diseases specific to each Tribal Nation.

Data Improvement

Due to the poor quality of Tribal data in the eastern and southern US, these teams spend a considerable amount of time trying to improve data on the federal and state level by advocating for Tribal data sovereignty. Efforts include participating in the data modernization projects from both the CDC and IHS and training Tribal Nation staff on best practices for documenting and managing the antiquated electronic health record (EHR) system, Resource and Patient Management System (RPMS). Additionally, this team provides technical assistance for biostatistics, data collection techniques and will also provide electronic health record support when the new EHR is implemented.

Mortality Project

This is a longstanding project that matches state death certificates with a roster of Tribal citizens in order to provide Tribal Nations with targeted, specific data that would otherwise be unavailable to them. All matched data is returned to the health clinic to honor Tribal data sovereignty. This project allows Tribal Nation decision makers to monitor this bedrock public health data and develop interventions to prevent untimely deaths.

Community Health Assessments

OTPH supports Tribal Nations in creating and disseminating their own community health assessments, tailored to their own unique needs. Support includes drafting questions, advising and supporting data collection methods, analysis and interpretation service.

Vaccine Uptake

In partnership with USET's Office of Economic Development (OED), this project seeks to improve vaccination rates among adults by targeting employers and providing education and support needed to maintain a healthy workforce.

Technical Assistance

These teams provide technical assistance to Tribal Nations as needed. Most recent examples include collaborating with a Tribal Nation and the CDC to assess the effect of environmental toxins on the community's

health, providing expanded mortality statistics to include an in-depth analysis of the most common causes of death, and providing an analysis of a Tribal exercise/healthy eating intervention.

Competency Support

Each epidemiologist is assigned to the other OTPH competencies in order to ensure appropriate epidemiological support to their interventions. This support is provided to the Integrated Community Health, Infrastructure & Planning, Workforce Development, Chronic Disease, Behavioral Health, Diabetes, and Dental, which are funded by cooperative agreements with other federal agencies.

Diabetes Support Center

OTPH's Diabetes Support Center, with responsibilities in Health Promotion and Disease Prevention (HPDP), also works closely with the Nashville Area Office (NAO). It provides leadership, direction, consultation and expertise in planning, developing, implementing, and evaluating the area diabetes programs by assisting Tribal Nations in interpreting program needs with regard to implementation of national diabetes objectives and standards of care. The diabetes competency provides expert professional nursing, educator, nutrition, and diabetes knowledge and skills to provide consultation, guidance, training, education, and technical assistance to other IHS Area diabetes programs, Tribal Nations, and the IHS. Finally, this program is an integral part of formulating and recommending policies, procedures and plans to establish and improve diabetes resources and services for individual Tribal health care delivery systems.

Dental Support Center

The Dental Support Center provides clinical support and education to Tribal dental programs as well as assistance with dental public health initiatives.

Integrated Community Health

The Integrated Community Health competency supports USET member-Tribal Nations in fostering relationships between medical, behavioral, and community healthcare while promoting Native brilliance across the lifespan. Specifically, this competency produces the award-winning webinar 'Reclaiming Native Psychological Brilliance' to draw upon the inherent strengths of Tribal communities. This competency jointly oversees the Opioid Task Force, which is a cross-sectorial approach to eliminating the opioid crisis in our member-Nations.

Public Health Planning and Infrastructure

The Infrastructure and Planning competency is tasked with improving the public health infrastructure by providing training and support to USET and Tribal Public Health staffs. Additionally, Infrastructure and Planning provides training to funeral directors across the USET area about the importance of correct racial misclassification on death certificates.

Chronic Disease Prevention

This competency aims to establish, strengthen, and broaden the impact of effective, sustainable chronic disease and health promotion, and prevention programs that enhance the health of Tribal Nations. Currently, the Chronic Disease Prevention competency provides Tribal Nations culturally specific intervention support including nutrition/physical activity, commercial tobacco prevention, type 2 diabetes prevention and heart disease/stroke prevention.

Behavioral Health

The Behavioral Health competency provides support to member-Tribal Nations in planning, developing, and implementing culturally appropriate behavioral health support. Recent projects include Narcan kit distributions, training around Youth and Adult Mental Health First Aid and safeTalk suicide intervention. This team has also created communication tools tailored to improving behavioral health in our region. These include instructional videos on administering Narcan, suicide awareness campaigns, and a series of Behavioral Health workbooks for children and youth. These resources are provided to Tribal Nations to distribute to the community. Staff within the Behavioral Health team assist Tribal Nation awardees with evaluating the success of the Substance Abuse and Suicide Prevention program

awardees. This competency also conducts Behavioral Health Needs Assessments and oversees the Opioid Task Force in close collaboration with the Integrated Community Health competency.

Workforce Development

This competency supports Tribal workforce development by identifying needs and training gaps and working with Tribal health staff and external partners to develop and establish programs that address health workforce disparities.

SEATTLE INDIAN HEALTH BOARD (SIHB)
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Urban Indian Health Institute

A Division of the Seattle Indian Health Board

UIHI Region & Parent Organization

Urban Indian Health Institute (UIHI) is a division of Seattle Indian Health Board (SIHB), a nationally recognized leader in culturally attuned healthcare for urban American Indian and Alaska Native (AI/AN) people. Located in King County, Washington state, SIHB is a community health center that provides health and human services to all people in a Native way.

SIHB opened its doors to the community in 1970, which marked the first time urban AI/AN people in Seattle had access to healthcare services for Native people by Native people. The organization emerged from the love of Native women leading local social justice movements of the 1960s. During the time, Native activists were forming several Native organizations to ensure urban Indians were visible and their needs were being met. Today, the mission of SIHB is to advocate for, provide, and ensure culturally appropriate, high-quality, and accessible health and human services to AI/AN people.

