ENGAGING TRIBAL NATIONS OF NORTH DAKOTA IN CONDUCTING COMMUNITY HEALTH ASSESSMENTS

NORTH DAKOTA DEPARTMENT of HEALTH

NDSU AMERICAN INDIAN PUBLIC HEALTH RESOURCE CENTER

Hau. Pilamaye Yelo. Mitakuye Pi.

Hello and Thank You to All My Relations,

The Indian Self-Determination and Education Assistance Act (PL 93-638) gave tribal nations the authority to operate their own health care programs in 1975. The potential for development of locally delivered and managed clinical and public health services across Indian Country has created hundreds of culturally appropriate clinical and public health programs and services. As important as providing these direct services, quality standards are essential as tribal health programs work to reduce health disparities and improve health outcomes in tribal communities.

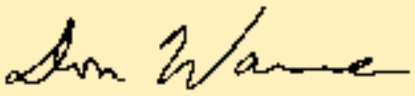
The Gaining Ground Initiative, managed by the National Network of Public Health Institutes, and supported by the Robert Wood Johnson Foundation, aims to promote ongoing quality improvement in public health departments, as they protect and improve health in their communities. The American Indian Public Health Resource Center at North Dakota State University is proud to be part of the North Dakota's Gaining Ground Network.

Through partnership with the North Dakota Department of Health – North Dakota Gaining Ground Network, the American Indian Public Health Resource Center developed the Engaging Tribal Nations in North Dakota in Conducting Community Health Assessments toolkit. This toolkit is designed as a step-by-step map for tribal and public health programs wishing to identify: Tribal community members' health priorities; unmet health needs in tribal communities; and the effectiveness of existing tribal health services.

On behalf of the NDSU American Indian Public Health Resource Center and Department of Public Health, I wish you success as you work to grow quality of health in Indian Country.

Anpetu waštеʼ yuhaʼ po. Tanyaŋ omani po.

Have a good day and a good journey,



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Introduction

A community health assessment (CHA) or community health needs assessment (CHNA) is a systematic review process to determine key health issues. Tribes, states, counties, and communities may engage in a CHA to identify its citizens' health needs. The development of a plan to address these needs is the goal of completing a CHA. This plan is often called a community health improvement plan or CHIP.

CHAs also help move entities towards attaining public health accreditation. Public health accreditation is a designation that a public health entity meets the quality and performance criteria designated by the Public Health Accreditation Board. Tribal input and considerations were included in creating these criteria throughout their development. Criteria focuses on evidence-based standards in improvement and protection of the public's health and are based on the 10 Essential Services of Public Health. Gaining public health accreditation is a lengthy process that includes time-intensive planning, documentation, infrastructure development and service provision improvement. In turn, meeting the standards and measures set forth by the accreditation criteria has numerous benefits (Public Health Accreditation Board, 2013):

- Identifying areas that a health program excels in
- Prioritization of long-standing concerns
- Stimulus for continued quality improvement in daily practice
- Performance and improvement opportunities
- Increased transparency and accountability within the health department
- Competitiveness in funding opportunities
- Improved management process
- Accountability with external stakeholders
- Improved communication with governing bodies
- Coordination of public health services
- Exercising tribal sovereignty

Completing a CHA is one of the first steps in reducing health disparities. The CHA provides formal identification of issues and needs; successful current approaches; opportunities to improve the efforts to reduce disparity; opens communication among stakeholders to work together towards disparity reduction; can provide previously unavailable funding resources to assist in disparity reduction; and guides the development of a plan to address the identified health disparity.

The Role of Tribal Public Health

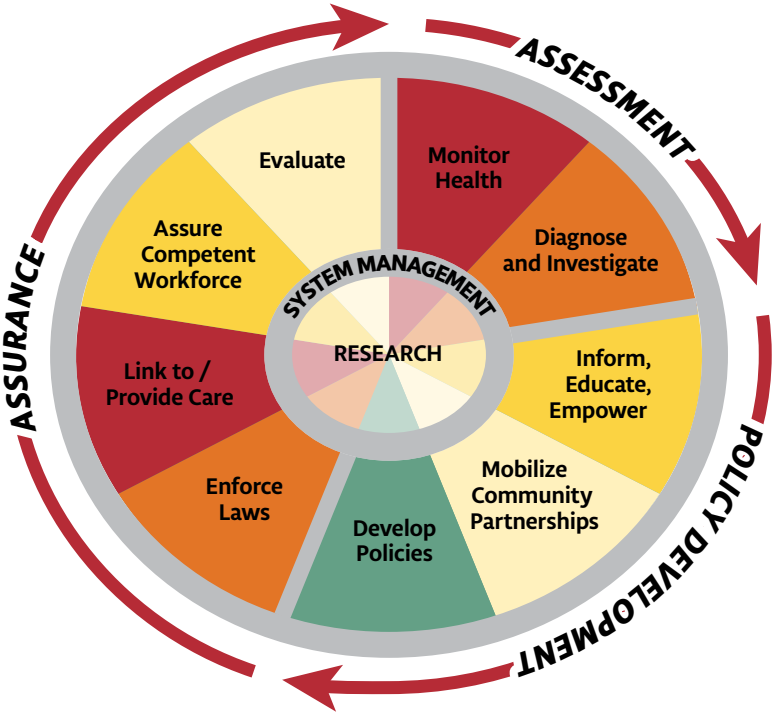
The World Health Organization (2016) defines public health as "What we as a society do collectively to assure the conditions in which people can be healthy." Tribal public health departments/programs achieve this by promoting physical and mental health through prevention of disease, injury, and disability. According to the Centers for Disease Control and Prevention (2013), this includes:

- Prevention of epidemics and the spread of disease
- Protection against environmental hazards
- Prevention of injuries
- Promotion and encouragement of healthy behaviors
- Responding to natural disasters and assisting communities in recovery efforts
- Assuring quality and accessibility of health services

TRIBAL PUBLIC HEALTH DEPARTMENT/PROGRAM STRUCTURE AND PERCEPTIONS

Public health efforts are organized differently in each tribal nation. Often tribal public health services do not look like state public health departments. Some tribal nations have departments, while others have programs and services that are integrated into various sectors. Some programs are highly unified in practice and funding, while others are decentralized throughout the community services.

Many programs within tribal communities essentially conduct public health work without acknowledging it as such. Due to decades of limited resources and funding, tribal perceptions of health are often skewed toward clinical contexts of treatment, rather than prevention. It is important to build upon traditional teachings of holistic health in order to acknowledge public health's role in overall wellness.



This wheel depicts the 10 Essential Services of Public Health, which provide a visual of the ways in which tribal public health programs work to ensure tribal communities are healthy (Centers for Disease Control and Prevention, 2014). A deeper look at these activities identifies where CHAs support the 10 Essential Services.

ASSESSMENT:

- **Monitor Health:** This is where CHAs and disease specific registries help identify health issues, disparities and scope. Tribal public health programs use this information to direct their efforts and secure funding to support efforts.
- **Diagnose and Investigate:** Outbreaks of infectious, water-, food– and vector– borne diseases are investigated to identify the exact illness and the source. This information is vital to end or reduce the community's risk of further illness.

POLICY DEVELOPMENT:

- **Inform, Educate and Empower:** Tribal public health programs offer community education to promote disease prevention. This is done through community education classes, public service announcements, and other methods. In the event of a disease outbreak, the tribal public health program will provide the community with information on ways to avoid and reduce their risk of infection. During natural disasters, the tribal public health program will provide educational information on safety and specific health related information. Through school systems, a tribal public health program may disseminate education about healthy living. A CHA can provide valuable information about what information and education channels are available and those that are needed in the community.
- **Mobilize Community Partnerships:** Efforts to ensure the health and well-being of an entire community, state, county or tribal nation, including conducting CHAs, are most successful when there is support and action by businesses, government, non-profit organizations, civic groups, and faith communities. When more partners are involved, more community members can be reached and more resources are available for use in emergency responses and the everyday work of tribal public health programs. Tribal public health programs may collaborate with local media and law enforcement in the event of emergencies, or assist in educating the community about public health issues. Ultimately, the CHA process creates a greater community focus on the tribal citizens' health.
- **Develop Policies:** Tribal public health programs can use the data collected during the CHA to develop a community health improvement plan to address health disparities. Tribal public health programs can also advocate for adoption or amendment of tribal, state and federal public health codes laws that will improve the health of the community. This is an important step in ensuring there are adequate resources for achieving the tribal public health program's goals.

Find more information and nationwide examples of tribal public health codes and laws in the National Congress of American Indian's (NCAI) Tribal Public Health Law Database at http://www.ncai.org/policy-research-center/initiatives/projects/tribal-public-health-law#database

