2022 American Indian and Alaska Native Health Status Report

Utah Department of
Health & Human Services
American Indian/Alaska Native Health & Family Services

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Purpose

The purpose of this report is to communicate the current tribal and Indian Health System priorities and provide insight into the health status of American Indian and Alaska Native (AI/AN) populations in Utah.

Introduction

There are eight federally recognized tribes in Utah: The Confederated Tribes of the Goshute Reservation, Navajo Nation, Northwestern Band of Shoshone Nation, Paiute Indian Tribe of Utah, San Juan Southern Paiute Tribe, Skull Valley Band of Goshute Indians, Ute Indian Tribe of the Uintah and Ouray Reservation, and the Ute Mountain Ute Tribe (figure 1). The AI/AN population in Utah is a highly mobile population moving between reservations and urban/suburban areas. In addition, a reservation can be located in more than one state. Half of the tribes located in Utah share more than one state boundary on a reservation. This can add layers of complexity when assessing health status and assuring access.

Unlike other racial and ethnic minority groups, a majority of AI/AN's are enrolled members of a federally recognized tribe. Federally recognized tribes are acknowledged by the U.S. government as sovereign entities. The legal bases for this status are recognized in the following; The "Commerce Clause" of the U.S. Constitution; treaties between the U. S. with the Indian nations, legislation, and subsequent federal policy; and Supreme Court decisions and Presidential Executive Orders (EO 13175, W.J. Clinton 4/29/94; Memorandums, G. W. Bush 9/24/04, B. Obama 11/5/09, and J. Biden 1/26/2021).[1-6] Because of this unique status, tribes have a 'government-to-government' relationship with the federal government. There are many federal programs that are operated by states; Medicaid, CHIP for example. In some circumstances, the federal government requires a state to work directly with a tribal government either individually or collectively to ensure a program meets the needs of their communities. This requires states where tribes are located to acknowledge that sovereignty and work with them on a 'government to government' basis as well. The state of Utah honors this recognition through the Utah Division of Indian Affairs Act, Utah Annotated Code 1953, 9-9-104.6, and Executive Order EO/2014/005.[7-9]

Enrollment in a federally recognized differs from racial self-identification and entitles a person to health services through the Indian Health Service (IHS), tribally owned and operated health facilities (often referred to as a '638' for PL 93-638 authority), and the Urban Indian Organization (UIO) – collectively referred to as the I/T/U or Indian Health System.[10] While the focus of the I/T/U is to provide services to tribally enrolled members of federally recognized tribes, many tribal facilities may also provide services to the broader community where they are located.

In Utah, the **I/T/U** consists of:

- **I =** One federal Indian Health Service (IHS) Facility in Fort Duchesne, Utah
    - Uintah & Ouray Service Unit
- **T =** Five Tribally owned and operated facilities (638 facilities) in Utah
    - *Sacred Circle Healthcare* (Confederated Tribes of the Goshute Reservation) 4 facilities
    - *Utah Navajo Health System* (Navajo Nation) 4 facilities
    - *Nwbsn Health and Human Services* (Northwestern Band of Shoshone Nation) 2 facilities
    - *FourPoints Health* (Paiute Indian Tribe of Utah) 4 facilities
    - *Nat-su Healthcare (Skull Valley Band of Goshute)*
- **U =** One Urban Indian Organization (UIO) located in Salt Lake City

- Urban Indian Center of Salt Lake

There are also multiple I/T/U facilities out of state that provide services to tribal members in Utah; Towaoc CO; Fort Hall, ID; Elko, NV; Shiprock, NM; Red Mesa, AZ; Tuba City, AZ.

The Utah Indian Health Advisory Board (UIHAB) is a group of health officials appointed by their respective tribes to communicate with state officials on health and public health issues. Every year, the Office of American Indian/Alaska Native Health and Family Services (IHFS) holds an annual retreat with UIHAB, where they decide on the top priorities to be addressed in the coming year(s). For 2022, a survey was administered to UIHAB representatives to assist in setting these priorities and to give them an opportunity to provide feedback on their relationship with state entities. A similar survey was sent to tribal leadership. Results of these surveys are shown in section one of this report.

Section two of this report is a health status update of the AI/AN population in 2020. Throughout this section, disparities will be identified between the AI/AN population and the general population. AI/AN have been subject to many systemic and structural disadvantages including poverty, poor access to resources, and historical trauma from violence, displacement, assimilation, and racism.[11] Any disparities in health outcomes or behaviors identified in this report should be viewed as outgrowths of these underlying inequities, not as inherent vulnerabilities of the AI/AN people.[11]

Figure 1: Utah Tribal Lands Map

Created by P. Perry; Utah Division of Water Resources 5/2005
Updated by K. John Utah Department of Health 11/2019

Data Notes

In this report, “general population” refers to the entire population of Utah and “AI/AN” refers to the non-Hispanic population who identify with AI/AN as their only race.

Data were pulled using Utah’s Indicator Based Information System (IBIS) version 2020.

Statistical significance was determined by comparing 95% confidence intervals. If the intervals did not overlap the difference was considered statistically significant.

The data in the report come from the year 2020. A few sections use data from 2019 and 2020 so reliable rates could be attained when aggregated together. This will be noted in the section header.

Section 1 – UIHAB and Tribal Leadership Surveys

In preparation for the UIHAB Annual Retreat a survey was administered to UIHAB representatives. This survey facilitated the setting of tribal health priorities for 2022 and provided a platform for UIHAB representatives to provide feedback about IHFS, UIHAB meetings, and relationships with state and local officials. Key points from the survey will be provided in this report, while a more detailed look into the survey and its results can be found in Appendix A.

UIHAB Priorities

As will be seen in section 2 of this report, AI/AN have unique health needs and are subject to unique structural barriers. The priorities set by UIHAB represent the tribes' biggest concerns and strategies to address these needs and barriers and are as follows:

1. Quality Health Services. This includes improving timeliness of care, patient satisfaction, infrastructure, staffing, availability of specialty care, and accreditation.
2. Mental/Behavioral Health. This includes reducing stigmatization of mental health disorders, addressing COVID impacts on mental health, improving availability of substance use disorder treatment and prevention, improving infrastructure and capacity, and providing culturally relevant care.
3. Diabetes/Obesity. This includes increasing healthy behaviors, easing access to treatment, improving programs, and providing culturally relevant care and education.
4. Data and Data Sharing. This includes increasing access to state data, better documentation, better systems, staff training, and data sharing agreement processes.
5. Medicaid/Medicaid Expansion. This includes consultation with tribes, qualified navigators, more education and outreach, improving familiarity with Utah Medicaid, and working to include traditional practices as billable services.

UIHAB Feedback

Feedback from UIHAB representatives is summarized in the following points. A more detailed view of the feedback can be seen in Appendix A.

- IHFS is generally viewed neutrally or positively. More work is needed to effectively disseminate data and communicate policy changes.
- The UIHAB monthly meeting is an effective tool that is viewed positively by UIHAB representatives.
- Relationships with LHDs are generally positive.
- Relationships with state leadership vary significantly by tribe but are generally neutral/positive.

Tribal Leadership Feedback

In addition to the survey sent to UIHAB representatives, a similar survey was sent out to tribal leadership to provide feedback about their relationship with the Office of AI/AN Health Affairs (OAIANHA), state and local leaders. The results of this survey can be viewed in full in Appendix B, but key feedback is summarized in the following points.

- OAIANHA is generally viewed neutrally or positively. More work is needed to effectively disseminate data to tribal leadership.

- Most tribal leaders are aware of, and receive updates from their UIHAB representative.
- Tribal leadership views on county leadership vary widely, with a majority indicating that county leadership does not understand tribal public health issues.
- State agency leadership is generally viewed in a more positive light than elected leadership when it comes to understanding tribal public health issues and the timeliness of tribal consultation.

IHFS Moving Forward

The feedback provided from these surveys will be used by IHFS in the upcoming year to improve our working relationship with the I/T/U and tribal leaders and guide our work with state and local partners.

More work is needed to effectively disseminate data and communicate policy changes. Most of this work is currently taking place during meetings, including UIHAB and the COVID-19 I/T/U Meeting. Moving forward, IHFS will:

- Improve email communications by explicitly stating that it contains policy changes or relevant data.
- Produce more written materials that can be disseminated via emails and meetings for both data dissemination and policy changes.
- Continue to produce quarterly reports and present to UIHAB.
- Monitor indicators associated with priorities set by UIHAB.

The UIHAB monthly meeting is an effective tool that is viewed positively by the tribes. Efforts will be made to transition to in-person meetings moving forward.

Relationships with LHDs are generally positive. IHFS will continue to advocate for the I/T/U and facilitate conversations between LHDs and tribal jurisdictions. IHFS will reach out to tribes/organizations that disagreed with the LHD statements.

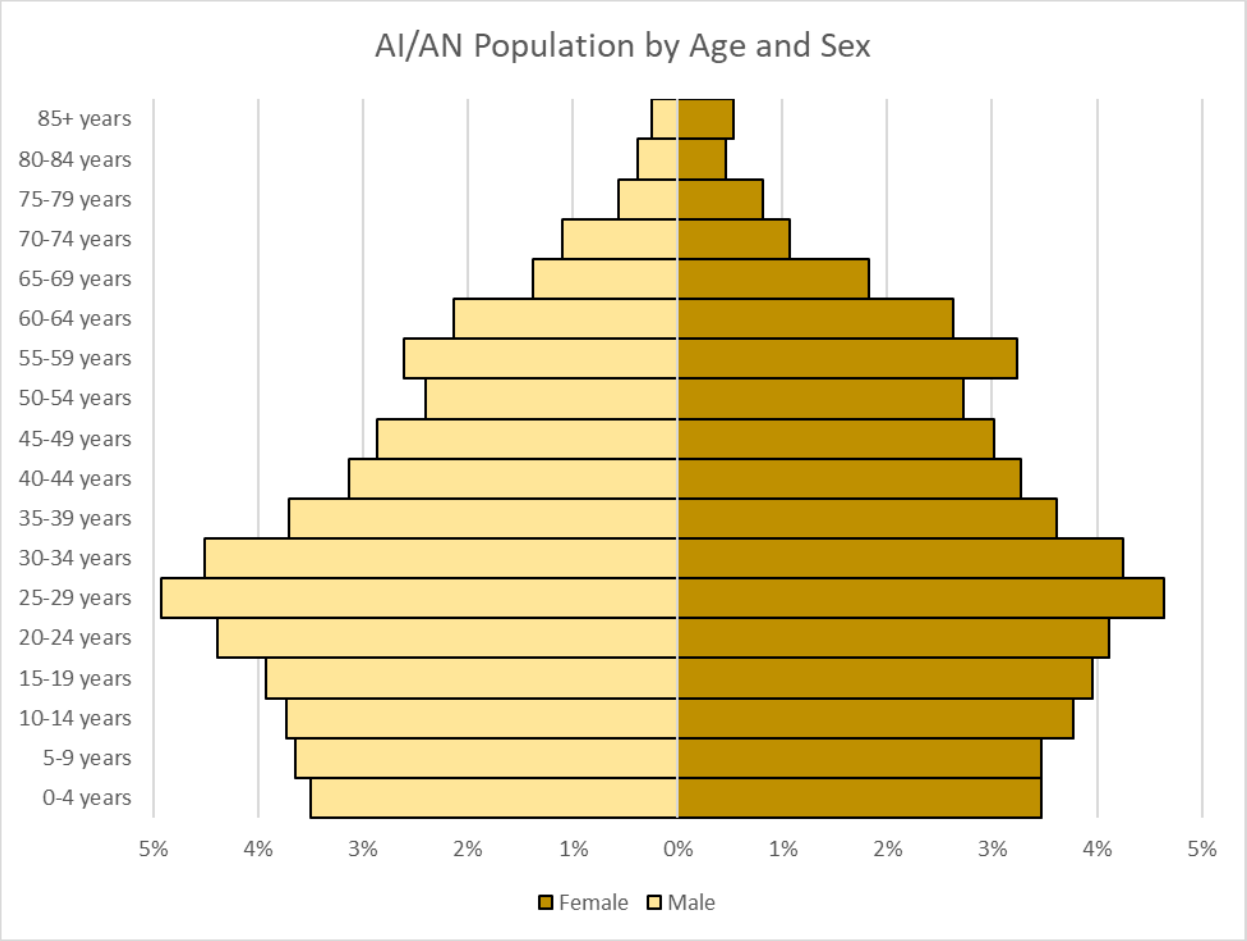
Relationships with state vary by tribe/organization. IHFS will continue to advocate for the I/T/U and facilitate conversations between state leadership and tribal jurisdictions. IHFS will reach out to tribes/facilities that disagreed with the statements about state leadership.

Section 2 – Health Status Overview

Demographics

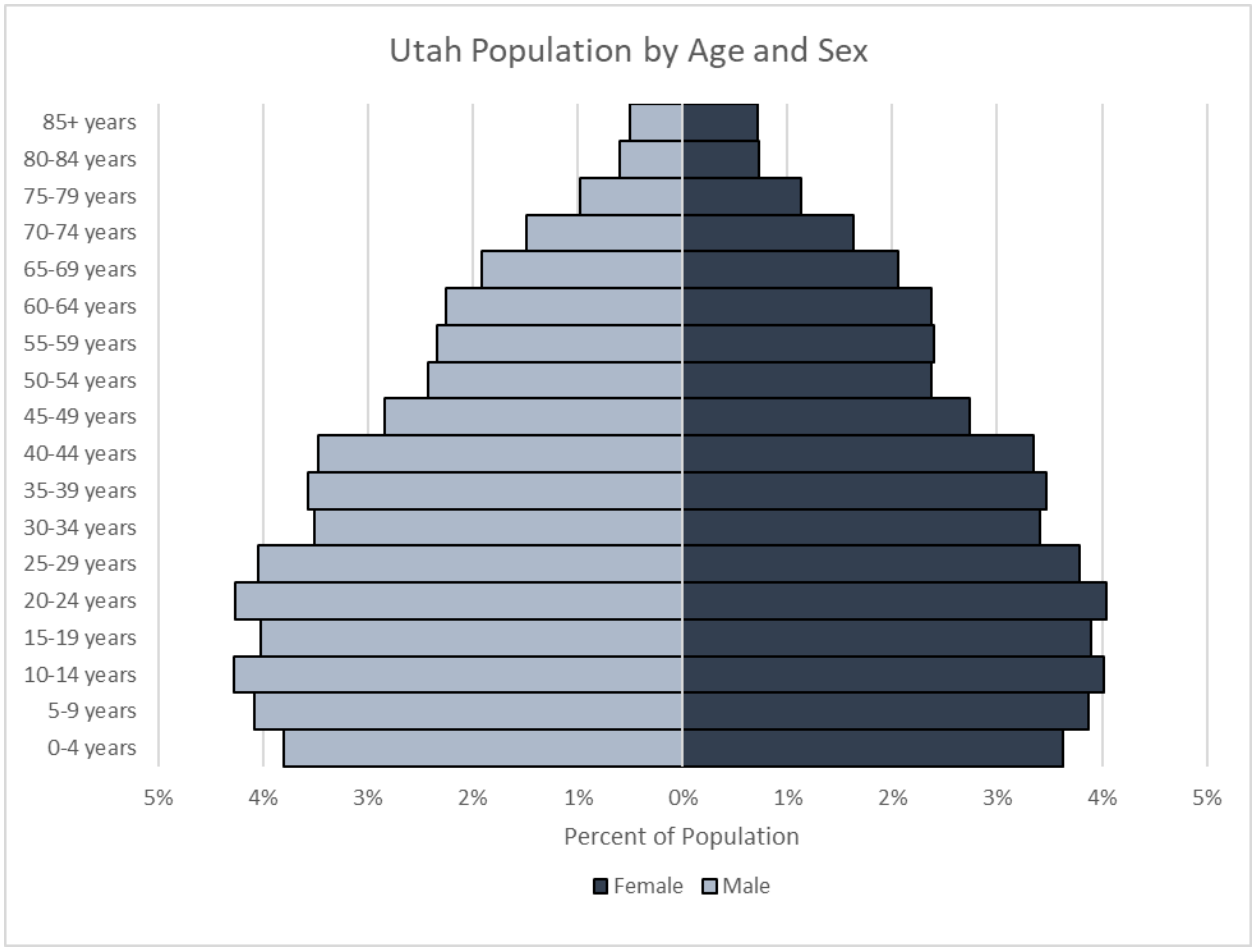
The AI/AN population by age and sex can be seen in figure 2. The AI/AN population has more extreme tapering from the middle-aged population towards the older and younger populations than is seen the general population's chart (figure 3.) This tapering indicates that AI/AN have a larger working-age population (70% of AI/AN are ages 15-64 compared to 64.5% statewide) and a smaller youth and elderly populations. These differences can be attributed to a higher mortality rate and lower birth rates among the AI/AN population over time.

Figure 2: AI/AN Population Pyramid



Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, U.S. Bureau of the Census, IBIS Version 2020

Figure 3: Utah Population Pyramid

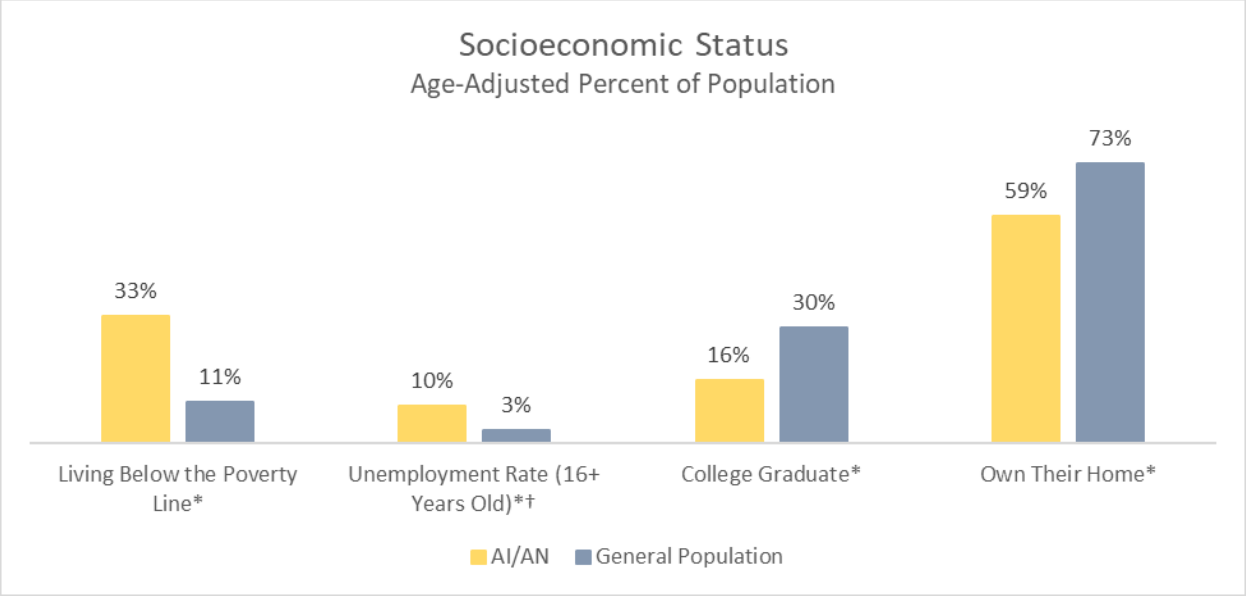


Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, U.S. Bureau of the Census, IBIS Version 2020

Socioeconomic Factors

Socioeconomic status refers to the social standing of a group and is "often measured as a combination of education, income and occupation".[12] Figure 4 examines four socioeconomic factors by comparing the AI/AN population with the general population of Utah. Compared to Utah overall in 2020, more AI/AN were living in poverty, more were unemployed, fewer were college educated, and fewer owned their own home. These differences point to imbalances in resource access, privilege, and power [12]

Figure 4: Socioeconomic Factors



Sources: Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health; American Community Survey. United States Bureau of the Census. County 5-years estimates, downloaded from https://data.census.gov/cedsci/ , Table S2302.