Guided by traditional beliefs and practices, SIHB has a unique approach to healthcare based on Indigenous knowledge. This allows SIHB to approach medicine through a holistic system of care, which for thousands of years has ensured the mind, body, and spirit are cared for equally.

With Traditional Indian Medicine at the center, SIHB is successful by:

1. Providing health and human services to Native people in the King County region.
2. Investing in the AI/AN workforce.
3. Supporting the health and well-being of urban Indian communities through information, scientific inquiry, and technology.
4. Valuing the health outcomes of all Native people by protecting the federal trust responsibility through advocacy.

American Indian/Alaska Native Population in Urban Areas

Urban Indians are Tribal people currently living off federally defined Tribal lands in urban areas across the United States. According to the 2020 U.S. Census, approximately 76 percent of AI/AN people live in urban areas.[36] Urban Indians represent the majority of AI/AN people but are often an overlooked population in society.[37]

Historically, many Native people were relocated to urban areas because of government policy. Some Native people also chose to move to urban areas due to lack of economic and educational opportunities, and limited access to healthcare and other services. This gave rise to diverse and inter-tribal communities of urban AI/AN people. Many Native people continued to struggle with employment, education, housing, health, and human services in unfamiliar urban contexts. Urban Indians frequently found the care they received from health organizations also did not meet their unique needs. This eventually gave rise to urban Indian programs and health

[36] County population by characteristics: 2010–2020. United States Census Bureau. Accessed January 29, 2024.

[37] Urban Indian Health. Uihi.org. Accessed January 29, 2024. uihi.org/urban-indian-health/

Figure 1: Map of Urban Indian Organization (UIO) Service Areas. 2021 CHP Aggregate Report: 41 UIOs

organizations providing services better aligned with the needs of the urban Indian community.

Although there is more access to culturally attuned health and human services today, urban Indians still suffer from health disparities at disproportionate rates compared to other ethnic groups. Genocide, assimilation, racism, and the purposeful destruction of lands, languages, and traditional practices gave rise to these health disparities and created a system designed to eliminate AI/AN Native people from it completely. But it did not work. Today, Native people are resilient and continue to grow stronger every day, and many are fighting to bring Native people back to being the healthiest people in the nation.

UIHI Overview

Urban Indian Health Institute (UIHI) is a Public Health Authority and one of 12 Tribal Epidemiology Centers (TECs) in the United States (U.S.). While the other TECs serve tribes and/or regions, UIHI is in service to AI/ANs living off tribal lands in urban areas nationwide.

UIHI was founded to serve the national network of 41 Urban Indian Organizations (UIOs) federally funded under Subchapter IV of the Indian Health Care Improvement Act. Today, UIHI has an official service relationship with the Urban Indian Health Network (UIHN), a cross-site nationwide network comprising 92 urban AI/AN-serving organizations, including the UIOs and other public health organizations that provide clinical and social services. Together, these urban Indian organizations serve over 5.7 million urban AI/AN people located across the country in 29 states and over 164 counties.

The mission at UIHI is to decolonize data for Indigenous people, by Indigenous people. UIHI recognizes research, data, and evaluation as Indigenous values, and by doing so, produces the best and most accurate data to strengthen the health of Native people. [3,4] UIHI builds capacity and provides information for UIOs and UIHNs, as well as local, state, and federal agencies, to inform services, programs, and policies in their respective areas that address AI/AN health initiatives and public health priorities by:

- Providing technical assistance for other TECs and organizations
- Fulfilling data requests for partners and legislators
- Offering trainings on Indigenous research and evaluation
- Developing informational materials regarding a variety of health-related topics
- Conducting and participating in culturally rigorous research

UIHI Staffing

Staff at UIHI are comprised of 37 professionals, eight support staff, and up to four public health interns during the summer. Program staff include the UIHI Director, Associate Officer, Director of Research and Evaluation, Public Health Services Program Director, and Family Services Program Director. Program staff includes Executive Assistant, Senior Evaluator, seven Evaluators, Fellow, Senior Epidemiologist, six Epidemiologists, five Senior Program Managers, seven Program Managers, six Program Associates, two Data Coordinators, and six Communications Team staff.

Partnerships

UIHI cultivates partnerships and collaboration with local and national working groups to secure investments in health surveillance, research, and policies to ensure optimal dissemination of health information to meet the needs of the urban AI/AN population served. UIHI works with UIO partners with the goal of strengthening their capacity to conduct community health assessments

[38] About UIHI. Uihi.org. Accessed January 31, 2024. uihi.org/about/

[39] The Story of Our Logo. Uihi.org. Accessed January 31, 2024. uihi.org/about/the-story-of-the-uihi-logo/

[40] Projects. Uihi.org. Accessed January 31, 2024. uihi.org/projects/

and evaluations, develop program initiatives, write grants, and make data-informed decisions to create, adapt, and run programs that address health disparities and public health priorities. For support of its data surveillance system, UIHI partners with local, county and state public health departments.

UIHI Projects

UIHI has developed and delivered technical assistance to UIOs nationwide for various projects focused on improving the health of urban AI/AN populations. As a TEC, UIHI manages public health information systems, investigates diseases of concern, manages disease prevention and control programs, communicates vital information and resources, responds to public health emergencies, and coordinates specific activities with public health authorities. UIHI projects provide information to assist other urban Indian-serving groups and organizations in improving the health of urban Indian communities.[40]

Promoting Health Equity

UIHI is dedicated to addressing health disparities and reaching health equity in a culturally rigorous way – by breaking down barriers, building beauty, and restoring culture. In 2019, UIHI Director Abigail Echo-Hawk (Pawnee) produced the "Indigenous Health Equity" report. This report highlights the efforts to address the health disparities that are often complicated by culturally inappropriate interventions and an inadequate understanding of the historical and ongoing trauma of AI/AN people, which results in persistent health disparities. UIHI is working toward health equity for AI/AN population through data, research, and evaluation drawn from cultural values and ancestral practices.