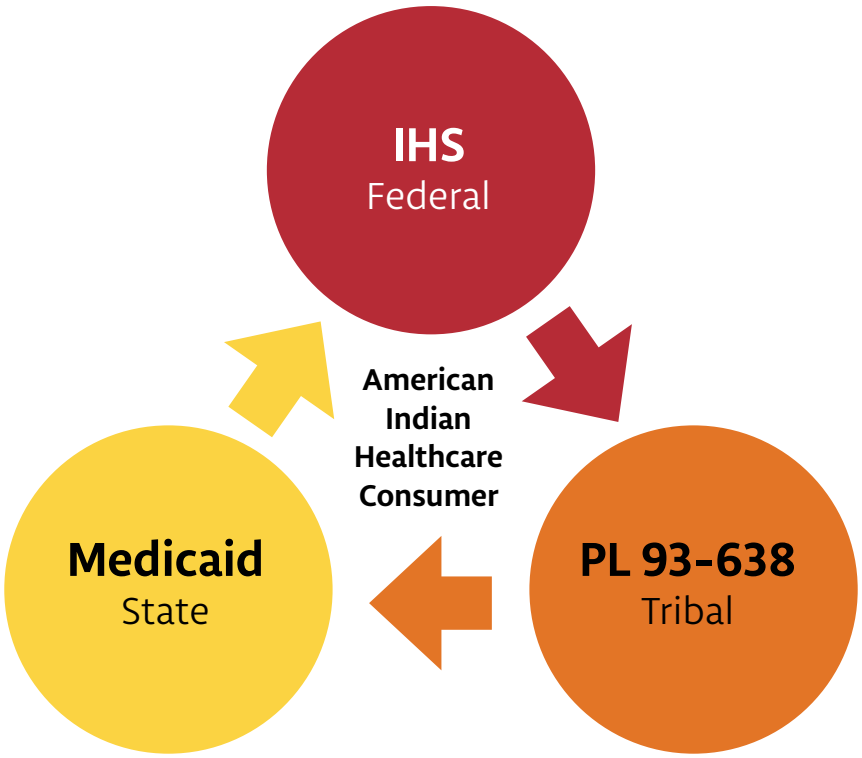
ASSURANCE

- **Enforce Laws:** Many laws exist in an effort to protect a community, state or nation's citizens. Examples include tribal nation and state seat belt laws to reduce traffic deaths and the United States Safe Drinking Water Act, which protects against the health risks of drinking contaminated water. Tribal public health programs review relevant laws, provide education and resources for compliance, and have the authority to enforce the laws. For example, tribal public health programs may conduct food service inspections and license daycares.
- **Link to/Provide Care:** In the event of a disease outbreak, tribal public health staff play a vital role informing the community about the symptoms of the disease, describing how to protect oneself against infection, and providing guidelines on when to see a doctor. In addition, some tribal public health programs offer screenings for and vaccinations against infectious diseases.
- **Assure Competent Workforce:** An educated, competent public health workforce is essential to ensuring a healthy community. Tribal public health programs do this through training and in some cases, licensing public health nurses, community health workers, emergency responders, community health representatives, and home care staff. A comprehensive CHA can provide information about the needs of the tribal public health workforce, such as training, education and advancement opportunities.
- **Evaluate:** Public health program evaluation is a way to determine if a program is positively affecting the community's health. Evaluation also identifies gaps in services, which the tribal public health program might address. A CHA can be use as part of an evaluation on the effectiveness of the tribal public health program's services.
- **Research:** Public health research encompasses a spectrum of sciences including basic science, clinical medicine, environmental science, nutrition, exercise science, economics, statistics, social science and behavioral sciences. The goal of public health research is to prevent disease, promote health and evaluate healthcare systems. By conducting and participating in research studies, tribal public health programs can learn more about the needs of the people they serve.

Tribal Public Health Systems

The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally recognized Tribes grew out of the special government-to-government relationship between the federal government and Indian Tribes. This relationship, established in 1787, is based on Article I, Section 8 of the Constitution, and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders. The IHS is the principal federal health care provider and health advocate for Indian people and its goal is to raise their health status to the highest possible level. The IHS provides a comprehensive health service delivery system for American Indians and Alaska Natives.

The Indian Health Service (IHS) agency is the primary health care provider and advocate for American Indians/Alaskan Natives (AIs/ANs). The agency ensures that AIs/ANs receive culturally appropriate personal and public health services. Located within the US Department of Health and Human Services, Congress determines the annual budget for IHS. It is important to note that the IHS budget has never been funded at the level needed to provide adequate care to all AIs/ANs. In fact, IHS facilities are so severely underfunded that many services become unavailable well before the end of the annual funding cycle. IHS programs bill Medicare, Medicaid, State Children's Health Insurance Program, and other insurers for services. IHS is not an insurance policy. The graphic below shows the relationship between federal, state, and tribal health systems and American Indian healthcare consumers (Warne, 2016).

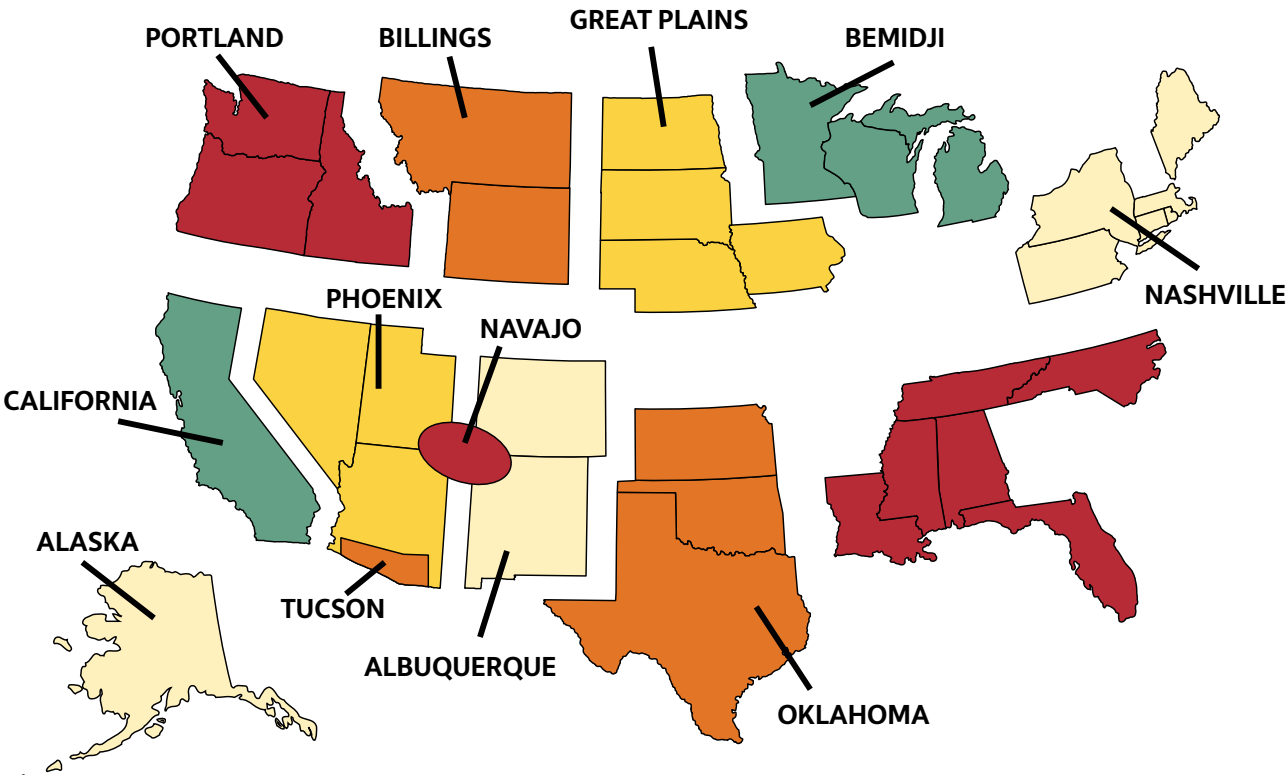


IHS is not a health insurance provider; IHS is the agency that provides health services to AIs/ANs. IHS hospitals and clinics will only provide services to federally recognized AIs/ANs. IHS has 12 service areas; North Dakota tribes are served by the Great Plains IHS area office, located in Aberdeen, South Dakota.

AREA INDIAN HEALTH BOARDS

The Area Health Boards serve as the communication link between the National Indian Health Board, Indian Health Service and the Tribes. The National Indian Health Board (NIHB) represents Tribal governments—both those that operate their own health care delivery systems through contracting and compacting, and those receiving health care directly from IHS. The Area Health Boards advise in the development of positions on health policy, planning, and program design. They gather information and review public opinion and proposals. In areas without an Area Health Board, the NIHB representative communicates policy information and concerns to the tribes in that area.

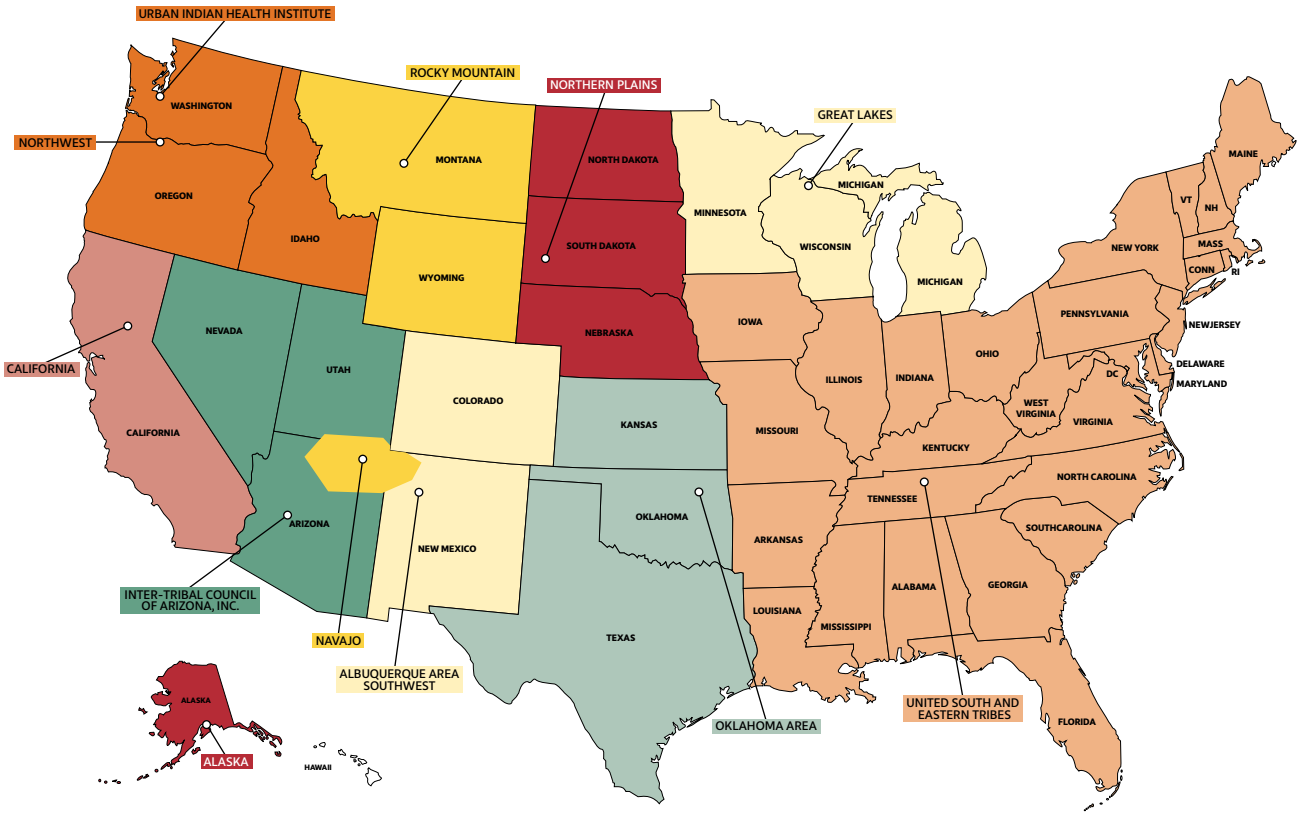
Indian Health Service Area Map (Warne, 2016)



TRIBAL EPIDEMIOLOGY CENTERS

Tribal Epidemiology Centers (TECs) are Indian Health Service, division funded organizations who serve American Indian/Alaska Native Tribal and urban communities by managing public health information systems, investigating diseases of concern, managing disease prevention and control programs, responding to public health emergencies, and coordinating these activities with other public health authorities.