**Statistically significant difference between AI/AN and the General Population.*

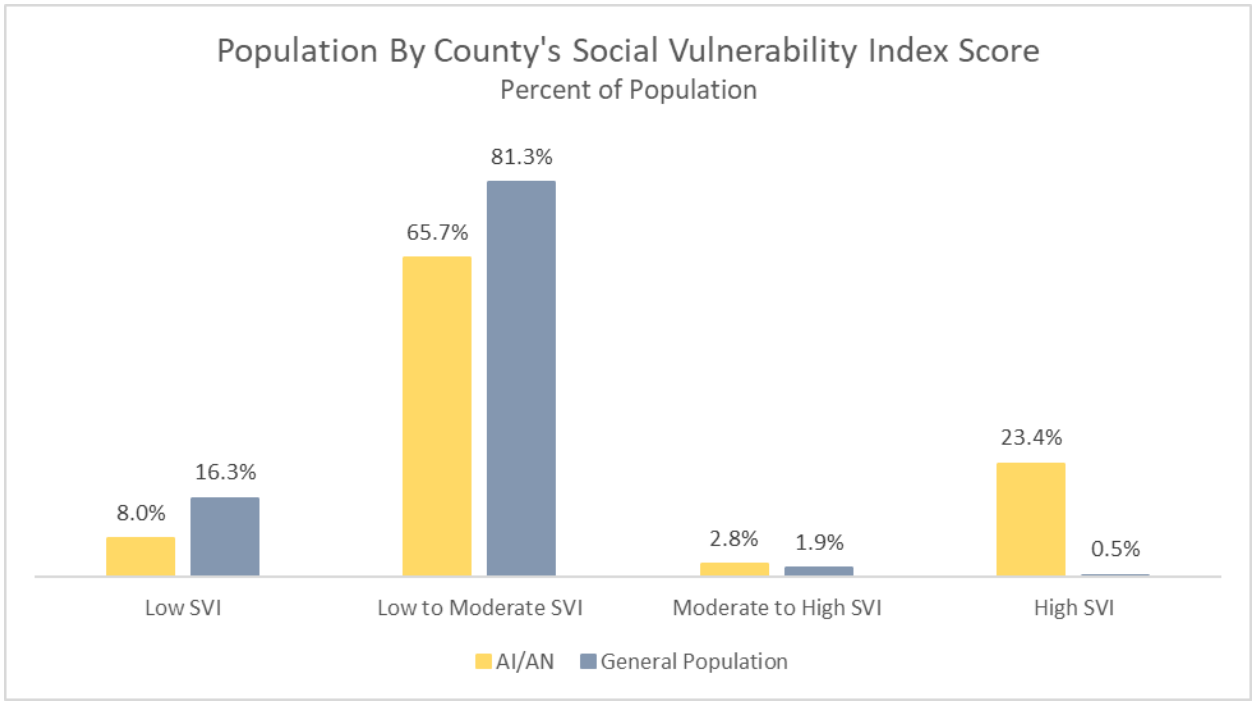
† Unemployment rates are a 2016-2020 ACS estimate.

Social Vulnerability Index

Socioeconomic factors also influence a population's susceptibility to public health emergencies. The Social Vulnerability Index (SVI) is a tool created by the Agency for Toxic Substances and Disease Registry (ATSDR) and the Centers for Disease Control and Prevention (CDC) that looks at indicators including socioeconomic factors, household composition, housing type, and transportation to determine how vulnerable a community is to a public health emergency.[13] Communities are given an SVI score based on the indicators ranging from low vulnerability to high vulnerability.

The percentage of the AI/AN population by county's social vulnerability score can be seen in figure 5. While most AI/AN live in areas of low to moderate social vulnerability, almost a quarter live in San Juan County which is the only county in Utah with high social vulnerability. This county also contains populations from three federally recognized tribes including the Navajo Nation, Ute Mountain Ute Tribe, and the San Juan Southern Paiute Tribe of Arizona.

Figure 4: Population by Social Vulnerability Index

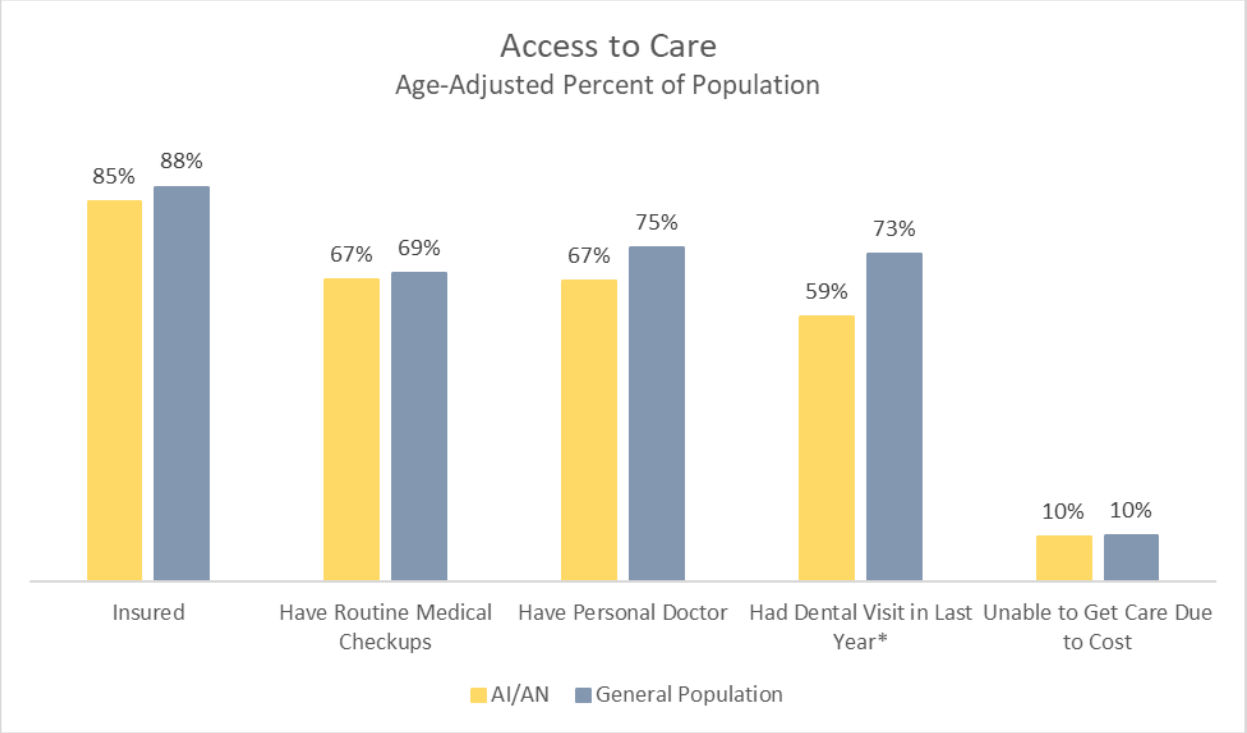


Sources: Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, U.S. Bureau of the Census, IBIS Version 2020; Agency for Toxic Substances and Disease Registry, CDC's Social Vulnerability Index (SVI), https://svi.cdc.gov/map.html

Access to Health Care

Access to health care is defined as "the timely use of personal health services to achieve the best health outcomes" and includes insurance coverage, source of care, timeliness of service, and a qualified, culturally competent health workforce.[14] Consistent access to health services can improve the quality and length of life by providing timely prevention and treatment.[15] Figure 6 demonstrates differences in access to care among Utah's AI/AN and general population in 2020.

Figure 6: Access to Health Care

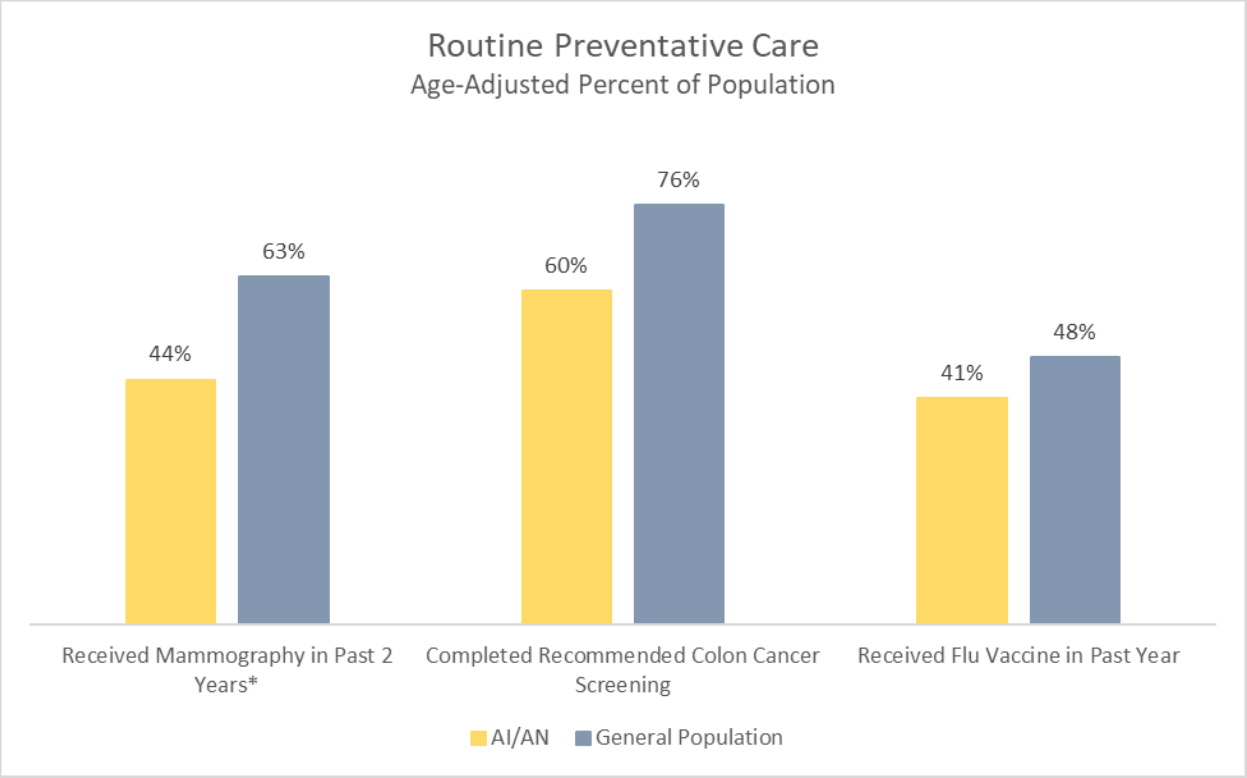


Source: Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health
**Statistically significant difference between AI/AN and the General Population.*

Preventative Care

An important component of healthcare access is access to preventative services. Figure 7 shows differences in routine preventative care between Utah's AI/AN and General population.

Figure 7: Preventative Care

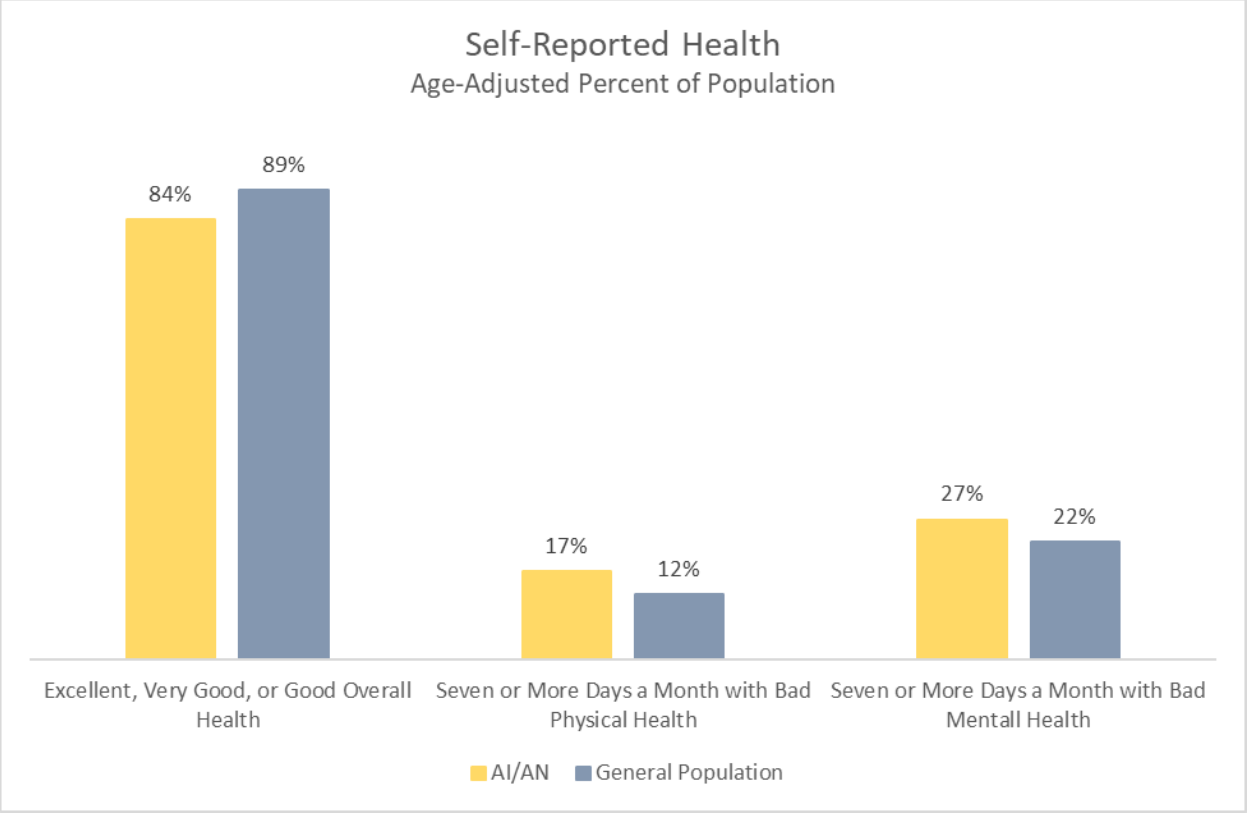


Source: Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health
**Statistically significant difference between AI/AN and the General Population.*

Self-Reported Health

The World Health Organization defines health as the "state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity".[16] This holistic view of health is difficult to assess with data pulled from medical records. Self-reported health is an indicator that is able to get at this more holistic definition by relying on a person's individual perceptions of their health.[17] While a subjective indicator, it is highly associated with mortality and other health outcomes.[17] While not statistically significant, AI/AN have poorer self-reported health than the general population as can be seen in figure 8.

Figure 8: Self-Reported Health Indicators

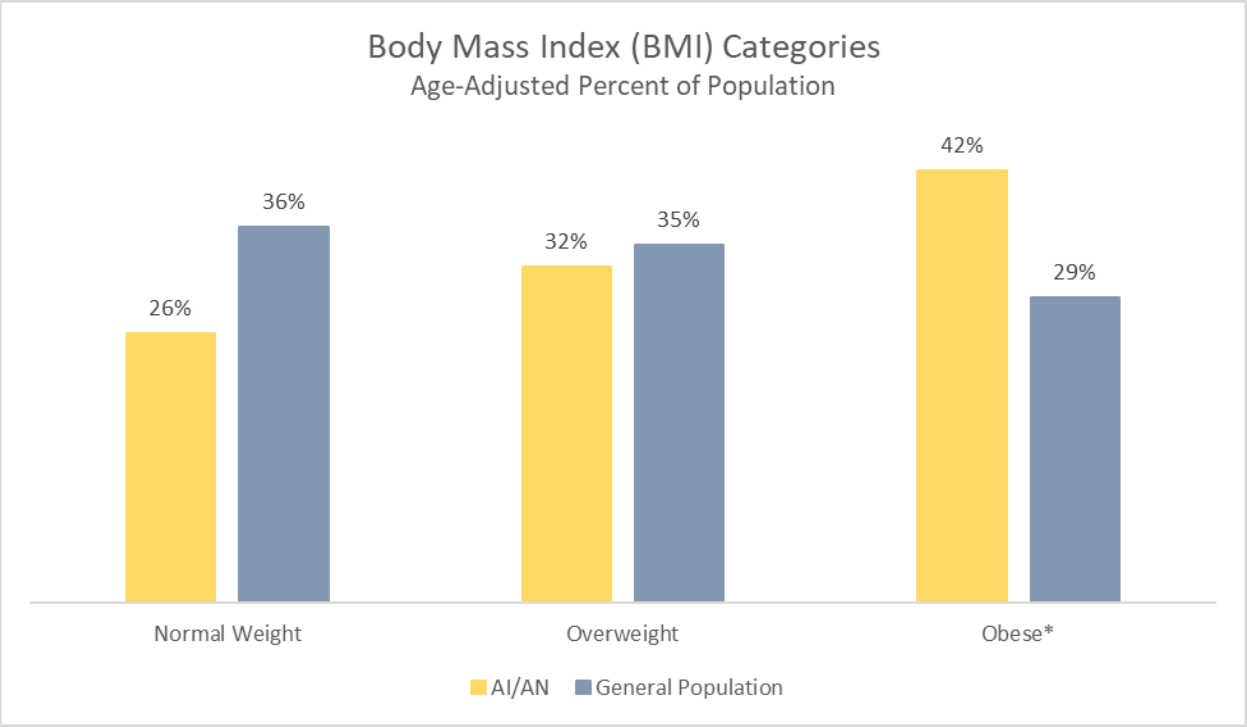


Source: Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health

Body Mass Index

A person's Body Mass Index (BMI) is a commonly used indicator used to determine a person's weight category. BMI is not a direct measure of body fat, but it is strongly correlated with several disease outcomes.[18] People with obesity have a higher risk of death, hypertension, type-2 diabetes, heart disease and stroke.[18]The proportions of Utah's AI/AN and general population by BMI can be seen in figure 9.