Cultural rigor requires us to first be grounded in our own ways of knowing, recognizing that the answers lie within our cultures. Our resilience is based on taking action to improve the health and well-being of future generations. That is the self-determination needed for true change. When undertaking any efforts toward achieving health equity among AI/AN people, UIHI Director Abigail Echo-Hawk says, "Don't come to us because we have the most problems; come to us because we have the answers".[41] The answers to solving health disparities for AI/AN people are within our communities and are carried in our stories, our land, and our DNA. Only when this knowledge is incorporated and valued will we begin to achieve health equity.[42]

Decolonize Data

Indigenous people have collected and interpreted data for millennia. Tribal nations and communities have always been scientists. According to the Urban Indian Dictionary, Decolonizing Data includes:

1. Reclaiming the Indigenous value of data collection, analysis, and research.
2. Data for Native people, by Native people
3. Recognizing the inherent strength of Indigenous people.[43]

UIHI and its partners are dedicated to decolonizing data, recognizing the dire need for data equity, sovereignty, and justice. At UIHI, research, data, and evaluation are recognized as Indigenous values. By reclaiming Indigenous data practices to ensure partners, providers, policymakers, and health advocates have access to information that will help, not hurt, communities.

Limitations in National Data

Often, national data is only available for AI/AN alone and is not inclusive of AI/AN individuals who also identify with another race or ethnicity. Therefore, the outcomes may be an underestimation of the true value of an outcome or risk factor for any indicator analyzed. UIHI houses the only national urban AI/AN health surveillance system where national datasets are acquired and maintained to speak to urban AI/AN people's health.[44]

[41] Echo-Hawk A. Urban Indian Health Institute. Seattle Indian Health Board. Accessed September 11, 2024. https://www.sihb.org/services-and-programs/urban-indian-health-institute/

[42] Echo-Hawk A. Indigenous health equity. Urban Indian Health Institute. Published August 7, 2019. Accessed January 26, 2024. https://www.uihi.org/resources/indigenous-health-equity/

[43] Decolonize Data: Accurate Data Tells Accurate Stories. Uihi.org. Accessed January 31, 2024. https://www.uihi.org/projects/decolonizing-data-toolkit/

Racial Misclassification

Racial misclassification impacts the accuracy of rates of disease, risk factors, and outcomes, which leads to underestimations. Racial misclassification occurs when the race of an individual is captured inaccurately, whether it be from the subjective use of personal observation by the data collector or using a surname to determine race/ethnicity. AI/AN people are more likely to experience incorrect classification on death certificates. Therefore, true morbidity and mortality rates among AI/AN people are assumed to be higher than presented in reports.

2021 Community Health Profile (CHP) Aggregate Report: 45 UIOs

Background

UIHI analyzed data from the American Community Survey (ACS), the National Vital Statistics System (NVSS), National Notifiable Disease Surveillance System (NNDSS), Behavioral Risk Factor Surveillance System (BRFSS), and National Survey on Drug Use and Health (NSDUH) to describe health outcomes among urban AI/AN people across more than 50 health indicators. With these data, UIHI created individual CHPs for 45 urban Indian organization (UIO) service areas throughout the U.S., which include 125 counties.

The 2021 CHP aggregate report addresses racial misclassification in data reporting and provides accurate health information for urban AI/ANs. Data on sociodemographic, mortality, infectious disease, maternal and child health, substance use, and mental health are aggregated across all UIO service areas. The data in this report are five-year estimates from 2013 to 2017. Key findings show urban AI/AN people frequently experience higher proportions of poverty and inequities in employment and education. Higher morbidity and mortality from chronic disease, infectious disease, unintended injury, homicide, and infant and maternal mortality are also observed among the urban AI/AN population when compared to non-Hispanic White (NHW) counterparts.

The CHP analysis by UIHI also acknowledges the role colonization has had on Indigenous communities and the health indicators listed in this report. The systemic rewards of colonization, genocide, and institutional white supremacy are major factors in positive health outcomes of beneficiaries of structural racism, non-Hispanic whites — and that is why that demographic is often used as the comparison group for AI/AN data. This report allows community health centers to determine how to best serve the needs of their relatives.

Best Practice

According to the 2020 Census, 76% live in urban areas. To meet the health needs of this population, numerous health and social service programs provide culturally attuned and holistic healthcare. Many of these programs offer services grounded in Indigenous knowledge, bringing traditional and Western medicine together. Improving community health through effective planning and decision-making requires reliable information. The CHP provides an overview of the health status of AI/AN populations who reside in the UIO service areas. While limited in scope and restricted to available data, this report provides valuable information for service providers serving an urban Indian population with unique needs and health priorities. The report is intended for use as a supplement to other local data available and can be used for program planning, applying for funding, identifying gaps in data, and conducting research.