Currently there are 12 TECs and 11 Area Indian Health Boards throughout the country. Following are a map of their locations and a table with their contact information.



AREA HEALTH BOARDS	TRIBAL EPIDEMIOLOGY CENTERS
Alaska Native Health Board 4000 Ambassador Drive, Suite 101 Anchorage, AK 99508 907-743-2524 www.anhb.org	**Alaska Native Tribal Epidemiology Center** 3900 Ambassador Drive, Suite 201, Anchorage, AK 99508 (907) 729-4567 anepicenter@anthc.org www.anthc.org
Albuquerque Area Indian Health Board 5015 Prospect Avenue NE, Albuquerque, NM 87110 (505) 764-0036 www.aaihb.org	**Albuquerque Area Southwest Tribal Epidemiology Center** 5015 Prospect Avenue NE, Albuquerque, NM 87110 (505) 764-0036 www.aastec.net
California Area Indian Health Board 4400 Auburn Boulevard, 2nd floor Sacramento, CA 95841 (916) 929-9761 www.crihb.org	**California Tribal Epidemiology Center** 4400 Auburn Boulevard, 2nd Floor Sacramento, CA 95841 (916) 929-9761 epicenter@crihb.org www.crihb.org/ctec
Midwest Alliance of Sovereign Tribes (Bemidji) 1011 Main Street, PO Box 265, Gresham, WI 54128 715-787-4494 m-a-s-t@frontiernet.net www.m-a-s-t.org	**Great Lakes Inter-Tribal Epidemiology Center** 2932 Highway 47 N. P.O. Box 9, Lac du Flambeau, WI 54538 (715) 588-3324 www.glitc.org/programs/epi-home
Inter-Tribal Council of Arizona (Phoenix) 2214 N. Central Ave. Suite 100, Phoenix, AZ 85004 602-258-4822 info@itcaonline.com www.itcaonline.com	**Inter Tribal Council of Arizona, Inc. Tribal Epidemiology Center** 2214 North Central Avenue, Suite 100, Phoenix, AZ 85004 (602) 258-4822 TECinfo@itcaonline.com www.itcaonline.com
Navajo Nation Department of Health Navajo Department Of Health Central Offices, Administration Bldg. #2, Morgan Boulevard, Window Rock, Arizona 86515 928-871-6350 www.nndoh.org	**Navajo Epidemiology Center** Window Rock Blvd, Administration Building #2, Window Rock, Arizona 86515 928-871-6254 NavajoEpi@nndoh.org www.nec.navajo-nsn.gov
Great Plains Tribal Chairmen's Health Board 1770 Rand Road, Rapid City, SD 57702 605-721-1922 info@gptchb.org www.gptchb.org	**Northern Plains Tribal Epidemiology Center** 1770 Rand Road, Rapid City, SD 57702 605.721.1922 ext 155 NPTEC@gptchb.org www.nptec.gptchb.org
Northwest Portland Area Indian Health Board 2121 SW Broadway, Suite 300, Portland, OR 97201 503-228-4185 www.npaihb.org	**Northwest Tribal Epidemiology Center** 2121 SW Broadway, Suite 300, Portland, Oregon 97201 503-228-4185 epicenter@npaihb.org www.npaihb.org/epicenter/ about_the_epicenter
Rocky Mountain Tribal Leaders Council (Billings) 711 Central Avenue, Suite 220 Billings, MT 59102 406-252-2550 www.rmtlc.org	**Rocky Mountain Tribal Epidemiology Center** 711 Central Ave. Suite 220, Billings, MT 59102 406-252-2550 www.rmtec.org
Southern Plains Tribal Health Board (Oklahoma) 9705 N Broadway Extension, Suite 150 Oklahoma City, OK 73114 405-652-9200 www.ocaithb.org	**Oklahoma Area Tribal Epidemiology Center** 9705 N Broadway Extension, Suite 150 Oklahoma City, OK 73114 405-652-9204 www.ocaithb.org
United Southern and Eastern Tribes, Inc. (Nashville) 711 Stewarts Ferry Pike Ste. 100 Nashville, TN 37214 615-467-1540 www.usetinc.org	**United South and Eastern Tribes Epidemiology Center** 615-872-7900 www.usetinc.org/departments/tribal-health-program-support/tribal-epidemiology-center/
	Urban Indian Health Institute 611 12th Avenue South, Seattle, WA 98144 (206) 812-3030 info@uihi.org www.uihi.org

The Community Health Assessment Process

There are many ways to approach conducting a CHA. The process involves many steps, each essential to the success of the CHA and the community health improvement plan (CHIP). There are various frameworks for conducting CHAs, but common steps in the CHA process are below.

COMMUNITY HEALTH ASSESSMENT PROCESS STEPS

Engage the community	Define and engage the community
Develop a plan	Determine why, readiness, cost, and framework; Obtain approval; Recruit a work team; Obtain memorandums; Develop goals and objectives; Develop work plan and timeline
Identify community health indicators	Brainstorm, collect and prioritize health indicators
Collect data	Select data collection sources, methods and tools; Determine record keeping and data storage processes; Collect data; Enter and store data
Analyze data	Create data analysis plan and community health profile
Identify health priorities	Create community health improvement plan
Communicate the results	Determine methods for sharing; Communicate the results

Engage the Community

DEFINE THE COMMUNITY

The first step in conducting a community health assessment is to engage the community. When in the beginning phases of conducting CHAs, there are four basic elements of successful efforts (Dwelle and Musumba, 2012):

- Key tribal leaders support the assessment
- The assessment uses best and promising practices
- There are sufficient resources for the assessment, such as people, money, and time
- The community is fully engaged in the assessment

Full community support and engagement are crucial to the assessment's success. First, determine what the purpose of the assessment is. Second, in order to build community relationships, decide what individuals, organizations, and groups to engage.

Tribal liaisons can help facilitate communication and open doors to the community. Successful tribal CHAs rely on tribal liaisons, including state-tribal liaison offices, to connect staff with key leaders. An important step in engaging tribal communities is to identify all key leaders, which you may discover are not always formal leaders. Informal leaders may be as influential as formal leaders and these leaders will know whom to talk to within the community. Tribal elders play an important role in the community and should be engage them in the assessment/project.

Created by the North Dakota Legislature in 1949, the **ND Indian Affairs Commission** (NDIAC) was one of the first such commissions established in the United States. Although the official function of the NDIAC has been modified over the years to reflect changes in federal and state policy, the main goal of the Commission has always been to create a better North Dakota through the improvement of tribal/state relations and better understanding between American Indian and non-Indian people. For more information about the NDIAC, visit: http://www.nd.gov/indianaffairs

Being knowledgeable of culture, beliefs, and values before entering the tribal community can be beneficial in developing working relationships. While tribal communities share some similarities, each tribe has their own culture, beliefs, and values. Understand that each tribe has a rich and sophisticated culture. Elders are often held in high regard, and should be engaged in the community health assessment process.

There are five federally recognized Tribes and one Indian community located at least partially within the State of North Dakota. These include the Mandan, Hidatsa, and Arikara Nation (Three Affiliated Tribes), the Spirit Lake Nation, the Standing Rock Sioux Tribe, the Turtle Mountain Band of Chippewa Indians, the Sisseton-Wahpeton Oyate Nation, and the Trenton Indian Service Area.

In total, there are 36,591 American Indians living in North Dakota, making up 5.4% of the total population. Almost sixty percent live on reservations and over forty percent of these American Indians are under the age of 20.

NORTH DAKOTA TRIBAL COMMUNITIES AND RESERVATIONS

ENGAGE THE COMMUNITY

Once the community has been defined, reach out to community liaisons for ideas on how to communicate about the project, distribute the health assessment, and share the assessment findings. Community buy-in is crucial and will determine if and how the tribe conducts a CHA. Involve the tribal community early in the development phase and continue to engage the community throughout the assessment. Work towards a common goal and form relationships with the community.

Community engagement as a practice takes many forms and exists on a continuum, ranging from an organization not engaging a community at all to following as the community directs the action. Following are the levels of the engagement continuum and strategies (King County, 2011):

COMMUNITY ENGAGEMENT CONTINUUM

Inform Community	Consult Community	Engage community in dialogue	Work together with community	Community directs action
Initiate effort and use variety of channels to inform community to take action	Gather information from the community to inform interventions	Engage community members to shape priorities and plans	Share in decision-making with community to co-create solutions together	Participate and provide technical assistance as the community initiates and directs strategy and action
Characteristics of Engagement				
• **Primarily one-way channel of communication** • **One interaction** • **Term-limited to event** • **Addresses immediate needs**	• Primarily one-way channel of communication • One to multiple interactions • Short to medium-term • Shapes and informs county programs	• Two-way channel of communication • Multiple interactions • Medium to long-term • Advancement of solutions to complex problems	• Two-way channel of communication • Multiple interactions • Medium to long-term • Advancement of solutions to complex	• Two-way channel of communication • Multiple interactions • Medium to long-term • Advancement of solutions to complex problems
Strategies				
Media releases, brochures, pamphlets, outreach to vulnerable populations, ethnic media contacts, translated information, staff outreach to residents, new and social media	Focus groups, interviews, community surveys	Forums, advisory boards, stakeholder involvement, coalitions, policy development and advocacy (legislative briefings and testimony), workshops, community-wide events	Co-led community meetings, advisory boards, coalitions, and partnership, policy development and advocacy (legislative briefings and testimony)	Community-led planning efforts, community-hosted forums, collaborative partnerships, coalitions, policy development and advocacy (legislative briefings and testimony)

Due to historical trauma and previous unethical research methods, some American Indians may be wary of participating in research. Prior to seeking funding or starting research with a tribe, seek tribal approval for the proposed project. Tribal approval can be through a tribal resolution and/or submitting to their IRB.