Figure 9: Body Mass Index

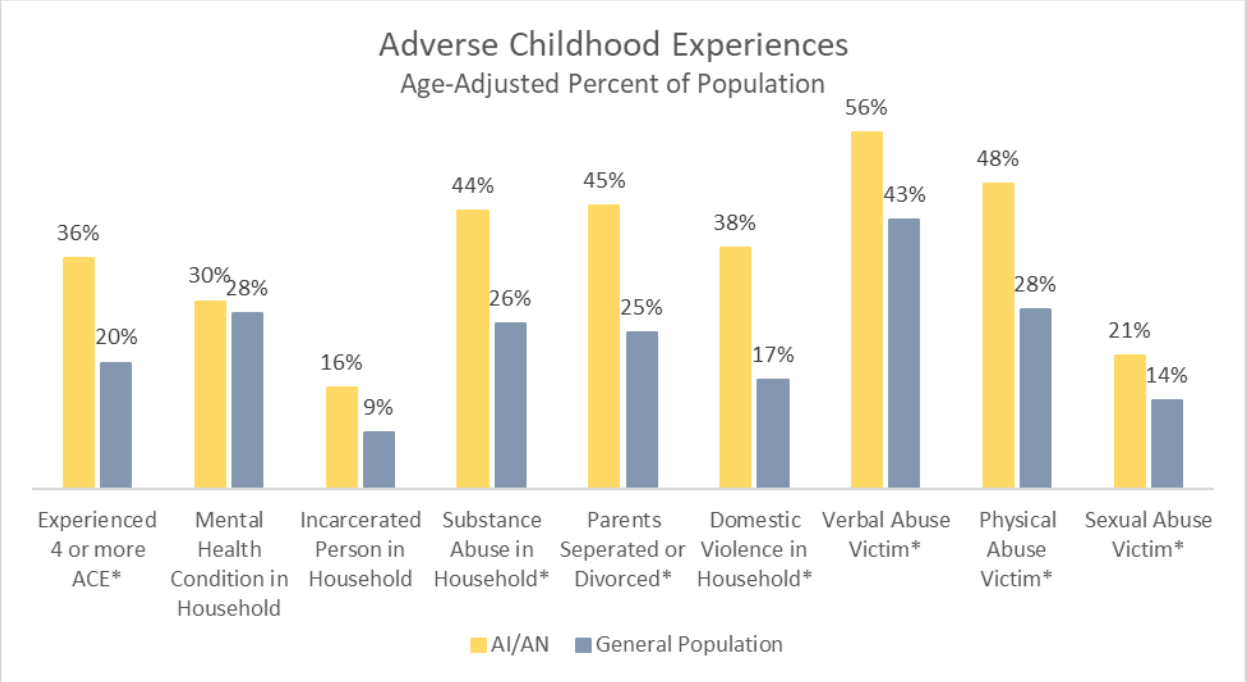


Source: Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health
**Statistically significant difference between AI/AN and the General Population.*

Adverse Childhood Experiences

Adverse childhood experiences are events that occur during childhood (ages 0-17) that are potentially traumatic or which could affect their safety and stability.[19] ACEs can lead to long-term stress which impacts a person's ability to form relationships and have steady employment. ACEs are also linked to a variety of mental and physical health problems including substance misuse.[19] Utah's AI/AN consistently have a higher prevalence of ACEs than the general population as seen in figure 10.

Figure 10: Adverse Childhood Experiences

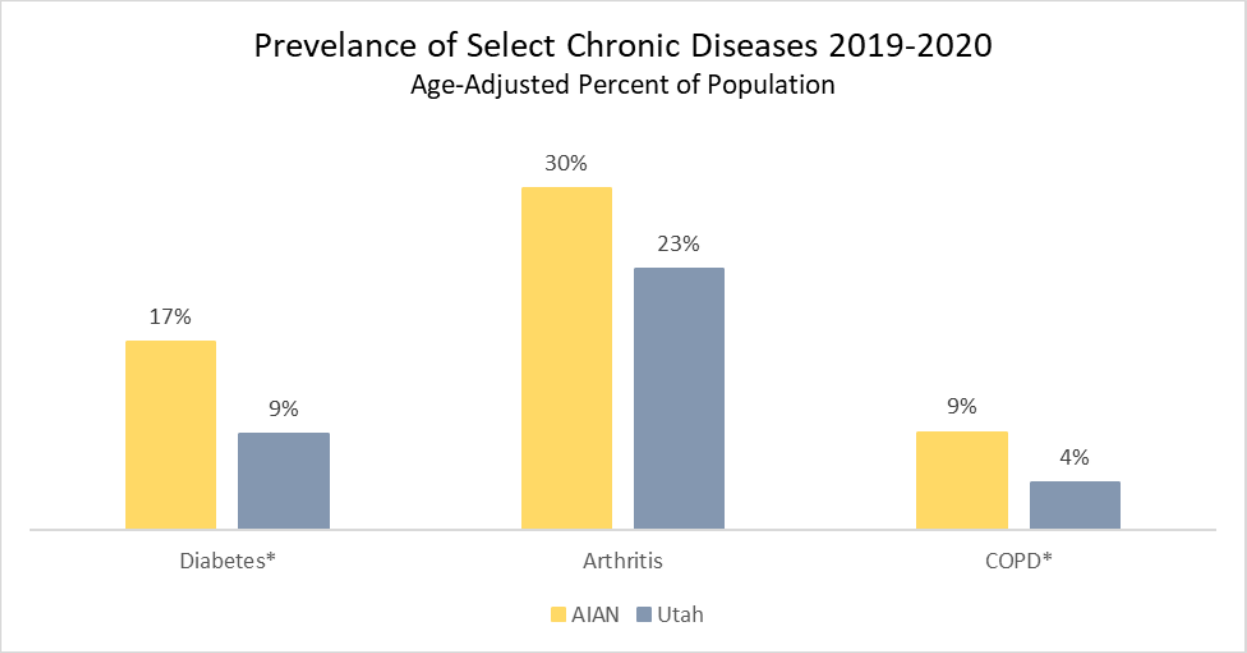


Source: Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health
**Statistically significant difference between AI/AN and the General Population.*

Chronic Disease Prevalence

In Utah, more AI/AN report having diabetes, arthritis, and chronic obstructive pulmonary disorder (COPD) than the general population (Figure 11.)

Figure 11: Chronic Disease Prevalence 2019-2020

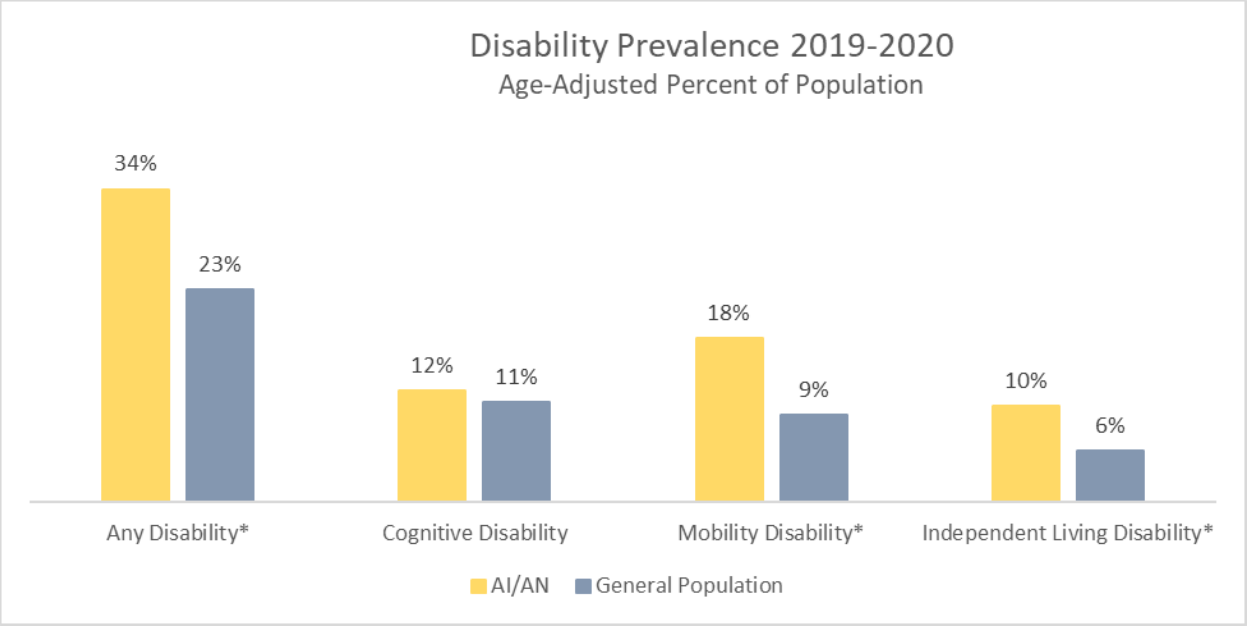


Source: Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health
**Statistically significant difference between AI/AN and the General Population.*

Disability Status

Disabilities are a broad range of conditions that limit a person's ability to engage in some activities or interact with the world around them.[20] In Utah, a higher percentage of AI/AN have disabilities than the general population (figure 12).

Figure 12: Disability Prevalence 2019-2020

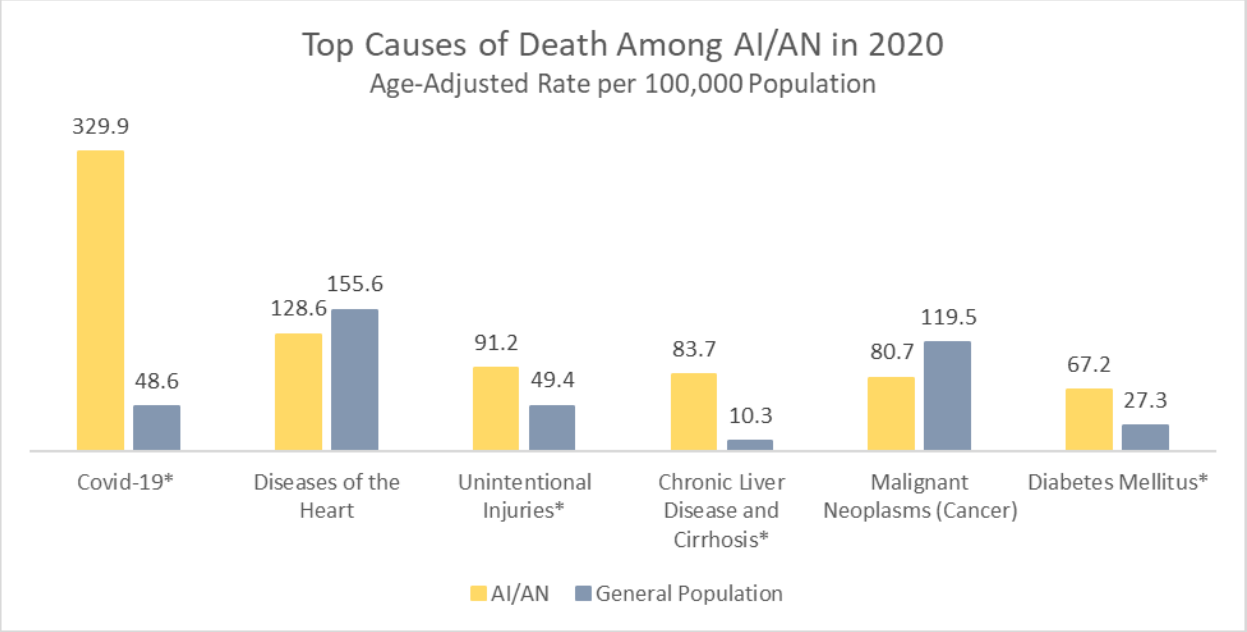


Source: Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health
**Statistically significant difference between AI/AN and the General Population.*

Overall Mortality

The top causes of mortality in 2020 among AI/AN are presented in figure 13. Significant disparities can be seen between AI/AN and the general population with AI/AN being about two times more likely to die from diabetes and unintentional injuries, seven times more likely to die from COVID-19, and 8 times more likely to die from Chronic Liver Disease and Cirrhosis. Differences in heart disease and cancer mortality are not statistically significant between AI/AN and the general population.

Figure 13: Top Causes of Mortality



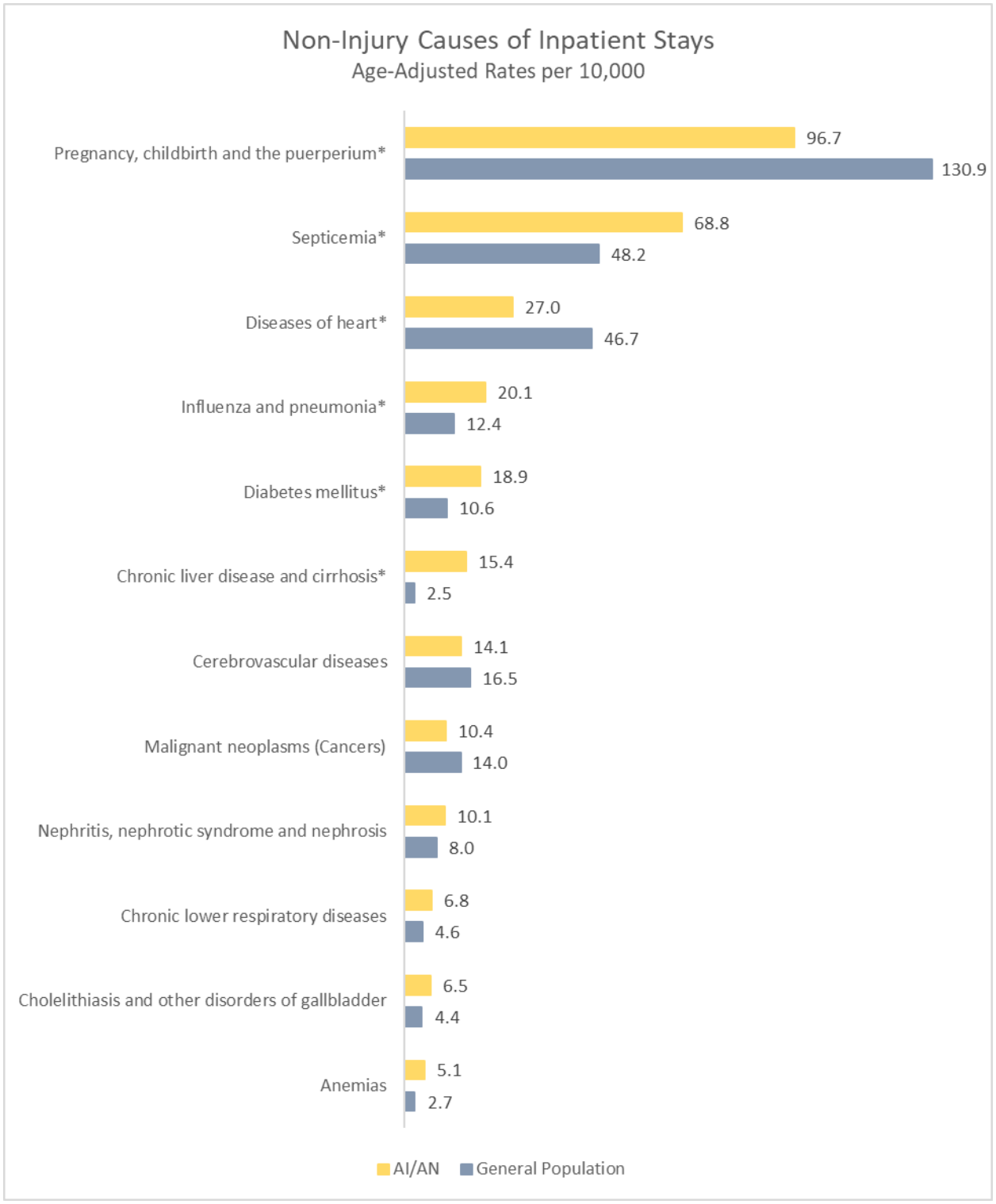
Sources: Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health; Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, U.S. Bureau of the Census, IBIS Version 2020
**Statistically significant difference between AI/AN and the General Population.*

Hospitalization

Rates of inpatient hospitalization stays for non-injury causes can be seen in figure 14. These rates support what is seen in the mortality data (figure 13) in that AI/AN are disproportionately affected by diabetes, liver disease, and infectious diseases. The lower hospitalization rate for pregnancy/childbirth may be attributable to the lower birth rate among AI/AN (figure 26.)

Rates for injury related hospitalizations can be seen in figure 15. While there are not statistically significant differences between AI/AN and the general population, drug poisoning hospitalizations are slightly higher for AI/AN.