For each indicator, prevalence or incidence is calculated for the AI/AN population and compared to the NHW population. NHW estimates are included as the comparison group to assess disparities in health indicators, in recognition of the effects of structural racism on health. The AI/AN population was defined

[44] Wilkie C. Community health profile, national aggregate of urban Indian organization service areas. Urban Indian Health Institute. Published October 29, 2021. Accessed January 29, 2024. https://www.uihi.org/urban-indian-health/urban-indian-health-organization-profiles/

as AI/AN only and AI/AN in combination with other races, unless otherwise indicated. The NHW population was defined as White only and excluded the Hispanic population, unless otherwise indicated. The systemic rewards of colonization, genocide, and institutional white supremacy are major factors in positive health outcomes of beneficiaries of structural racism, non-Hispanic whites — and that is why that demographic is often used as the comparison group for Native data.[45]

CHP Report: https://www.uihi.org/resources/community-health-profile-national-aggregate-of-urban-indian-organization-service-areas/

Our Bodies, Our Stories

Background

The risk of rape or sexual assault is 2.5 times higher for Native women than the rest of the country. Murder is the third leading cause of death for Native women. These numbers likely underestimate the true extent of violence due to systematic underreporting, misclassification, and ongoing distrust of law enforcement. Despite this ongoing crisis, very little is known about the victimization of Native women living in urban settings, and UIHI is ensuring they are no longer seen as invisible in life, in the media, and in the data.

[45] Wilkie C. Community health profile, national aggregate of urban Indian organization service areas. Urban Indian Health Institute. Published October 29, 2021. Accessed January 29, 2024. https://www.uihi.org/urban-indian-health/urban-indian-health-organization-profiles/

Best Practice

In 2010, UIHI partnered with the Division of Violence Prevention at the Centers for Disease Control and Prevention (CDC) to administer a comprehensive sexual violence survey to better understand the experiences of urban Native women in Seattle, Washington. King County, where Seattle is located, has a large urban Indian population of approximately 44,500 people. This survey attempted to gather a well-rounded understanding of multiple forms of sexual violence perpetrated against this population, including whether a woman was raped or coerced into sex.

To gather a full understanding of any experiences of sexual violence against urban Native women, participants were asked personal questions about their individual experiences and any resulting effects. Participants were asked about their current health and socio-economic status, how many times they experienced any form of unwanted sexual attention, and the resulting effects of their first and most recent incident of sexual violence. They were also asked how many times in their lifetime they experienced sexual harassment and sexual violence.

After all the surveys were collected, the data was entered into a database and analyzed by UIHI. This analysis examined health outcomes and any associations—such as suicide attempts or substance misuse—among lifetime victims of rape and/or coercion.[46]

Our Bodies, Our Stories Report: https://www.uihi.org/projects/our-bodies-our-stories/

Decolonize Data Toolkit

Background

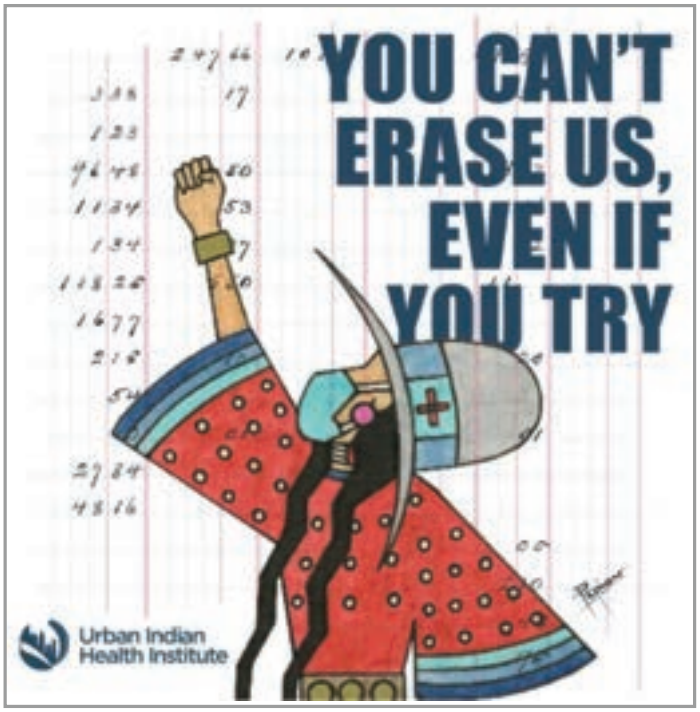
Indigenous people have always been data stewards. We gathered, analyzed, and shared data to ensure the well-being of our people. These data practices were grounded in cultural values, including reciprocity, relationship, responsibility, and accountability. Our culturally based methodologies sustained thriving communities for thousands of years until interrupted by colonialism.

Best Practice

Now we are demanding Indigenous Data Sovereignty—the right of Indigenous Peoples and nations to govern data about their peoples, lands, and resources. This report has the principles of decolonizing data, as defined by UIHI, and specific to AI/ANs.[47]

Decolonize Data Toolkit: https://www.uihi.org/projects/decolonizing-data-toolkit/

https://www.uihi.org/wp-content/uploads/2023/03/UIHI-TextOnly_Pocketbook-final_screen.pdf



[46] Our bodies, our stories. Urban Indian Health Institute. Published August 23, 2018. Accessed January 29, 2024. uihi.org/projects/our-bodies-our-stories/

[47] Decolonize Data: Accurate Data Tells Accurate Stories. Uihi.org. Accessed January 31, 2024. uihi.org/projects/decolonizing-data-toolkit/


#decolonize data

TEC Data Challenges & Recommendations

Data are the foundation for good public health decision-making. Gaining access to and improving AI/AN data quality is a priority. Tribal Epidemiology Centers (TECs) work as advocates and educators to increase access to data and improve data quality to understand the health status of AI/AN people better and make progress in reducing health inequities.[49]

