

MCH EPI Conference

Plenary II: MCH in Indian Country - Partnerships to Identify and Address Health Disparities

December 8 – 11, 2008

JUDITH THIERRY: I thought I was going to have to compete with Frank Sinatra. Good Afternoon. I'm Judi Thierry. I'm maternal and child health coordinator for the Indian Health Service. It's my pleasure to be here this afternoon on this plenary session that's been in the planning probably for nine months. I want to acknowledge Sam Costner, Myra Tucker, May Caster who had an early conversation with Sam. And May is now working in Afghanistan at Rabia Balkhi Hospital as a physician analyzing anti-natal data there.

There are several people I want to acknowledge in the audience here: Heather McCormick from Health Canada First Nations and Inuit Health branch. Welcome, Heather; our tribal epicenter staff who really are the grassroots on the ground, functional group making things happen in Indian country, and this is really because of Closing the Health Gap SIDS initiative funds that were provided to us by CDC and office of Minority Health out of Department of Health and Human Services. These funds came to us in 2004 and it was my delightful job to figure out what to do with the money.

In an Indian country we know there's gaping disparities and particularly around infant mortality and particularly around post neo-natal infant mortality and SIDS. So, the initiative was described as SIDS and infant mortality reduction. Really to tackle SIDS in Indian country and infant mortality when we know there's 350 to 400 infant deaths that are American-Indian Alaskan Native annually. That it's very difficult to look at one tribe or one region and focus your efforts there. And we knew with the budding tribal epidemiology centers in urban Indian health institute and their epidemiology center that we could really take ground and look at our epidemiology issues that we needed to address with SIDS and infant mortality.

Clearly, we need to do outreach too and some funds went for that, but sitting here in the front row are many of the tribal epidemiology recipients who had three years of funding to create, kind of, let's say, a baby footprint for MCH in their tribal programs. Some of them already indeed had lots of tribal EPI work going on for MCH, but this really gave a strong foothold, toehold for MCH and here we are today with a plenary.

So, I just really want to acknowledge all of you for that, and the planning committee for this conference, and Laurie Chestnut who is not in uniform but she should be because she has been my commander during all of this, and the slides that she and her husband put together compliments of Denver Archives, Indian Health Service Photo System Archives, and Office of Women's Health. You'll see

some colored photos there -- are from Office of Women's Health body works toolkit, which is a toolkit that has been out for about two or three years. This now has a Hispanic version and also has an American-Indian Alaskan Native version that we'll be launching. I'll talk a little bit about that.

So, I'm just going to get out of these slides here and I haven't talked about our presenters here. Our intent is for me to give you a very brief EPI overview and then provide you with a real education from Stacey Bowen, the Executive Director from the National Indian Health Board who will be giving us really the advocacy point of view and what it takes to work in Indian country on Capitol Hill with tribes, with urban programs, with health boards across the country, and with Congress.

Okay, let's see. Sorry, I think I'm there. The Indian Health Service has been in existence since 1955. Funding for it came through the Snyder Act and the Transfer Act and the Indian Health Care Improvement Act, but the organization as we know it now with the comprehensive health care system really from cradle to grave began in 1955 and is continuing to evolve. And I really say that the tribal epidemiology centers our allowing us to really take ground on public health issues that in a hospital-based clinic system, Alaskan Native village health care system probably is not sufficient to address the over-arching public health issues like tobacco, infant mortality. So, with the tribal epicenters along with the Indian Health Care System as we know it, we really have great capacity here.

You'll see the areas divided up in regions. Most Federal agencies have regions of sorts. HRSA does and we do too. We serve 1.9 million users in our system -- that's people who are in our system at least once in three years. Reliably, our infants are in our system. We have about 22,000 infants that we take care off annually; 25,000 pre-natals; we deliver 10,000 women annually. For U.S., American-Indian and Alaskan Natives there's about 42,000 births annually. And so our service units contain one -- California's service unit per state; Navajo has its own service unit. So, here's a tribe as an area. But as you see, in Aberdeen area that's four states, 18 tribes, one epidemiology center is located there and the area offices are named by the city that the area office is in. So, it's Aberdeen Area and Aberdeen Billings and Billings etc.

Our health care system, we talk about it as ITU, Tribal is T urban and I is the direct or Indian Health Service side. And you can see here our Federal Tribal Urban Indian Health programs, and the various hospitals area office, health stations, and even school clinics. I would like to think that we had more school clinics and I'll talk about that later also for youth needs.

Here's a map of the Indian health. I can put this on view -- I forgot to do that -- a map of our urban programs and here you'll see 34 sites in major metropolitan areas. If you look at Detroit, it actually runs through across four counties over to Grand Rapids. So, these little dots aren't just that place there, it really extends

across counties. And it gives you a picture that roughly 60% of our American-Indian Alaskan Native population do not reside on reservations. They may be from reservations, but they really live in urban communities and some of them that has been their home since assimilation times and Stacey probably will talk about that briefly.

Again, here's our epidemiology centers that were funded through the Closing the Health Gaps SIDS initiative. Also, we wanted to make sure that the rain fell evenly and as you can see, with the areas and the tribes and the urban programs that to really get bang for the buck, we wanted to put it with the epicenters and all of the existing ones that existed in 2004. Since that time, four more, five more have come on board: Navajo, Billings Area, and Oklahoma as well. So, here is your epidemiology programs.