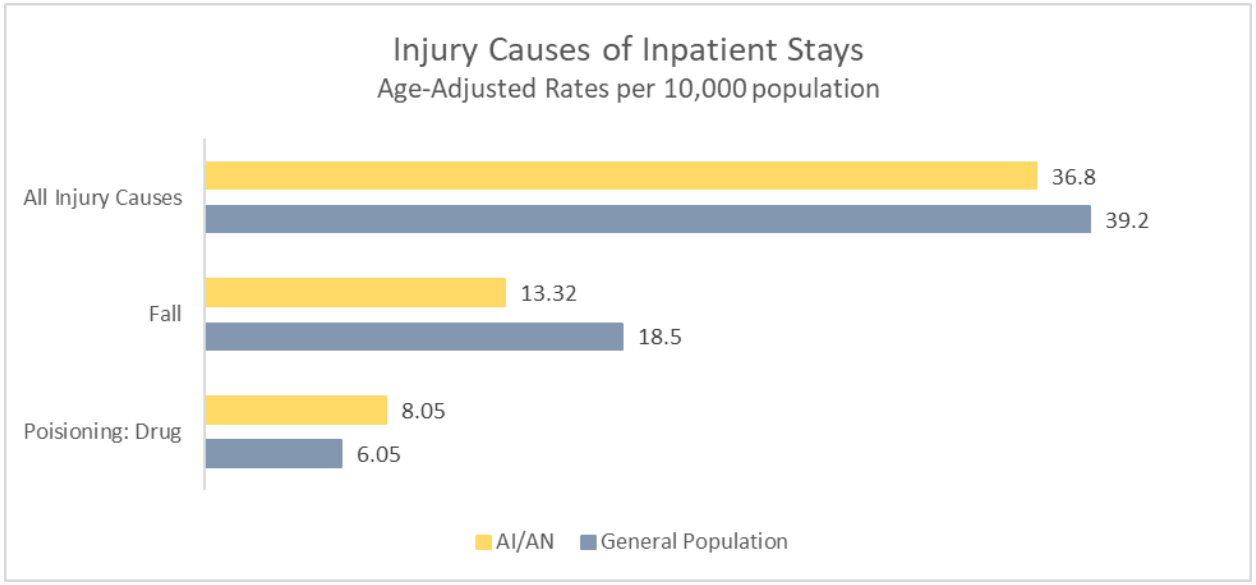
Figure 14: Non-Injury Causes of Inpatient Hospitalization



Source: Utah Inpatient Hospital Discharge Data, Office of Health Care Statistics, Utah Department of Health; Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, U.S. Bureau of the Census, IBIS Version 2020

**Statistically significant difference between AI/AN and the General Population.*

Figure 15: Injury Causes of Hospitalization



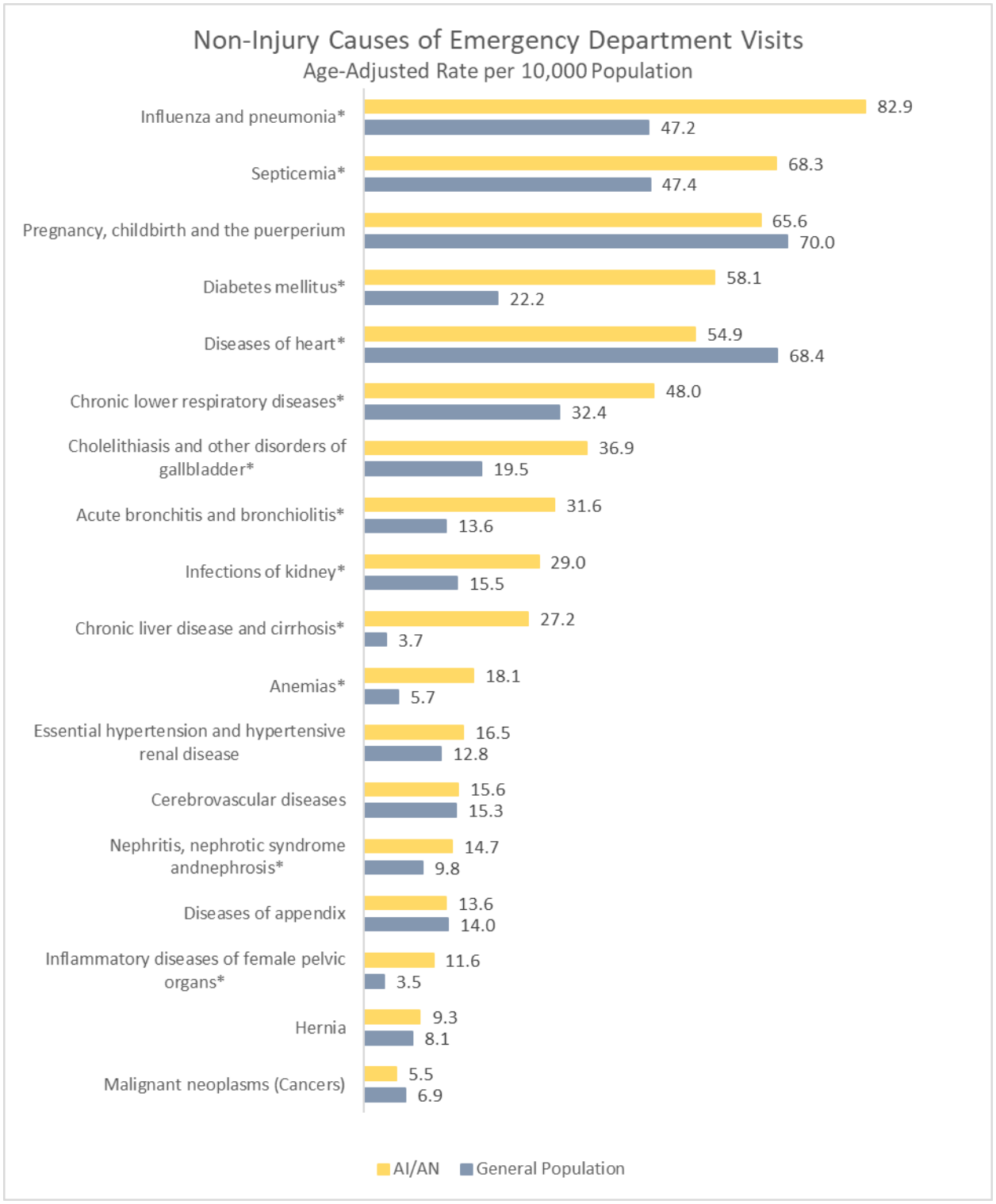
Source: Utah Inpatient Hospital Discharge Data, Office of Health Care Statistics, Utah Department of Health; Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, U.S. Bureau of the Census, IBIS Version 2020

Emergency Department Visits

Much like the hospitalization and mortality data, the impact of influenza/pneumonia, septicemia, diabetes and liver disease/cirrhosis on the AI/AN population can be seen in the rates of non-injury related emergency department (ED) visits. Of the diseases presented in figure 16, only heart disease and cancer have higher rates for ED visits among the general population.

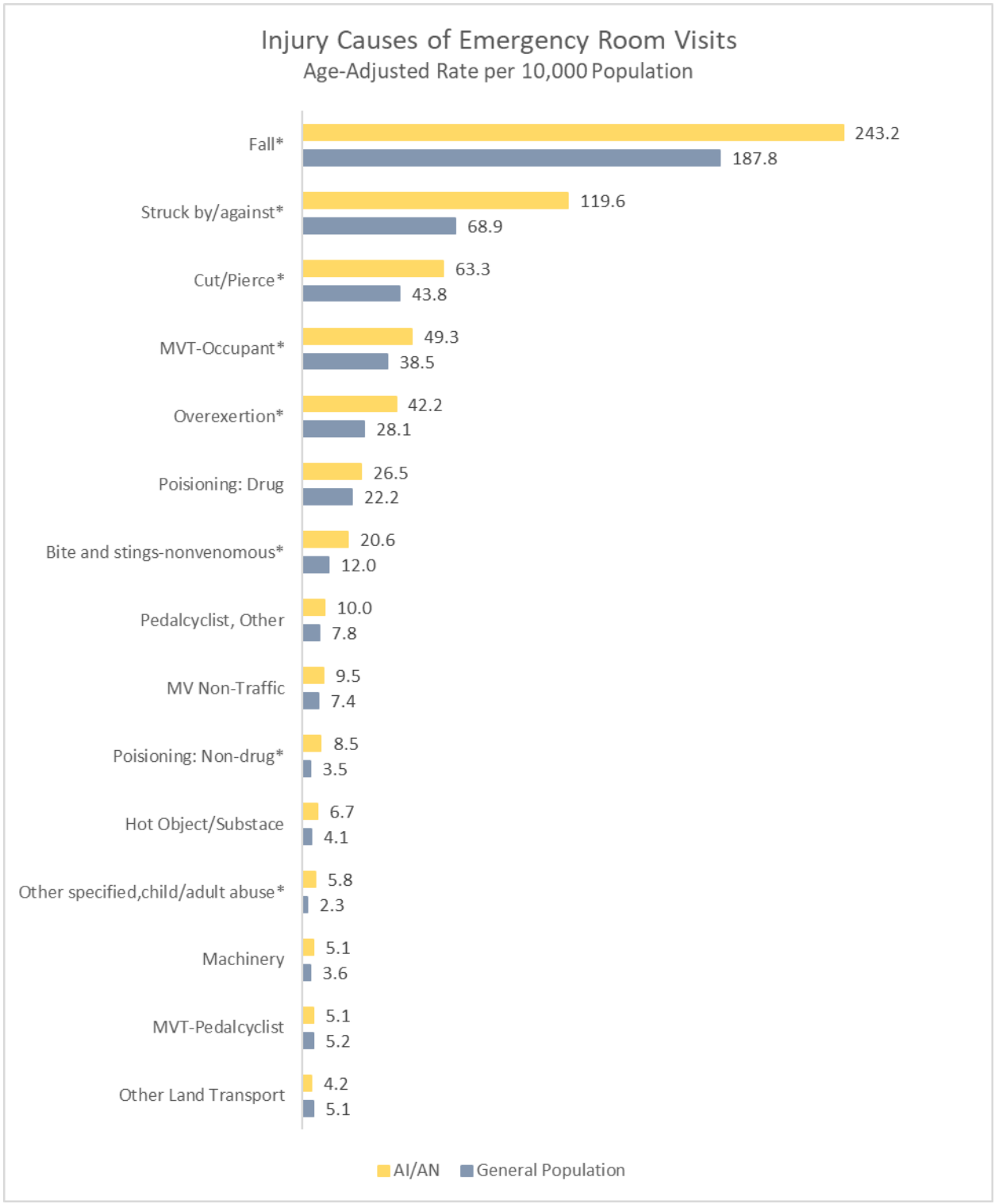
Injury related causes of ED visits can be seen in figure 17. AI/AN have significantly higher rates of ED visits for the top five causes of injury related ED visits.

Figure 15: Non-Injury Causes of Emergency Department Visits



Sources: Utah Emergency Department Encounter Database, Bureau of Emergency Medical Services, Utah Department of Health; Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, U.S. Bureau of the Census, IBIS Version 2020
**Statistically significant difference between AI/AN and the General Population.*

Figure 16: Injury Related Causes of Emergency Department Visits

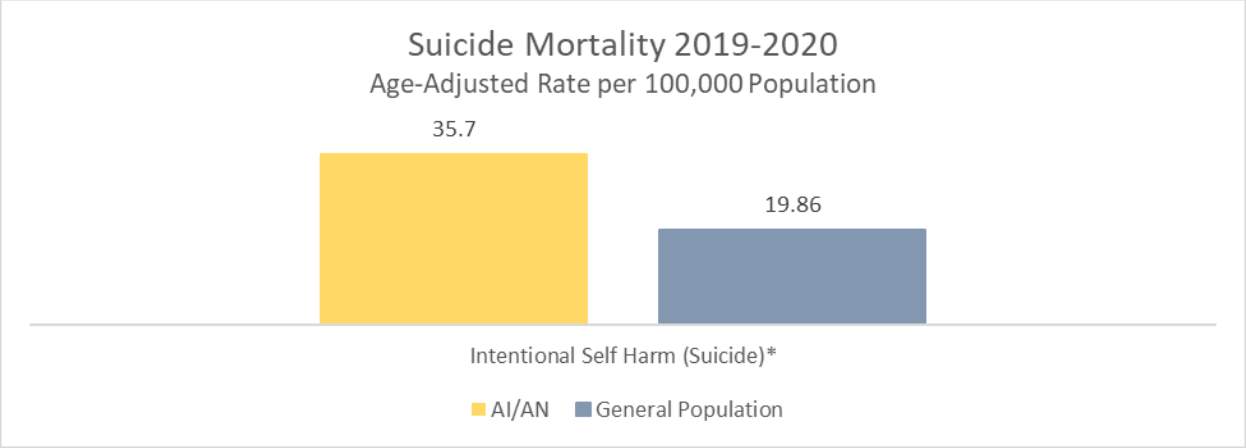


Sources: Utah Emergency Department Encounter Database, Bureau of Emergency Medical Services, Utah Department of Health; Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, U.S. Bureau of the Census, IBIS Version 2020
**Statistically significant difference between AI/AN and the General Population.*

Suicide

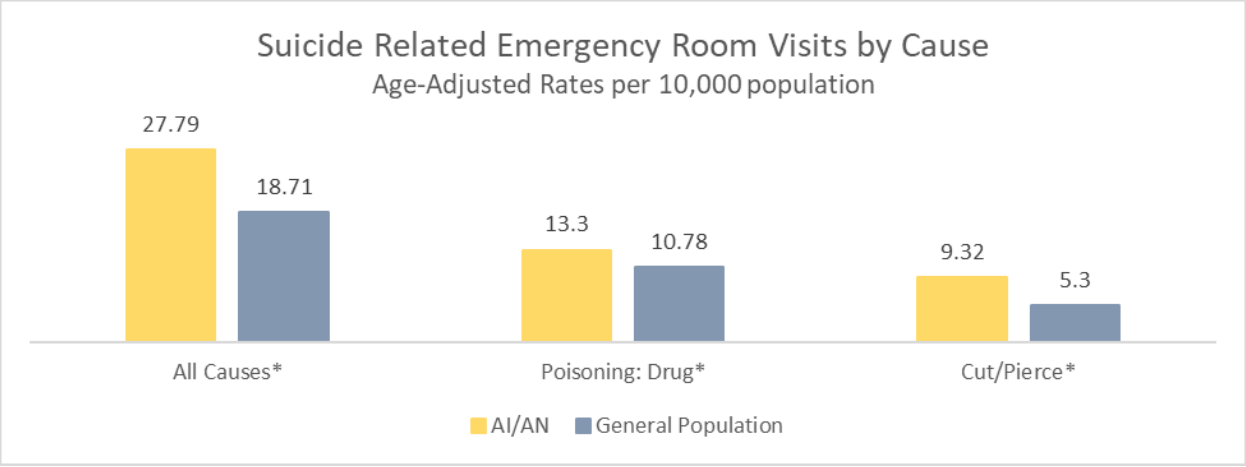
Utah has one of the highest suicide rates in the United States and AI/AN have the highest suicide rate of any racial demographic in the United States.[21,22] AI/AN in Utah had a significantly higher suicide rate than the general population (figure 18.) Suicide attempts resulting in ED visits are also higher among AI/AN, including suicide attempts involving cutting/piercing or drug poisoning (Figure 19). AI/AN suicide attempts resulting in an ED visits occurred predominantly in the Salt Lake and TriCounty Health Districts with a rate of 36.54 and 73.93 per 10,000 population respectively.

Figure 17: Suicide Mortality 2019-2020



Sources: Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health; Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, U.S. Bureau of the Census, IBIS Version 2020
**Statistically significant difference between AI/AN and the General Population.*

Figure 18: Suicide Attempts Resulting in an Emergency Room Visit 2019-2020



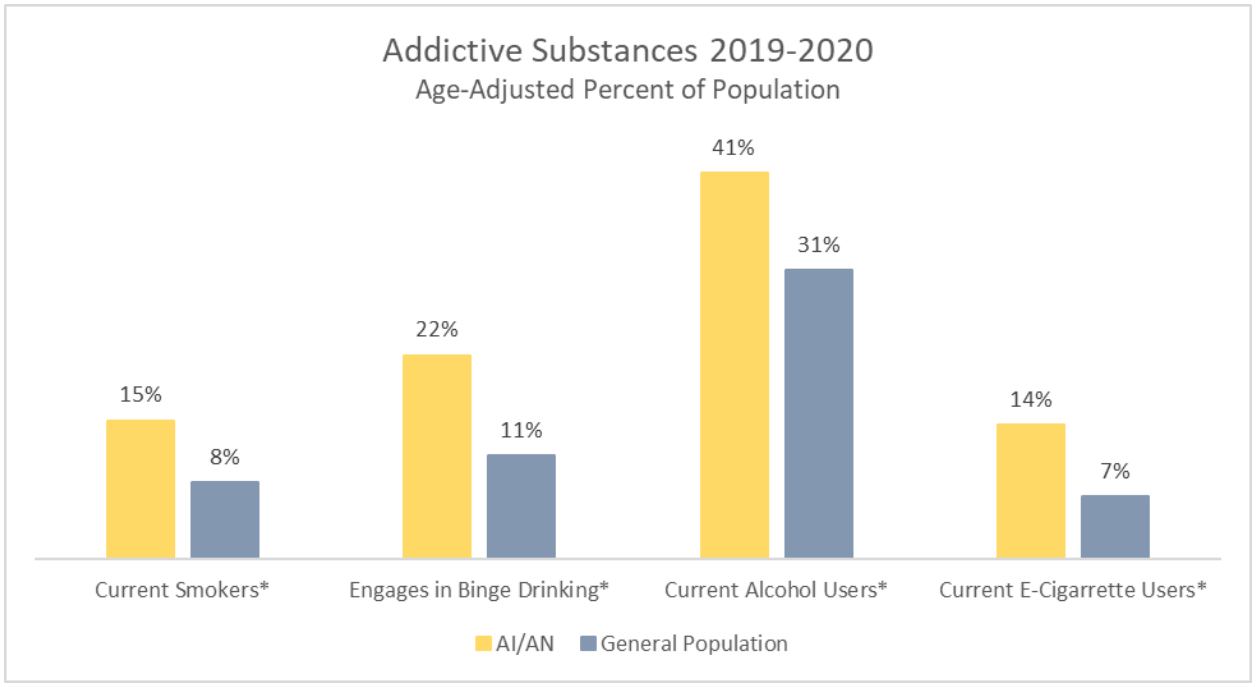
Sources: Utah Emergency Department Encounter Database, Bureau of Emergency Medical Services, Utah Department of Health; Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, U.S. Bureau of the Census, IBIS Version 2020
**Statistically significant difference between AI/AN and the General Population.*

Substance Use/Misuse

Compared to Utah's general population, significantly higher proportions of AI/AN smoke, consume alcohol and use e-cigarettes (figure 20.) The high prevalence of these behaviors is a contributing factor to the disparities seen among AI/AN in diabetes, liver disease/cirrhosis, lung disease and injury outcomes (Figures 13- 17).[23,24]

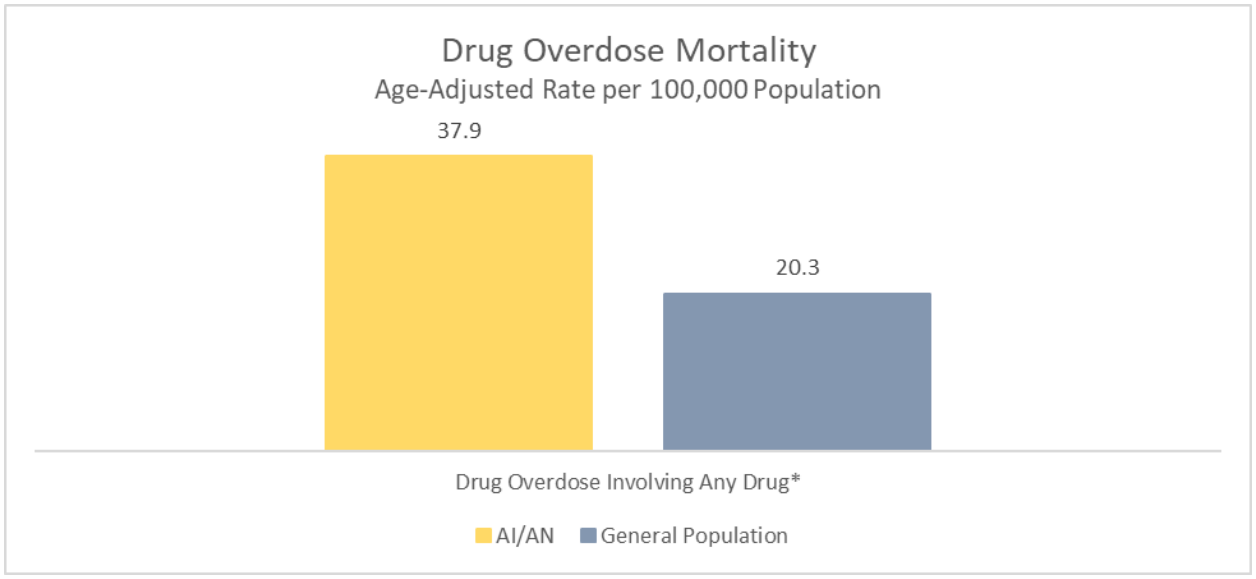
AI/AN have a higher rate of drug overdose deaths and drug related ED visits than the general population (figure 21-22). For ED visits, AI/AN have statistically similar rates of opioid related visits compared with the general population, but have higher rates of stimulant and amphetamine related visits as well as a higher rate of visits for alcohol poisoning (figure 22). AI/AN drug related ED visits were highest in TriCounty, Weber-Morgan, and Salt Lake Health Districts with rates of 69.37, 46.38, and 31.66 per 10,000 respectively.