ENGAGEMENT AND COMMUNICATION TIPS

When engaging/communicating with a tribal community, there are several tips that may prove useful:

- Always ask for permission first before starting any research.
- Use a tribal liaison/champion to open doors.
- Be present in meetings and listen. Do not talk out of turn.
- Frequently ask for feedback to make sure that everyone is on the same page.
- Be respectful of the tribal community's time. Bring a general outline of what you are expecting for the visit, but understand that you may not cover everything.
- Many tribal governments are not wealthy and it may be difficult for Tribal officials to attend meetings or to exchange correspondence. Also, tribal governments often do not have large support staff to assign to meetings and follow-up.
- Understand tribal sovereignty and the importance of engaging tribal elders and including them in the decision making process. Respect tribal council representatives as elected officials of a government.
- Do not assume one Tribe or one leader speaks for all. Take the time to find the key players.
- Spend quality time with the tribe.
- Relationship building will be an ongoing process, so frequently visit with the tribal community.
- Do not rely solely on written communications. Follow-up written correspondence with telephone calls, faxes, or in-person contacts.
- If possible, arrange meetings with refreshments and/or a meal.
- When you make a request of a tribe, bring resources, gifts and/or assistance. Do not approach a tribe just to ask for their time and help without bringing something to contribute as well.
- Once the research has been completed, share findings with the tribe. It is important to give back to the community.

Some information taken from the ND American Indian Affairs Commission and MN Indian Affairs Council websites.

Develop a Plan

The next step to conducting a CHA is planning. The CHA plan is the road map, timeline and foundation of the process. Below is a list of the steps to planning a CHA, and more information about each:

Step 1: Determine why to do a CHA

Step 2: Determine the cost of a CHA

Step 3: Determine a CHA framework to utilize

Step 4: Obtain tribal leadership and IRB approval

Step 5: Recruit a CHA work team

Step 6: Obtain Memorandums of Agreement

Step 7: Develop CHA goals and objectives

Step 8: Develop a work plan and timeline

STEP ONE: DETERMINING WHY TO DO A CHA

Reasons why a tribal community or public health program may want to conduct a CHA:

- To apply for public health accreditation
- To involve the community in addressing health issues
- To prioritize health issues
- To track trends in health disparities
- To gather data to inform health improvement planning, resource development and/or program evaluation
- To assess tribal health service operations. A community health assessment can be a helpful tool in the tribal clinical services contracting feasibility study process.

In the tribal clinical services contracting feasibility study process, a tribal nation determines if it is equipped to administer health services independently. This process is often known as "638", named after Public Law 93-638 or the Indian Self-Determination and Education Assistance Act. More information about this process can be found at http://helmsleytrust.org/sites/default/files/638%20Toolkit.pdf

Assessing Community Readiness

Readiness assessments are developed to determine the likelihood of a community's participation in the tribal community health assessment process. A community's willingness to discuss health related problems is an indicator of whether the community at large will be part of the tribal community health assessment. They identify what is being done, what else could be done and what resources are needed to do.

Community health assessments are typically low cost, have local experts leading them, are designed for the community and are culturally specific. They can also be helpful in identifying possible solutions to health problems in the community.

There are eight steps to conducting a community readiness assessment:

1. Decide what specific issue(s) you want to discuss
   - Example: Binge drinking rates in youth ages 13-21
2. Decide who will be interviewed and within what location(s)
   - Example: youth ages 13-21, parents of youth ages 13-21 and law enforcement in the tribal community
3. Develop your interview questions
   - The main categories of a community readiness assessment are:
     - What the community knows about the problem
     - How the community feels about the problem
     - What is currently being done to fix the problem
     - What ideas they have for fixing the problem
     - What resources are there and what are needed to fix the problem

Example: How many times per week do you drink 3 or more alcoholic drinks? What could you do instead of drinking? How many times per week do you respond to calls that involve underage drinkers? Of them, how many involve binge drinking?

Following is an example of a readiness assessment.

Sample Community Readiness Assessment

PROBLEM: INFORMATION DOES NOT EXIST TO DETERMINE IF THE TRIBAL PUBLIC HEALTH PROGRAM IS MEETING THE NEEDS OF THE COMMUNITY	
Does the community think they are healthy?	
Has there been a recent health related outbreak or scare in the community that has caused people to be concerned?	
Does tribal leadership think the community is healthy?	
How does local media portray the health of the community?	
What health problems are being reported?	
What ideas does the community have as to the cause of the health problems?	
What ideas does the community have as to solutions to health problems?	
EXISTING RESOURCES	
What facilities are available to support health improvement?	
What funding exists to support health improvement?	
What in-kind services are available to support health improvement?	
What professionals are available and how much time are they available to support health improvement?	
What volunteers are available and how much time are they available to support health improvement?	
VISION	
Is there a community vision for improved health?	
How much of the community holds this vision?	
Who in the community holds this vision?	
Will more members of the community support the vision?	
What must be done to get more community support for the vision?	
Is there professionals or volunteers in the community with the skill set to develop a measurable, objective community assessment?	
COMMITMENT	
Is the community and its leadership committed to improving community health?	
Will stakeholders be involved?	
What are barriers to participating in the community health assessment?	
What do people want to get out of the community health assessment?	
Is it likely action will be taken as the result of the community health assessment?	
Will resources to support the community health assessment and a community health improvement plan be available?	
Does the community historically work together on health related efforts?	
NETWORK	
What work groups exist that could join this effort?	
What community organizations exist that should join this effort?	
Does tribal leadership support the effort?	
How likely is tribal leadership to support health improvement recommendations that result from the community health assessment?	

4. Decide who your key respondents will be. A key respondent is someone you interview specifically because they are very knowledgeable about the issue.
    - Example: The school resource officer, 3 local patrol officers, 24 students- 4 students in each grade 7-12 at the local high school, 12 parents/guardians- 2 from each class grades 7-12
5. Conduct the interviews
    - Tape interviews for transcription.
6. Transcribe the interviews
    - Be sure to transcribe the interviews word for word, exactly as the persons said them.
7. Score the interviews to determine readiness
   Example:
   Scale of 1 to 5, with 1 means no knowledge and 5 means high level of knowledge

   Community Readiness Scoring Matrix

LAW ENFORCEMENT OFFICERS	OFFICER 1	OFFICER 2	OFFICER 3
Knowledge of community resources	2	5	4
Knowledge of community prevention efforts	2	4	3
Knowledge of the scope of underage binge drinking in the community	5	5	5
Willingness to participate in community health assessment	5	5	5
Individual Law Enforcement Readiness Score	3.5	3.5	3
Total Law Enforcement Readiness Score	3.33		

8. Write a community readiness assessment report

   The report should include scoring for all the interviews, information regarding the meaning of the rating scale, themes that emerged from the interviews, strengths and weaknesses that were identified in relation to the issue and potential community members to invite to be part of the community health assessment team.

    - Colorado State University offers a community readiness toolkit at www.triethniccenter.colostate.edu/communityreadiness_home.htm.
    - The University of Kansas Work Group for Community Health and Development offers a community readiness toolkit at www.ctb.ku.edu/en/table-of-contents/overview/models-for-community-health-and-development/community-readiness/main.

STEP TWO: DETERMINE THE COST OF A CHA

Cost will vary dependent on a variety of factors. Potential costs associated with conducting a CHA include, but are not limited to:

- Staff or consultant time
  - To develop assessment tools
  - To administer the assessment tools
  - To analyze the assessment
  - To write the CHA report
- Meals and meeting space to collect data and report findings back to the community
- Incentives for participants
- Travel costs
- Software and equipment for data collection, transcription and analysis
- Contracted technical assistance

Potential sources for financial support of a CHA include planning to include it in the tribal health program budget, cost sharing with the state department of health, partnering to share costs and relevant data with another tribal program also conducting a community assessment, grants and foundations. Below are lists of potential funding resources for accreditation efforts and community health assessments.

FUNDING RESOURCES FOR ACCREDITATION	FUNDING RESOURCES FOR COMMUNITY HEALTH ASSESSMENTS
• Robert Wood Johnson Foundation • Center for Disease Control and Prevention • Public Health Foundation • National Association of County and City Health Officials (NACCHO) • Health Resources and Services Administration • National Indian Health Board	• Robert Wood Johnson Foundation • Center for Disease Control and Prevention • Mayo Clinic • Health Resources and Services Administration • First Nations Development Institute • National Association of County and City Health Officials (NACCHO) • United Health Foundation

Following is a sample CHA budget.

TRIBAL COMMUNITY HEALTH ASSESSMENT BUDGET WORKSHEET - SAMPLE

	ITEM	BUDGET	ACTUAL	DIFFERENCE
EXPENSES				
1.	Staff time/salary			
	Project lead			
	Support staff			
2.	Office space			
3	Office furniture			
4.	Office Equipment			
	Phone			
	Computer			
	Copier			
	LCD projector			
5.	Telecommunications			
	Phone			
	Internet			
	Fax			
6.	Postage			
7.	Printing			
	Data collection tools (surveys)			
	Final reports			
8.	Supplies			
	Office supplies			
	Participant incentives			
	Meeting refreshments			
	Data software			
9.	Meeting space rental			
	Data collection events			
	CHA Working committee meetings			

	Final data presentation event			
10.	Travel			
11.	Advertisement			
	Data collection events			
	Final report presentation			
12.	Training			
	Research methods/data analysis			
13.	Consultants			
	Data analysis			
	Report creation			
	Total Expenses			
INCOME				
1.	XYZ Community Grant			
2.	Tribal Public Health Unit			
3.	Tribal Council Allocation			
	Total Income			
TOTAL (INCOME-EXPENSES)				

STEP THREE: DETERMINE A CHA FRAMEWORK TO UTILIZE

The purpose of the CHA should be the guide for which model to utilize. Models specific to tribal communities are the Five Steps to Community Assessment for American Indian/Alaska Native Head Start Programs the Community Health Profile Project Toolkit and the Tribal CHA for Public Health Accreditation: A Practical Guide and Toolkit.