AI/AN people are often misrepresented in local, state, and federal data and health status reports. This is due to various challenges, like the absence of race and ethnicity data, small population sizes, or data collection instruments that may need to be culturally appropriate for AI/AN people. Articles in two TEC journal supplements with the Journal of Public Health Management and Practice and Public Health Reports share examples of TEC work with their partners to address data challenges and gaps and describe how current practices do not accurately represent AI/AN people.[50, 51]

Responding to a Congressional request made during a hearing of the Committee on Energy and Commerce in June 2020, the U.S. Governmental Accountability Office (GAO) report produced a report titled "Tribal Epidemiology Centers: HHS Actions Needed to Enhance Data Access." Based on data and information collected in document reviews and in key informant interviews, the report, published in March 2022, describes factors affecting the TECs' access to DHHS data.[52] The GAO identified three major challenges:

- Data quality and timeliness can affect the use of data
- TECs' access to data is varied
- Lack of policies, guidance, and procedures hinders TEC access to data

This report section is framed by the three major GAO findings with explanations of each. The following section provides recommendations for collecting, analyzing, and sharing AI/AN data.

[49] Mohelsky, R., Redwood, D., Fenaughty, A., Provost, E., Dalena, C., & McGuire, L. (2019). An innovative tribal-state partnership: the development of the Healthy Alaskans 2020 Statewide Health Improvement Plan. Journal of Public Health Management and Practice, 25, S84-S90.

[50] Novick, L.F., ed. (2019). Tribal Epidemiology Centers: Advancing public health in Indian Country for over 20 years. Journal of Public Health Management and Practice, 25, S1-S100.

[51] Cassidy, L.D, Kenyon, D, & Ritchey, J., eds. (2023). Public Health Matters: Insights From Tribal Epidemiology Centers, Public Health Reports, S2(138), S1-S83.

[52] GAO Report: Tribal Epidemiology Centers: HHS Actions Needed to Enhance Data Access (March 2022). Accessed from gao.gov/products/gao-22-104698.

Challenge 1: Data Quality and Timeliness Can Affect the Use of Data

For data to be useful, it must be of good quality and it must be timely. Inaccurate, missing, or misclassified information on race and ethnicity are common issues that affect the quality of the data:

1. Lack of race, ethnicity, and Tribal affiliation data due to structural problems and historical legacies prevent accurate and complete data collection on race. Even if the data system collects race and ethnicity, often results are collapsed into multiple racial groups, making any useful analysis by race impossible for AI/AN people who often are of one or more races, in addition to holding Tribal citizenship or heritage.
2. Racial misclassification affects population health data quality and AI/AN people are more likely to be misclassified than individuals of other races. This results in under-counting the number of individuals in a population and underestimated disease and mortality rates.[53, 54] Some reasons why data are misclassified include:
   - Systems that do not allow people to self-identify their race or allow choosing more than one race.
   - Observers who assume race based on appearance, name, or other characteristics, and report that data (e.g. coroners, funeral directors, or medical examiners).
   - Data systems do not interact (e.g. cancer and other disease registries may rely on death records for demographic data).
   - The child's race may be assigned at birth as the race of the mother.
3. Small population sizes of AI/AN people and communities are not conducive to routine sampling methodologies used in national health surveys resulting in undercounting and underreporting of AI/AN people. Privacy issues are also a concern with small population sizes. The ability to be counted, while protecting privacy, is essential to address inequities.
4. Data collection instruments may not be culturally appropriate for AI/AN people. A notable example has to do with tobacco. When government agencies refer to the "use of tobacco" they are referencing commercial tobacco use.[55] The tobacco plant is held sacred in many AI/AN cultures and has a very different use than commercial tobacco. Surveys commonly used by federal and state agencies do not make this distinction, resulting in data that could be inaccurate for AI/AN respondents who use ceremonial tobacco.
5. Mistrust in state and government-sponsored activities may lead to low participation in data collection efforts. Prior experiences have resulted in lasting community trauma and AI/AN people and communities are often distrustful and cautious of data-related activities.
6. Structural, geographical, or other barriers to inclusion such as access to stable telecom or WiFi may create difficulty in reaching AI/AN populations leading to lower survey response rates and undercounting.
7. Timely data is critical and active public health surveillance requires almost real-time access to data. Tribal leaders and the TECs need timely data to make informed decisions or accurately monitor trends of health events. This became especially apparent during the COVID-19 pandemic when there was a gross undercount of the impact COVID-19 had on AI/AN people and communities.[56]

[53] Joshi, S., & Warren-Mears, V. (2019). Identification of American Indians and Alaska Natives in public health data sets: a comparison using linkage-corrected Washington State death certificates. Journal of public health management and practice, 25, S48-S53.

[54] Dougherty, T. M., Janitz, A. E., Williams, M. B., Martinez, S. A., Peercy, M. T., Wharton, D. F., ... & Campbell, J. E. (2019). Racial misclassification in mortality records among American Indians/Alaska Natives in Oklahoma from 1991-2015. Journal of public health management and practice, 25, S36-43.

Challenge 2: Access to Data is Varied

TECs experience barriers and continue to have challenges accessing data.

- Federal and state staffing changes cause barriers to access or inconsistent data-sharing practices.
- Legal requirements for programs within one federal or state organization are different for each data set.
- Systems are antiquated or incompatible, resulting in the inability to transfer data.

Challenge 3: Lack of Policies, Guidance, and Procedures Hinders Access to Data

Each entity has different policies, procedures, templates, guidance, etc. to access datasets. The inconsistencies extend to departments and divisions within federal agencies, states, etc. Access is often dependent on the organization's data steward or IT professional. Additionally, there is a lack of:

- Organizational level policy that guides departments on TEC's public health authority.
- Appropriate data sharing practices.
- Consistent messaging within DHHS affirming TECs' authority to access data.
- Policies, guidance, and procedures related to TEC requests for such data.
- Transparency related to the DHHS review process for data requests.