Figure 20: Addictive Substance Use 2019-2020



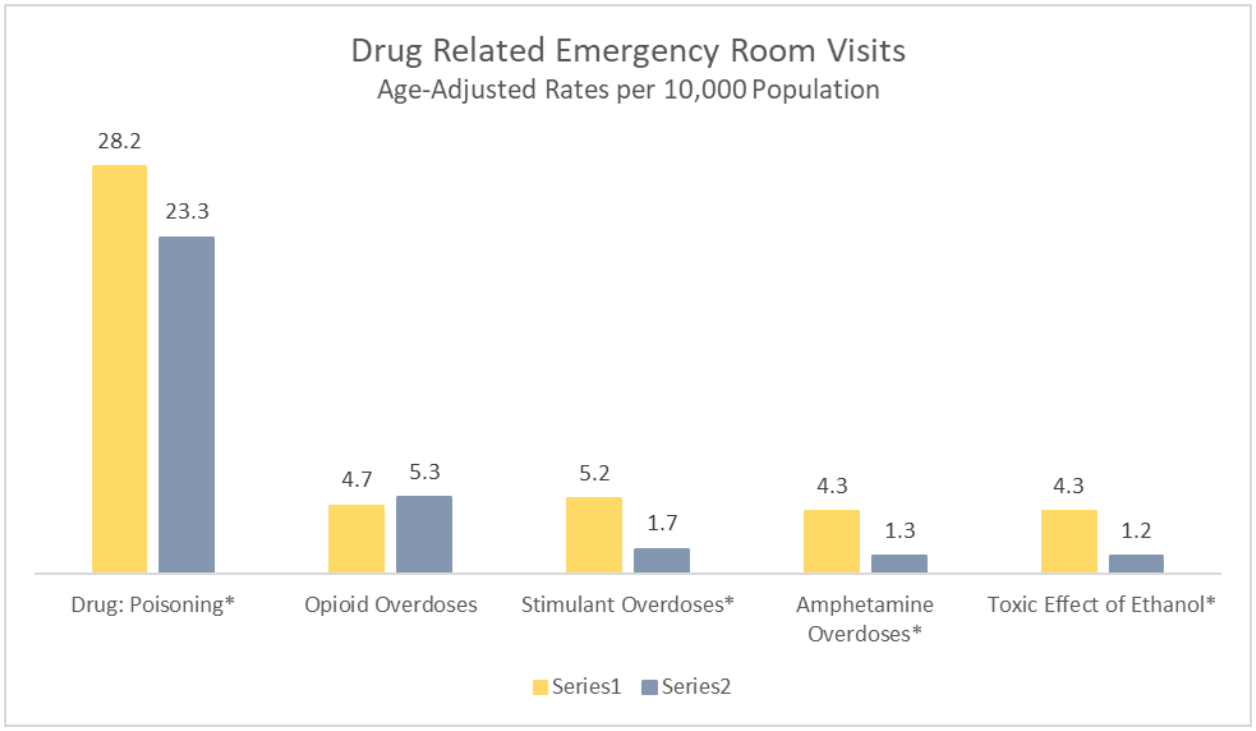
Source: Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health
**Statistically significant difference between AI/AN and the General Population.*

Figure 21: Drug Overdose Mortality 2019-2020



Sources: Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health; Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, U.S. Bureau of the Census, IBIS Version 2020
**Statistically significant difference between AI/AN and the General Population.*

Figure 22: Drug Related Emergency Room Visits 2019-2020



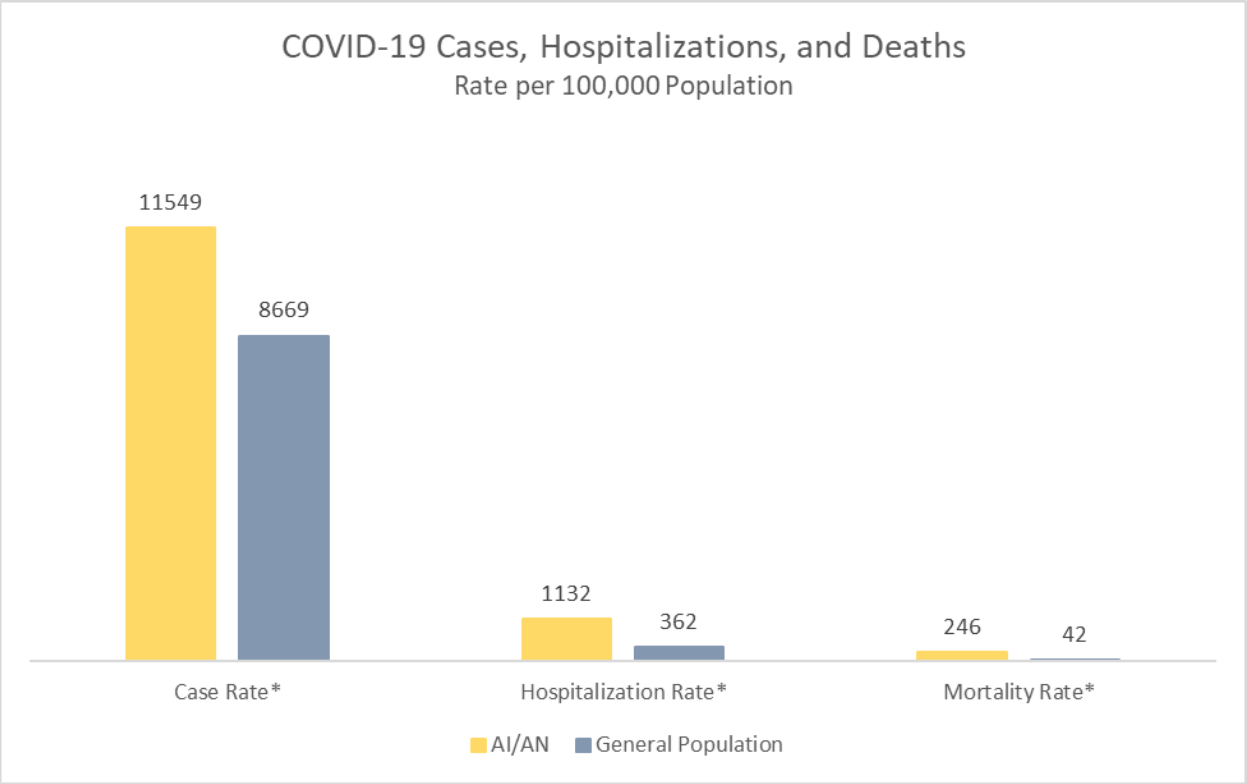
Sources: Utah Emergency Department Encounter Database, Bureau of Emergency Medical Services, Utah Department of Health; Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, U.S. Bureau of the Census, IBIS Version 2020
**Statistically significant difference between AI/AN and the General Population.*

COVID-19

Tribes were among the hardest hit communities in Utah during the COVID-19 pandemic.[25] Across the state, AI/AN were more likely to be infected, hospitalized, and die from COVID-19 than Utah's general population (figure 23.)

These differences in health outcomes point to underlying inequities that were exacerbated by the pandemic which include poor access to health care, stable housing, education and healthy foods. These systemic inequities in turn contribute to higher rates of other diseases like obesity and diabetes which increase the likelihood of hospitalization and death from COVID-19.[26] If infected, AI/AN were over 2 times more likely to be hospitalized, and 4 times more likely to die than the general population (figures 24 and 25).

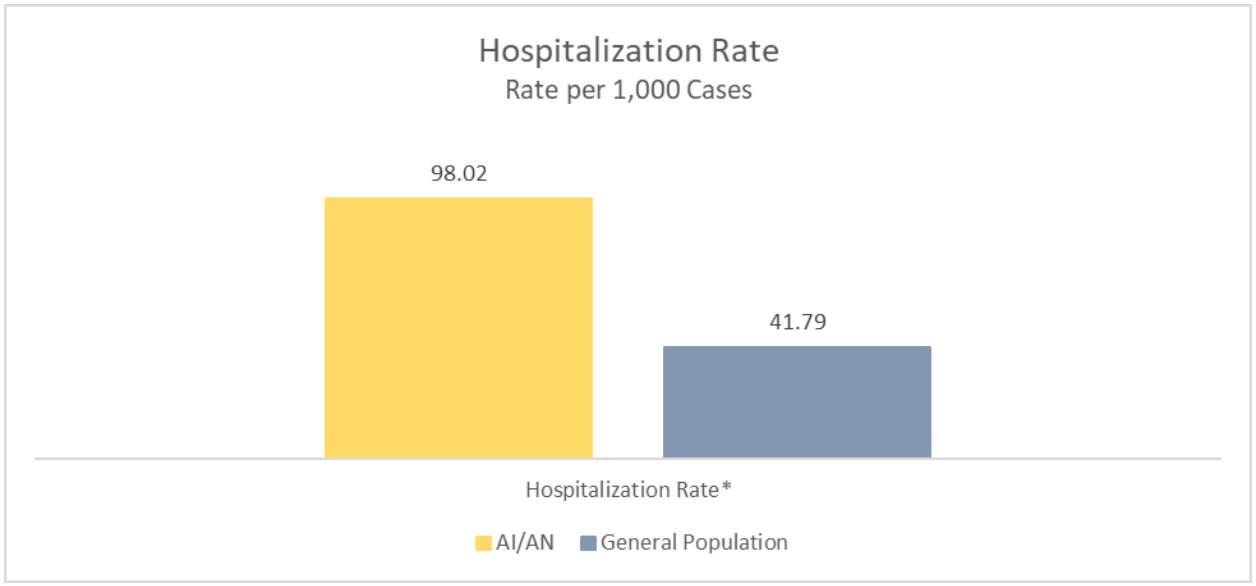
Figure 23: COVID-19 Case, Hospitalization, and Mortality Rates



Sources: Utah Department of Health, Bureau of Epidemiology; Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health; Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, U.S. Bureau of the Census, IBIS Version 2020

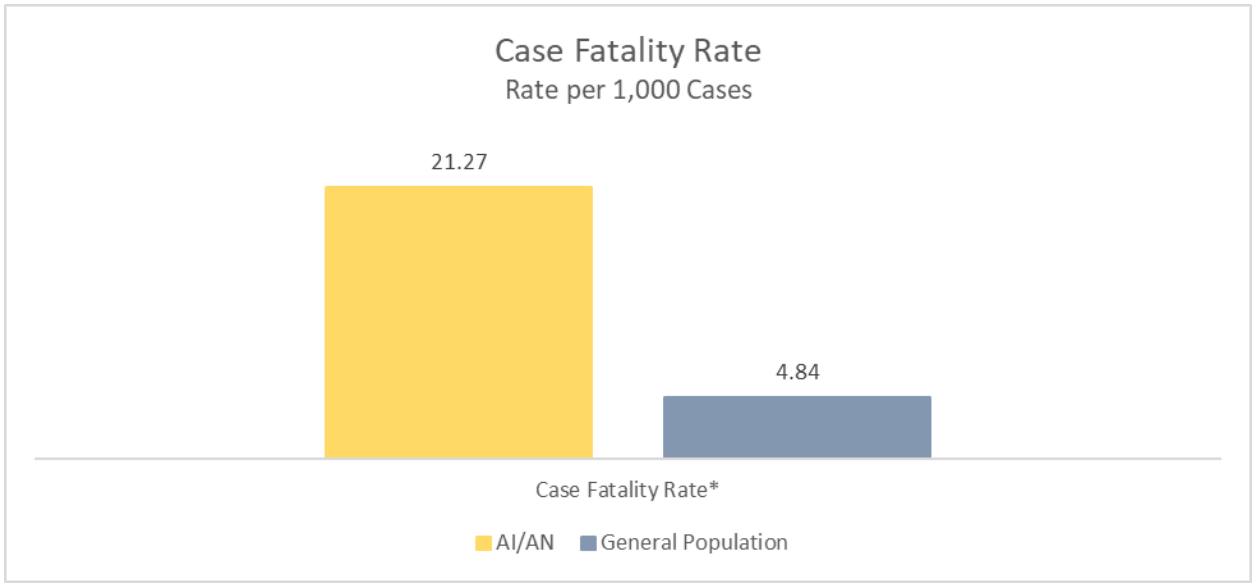
**Statistically significant difference between AI/AN and the General Population.*

Figure 24: COVID-19 Hospitalization Rate



Sources: Utah Department of Health, Bureau of Epidemiology; Utah Death Certificate Database, Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, U.S. Bureau of the Census, IBIS Version 2020
**Statistically significant difference between AI/AN and the General Population.*

Figure 25: COVID-19 Case Fatality Rate

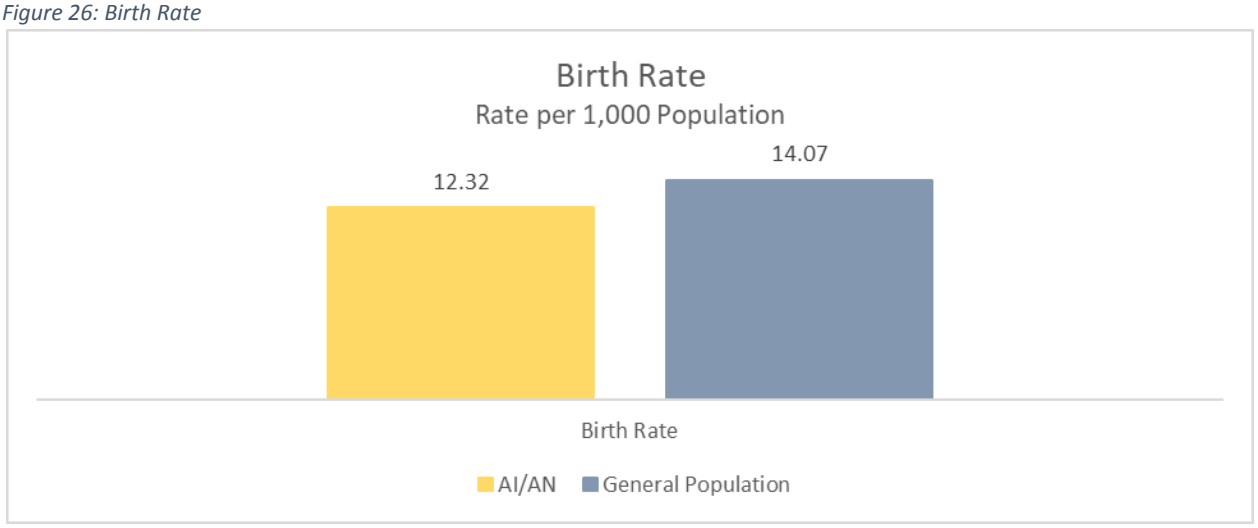


Sources: Utah Department of Health, Bureau of Epidemiology; Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health; Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, U.S. Bureau of the Census, IBIS Version 2020
**Statistically significant difference between AI/AN and the General Population.*

Maternal and Infant Health

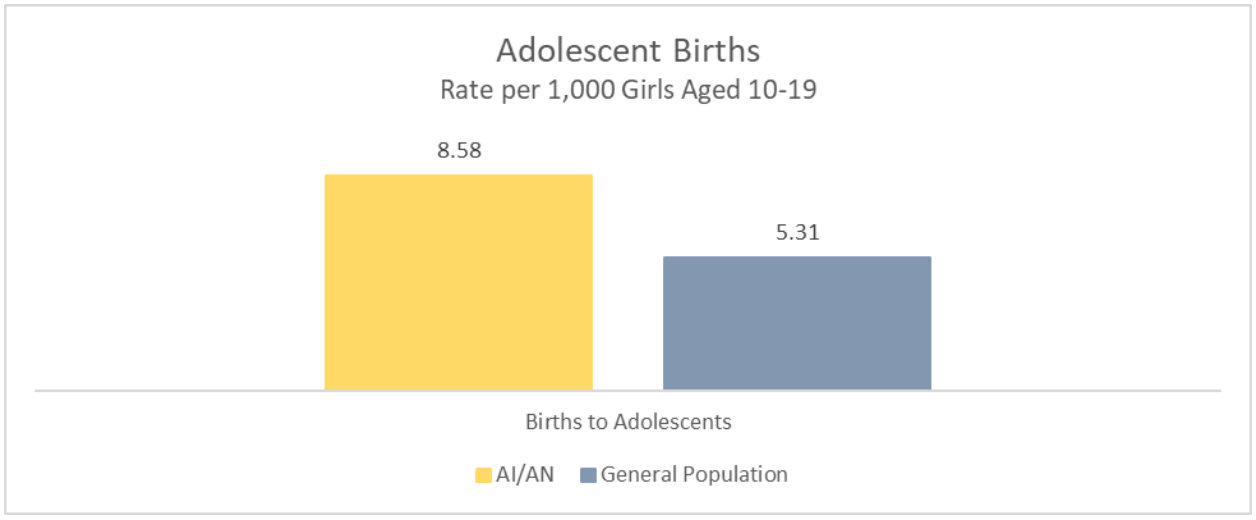
While not statistically significant, AI/AN have a lower birth rate than the general population (figure 26) and a higher rate of births to adolescent girls (figure 27). Differences in a mother's pre-pregnancy birth weight, gestational diabetes, tobacco use, and timeliness in seeking prenatal care put more AI/AN mothers and infants at risk for complications including birth defects, low birth weight, and death (figure 28).[27,28]

Figure 26: Birth Rate



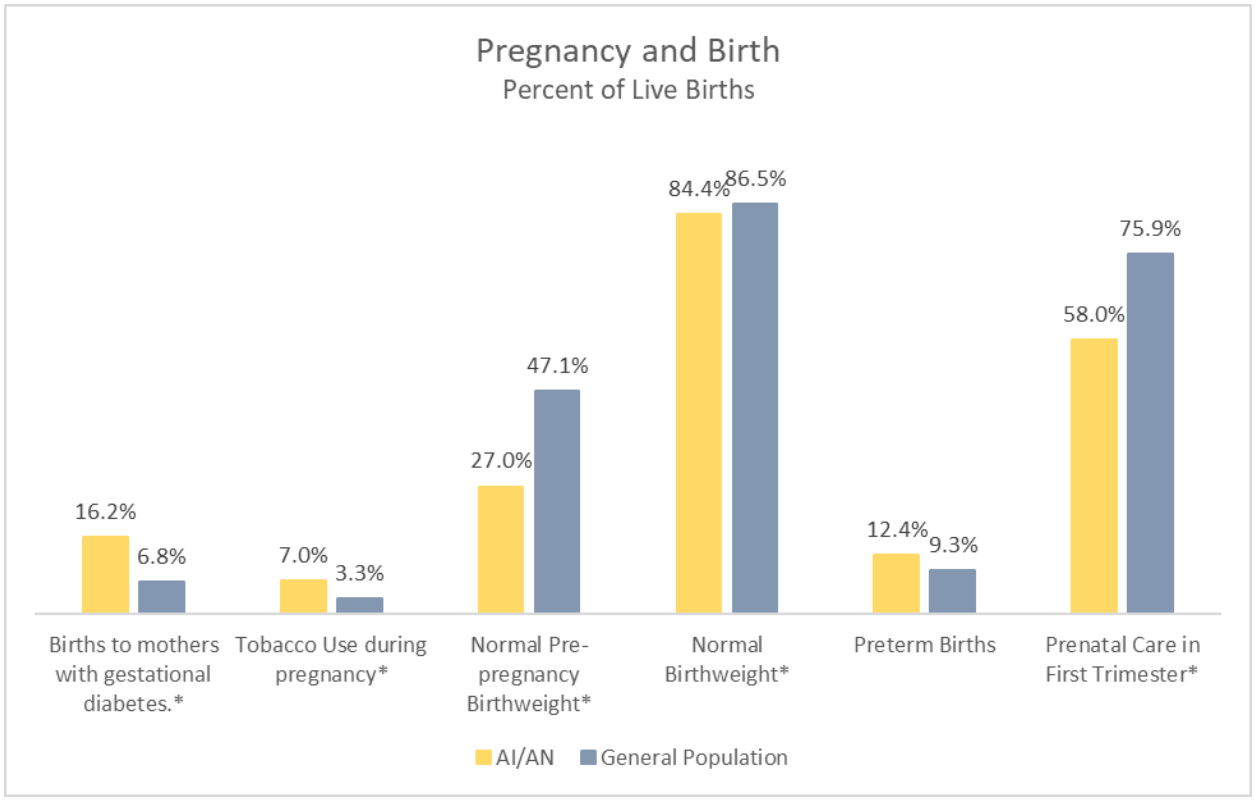
Sources: Utah Birth Certificate Database, Office of Vital Records and Statistics, Utah Department of Health. Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, U.S. Bureau of the Census, IBIS Version 2020

Figure 27: Adolescent Birth Rate



Sources: Utah Birth Certificate Database, Office of Vital Records and Statistics, Utah Department of Health. Population Estimates by Age, Sex, Race, and Hispanic Origin for Counties in Utah, U.S. Bureau of the Census, IBIS Version 2020

Figure 28: Pregnancy and Birth Risk Factors and Outcomes



Source: Utah Birth Certificate Database, Office of Vital Records and Statistics, Utah Department of Health

**Statistically significant difference between AI/AN and the General Population.*

Limitations

Many indicators were not included due to small numbers and unreliable rates. Additionally, many data sets including Pregnancy Risk Assessment Monitoring System (PRAMS), Youth Behavior Risk Survey, and birth defect data group AI/AN into the “Other” race category.