Other models include Mobilizing for Action through Planning and Partnerships from the National Association of County and City Health officials, the CHA and Group Evaluation from the Centers for Disease Control and Protections, The Community Tool Box from University of Kansas and the Association for Community Health improvement's CHA Toolkit.

ORGANIZATION	WEBSITE	PURPOSE
Northwest Portland Area Indian Health Board	http://www.npaihb.org/images/resources_docs/Toolkit_Final.pdf	Indian Community Health Profile Project Toolkit
AED Center for Early Care and Education and American Indian Technical Assistance Network	http://www.fhi360.org/sites/default/files/media/documents/Five%20Steps%20to%20Community%20Assessment.pdf	American Indian/Alaska Native Head Start Programs
Tribal Epidemiology Center Inter-tribal Council of Arizona, Inc.	http://itcaonline.com/wp-content/uploads/2011/03/Tribal-CHA-Toolkit-for-Public-Health-Accreditation-Pilot-Version.pdf	Tribal Community Health Assessment for Public Health Accreditation
National Association of County and City Health Officials	http://www.naccho.org/topics/infrastructure/mapp/	Mobilizing for Action through Planning and Partnerships (MAPP)
Centers for Disease Control and Prevention	http://www.cdc.gov/healthycommunitiesprogram/tools/change.htm	Health Communities Program Resources
University of Kansas	http://ctb.ku.edu/en/tablecontents/index.asp	Community Toolbox: Developing an Organizational Structure
Association for Community Health Improvement	http://www.assesstoolkit.org	Community Health Assessment Toolkit

STEP FOUR: OBTAIN TRIBAL LEADERSHIP AND IRB APPROVAL

It is likely required that approval from the Tribal Council or other tribal governing body, such as a tribal health committee, be given prior to beginning a CHA in a tribal community. This maybe through a tribal resolution or other tribal legal action.

The tribal health program director or other tribal health-related director may work with you to write a resolution for a CHA. Next, he or she may contact a tribal council member and request the resolution be considered at an upcoming tribal council meeting. When writing the resolution, it is important to clearly state a tribal CHA will be completed, the reason for completing it is, who will own the data and the sought or acquired funding source, if applicable.

NORTH DAKOTA TRIBAL COUNCIL CONTACT INFORMATION

Mandan Hidatsa Arikara Nation
404 Frontage Road
New Town, ND 58763

701-627-4781

www.mhanation.com

Standing Rock Sioux Tribe
P.O. Box D
Fort Yates, ND 58538

701-854-8500

www.standingrock.org

Turtle Mountain Band of Chippewa Indians
P.O. Box 60
Belcourt, ND 58316

Tel: 701-477-3191

www.tmbci.org

Spirit Lake Nation
P.O. Box 359
Fort Totten, ND 58335

701-766-4221

www.spiritlakenation.com

After seeking tribal approval, you may need to seek Institutional Review Board (IRB) approval from the appropriate programs (tribal IRB, university IRB, area IHS IRB, and/or national IRB). IRB approval is needed whenever biomedical and behavioral research involves humans. The IRB committee is in charge of approving, monitoring, and reviewing biomedical and behavioral research. Your research should be designed to follow the ethical and guiding principles used by the IRB you obtain approval from. The U.S. Department of Health and Human Services advises IRB principles that pertain to: 1. Respect for person, 2. Beneficence, and 3. Justice, but tribes may determine their own guiding principles. Tribal Nations Research Group incorporates the Seven Teachings of the Turtle Mountain Band of Chippewa Indians as the overlying guiding principles for their IRB: To cherish knowledge is to know WISDOM

- To know LOVE is to know peace
- To honor Creation is to have RESPECT
- BRAVERY is to face the foe with integrity
- HONESTY in facing a situation is to be honorable
- HUMULITY is to know yourself as a sacred part of the Creation
- TRUTH is to know all of these things.

The IRB process at each level can take some time, so start early and plan accordingly. Principal investigators must submit an IRB application and required supplemental materials to the appropriate IRB office before starting any research. Anyone who is involved with the research should complete IRB training either in person or online. It is important to remember that until IRB approval is received no research or recruiting of participants can begin. Upon receiving the completed application, the IRB committee will review the application and approve it once all requirements have been met.

See below for the IRB contact information for North Dakota universities/colleges, IHS, and tribal research groups. Check with the tribe to determine what IRB to consult. Check out the websites for more information, materials and templates for completing the application.

Indian Health Service (IHS) National IRB
5600 Fishers Lane, Rockville, MD 20852
Tel: 301.443.4700
Fax: 301.443.0114
irb@ihs.gov
www.ihs.gov/dper/research/hsrp/instreviewboards

North Dakota State University IRB
Research 1
1735 NDSU Research Park Drive
NDSU Dept. #4000, PO Box 6050
Fargo, ND 58108-6050
Tel: 701.231.8995

NDSU.IRB@ndsu.edu
www.ndsu.edu/research/integrity_compliance/irb/

Sitting Bull College IRB
9299 Highway 24, Fort Yates, ND 58538
Tel: 701.854.8051
www.sittingbull.edu/sitting-bull-college/community/institutional-review-board/

Tribal Nations Research Group
(Turtle Mountain Band of Chippewa Indians IRB)
P.O. Box 1906, Belcourt, N.D. 58316
Tel: 701.477.5526
www.tnrg.org

United Tribes Technical College IRB
3315 University Drive, Bismarck, ND 58504
Tel: 701.221.1734
www.uttc.edu/academics/irb/default.asp

University of North Dakota IRB
Twamley Hall Room 106
264 Centennial Drive Stop 7134
Grand Forks, ND 58202-7134
Tel: 701.777.4279
Fax: 701.777.6708
Email: UND.irb@research.UND.edu
www.und.edu/research/resources/human-subjects/

SOVEREIGNTY

Tribes in the U.S. are considered sovereign, which means the tribe has the authority/power to govern within the tribal borders without any interference from outside sources. Sovereignty status gives a tribe the opportunity to define their own membership, regulate tribal business and domestic relations, and manage tribal property. The US government has an obligation to protect tribal treaty rights, assets, resources, and lands.

The Indian Self Determination and Education Assistance Act (ISDEA) of 1975, (PL 93-638) authorizes the Department of Health and Human Services to enter into a contract with federally recognized Indian tribes. This law authorizes tribes to:

- Create their own research agendas.
- Control their own healthcare services.
- Require that researchers seek approval from the tribe before conducting the research on the reservation.

Upon entering a contract or grant with the Department of Health and Human Services or other government agencies, the tribe has the authority to administer the funds. This gives the tribe greater control over their welfare. When entering into tribal communities, it is crucial to maintain the role of tribal sovereignty.

For more information on sovereignty and self-determination, go to http://www.bia.gov/cs/groups/mywcsp/documents/collection/idc017334.pdf.

Following is an example of a CHA resolution for submission to a tribal council.

Resolution No. _____

RESOLUTION OF THE

GOVERNING BODY OF THE (insert tribal nation name)

A Resolution Entitled, "Community Health Assessment and Community Health Improvement Plan to evaluate the public health needs of the (insert tribal nation name).

WHEREAS, This Nation having accepted the Indian Reorganization Act of June 18, 1934, and the authority under said Act and having adopted a Constitution and By-laws pursuant to said Act; and

WHEREAS, The Constitution and By-laws of the (insert tribal nation name) was adopted by the membership of the Tribes on (insert date) pursuant to the Indian Reorganization Act of 1934 and duly approved by the Secretary of Interior, and

WHEREAS, Article III of the Constitution of the provides that (insert tribal nation name) The Tribal Council is the governing body of the Tribes; and

WHEREAS, The Constitution of the (insert tribal nation name) authorizes and empowers The Tribal Council to engage in activities on behalf of and in the interest of the welfare and benefit of the Tribes and of the enrolled members thereof; and

WHEREAS, The (insert tribal nation name) public health program has been a place of disease prevention, promotion of health and community health analysis for tribal members, and

WHEREAS, (insert tribal nation name) public health program seeks accreditation through the Public Health Accreditation Board in an effort to advance the quality and performance of the (insert tribal nation name) public health program, and

WHEREAS, A community health assessment is a requirement of Public Health Accreditation Board application, and

WHEREAS, The community health assessment will include establishing baseline data through secondary data collection and primary data collection using methods such as surveys and community forums, and

Resolution No. _____

WHEREAS, Upon completion of the community health assessment, a community health plan will be completed by the (insert tribal nation name) public health program to address public health issues identified in the afore mentioned community health assessment, and

WHEREAS, (insert tribal nation name) public health program working with the (insert name of tribal community college) to store and manage the data collected, and

WHEREAS, The NDSU American Indian Public Health Resource Center's mission is to address inequalities in American Indian Health status by increasing access to public health resources, and

WHEREAS, NDSU's American Indian Public Health Resource Center will provide technical assistance free of charge to the (insert tribal nation name) public health program upon request in conducting the community health assessment and writing the community health improvement plan, and

WHEREAS, The (insert tribal nation name) public health program will seek funding to support the completion of the community health assessment and the community health improvement plan, through grants and foundations, and

WHEREAS, The data and results of the community health assessment, and the community health improvement plan are owned by the (insert tribal nation name) may not be released without resolution of the (insert tribal nation name) tribal council, and

NOW THEREFORE BE IT RESOLVED that the (insert tribal nation name) public health program is authorized to conduct a community health assessment and develop a community health improvement plan based on findings of the afore mentioned assessment of the (insert tribal nation name).

Resolution No. _____

CERTIFICATION

I, the undersigned, as Secretary of the Tribal Council of (insert tribal nation name) hereby certify that the Tribal Council is composed of (#) members of whom (#) constitute a quorum, _____were present at a Regular Or Special Meeting thereof duly called, noticed, convened, and held on the _____ day of _____, 2016; that the foregoing Resolution was duly adopted at such meeting by The affirmative vote of _____ members,____members opposed, ____ members abstained, _____members not voting, and that said Resolution has not been rescinded or amended in any way.