[55] California Rural Health Board. Resource Guide for Assisting American Indian Smokers to Quit. Tobacco Education & Prevention Technical Support Center. 2010

[56] Urban Indian Health Institute. (2020). Best Practices for American Indian and Alaska Native Data Collection. Accessed from uihi.org/resources/best-practices-for-americ an-indian-and-alaska-native-data-collection/

A brief overview of applicable laws

O'Connell and Abourezk provide an excellent overview of the legal foundation of the TECs and the following summarizes their publication.[57]

TECs were first approved by Congress in 1992 as part of amendments to the Indian Health Care Improvement Act (IHCIA)[58] TECs have seven core functions mandated by federal law performed "[i]n consultation with and on the request of Indian Tribes, Tribal organizations, and Urban Indian Organizations:"[59]

- Collecting data and monitoring health
- Evaluating data and programs
- Identifying health priorities
- Making recommendations for health service needs
- Making recommendations for improving health care delivery systems
- Providing epidemiologic technical assistance
- Providing disease surveillance

In 2010, the IHCIA was permanently reauthorized as part of the Patient Protection and Affordable Care Act, providing TECs with stable, continuous funding. It affirmed and enhanced the trust responsibility of the federal government to deliver improved health care to millions of AI/AN people.[60] The 2010 IHCIA included new language on the legal status of TECs. First, TECs were designated as public health authorities under the Health Insurance Portability and Accountability Act (HIPAA), which allows them to access protected health information. Public health authorities may receive protected health information under the Privacy Rule "for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions."[61] Next, the 2010 IHCIA mandated data sharing by the secretary of the DHHS with TECs.[62] Finally, funds designated for each of the TECs are not divisible among the Tribes in the areas.[63] These provisions provide a strong legal foundation for the establishment of the TECs and the disclosure of protected health information to TECs.

TECs originated 30 years ago to help address health inequities experienced by AI/AN communities and Congress provided the mandate and legal framework for them to do so. Federal agencies, however, have been slow to fulfill that mandate, with a disparate impact on the health of AI/AN people. While there has been a general policy push to protect individual patient information, which must be balanced against the needs of Tribal public health organizations to protect AI/AN communities from public health threats, such as COVID-19.

The Tribal, federal, state, and local health data that TECs obtain, analyze, and disseminate provide a unique lens to the health status of AI/AN people throughout the United States. TECs often collaborate with other jurisdictions, including state, local, and federal agencies. Data-sharing agreements make some of these data requests possible. However, many state and local jurisdictions will not engage in data-sharing agreements with TECs, creating delays in accessing data. Improved transparency and reciprocity between all partners working towards a goal of increasing access to all available health-related data sets, allows for more complete and accurate information at each level.

[57] O'Connell, M. C., & Abourezk, C. (2023). Facilitating the Urgent Public Health Need to Improve Data Sharing With Tribal Epidemiology Centers. Public health reports (Washington, D.C.:1974), 138(2_suppl), 80S–83S.

[58] Indian Health Amendments of 1992. Pub L No 102-573. §210, 106 Stat 4552 (1992).

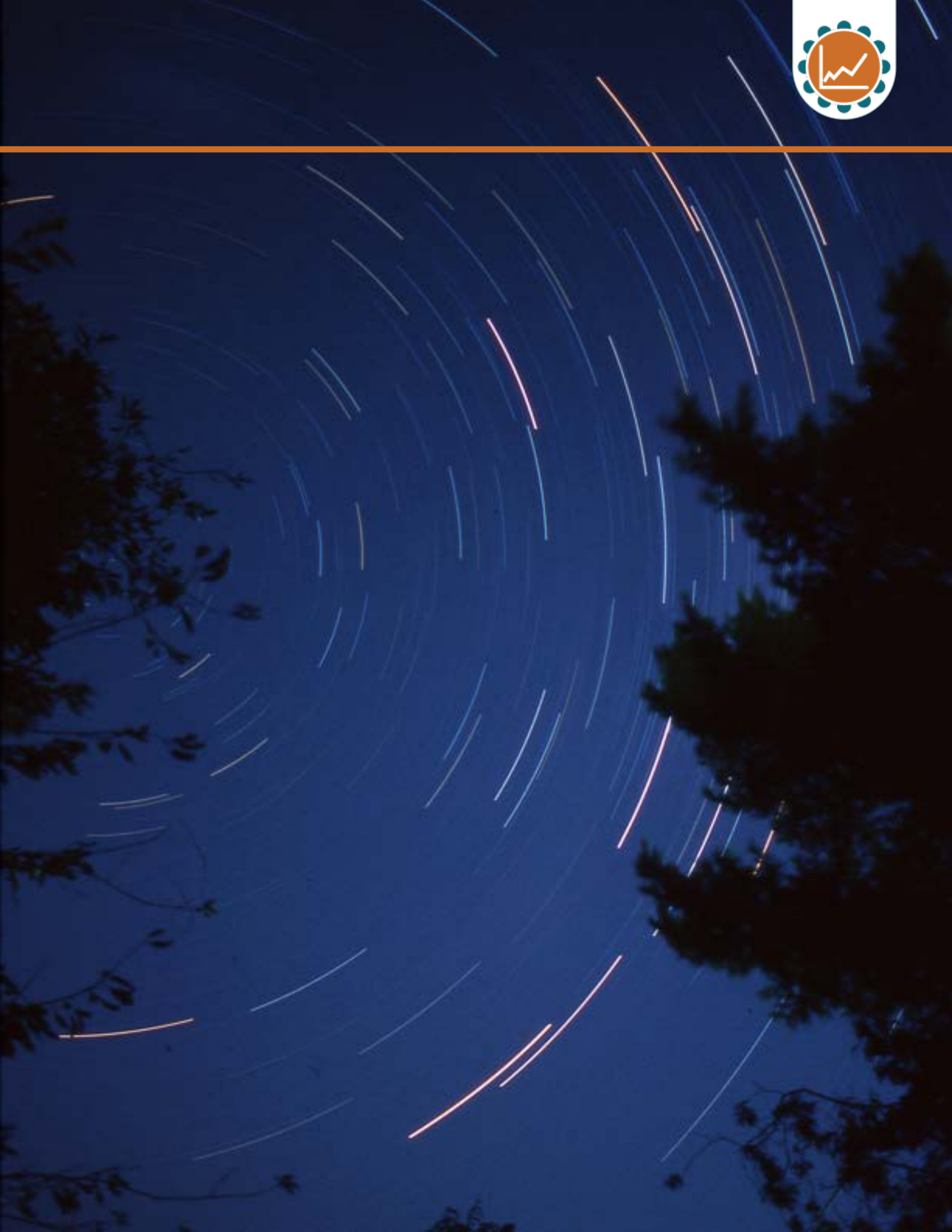
[59] 25 USC§ 1621 m: Epidemiology centers (2010).