Current IHFS Strategic Goals

- Raise the health status of AI/AN’s to that of Utah’s general population.
- Standardize consultation and conferment within the department.
- Improve data collection, reporting, analysis and sharing.
- Build best practice as public health, health, and Indian health policy subject matter experts.
- Ensure equitable access to public health and health care access, information, and resources.
- Regularly convene and facilitate the UIHAB.

Recommendations

- Expand and strengthen Consultation and Conferment processes with the Indian Health System & Tribal leadership with state executive and legislative leadership,
    - More active role in policy development, legislative processes and implementation of state health and public health actions,
- Recognition and Inclusion of this vital healthcare delivery system in Utah as a partner in health and public health practice and planning,
    - Inclusion of the I/T/U in future funding methodologies,
    - Inclusion of I/T/U jurisdictions in data collection and reporting methodologies,
- Support more aggressive Health Policy strategies to improve direct access to resources & services for the I/T/U,
    - Support harm reduction strategies for substance misuse.
    - Medicaid reimbursement for traditional healing

Acknowledgment

This report was approved by Utah Indian Health Advisory Board (UIHAB) on June 13, 2022.

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Appendix A: Utah Indian Health Advisory Board Survey

In preparation for the Utah Indian Health Advisory Board (UIHAB) Annual Retreat a survey was created to give UIHAB representatives the opportunity to:

1. Review successes/barriers in achieving the 2021 priority topics
2. Set the priority topics for 2022
3. Give feedback on the Office of American Indian/Alaska Native Health Affairs, monthly UIHAB meetings, local health departments (LHD), and state leadership.'

On January 31st the survey was sent out to representatives from the Indian Health Service, Tribally owned and operated facilities, and the Urban Indian Center of Salt Lake (I/T/U). Follow up emails were sent on February 3rd and February 7th.

There were 12 responses to the survey from 9 tribes/facilities, including:

- The Confederated Tribes of the Goshute Reservation
- Northwestern Band of Shoshone Nation
- Paiute Indian Tribe of Utah
- San Juan Southern Paiute Tribe
- Skull Valley Band of Goshutes
- Uinta/Ouray Indian Health Service Facility
- Utah Navajo Health System
- Urban Indian Center of Salt Lake
- Ute Mountain Ute Tribe

Responses were collected, analyzed and condensed into a presentation on Thursday February 10th for the UIHAB Annual Retreat.

Note that before the Utah Department of Health was merged with the Utah Department of Family Services IHFS was the Office of AI/AN Health Affairs (OAIANHA), and will be referred to as such in the appendices.

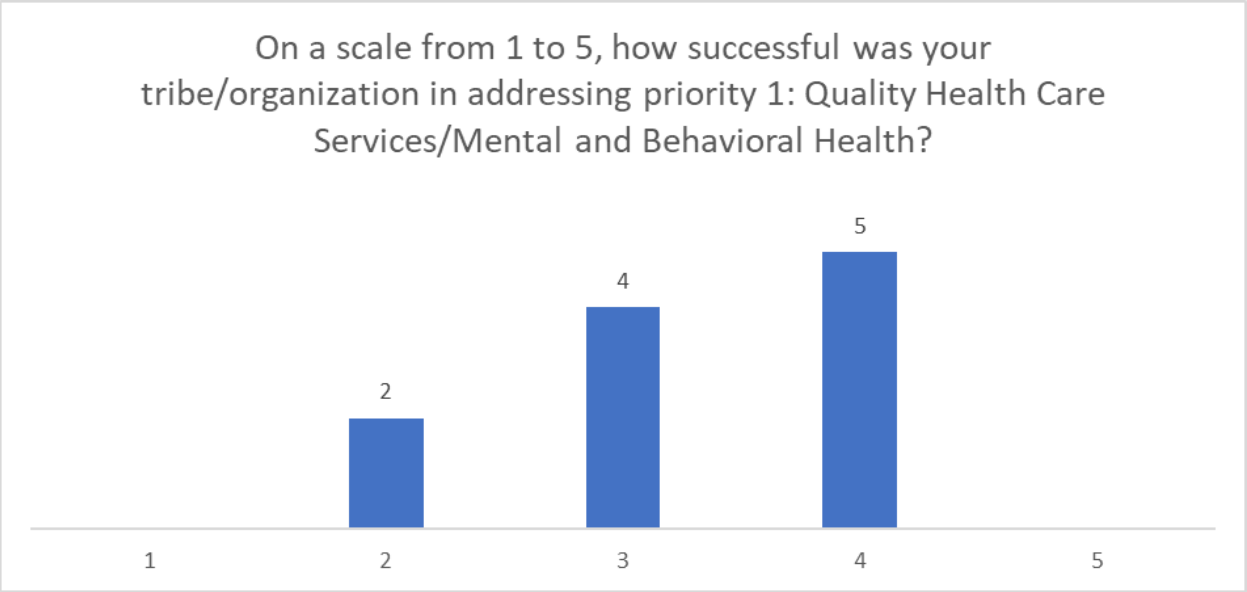
Part 1: 2021 UIHAB Priorities

In February of 2021, UIHAB set their top 3 priorities that would be their focus during that year. They include:

1. Quality Health Care Services/Mental Behavioral Health
2. Data and Data Sharing
3. Diabetes/Obesity & Medicaid/Medicaid Expansion

Respondent's self-reported success for addressing priority 1 can be seen in figure A1.

Figure A1: Respondent's self-reported success on Priority 1.



Respondents provided the following answers when asked what contributed to the successes seen in addressing priority 1:

- Collaboration with [the tribe's] social services.
- Accreditation Association for Ambulatory Health Care (AAAHC)
- Collaborations with outside clinics.
- Hired additional staff, wrote additional grants and extended hours.
- Lack of involvement from service providers.
- Working hard on collaboration of resources was our priority.
- Having regularly scheduled monthly meetings.
- Inpatient and outpatient rehabilitation services, MAT program, and outpatient counseling.
- Collaboration with [out of state] Indian Health Service medical centers.

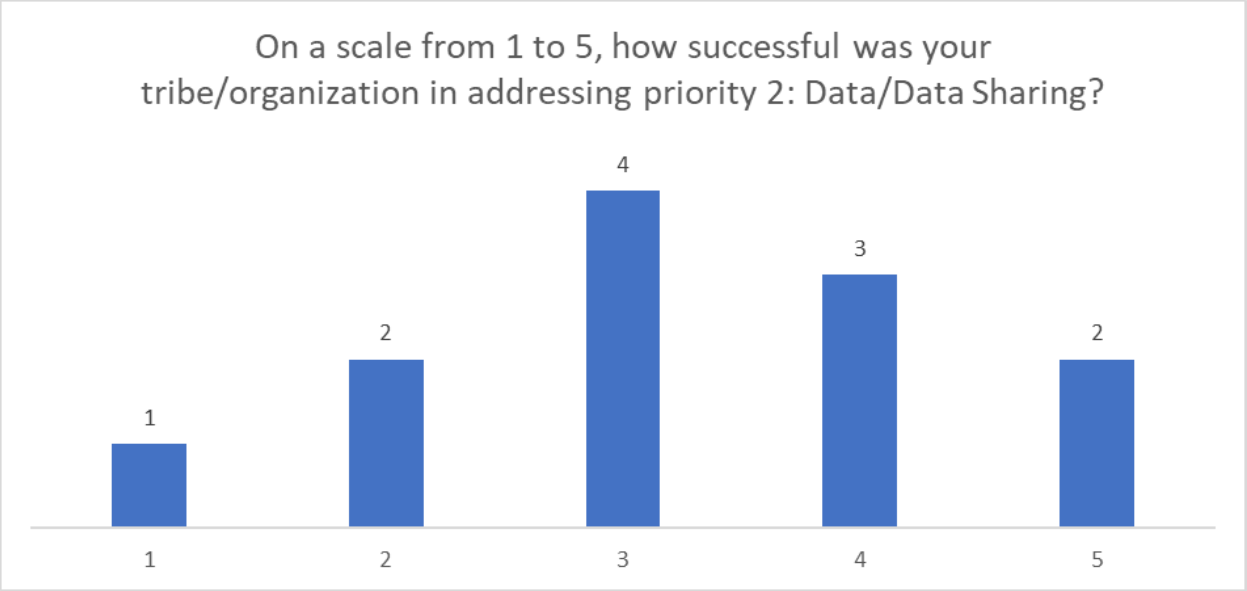
Respondents provided the following answers when asked what limited the success seen in addressing priority 1:

- Decreased face to face contact with patients and community members (less ability for outreach and awareness events as well as more telehealth visits for behavioral health and social services) due to COVID.
- Staff and administrative fatigue due to stresses related to COVID response and ongoing pandemic
- Staffing shortages, turnover, and difficulty hiring across all types of positions.
- COVID-19 pandemic and staff turnover.
- No health clinic of our own.
- There is still more need for behavioral health services than we can supply.
- Service departments are [out of state] and do not come to [our community.]
- · Restricted travel for our specialty clinic provider.
- · Limited staff to support goals/objectives.

- Low patient volume, which is probably related to low marketing and patients not showing up for their appointment.
- Covid-19 pandemic, lack of facility and lack of appropriate funding to [the tribe's] own behavioral health program.

Respondent's self-reported success for addressing priority 2 can be seen in figure A2.

Figure A2: Respondent's self-reported success on priority 2.



Respondents provided the following answers when asked what contributed to the successes seen in addressing priority 2:

- Work with emergency management.
- Supportive IT manager/staff, collaboration with association of Utah Community Health and other Utah health centers, implementation of HER add on (Azara) for data reporting and sharing.
- Increased technical support, collaboration with Utah Department of Health.
- Implemented a data warehouse and attended to integrate all aspects of data into it.
- Weekly ICS meetings with tribal emergency departments.
- Data sharing for grants.
- For the most part, our health department personnel positions were unfilled.
- Tribal mental health program had no program administrator and staffing concerns.

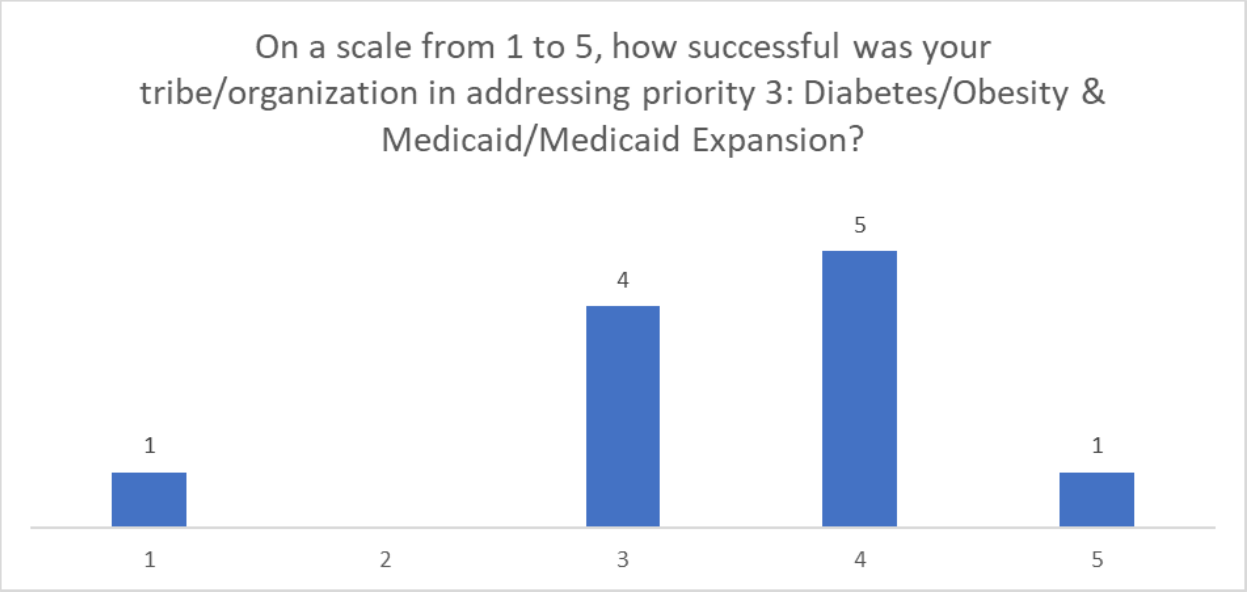
Respondents provided the following answers when asked what limited the success seen in addressing priority 2:

- Staff availability and time (IT, medical, admin) for implementation due to COVID response.
- Outdated EMR and data quality issues.
- Limited data availability.
- Some programs like dental and pharmacy have been tough to integrate.
- Wasn't always given call-in number for the meetings with the tribe.
- Staffing

- Limited Staff.
- Organization of record keeping

Respondent's self-reported success for addressing priority 3 can be seen in figure A3.

Figure A3: Respondent's self-reported success on priority 3.



Respondents provided the following answers when asked what contributed to the successes seen in addressing priority 3:

- Implemented new program for tribal members with diabetes (continuous glucose monitors) with good success from those who participated.
- Continued focus on prevention and intervention throughout SDPI wellness programs.
- Working with Comagine on NDPP classes.
- Social Media
- Medicaid enrollment has been successful.
- Diabetes/obesity are chronic issues that continue to be a challenge.
- Not much as far as education for the community or preventive measures provided.
- Virtual meetings were outstanding provided to Tribes from CMS, CDC, and IHS.
- Outreach/staff/program planning
- Health fairs with diabetic and BMI screening.
- Social worker who helps tribal members and incoming patients to enroll in Medicaid.
- Patient referral to IHS service providers.

Respondents provided the following answers when asked what limited the success seen in addressing priority 3:

- Limitations r/t COVID and appointments.
- No social worker.
- Had to put some programs (like NDPP courses) on hold a few times due to COVID.

- Diabetes and obesity continue to be challenges across all of America. Changing human behavior and habits is very tough.
- COVID
- Could have been more participation.
- Limited funding and staffing
- Patients not showing up for their follow-up appointments.
- Resistance to enroll in Medicaid due to IHS funding.
- Appropriate funding and a human services building.

Part 2: 2022 UIHAB Priorities

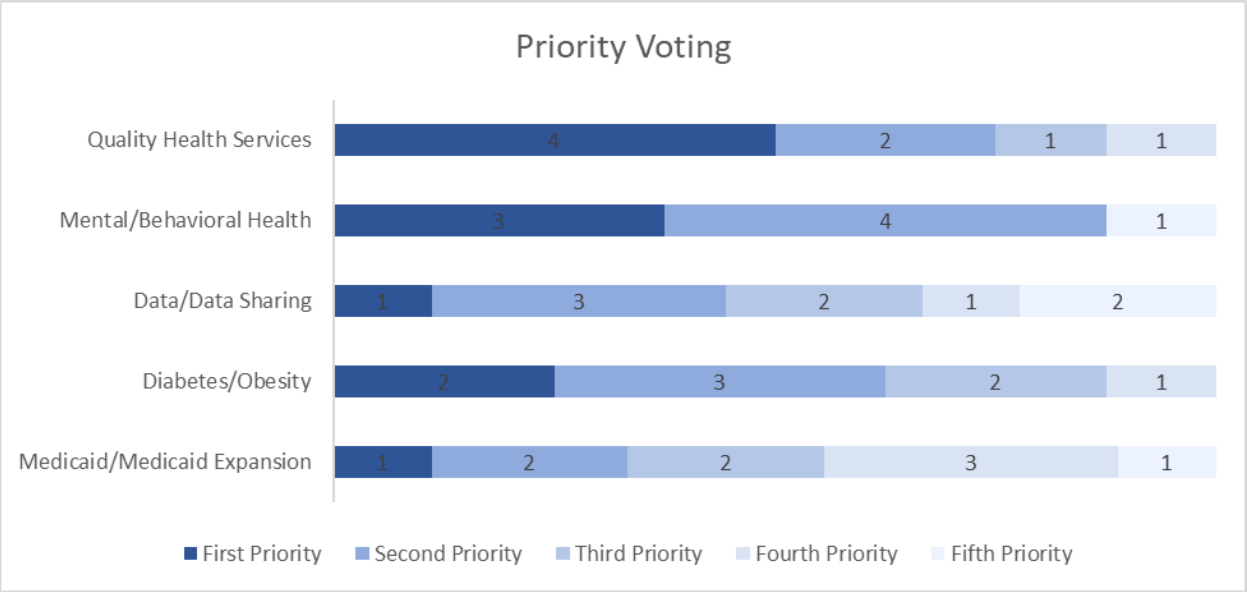
Respondents were shown a list of potential topics and asked to rank them from their first to 5th priority. Respondents could prioritize multiple topics at the same level and could also select “other” to specify what topic should be prioritized at that level instead of the provided list. The list of topics was based off of the 2021 priorities and included:

· Quality Healthcare services
· Mental/Behavioral Health
· Data/Data Sharing
· Diabetes/Obesity
· Medicaid/Medicaid Expansion

To ensure that no one tribe/organization unduly dominated the priority setting discussion for all of UIHAB, the response with no listed tribe/organization affiliation was excluded and responses from the same tribe/organization were averaged together. For example, if one respondent ranked mental/behavioral health as the first priority, but another respondent from the same tribe ranked it at third, their response was combined and that topic was placed at as second priority for their Tribe. This was used on responses from the Ute Mountain Ute Tribe and the Confederated Tribes of the Goshute Reservation, which both had two respondents to the survey.