Chairman [ ] voting. [ ] not voting.

Dated this ____ day of _____, 2016

ATTEST:

_____ _____

Tribal Secretary (insert name) Tribal Chairman (insert name)

Tribal Council Tribal Council

(insert tribal nation name) (insert tribal nation name)

STEP FIVE: RECRUIT A CHA WORK TEAM

The development of a work team helps ensure that a many members of the community will be represented in the CHA. The work team also brings a variety of skill sets to the assessment process and plan, making the work for efficient. When determining who to invite consider inviting people who are staff in leadership roles, people with experience in public health and have areas of expertise and people who can assist in access to information /data pertinent to the CHA.

Meeting regularly should help the CHA process moving forward. Regular meetings provide a forum for team members to communicate progress in the varied areas of the assessment process, bring challenges to the team for problem solving, as well as discuss next steps collaboratively.

STEP SIX: OBTAIN MEMORANDUMS OF AGREEMENT

A Memorandum of Agreement (MOA) is a collaborative document between agencies. MOAs are used to define the terms of the agencies working together and what each agency will do. It is important to obtain a MOA with agencies from whom data or services will be provided as part of the CHA.

POINTS TO COVER IN A CHA MEMORANDUM OF AGREEMENT

- Purpose and Description of the CHA
- Articles of Agreement and Responsibility
- Confidentiality Clause
- Storage of Secure Data
- Time Period the MOA is Valid
- Signatures of the Agency Directors

It is also important to have discussions during the early stages of planning about data ownership and sharing, especially when working with tribal communities who have the ability to exercise their sovereignty over data collected on tribal members or lands. Following is an example of a data sharing agreement that outlines permissions and restrictions for data access and ownership.

Following are sample agreements that on CHA partnership and data ownership and access (Inter Tribal Council of Arizona, Inc.: Tribal Epidemiology Center, 2013).

MEMORANDUM OF AGREEMENT

BETWEEN THE (insert tribal community name)

AND

The American Indian Public Health Resource Center

THIS MEMORANDUM OF AGREEMENT is entered into on the _____ day of _____, 2016, between (insert tribal nation name) and the American Indian Public Health Resource Center (AIPHRC).

WHEREAS, the American Indian Public Health Resource Center 's mission is to address American Indian public health disparities through technical assistance, policy development, self-determination feasibility analysis, education, research and programming in partnership with tribes, in North Dakota, across the Northern Plains and the nation.

WHEREAS, (insert the tribal nation name) is a federally recognized Indian tribe and sovereign entity vested with responsibility and authority to protect and enhance the health, safety and welfare of its Tribal community members.

WHEREAS, the AIPHRC and the (insert tribal nation name) (collectively the "Parties") wish to partner with one another to develop certain community health profiles and other health related data projects as needed to define and measure the health status of persons living within the (insert tribal nation name) and to identify and track trends in health outcomes that affect members of the (insert tribal nation name) in a manner consistent with the priorities of the (insert tribal nation name).

WHEREAS, the Parties recognize the need to set forth and define the terms under which the (insert tribal nation name) and the AIPHRC will share and utilize demographic information, socio-economic information, medical information, health care information, other health and community related data (collectively "Tribal Health Data") pursuant to (insert name of grant or project, if applicable) solely for the purposes of this Agreement.

NOW, THEREFORE, in consideration of the mutual promises and representations set forth in this Agreement, the AIPHRC and (insert tribal nation name) mutually agree as follows:

SOVEREIGN IMMUNITY

The (insert tribal nation name) shall have such immunity as provided by applicable law, and unless expressly provided herein, nothing in this Agreement shall be construed as a waiver of sovereign immunity by the (insert tribal nation name) whether express or implied, or as a consent to the jurisdiction of any Federal or State Court.

PARTNERSHIP TASKS

The (insert tribal nation name) and the AIPHRC agree to share Tribal Health Data and to coordinate their efforts so that the AIPHRC has the necessary information to develop a written report outlining the health status of the (insert tribal nation name) population ("Community Health Profile") for delivery to the leadership of the (insert tribal nation name) and its tribal health department and related subdivisions or departments as required by (insert project or grant title if appropriate) and this Agreement.

The AIPHRC will assist (insert tribal nation name) in the identification and assessment of health datasets that will be included in the Community Health Profile.

The (insert tribal nation name) agrees to communicate regularly with The AIPHRC on this project and to meet with THE AIPHRC staff members upon the request of The AIPHRC point of contact ("POC") identified in Section ___, below, in order to coordinate the development of the Community Health Profile and to ensure that all data quality needs or other requirements of (insert name of project or grant, as applicable) are met in a timely manner.

After The AIPHRC has analyzed the Tribal Health Data and other applicable information received from the (insert tribal nation name) representatives of the (insert tribal nation name) and The AIPHRC will work together to develop a format for the Community Health Profile that best meets the needs of the (insert name of tribal nation). The (insert name of tribal nation) thereafter agrees to promptly review any drafts of the Community Health Profile prepared by The AIPHRC and to provide material feedback and guidance to assist The AIPHRC so that The AIPHRC can finalize the Community Health Profile as required by this Agreement. The Parties acknowledge and agree that the Community Health Profile or other materials prepared under this Agreement may be used, in whole or in part, by the (insert name of tribal nation) to assess the (insert tribal nation name) readiness for public health department accreditation by the Public Health Accreditation Board.

CONFIDENTIALITY

The Parties to this Agreement, including their employees and subcontractors, agree to comply with the Privacy Act of 1974, as amended at 5 U.S.C. 552a, and the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191), as well as all other requirements of law.

The Parties agree that, except as provided in subsection C(3) below, all Tribal Health Data or related information delivered to The AIPHRC under this Agreement will be delivered in an aggregated form or will otherwise be de-identified through the removal of any information which can be used to identify a person uniquely and reliably, including but not limited to name, date of birth, social security number, address, telephone number, e-mail address, mother's maiden name or other similar information ("De-Identified Information").

All Tribal Health Data delivered to The AIPHRC by the Tribal Community under the terms of this Agreement shall be delivered through a safe and secure means such as: an encrypted "zip file" sent from an encrypted e-mail from the Health Director or designated staff, or saved on an encrypted flash drive as mutually agreed upon by the Parties.

At the request of The AIPHRC POC, (insert name of tribal community) may deliver non-aggregated information or information containing personal identifying information to The AIPHRC where such information is necessary to meet the requirements (insert name of grant or project as appropriate) or this Agreement.

Any other provisions of this Agreement notwithstanding, the (insert tribal nation name) shall bear the sole responsibility to review all Tribal Health Data or other information in advance of providing such information to The AIPHRC in order to ensure the (insert tribal nation name) continued compliance with any other existing obligations that it may have under contract or law to prohibit the secondary dissemination of specific protected health information beyond the (insert tribal nation name).

All Tribal Health Data received by The AIPHRC, including specific and direct identifying information gathered or acquired by The AIPHRC under this Agreement, whether intentionally or inadvertently, is understood by the Parties to be sensitive and confidential information that will remain protected from unwarranted or unnecessary disclosure or dissemination as required by the Privacy Act of 1974, as amended at 5 U.S.C. 552a, the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191), as applicable, and other provisions of law.

The AIPHRC will require all staff to maintain the Tribal Health Data or other information shared under this Agreement as confidential. The AIPHRC agrees take appropriate disciplinary action against any person determined to have violated the requirements of this Agreement, and to notify the POC for the (insert tribal nation name) in writing within forty-eight (48) hours of learning of any violation of the confidentiality requirements of this Agreement.

The (insert tribal nation name) may condition the delivery of Tribal Health Data or other protected health information to the AIPHRC upon such other reasonable terms and conditions, as it may deem necessary for the protection of patient confidentiality rights and privacy requirements consistent with the duties under applicable (insert tribal nation name) law or policy or other legal requirement. Such additional terms and conditions shall be set forth in writing, executed by both parties and attached to this Agreement in the form of an exhibit or addendum.

The (insert tribal nation name) and the AIPHRC agree that, to the extent permitted by law, the AIPHRC may use information from the Indian Health Service for purposes of preparing the Community Health Profile for delivery to the (insert tribal nation name), or in order to fulfill any other requirement of (insert name of grant or project as applicable) or this Agreement.

PRIMARY CONTACTS

The Parties have each designated the following primary contacts, who are responsible for the day-to-day administration of and compliance with the terms of this Agreement:

(Insert Tribal Nation Name)	**American Indian Public Health Resource Center**
Name:	Name:
Title:	Title:
Phone:	Phone:
Fax:	Fax:
Email:	Email:

AMENDMENTS

This Agreement may be amended from time to time as mutually agreed by the Parties, including for purposes of undertaking future health related data projects as specified by the (insert tribal nation name) and mutually approved by (insert tribal nation name) and the AIPHRC. All amendments must be in writing and signed by both Parties.

INDEMNIFICATION

To the fullest extent permitted by law, (insert tribal nation name) agrees to defend, indemnify, and hold harmless North Dakota State University and the American Indian Public Health Resource Center and its members officers, agents, and employees from all claims, losses, and causes of actions arising out of, resulting from, or in any manner connected with this Agreement, to the extent such claim, loss, cause of action, damage or injury is caused or contributed to by the negligent acts or omissions of the indemnifying party.

TERMINATION

This Agreement may be terminated with or without cause with thirty (30) days written notice delivered by registered or certified mail as required by Section __ of this Agreement. Upon the expiration or termination of this Agreement for any reason, the AIPHRC shall promptly return or destroy all Tribal Health Data or other information in the possession of the AIPHRC, except as may be required by the record retention requirements of (insert name of grant or project as applicable) or applicable law. This Section F shall survive the expiration or termination of this Agreement.

NOTICES

All communications and notices to the Parties hereto shall be in writing and shall be deemed duly given if delivered by registered or certified mail to the primary contacts listed in Section ___ of this Agreement.

TERM

This Agreement shall remain in effect from the date of execution until termination by either of the Parties, or until the project contemplated by (insert name of grant or project as applicable) is completed.

TOTAL AGREEMENT

This Agreement constitutes the total agreement between the Parties. No promises, terms or conditions that have not been expressly recited or incorporated herein shall be binding upon either of the Parties.