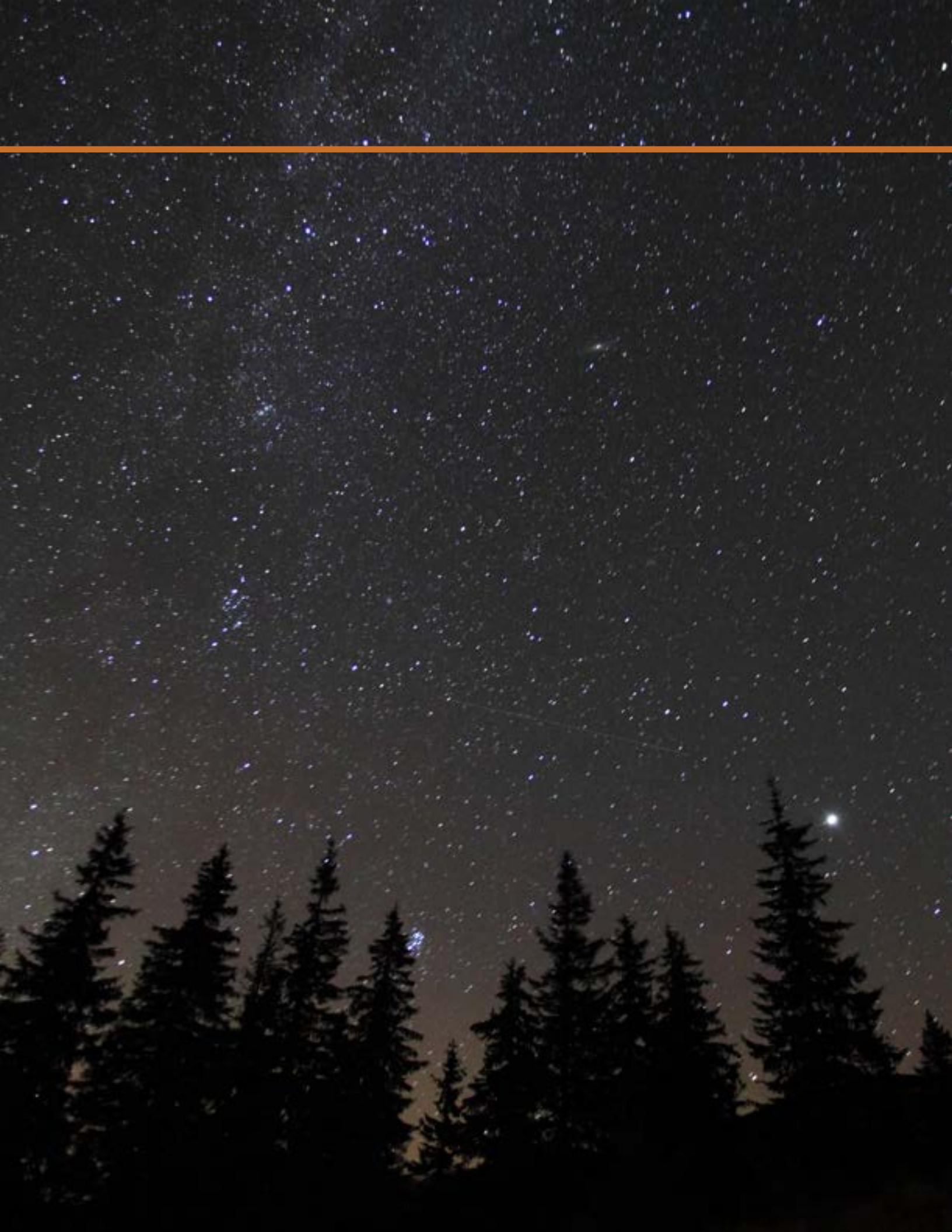
[60] Indian Health Service. Indian Health Care Improvement Act made permanent press release. March 27, 2010. Accessed May 14, 2022. ihs.gov/newsroom/pressreleases/2010pressreleases/indianhealthcareimprovementactmadepermanent 45 CFR §164.512(b) (2000).

[61] 45 CFR § 164.512(b) (2000).

[62] 25 USC§ 1621 m: Epidemiology centers (2010).