The response to their ranking for the five main topics can be seen in figure A4.

Figure A4: Priority rankings given to the top 5 topics.



During analysis, point values were assigned to each rank – 5 points for first priority, 4 points for second and so on. Each topic was then scored based on these point values and the number of votes for each rank. The scores for eat topic, including the "other" topics, can be seen in figure A5.

Figure A5: Score given to each topic based on voting.

During the Annual Retreat UIHAB decided to adopt the top five scores as their 2022 priorities. Other responses with lower scores were integrated into the details of the top 5 priorities.

Part 3: General Feedback

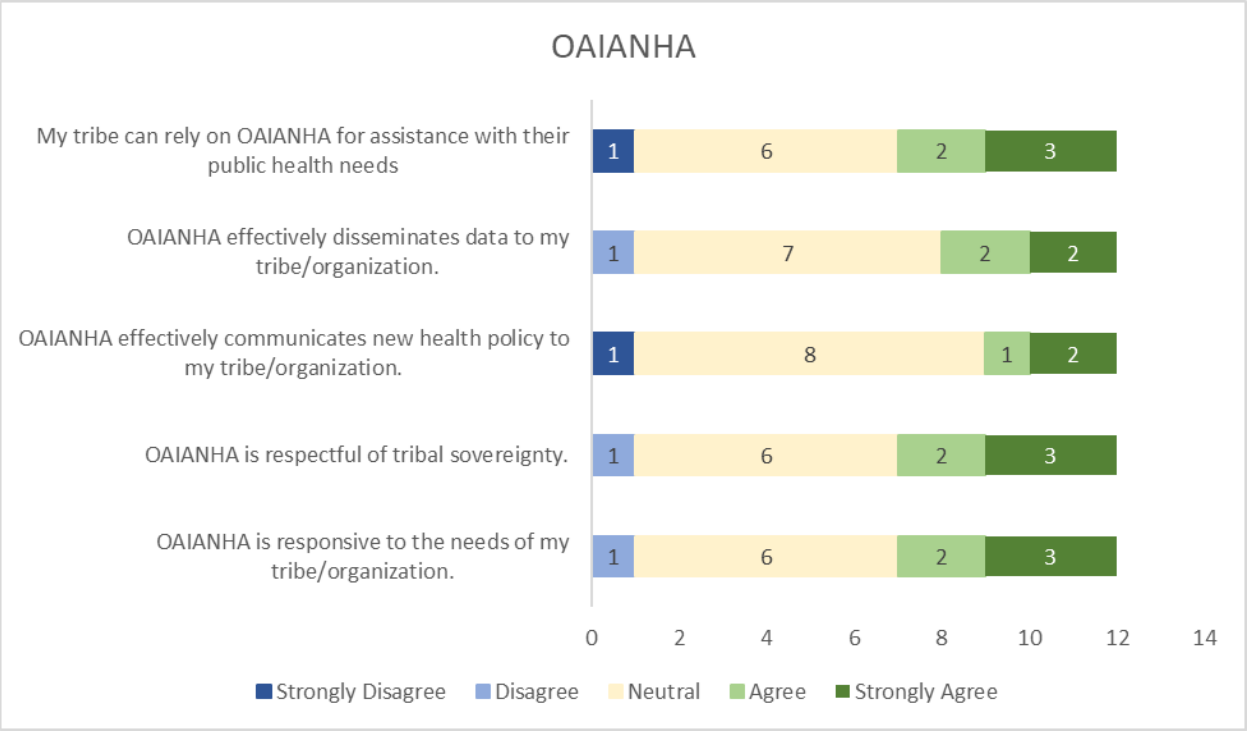
The final purpose of this survey was to solicit feedback from UIHAB representatives about OAIANHA, UIHAB , local health departments, and state elected and appointed leadership. For each topic, respondents were presented with a list of statements about the organization or topic, and asked to indicate to what extent they agreed with the statement.

Generally, respondents indicated similar levels of agreement for all statements in a section.

OAIANHA

The feedback from tribal health representatives about OAIANHA can be found in figure A6.

Figure A6: Feedback for OAIANHA



The majority of respondents indicated that they were neutral on all statements, 3-5 indicated agreement, while one respondent disagreed with all statements. During the annual retreat, OAIANHA followed up with UIHAB representatives about what data they should provide and how they can best communicate health policy. They indicated that any and all health-related data would be appreciated from OAIANHA – including COVID-19 data, substance use data, tobacco use data, and social determinants of health. They also indicated that the best ways to communicate health policy are through email, quarterly reports, and the monthly UIHAB meeting.

In addition to general feedback, specific questions were asked about commercial tobacco and substance use disorder. Responses to commercial tobacco questions can be seen in figures A7 and A8, responses to substance use disorder questions can be seen in figures A9 and A10. The data from these questions will be used to prioritize outreach by OAIANHA opioid and tobacco coordinators.

Figure A7: Prioritization of commercial tobbacco by tribe/organization.

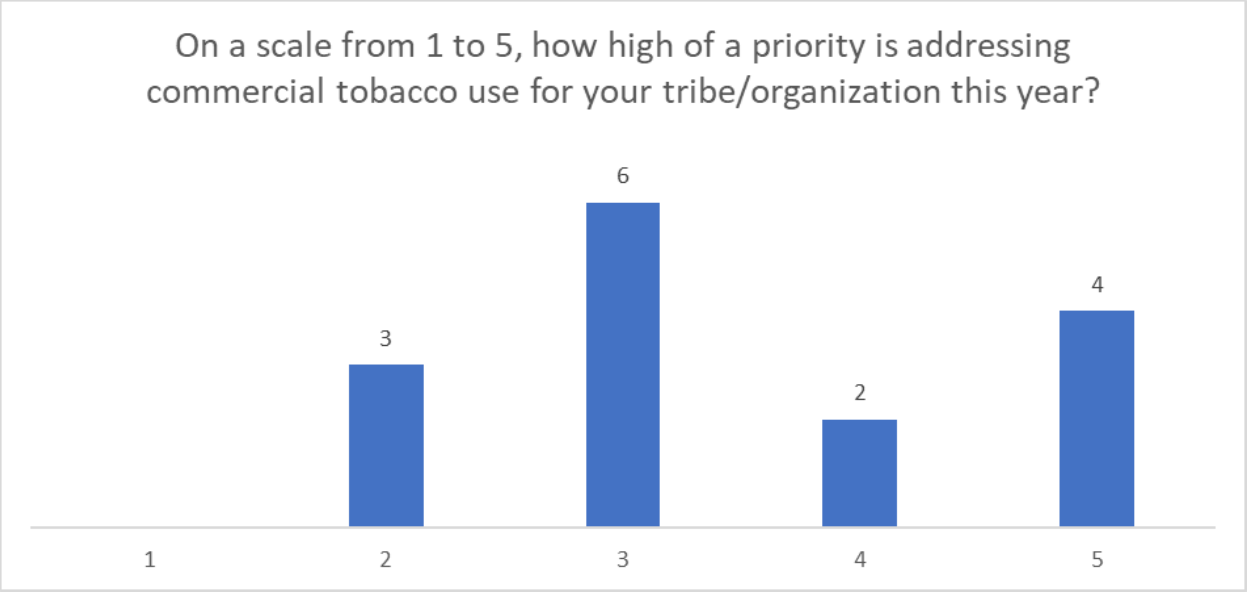


Figure A8: Willingness to engage with OAIANHA on commercial tobacco.

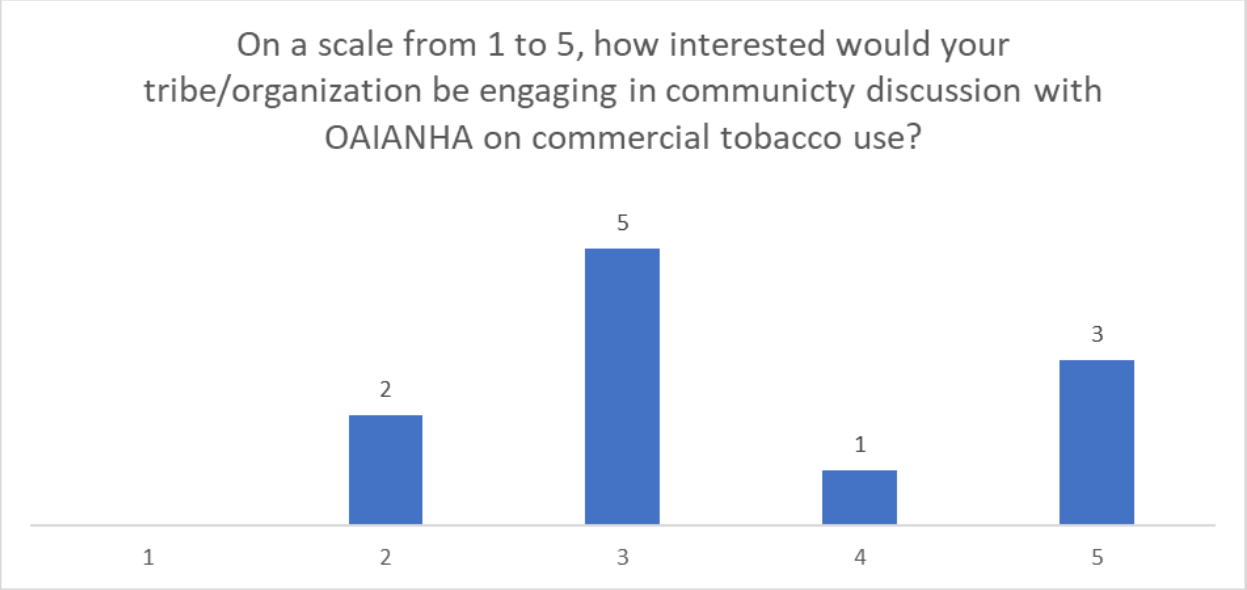


Figure A9: Prioritization of substance use disorder by tribe/organization.

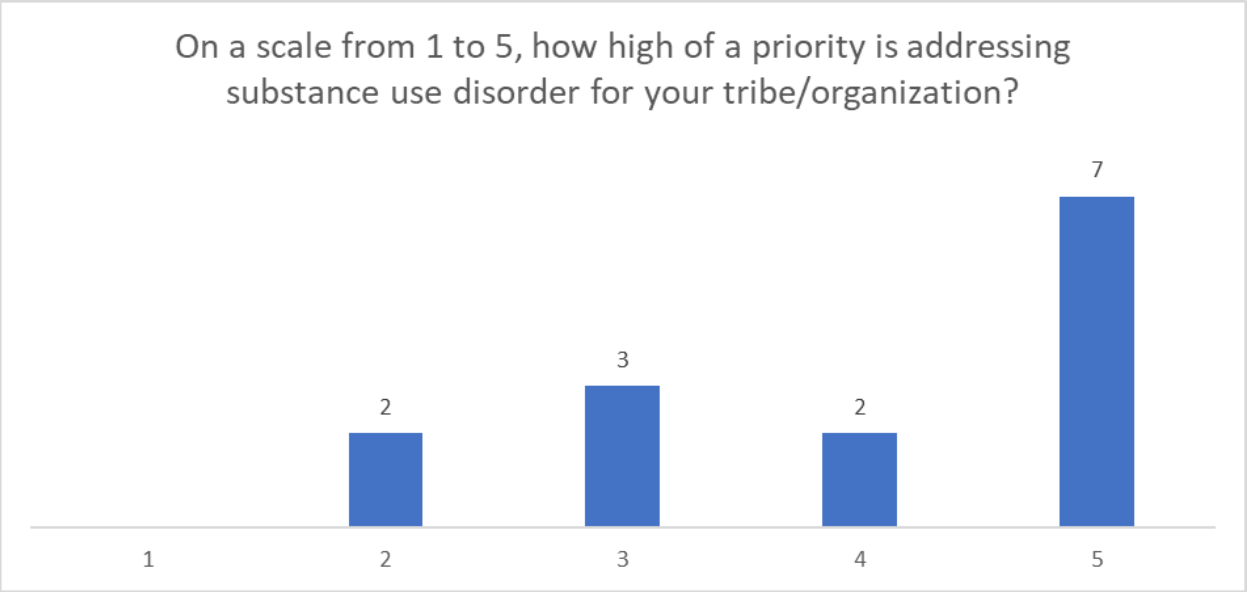
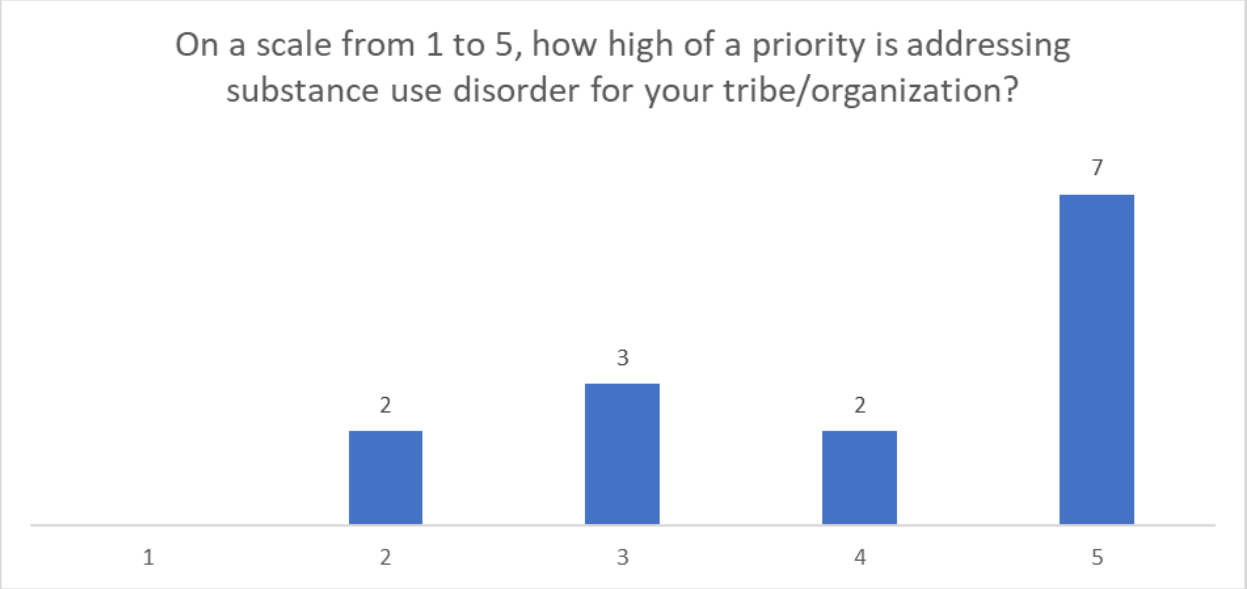


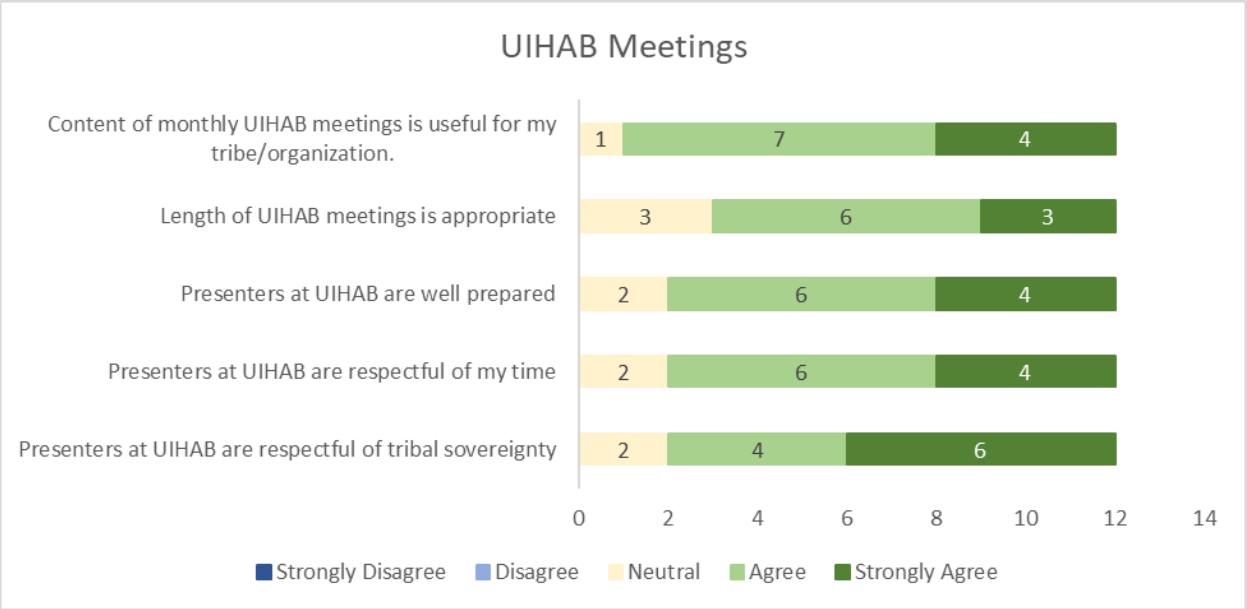
Figure A10: Willingness to engage with OAIANHA on substance use disorder.



Monthly UIHAB Meetings

Feedback was generally positive about the monthly UIHAB meetings organized by OAIANHA. Attendees at the annual retreat were asked what they would change about these meetings and the consensus was that they would like these meetings to be in person when possible. The feedback from tribal health representatives about monthly UIHAB meetings can be found in figure A11.

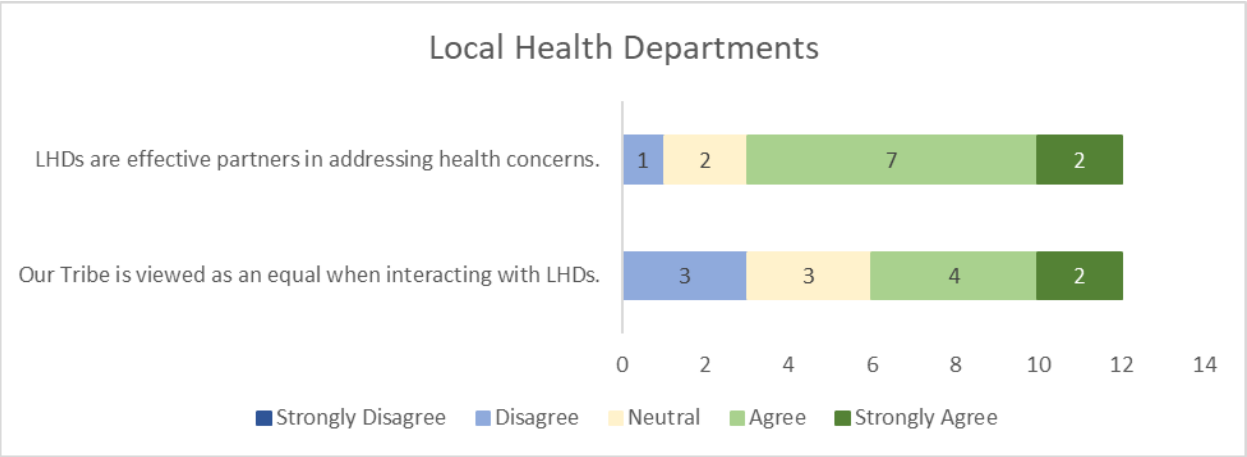
Figure A11: Feedback about UIHAB monthly meetings.