IN WITNESS WHEREOF, the parties have executed this Agreement as the Effective Date: (insert date)

SIGNED:

(insert name of tribal nation)	American Indian Public Health Resource Center
By _____	By _____
Name _____	Name _____
Title _____	Title _____
Agency _____	Agency _____
Date _____	Date _____

SAMPLE – DATA SHARING MEMORANDUM OF UNDERSTANDING

The **(insert name of tribal nation)** and the **American Indian Public Health Resource Center** agree to share information in accordance with the terms and conditions stated in this memorandum of understanding. This exchange includes, but will not be limited to morbidity and mortality information. Only aggregate data/information will be released on the health reports or tribal community health profiles that will be prepared. Personal identifying information will not be shared at any time.

The American Indian Public Health Resource Center agrees to provide **(insert name of tribal nation)** with the following:

- Names of the authorized staff to whom the **(insert name of tribal nation)** can provide the information designated under Section 2.
- Copies of certificates of completion on computer privacy and security training of those staff designated.
- Final copy of tribal community health profiles.
- Copies of the progress reports that include periodic overall update, projects in progress, completion dates of relevant tasks and outcomes.

(Insert name of tribal nation) agrees to provide the **American Indian Public Health Resource Center** the following:

- Access to paper and electronic health records.
- Meet with **(insert name of tribal nation)** staff when necessary if data issues arise.
- Training from a tribal staff member to properly query and access data available by an agreed upon schedule.

In addition, the parties agree to:

- Comply with the Privacy Act and HIPPA law where applicable.
- Follow existing tribal data access procedures.
- Carefully restrict use of the information gained. The information may only be used for public health purposes and for aggregated statistical tabulations and analyses. The data shall not be used to identify individuals unless appropriate legal agreements between parties are in effect.
- This memorandum of understanding will be effective when fully executed by both parties. This agreement may be terminated with or without cause at any time upon thirty (30) day written notice to the other party, otherwise this agreement will continue to remain in effect. The agreement may be revised by written modification at any time by mutual agreement of the parties.

The parties understand and agree to the terms outlined above.

Dated this _____ day of _____, 2016

_____ _____

Signature Signature

STEP SEVEN: DEVELOP CHA GOALS AND OBJECTIVES

A **project goal** answers the questions:

- "What is our ideal?" and
- "What do we want to achieve?"

For example: All tribal services and tribal members will meet all health measures in the Healthy People 2020 Initiative. The Healthy People 2020 initiative of the Centers for Disease Control and Prevention tracks 1,200 objectives in 42 topic areas. This is not achievable goal. Reaching the tobacco use section goal of the Healthy People 2020 initiative (to reduce illness, disability, and death related to tobacco use and secondhand smoke exposure) is more realistic.

Project objectives are important; they define success and the measures of its achievement. An example of a tobacco use objective is to reduce the number of new smokers aged 12-17.

- Goal: Ideal, a target
- Objective: What does success look like? a specific result

Example:

GOAL	OBJECTIVE
Identify tribal community health concerns	• Gather secondary data • Perform CHA surveys with 25 percent of enrolled members
Determine tribal health programs readiness for public health accreditation	Complete PHAB Accreditation Readiness Self Study

Questions to ask when defining objectives might be:

- Who or what will change?
- How many people, services or numbers will change?
- When will the change occur? What is the time frame?

"SMART" is a tool for writing objectives that maybe helpful to work groups in the planning phase of a CHA. The following two pages are a document from the Center for Disease Control (2009) about writing SMART objectives.

Smart	What are we going to do and with whom will we do it?
Measurable	Can it be measured? How will it be measured?
Achievable	Is there adequate support, time and resources?
Relevant	Does the objective work toward the goal?
Time-Bound	When will it be completed?

EVALUATION eTA

Evaluation Briefs

No. 3b | January 2009

Writing SMART Objectives

This brief is about writing SMART objectives. This brief includes an overview of objectives, how to write SMART objectives, a SMART objectives checklist, and examples of SMART objectives.

Overview of Objectives

For DASH funded partners, program planning includes developing five-year program goals (a broad statement of program purpose that describes the expected long-term effects of a program), strategies (the means or broad approach by which a program will achieve its goals), and annual workplan objectives (statements that describe program results to be achieved and how they will be achieved). Objectives are more immediate than goals; objectives represent annual mileposts that your program needs to achieve in order to accomplish its goals by the end of the five-year funding period. Each year, your workplan objectives should be based on the strategies you have selected to reach your program goals. Because strategies are implemented through objectives and program activities, multiple objectives are generally needed to address a single strategy. Objectives are the basis for monitoring implementation of your strategies and progress toward achieving your program goals. Objectives also help set targets for accountability and are a source for program evaluation questions.

Writing SMART Objectives

To use an objective to monitor your progress, you need to write it as a SMART objective. A SMART objective is:

1. **Specific:**
   - Objectives should provide the "who" and "what" of program activities.
   - Use only one action verb since objectives with more than one verb imply that more than one activity or behavior is being measured.
   - Avoid verbs that may have vague meanings to describe intended outcomes (e.g., "understand" or "know") since it may prove difficult to measure them. Instead, use verbs that document action (e.g., "At the end of the session, the students will list three concerns...")
   - Remember, the greater the specificity, the greater the measurability.
2. **Measurable:**
   - The focus is on "how much" change is expected. Objectives should quantify the amount of change expected. It is impossible to determine whether objectives have been met unless they can be measured.
   - The objective provides a reference point from which a change in the target population can clearly be measured.
3. **Achievable:**
   - Objectives should be attainable within a given time frame and with available program resources.
4. **Realistic:**
   - Objectives are most useful when they accurately address the scope of the problem and programmatic steps that can be implemented within a specific time frame.
   - Objectives that do not directly relate to the program goal will not help toward achieving the goal.
5. **Time-phased:**
   - Objectives should provide a time frame indicating when the objective will be measured or a time by which the objective will be met.
   - Including a time frame in the objectives helps in planning and evaluating the program.

CDC Department of Health and Human Services
Centers for Disease Control and Prevention

Objectives Checklist

Criteria to assess objectives	Yes	No
1. Is the objective SMART? ▪ **Specific:** Who? (target population and persons doing the activity) and What? (action/activity) ▪ **Measurable:** How much change is expected ▪ **Achievable:** Can be realistically accomplished given current resources and constraints ▪ **Realistic:** Addresses the scope of the health program and proposes reasonable programmatic steps ▪ **Time-phased:** Provides a timeline indicating when the objective will be met		
2. Does it relate to a single result?		
3. Is it clearly written?		

SMART Objectives Examples

Non-SMART objective 1: Teachers will be trained on the selected scientifically based health education curriculum.

This objective is not SMART because it is not *specific*, *measurable*, or *time-phased*. It can be made SMART by *specifically* indicating who is responsible for training the teachers, how many will be trained, who they are, and by when the trainings will be conducted.

SMART objective 1: By year two of the project, **LEA staff** will have trained **75% of health education** teachers **in the school district** on the selected scientifically based health education curriculum.

Non-SMART objective 2: 90% of youth participants will participate in lessons on assertive communication skills.

This objective is not SMART because it is not *specific* or *time-phased*. It can be made SMART by *specifically* indicating who will do the activity, by when, and who will participate in lessons on assertive communication skills.

SMART objective 2: By the end of the school year, district health educators will have delivered lessons on assertive communication skills to 90% of youth participants **in the middle school HIV-prevention curriculum.**

Resources

Brief 3: Goals and Objectives Checklist Available at http://www.cdc.gov/HealthyYouth/evaluation/resources.htm

Brief 5: Integrating the Strategic Plan, Logic Model, and Workplan. Available at http://www.cdc.gov/HealthyYouth/evaluation/resources.htm

Strategic Planning Kit for School Health Programs. Available at http://www.cdc.gov/HealthyYouth/evaluation/sp_toolkit.htm

Tutorial 3: Writing Good Goals and Smart Objectives. Available at http://www.cdc.gov/HealthyYouth/evaluation/resources.htm

For further information or assistance, contact the Evaluation Research Team at ert@cdc.gov. You can also contact us via our website: http://www.cdc.gov/healthyyouth/evaluation/index.htm.

STEP EIGHT: DEVELOP A WORK PLAN AND TIMELINE

The CHA lays out what activities need to be completed to meet the objectives and attain the goal of the assessment. The work plan organizes roles and responsibilities of the CHA work group. It can also serve a dual purpose as the timeline for the CHA.

Decisions are made together as a group in tribal communities, therefore more time may be needed to make these decisions (Grandbois, 2014). Due to the length of time required to obtain all tribal approvals, the community health assessment process may not fit into a grant funding period. It is helpful to discuss the timeframe with tribal leaders and stakeholders prior to submitting for funding. When developing the community health assessment plan engage the stakeholder group in determining realistic timelines.

Following is a sample work plan and timeline.

SAMPLE WORK PLAN AND TIME LINE

Tasks	Person Responsible	Time Frame	Due Date	Notes
Develop a plan				
Determining why to do a CHA				
Develop a budget				
Determine a CHA framework to utilize				
Obtain tribal leadership and IRB approval				
Recruit a CHA work team				
Obtain Memorandums of Agreement				
Develop CHA goals and objectives				
Develop a work plan and timeline				
Engaging the community				
Define the community who will be assessed				
Determine the audience who will use the CHA				
Determine how the community will be engaged in the process				
Identify community health indicators				
Determine health priorities				
Collect data				
Obtain data sharing agreements				
Develop collection tools				
Determine data collection method(s)				
Develop record keeping process				
Begin data collection				
Data analysis				

Tasks	Person Responsible	Time Frame	Due Date	Notes
Determine a time line for data analysis				
Determine who will be responsible for data entry and analysis				
Determine how and where data will be stored, as well as when it will be destroyed				
Obtain technology required for analysis				
Sign contract with outside entity to analyze data, if determined to be best approach				
Develop data presentation based on data analysis				
Tribal community health profile				
Determine what findings will be included in the community health profile				
Write report of findings				
Report findings				
Submit to Public Health Accreditation Board				
Determine plan to share the report with stakeholders				
Determine plan to share the report with the community				
Complete reporting activities				
Identify health priorities				
Develop a tribal health plan				
Next steps				
Develop a tribal health department strategic plan				

Identify Community Health Indicators

WHAT DATA TO INCLUDE IN THE TRIBAL CHA?