[63] 25 USC§ 1621 m: Epidemiology centers (2010).





TEC Recommended Practices

In their publications, Best Practices for American Indian and Alaska Native Data Collection[64] and Addressing Racial Misclassification[65], the Urban Indian Health Institute (UIHI), recommends the following practices to collect, analyze, and present data for AI/AN populations.

Data Collection and Data Quality

1. Grant TECs access to the National Electronic Disease Surveillance System because they are designated public health authorities.
2. Mandate collection of race and ethnicity in health data that utilizes local, state, federal, and territorial funds.
3. States and territories need to report race/ethnicity information to the CDC.
4. Collect Tribal affiliation.
5. In data collection, AI/AN should always be defined as AI/AN alone and separate US AI/AN from others (e.g. South American AI). If the AI/AN individual identifies as another race, include the individuals who are AI/AN in any combination with any other race and include those who identify as Latinx/Hispanic.
6. Avoid reporting data collected and findings from analysis as 'multi-racial' and 'other' when possible.
7. Data tools used for collecting race and ethnicity should allow for the selection of multiple races with the ability to disaggregate the data once collected.
8. Funeral homes, medical examiners, and coroners must ask the next of kin or informant how the decedent would have described their race/ethnicity and Tribal affiliation and should abstain from placing information on the death certificate based on subjective observation.
9. Provisions in state and territorial law should be made for the next of kin or informant to amend the death certificate after it is filed if the race/ethnicity information is incorrect or is unknown at the time the death certificate is filed.
10. Regular feedback to public health personnel at the local, state, and territorial levels about missing race data along with a plan for quality improvement.
11. Link or allow linkage of data sets to correct for racial misclassification.
12. Oversample the AI/AN population, where feasible and advisable.
13. Report limitations of data collection and analysis.
14. Conduct mixed-methods research (quantitative and qualitative).

[64] Urban Indian Health Institute. (2020). Best Practices for American Indian and Alaska Native Data Collection. Accessed from uihi.org/resources/best-practices-for-american-indian-and-alaska-native-data-collection/

[65] Urban Indian Health Institute. (2021). Addressing Racial Misclassification. Accessed from uihi.org/resources/addressing-racial-misclassification/

Data Analysis

1. Aggregate data on AI/AN populations.
2. Use weighted sampling for AI/AN populations.
3. Limit stratification in analysis to restrict the reduction of sample size.
4. Avoid reporting data collected and findings from analysis as 'multi-racial' and 'other' when possible.
5. For numerators, include people who are AI/AN alone and, if multi-race, include people who are AI/AN in any combination with other races.
6. For denominators, counts of AI/AN alone or in any combination can be obtained from data.census.gov using the American Community Survey. Data are available down to the county level in the United States. Data are available by gender and age down to the state/territory level. Additional data on AI/AN alone or in any combination with other races may be obtained from state, territorial, and Tribal population forecasting organizations.
7. Consider aggregating the data of several adjacent counties or presenting data at the state level to protect the privacy of small populations and consider aggregating data across time to include a longer time frame for the analysis.
8. Consider how surveillance data for other conditions with small numbers are presented and discussed.
9. Consider analyzing defined setting outbreaks (long-term care facilities, jails and prisons, homeless shelters, etc.) as separate cases from cases assumed to have been exposed elsewhere in the community. This serves two purposes: 1) it can highlight which defined settings pose a specific morbidity risk to AI/AN and 2) if a defined setting makes up a substantial proportion of deaths in a county or state, including those deaths in the analysis of the community can hide the true mortality burden.
10. Do not release Tribally specific data without a Data Use Agreement from the Tribe that grants such a release.

Building Trust and Relationships[66]

1. Establish relationships with state and regional health departments to secure data access and implement data-sharing agreements.
2. Establish relationships with T/TO/UIOs to ensure staff are known and trusted, demonstrate they can meet community needs, and add value to the communities served.
3. Commit to knowing and understanding AI/AN communities, comply with local protocol, and respect and honor culture and history.
4. Adapt data collection practices to local needs to enhance response rates and increase sample size that is difficult to obtain otherwise.
5. Discuss data sources, measures, collection, and dissemination approaches with community representatives and work with Institutional Review Boards (IRBs), as appropriate, to have activities approved.
6. Give credit to the community members for contributions and include them as co-authors on reports and publications.
7. Build community capacity and provide training and technical assistance on a wide breadth of public health topics including data collection and analysis, data visualization, and data sharing practice.
8. Hire members of the community to serve as consultants or provide funding so partners can develop and implement projects.
9. Respect the privacy of the communities and avoid unnecessary comparisons.
10. Honor Tribal sovereignty and discuss findings with partners. Results should be shared only on approval by partners.

[66] Native American Center for Excellence. (n.d.). Steps for conducting research and evaluation in Native communities. Accessed from samhsa.gov/sites/default/files/nace-steps-conducting-research-evaluation-native-communities.pdf.

These recommended practices and approaches to enhance the collection and analysis of AI/AN data are the core and driving mission of the TECs and the work they do to support T/TO/UIOs and Tribal communities. The TECs and seven core functions were created to reduce the health inequities that AI/AN people have persistently faced. The designation of TECs as public health authorities in 2010 represented an additional significant step toward achieving health equity for AI/AN people[67] and it is past time to ensure recognition of this authority to improve data access and decrease these data inequities.

[67] O'Connell, M. C., & Abourezk, C. (2023). Facilitating the Urgent Public Health Need to Improve Data Sharing With Tribal Epidemiology Centers. Public health reports (Washington, D.C. : 1974), 138(2_suppl), 80S–83S. doi.org/10.1177/00333549231152197

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