Local Health Departments

The feedback from tribal health representatives about their relationship with local health departments can be found in figure A12.

Figure A12: Feedback about relationship with LHDs.

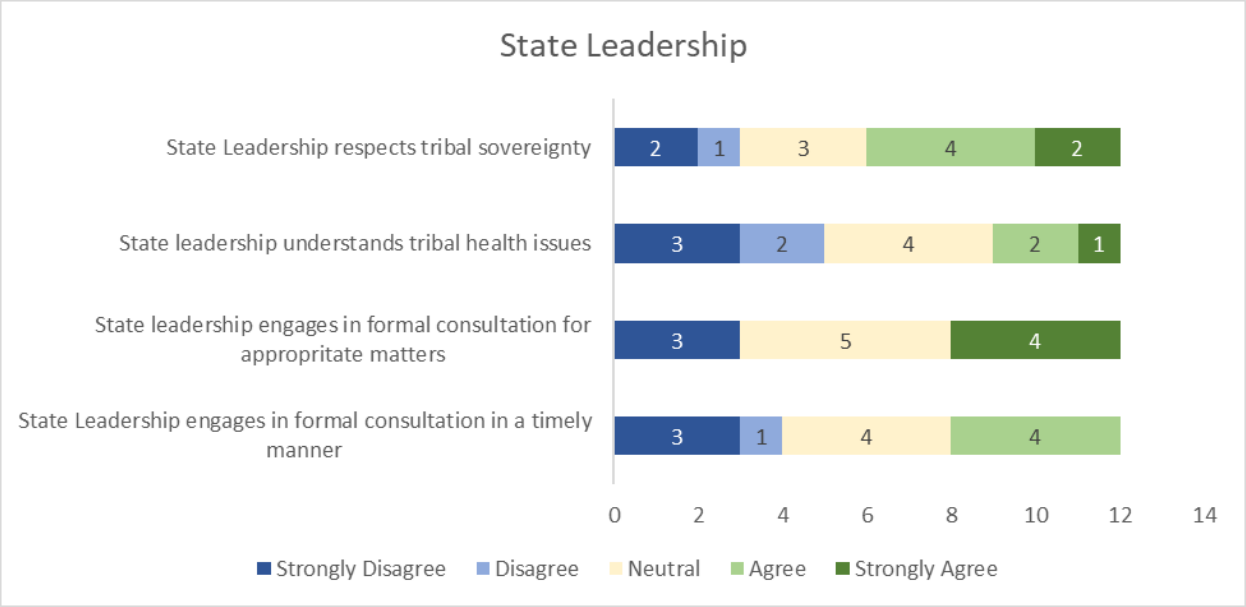


Most respondents indicated that their relationship with the LHDS are effective and respectful. During the annual retreat, feedback for LHDs hinged primarily on the importance of tribal sovereignty and authority.

State Leadership

The feedback from tribal health representatives about their relationship with state elected and appointed leadership can be found in figure A13.

Figure A13: Feedback about relationship with state leadership.



Responses to statements about state elected and appointed leadership varied significantly by respondent. Like the responses regarding LHDs, feedback given during the retreat for state leadership hinged primarily on the importance of tribal sovereignty and authority.

Key Highlights from Feedback

- While responses vary by tribe/organization, OAIANHA is generally viewed neutrally or positively.
    - More work is needed to effectively disseminate data and communicate policy changes.
- The UIHAB monthly meeting is an effective tool that is viewed positively by the tribes.
- Relationships with LHDs are generally positive.
- Relationships with state leadership vary significantly by tribe.

OAIANHA Moving Forward

The feedback provided in the prior sections will be used by OAIANHA in the upcoming year to improve our working relationship with the I/T/U and guide our work with state and local partners. OAIANHA actions will be based on the feedback received in each section

OAIANHA Feedback: While responses vary by tribe/organization, OAIANHA is generally viewed neutrally or positively. More work however is needed to effectively disseminate data and communicate policy changes. Most of this work is currently taking place during meetings, including UIHAB and the weekly I/T/U report. Moving forward, OAIANHA will:

- Improve email communications by explicitly stating that it contains policy changes or relevant data.
- Produce more written materials that can be disseminated via emails and meetings for both data dissemination and policy changes.
- Continue to produce quarterly reports and present to UIHAB.
- Monitor indicators associated with priorities set by UIHAB.
-

UIHAB Feedback: The UIHAB monthly meeting is an effective tool that is viewed positively by the tribes. Efforts will be made to transition to in-person meetings moving forward.

LHD Feedback: Relationships with LHDs are generally positive. OAIANHA will continue to advocate for the I/T/U and facilitate conversations between LHDs and tribal jurisdictions. OAIANHA will reach out to tribes/organizations that disagree with the LHD statements.

State Feedback: Relationships with state vary by tribe/organization. OAIANHA will continue to advocate for the I/T/U and facilitate conversations between LHDs and tribal jurisdictions. OAIANHA will reach out to tribes/organizations that disagree with the LHD statements.

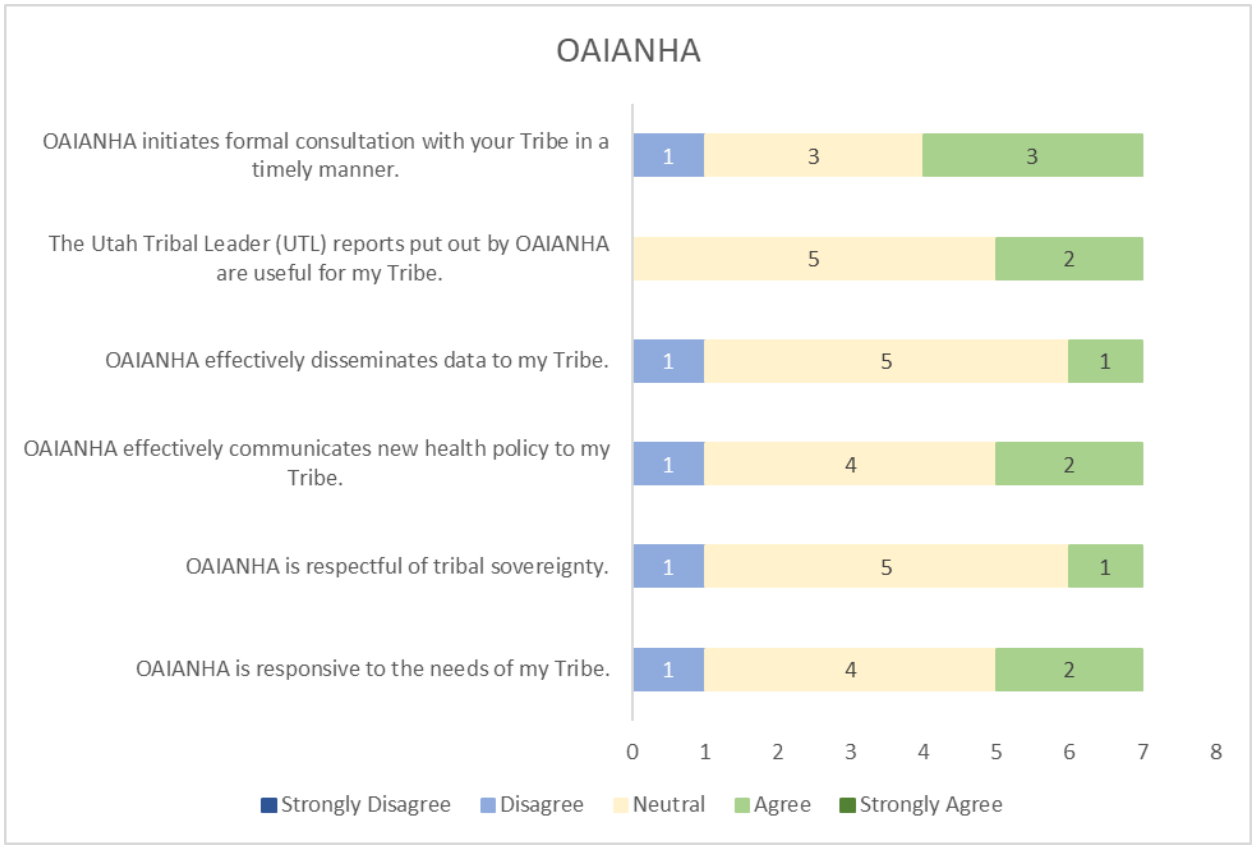
Appendix B: Tribal Leadership Survey

After the survey was administered to UIHAB representatives, a survey was created for tribal leadership to assess their views on the Office of American Indian/Alaska Native Health Affairs, UIHAB, and state and local leadership. Unlike the UIHAB survey.

The survey was sent to elected tribal leadership on February 14th and was open until March 1st. There were 8 responses from tribal leaders representing 7 of the 8 tribes, the other response did not indicate the tribe they represent. Only the Ute Mountain Ute Tribe did not have a leader respond to this survey.

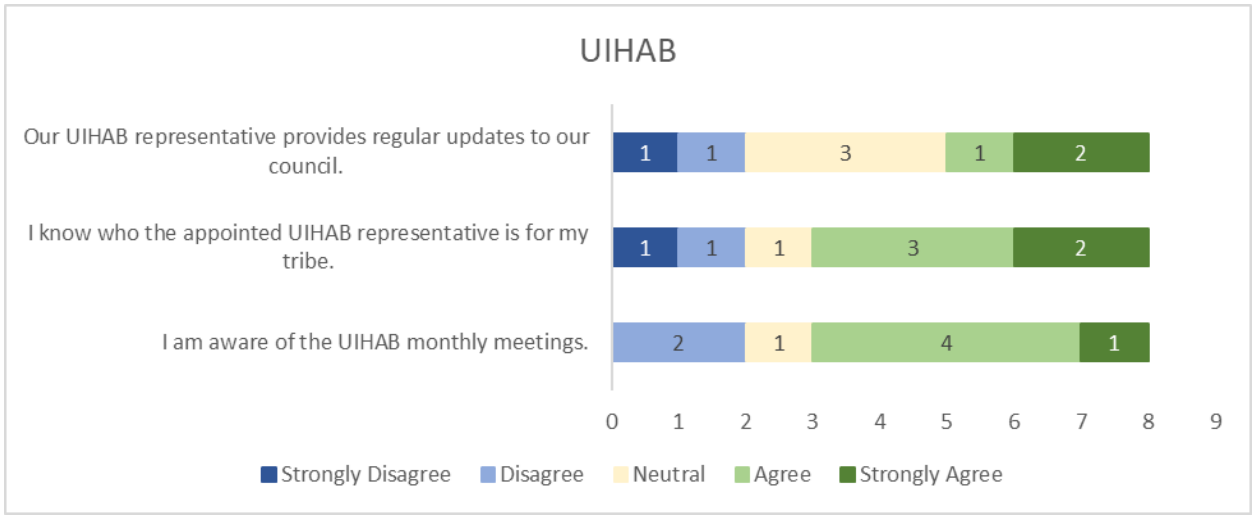
Feedback for OAIANHA can be seen in figure B1. Most tribal leaders were neutral about, or agreed with, statements about OAIANHA. Only one tribe disagreed with any of the statements above. With the exception of the statement on respecting sovereignty, these results mirror what was seen in the UIHAB survey.

Figure B1:Feedback about OAIANHA



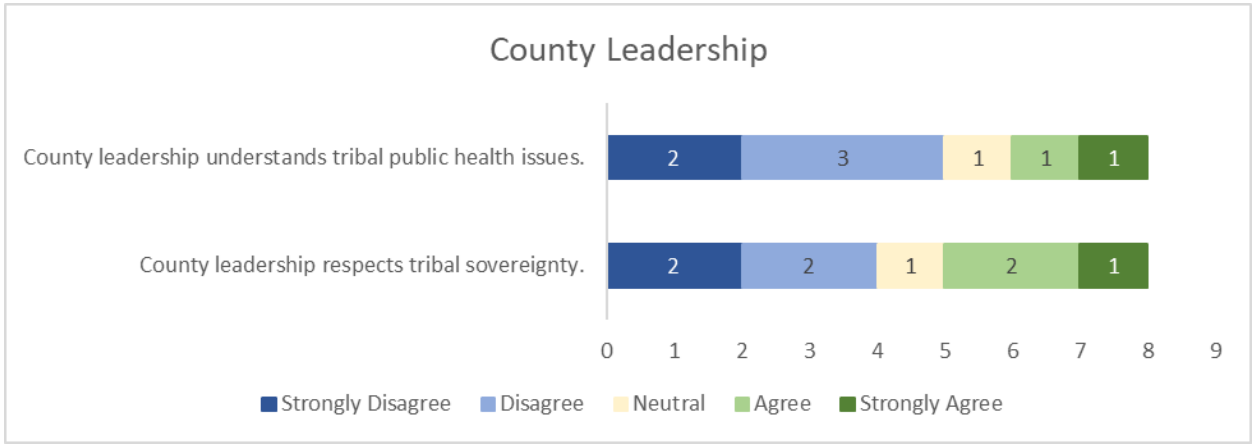
Monthly UIHAB meetings and the annual UIHAB annual retreat is one of the most common ways for OAIANHA to provide updates to tribes through their representatives. The statements about UIHAB were intended to determine if UIHAB was on the minds of tribal leadership and if they were receiving updates. Figure B2 demonstrates that most respondents are aware of their UIHAB representative and the meetings, but fewer are receiving regular updates.

Figure B2: Feedback about UIHAB



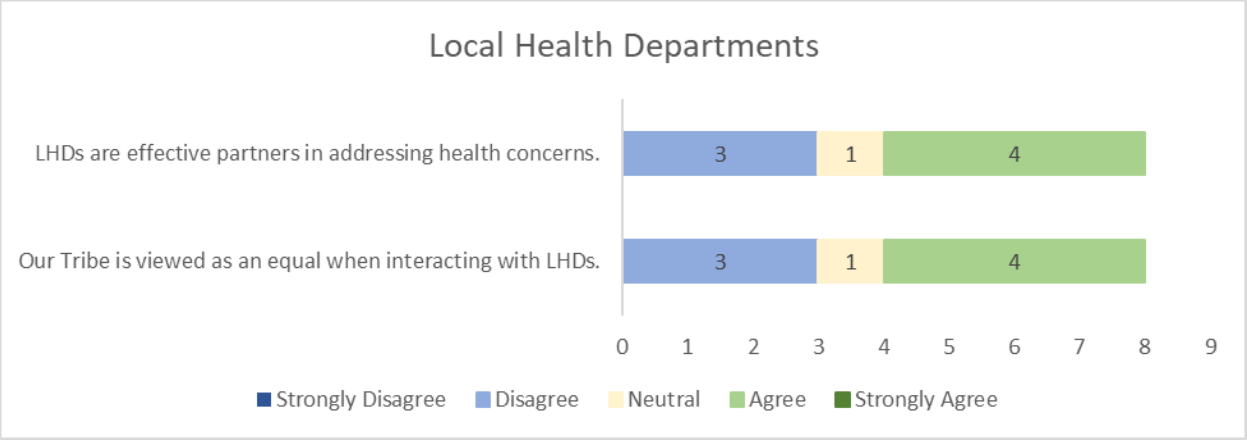
Most respondents indicated that county leadership does not understand tribal public health issues. Additionally half indicated that county leadership are not respectful of tribal sovereignty (figure B3.)

Figure B3: Feedback about County Leadership



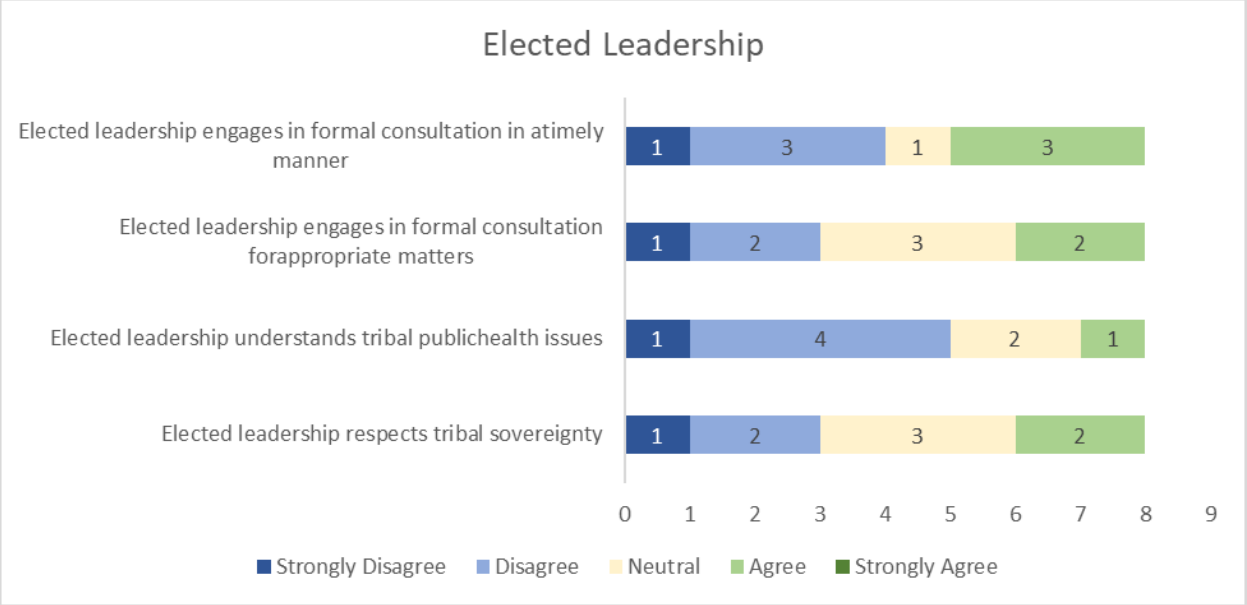
Half of respondents indicated that local health departments (LHDs) are effective partners when addressing health concerns and that they are viewed as equal partners when interacting with them. (figure B4.) This departs significantly from UIHAB's views on Local Health Departments, which can be seen in Appendix A figure 12.

Figure B4: Feedback about Local Health Departments



Tribal leaders tended to disagree with statements about elected state leadership, particularly about the timeliness of consultation and their understanding of tribal public health issues (figure B5.)

Figure B5: Feedback about State Elected Leadership



Tribal leadership was more neutral regarding state agency leadership compared to state elected leadership (figure B6.) This may be attributable to a lack of familiarity with agency leadership among tribal leaders or better performance by agency leadership in these areas.

Figure B6: Feedback about State Agency Leadership