This is a slide that I think just kind of gives us all pause from quiet crisis Federal funding that needs Indian country U.S. Commission on Civil Rights. Native Americans rank at or near the bottom of nearly every social health and economic indicator. Health care expenditures across several payment systems here are highlighted with Indian Health Service Medical Care in 2003 at \$1,900 per capita; Medicare expenditures \$5,900; VA \$5,200; U.S. per capita \$5,000; Medicaid at \$38; and Federal Prisons at \$3,800.

I'm going to show you some slides from regional differences, which is a statistics chart book that's put out every five or so years from the Indian Health Service. We would like to catch up with ourselves. This is 1999-2001 data. It's a labor of love by JoAnn Pappalardo and the statistics branch at Indian Health Service and she's available for questions really readily by phone. I have this as a PDF if you would like me to e-mail it to you, please just contact me. It's not online yet at the IHS but this goes to show you here that the poverty level is a great burden. We heard in the plenary this morning the socio-economic indicators of economics. And for Indian country, poverty is an everyday issue and manifests itself at 29 percent here. And this is, again, 1999-2001 data so we really probably are seeing even higher rate and the gap for all U.S. races here is noted.

Unemployment. I'm just going to briefly look at a few economic indicators.

Unemployment for males in Indian country four times. Our average and our usual population is four times the U.S. races. And when you look, at Billings, which is the bottom line there, roughly 26 percent to 27 percent of males are unemployed. In many reservations, this is much higher: 70s, 80s, 90s and sometimes 100 percent.

This is a picture from the IHS archives also. I want you to just kind of just have this icon in your mind. I think a picture is worth thousand words. And here we have youth and the elder and many of our programs, while this is -- look at disparities -- whenever our programs in the administration on Native Americans

are working to retain language, retain traditions, pass that on and it really is in the elders' voices and their sharing. And here we have youth, in a revelry moment with an elder comforting each other. I think it teaches respect and just many values that are inculcated in our tribal cultures.

Percent user population under age five, we are young, we are a pyramidal type population here. And as you see, the elders, we don't have as many elders and we are far below the U.S. rates of 21.9%. Making us, again, this issue -- this gap of our elders passing on traditions, this shows up in the years of potential life loss. But, it's really looking at what else is being lost with early loss of life. This quick slide by Donna Perry, who's chief of staff at Chinle Regional Medical Center on Navajo, who's herself a pediatrician and adolescent medicine specialist.

Compared Navajo nation high schools with Bureau of Indian Education high school students Arizona and USA in 2003 and I want to point out here, and I think for the states this is important to look at. If you look at offered drugs on school property, it's pretty much the same across the board there. Looks like drugs are pretty much an equal opportunity no matter the culture, at least here in the slide. Smoke cigarettes in the past year 37.7% for Navajo high school students, 21 for US.

Clearly, there's a gap here and points to a need for tobacco cessation or tobacco control programs. We know with tobacco that starting early, you smoke for your life and you smoke heavier. And we also know, working with office on women's health tobacco and low SCS status that we have an education gap here that people who are low GED, no GED, or haven't had finished high school are more likely to continue to smoke and smoke, and to stay smokers.

PE classes here are also, you see the gap here not consistent. However, Bureau of Indian Education seems to hold up, but other, the Navajo nations. So, it may see a policy issue around, looking at maybe a school health index and what you could do. Infant mortality, again as I said, it varies across the system. And this is a slide from that Urban Indian Health Institute epicenter. Here, you see L.A., running around 7 to 8 percent and Chicago, in the red, upwards of 22 infant mortality rate.

Diabetes, the obesity, tsunami that's hit us, our IHS rates our astronomical. Navajo, you can see here is at 77.2 per thousand live births. Recently, with CDC we did a maternal morbidity paper with Stephen J. Bacak, Myra Tucker, myself, and Edna Paisano, looking at Indian health service administrative data and patient care data, on maternal morbidity as related to cesarean section. Our section rates are actually lower than the U.S. We do a lot of evac's.

We're trying to reverse the trend that the U.S. is taking. Some women who smoke during pregnancy, I've talked about tobacco are women are smoking heavily and the low birth weight group tends to have 25 percent of those women probably are smokers.

The last slide here there are two reasons I don't smoke. This is on the Northern Plains Epicenter, the tobacco project at Aberdeen Area Troubled Chairman's Health Board. Christine's nodding her head. And Fabian Kennedy has been running a community-wide programs. This one obviously has got emotional messaging, clean air, two healthy babies. This is culturally sensitive, culturally specific. And will be living on billboards in South Dakota. This is in partnership with three states in tobacco funds.

Lastly, again, just to acknowledge our tribal epidemiology centers, how the rest of the session's going to go is Stacy will be coming up here when I get her slides. And then, we will be moving to our other plenarists. We wanted, in this session, to give you the opportunity to see what other states were providing and we thought, well, 90 minutes, we can't get everybody up here, but that would be good, maybe next time or in another breakout session we could hear about other states. And -- but we chose Alaska and Thalia Wood will be going first, from the State of Alaska EPI program and then Sharon Smith, from the State of Minnesota, who's state appointed liaison, tribal liaison, and then Alexis Avery

from the State of New Mexico. So, I really thank you all for the work you've done and we look forward to your presentations. Stacy, I'll try and pull you up here.