The tribal CHA should include information about the community's citizens that will help in assessing community health status, identify areas for health improvement, and identify causes of health challenges and resources to address them. Public health accreditation requires documentation and evidence that comprehensive, broad-based data and information was collected from a variety of sources.

BRAINSTORMING HEALTH PRIORITIES

The health-focused areas of the tribal CHA are determined by the tribe's areas of interest regarding health status of its members. Focus areas should align with the goals and objectives of the tribal public health program and the Tribal CHA project. This can be achieved by asking key stakeholders the following questions:

- Name the top three health related issues in your community.
- What health conditions should be monitored through the tribal CHA?

SELECTING HEALTH INDICATORS

Health indicators are the measure of one or more aspects of the health of a person or community. Examples of health indicators are life expectancy and infant mortality. Health indicators are used to identify public health concerns at specific points in time, changes over time, differences in segments of the population and success of programs for influencing health outcomes. Health indicators give an overall picture of a community's health.

Community Health Status Terms

Health Indicator	A characteristic of an individual, population or environment that is subject to measurement and can be used to describe one or more aspects of the health of an individual or population (Health Indicator, 2013).
	Can be used to define public health problems at a particular point in time, to indicate change over time in the level of the health of a population or individual, to define differences in the health of populations, and to assess the extent to which the objectives of a program are being reached (Health Indicator, 2013).
	They may also include indicators that measure social and economic conditions and the physical environment as it relates to health, measures of health literacy and healthy public policy. This latter group of indicators may be used to measure intermediate health outcomes, and health promotion outcomes (Health Indicator, 2013).
Health Statistics	Numbers about some aspect of health. Vital statistics include births, deaths, marriages and divorces.
	Provides researchers with patterns of disease. These patterns help identify who is at risk for certain diseases, ways to control disease and determining which diseases to study. Incidence rate or mortality rate are terms of health statistics.
Incidence Rate	The number of new cases per population at risk in a given time period.
Mortality Rate	The ratio of deaths in an area to the population of that area.
Morbidity Rate	The frequency with which a disease appears in a population.
Prevalence	The number of people living with a certain disease during a period. This information is used for public health planning. Prevalence is sometimes also referred to as percentage or proportion.

Common Health Focus Areas and Indicators

CATEGORIES	EXAMPLES OF COMMON INDICATORS
Demographics and Socioeconomic Characteristics	• Tribal members / Tribal Community members (number and percent distributions by age and gender) • High school completion (percent) • Unemployed (percent) • Median Household Income (dollars)
Quality of Life	• Self-rated health status (percent) • Poor health days (percent)
Health Behavior Factors	• Activity limitation (percent) • Current commercial tobacco smoker (percent) • Healthy weight status – compared to underweight, overweight, and obese (percent)
Environment	• Athletic or recreational facilities on Tribal lands (number) • Healthy food access (number of stores / average distance traveled) • Housing information
Morbidity and Mortality	• Asthma – Adult asthma admission rate (rate per 100,000) Asthma deaths (rate per 100,000) Asthma hospitalizations (rate per 10,000) • Cardiovascular Disease – Congestive heart failure admission rate (rate per 100,000) – Coronary heart disease deaths (rate per 100,000) – Heart disease deaths (rate per 100,000) – Hypertension, adults (percent) – Stroke deaths (rate per 100,000) - • Cancer – Overall cancer deaths (rate per 100,000) Incident cancer –for breast, colorectal, and lung (rate per 100,000) – Incident overall cancer (rate per 100,000)

Morbidity and Mortality CONTINUED	• Kidney Diseases – Chronic kidney disease (percent) – Chronic kidney disease deaths (rate per 100) – End-stage renal disease (rate per 1,000,000) • Diabetes – Annual dilated eye examinations (percent, persons with diabetes) – Annual foot examinations (percent, persons with diabetes) – Blood pressure under control (percent, persons with diabetes) – Diabetes-related deaths (rate per 100,000) – Diagnosed diabetes (percent) – HbA1c greater than 9 percent (or less than 7 percent) (percent, persons with diabetes) – HbA1c Test, at least two times a year (percent, persons with diabetes) • Injuries – Elder falls (rate per 100,000) – Unintentional injuries (rate per 100,000) – Motor vehicle crash injuries (rate per 100,000) • Mental and Behavioral Health – Diagnosed depression and anxiety disorder (rate per 100,000) – Suicide-related deaths (rate per 100,000) – Visits due to substance abuse or dependence (rate per 10,000) • Sexually Transmitted Infections – Incident cases of Chlamydia (rate per 100,000) – Incident cases of Syphilis (rate per 100,000) – Incident cases of HIV/AIDS (rate per 100,000) STI screening (percent) • Preventative Screenings – Blood pressure screening (percent) – Breast cancer screening (percent) – Mammogram (percent) – Cervical cancer screening (percent) – Pap test (percent) – Colorectal cancer screening (percent)
Social Determinants of Health	• Children in poverty (percent) • Families in poverty (percent)

Prioritize Health Indicators

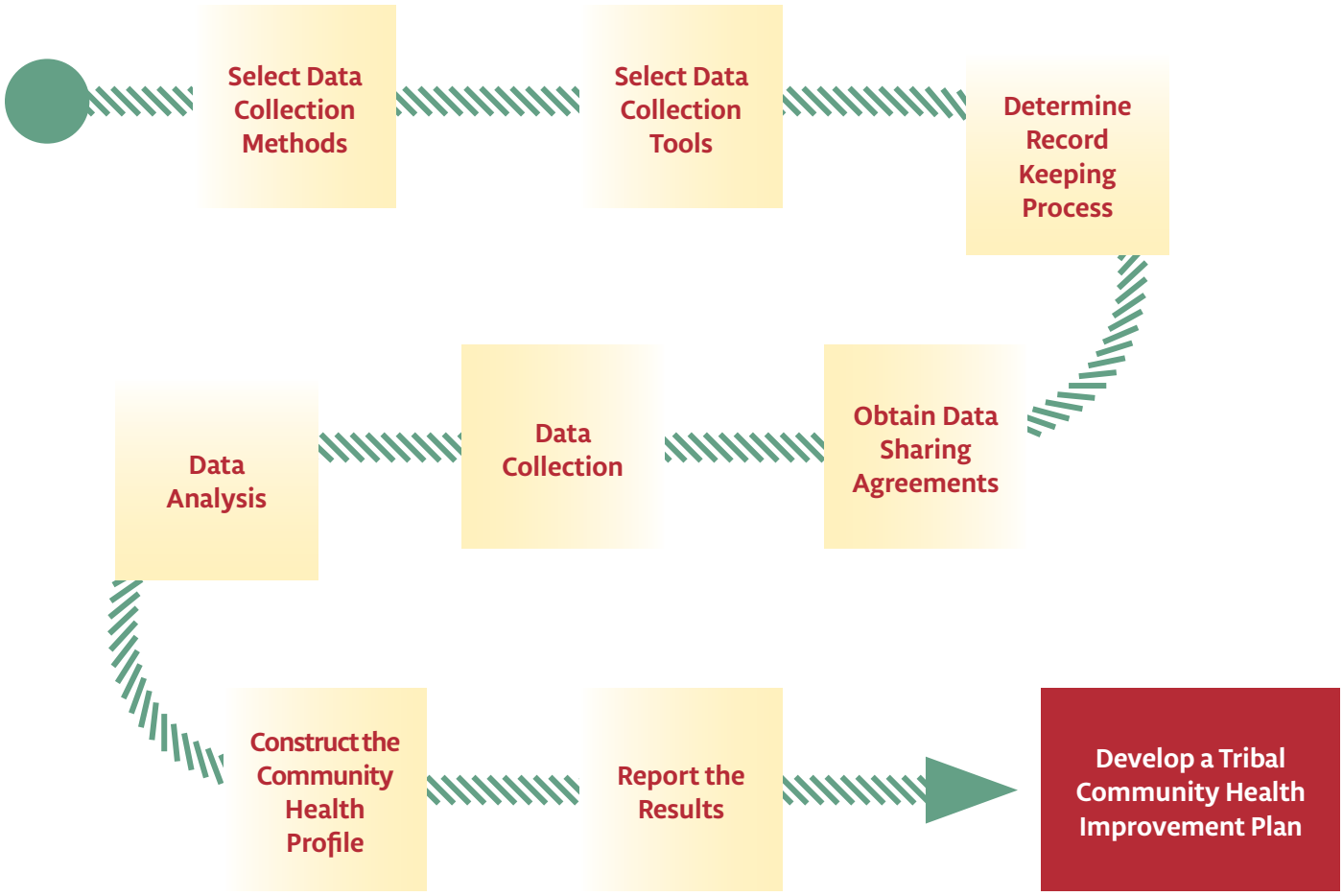
It is important to prioritize health indicators to make sure you have enough data to provide a clear picture of the community's health, and to make sure that data collection is manageable. The following criteria can be helpful in prioritizing health indicators:

- Importance (determined by tribal leadership and the community)
- Scope of the problem (how many people are affected)
- Seriousness (leading causes of death)
- Trends (increase in prevalence)
- Equity (health disparities)

Collect Data

After determining the health indicators, there is a process for collecting and analyzing data. The following shows the steps to collecting and analyzing data for a tribal community health improvement plan.

STEPS TO COLLECTING AND ANALYZING DATA



Data Sources

Once the list of health indicators has been determined, the sources of data must be identified for each indicator. Primary data collection (such as surveys and focus groups) and secondary data collection (such as vital statistics, census data, and Indian Health Services data.) will provide the information related to each indicator. The chart below shows common data sources for each type of previously mentioned indicator:

DEMOGRAPHIC AND SOCIOECONOMIC CHARACTERISTICS

- Tribal enrollment office
- U.S. Census Bureau
- Tribal schools, colleges and universities
- State colleges and universities
- Economic Security Department
- Head Start

QUALITY OF LIFE

- Social and human services – tribal, county, state
- Elder services
- Behavioral and mental health services
- Healthcare facilities, hospitals, emergency medical services
- Indian Health Service facilities
- Law enforcement – tribal, county, state
- Court systems – tribal, county, state

HEALTH BEHAVIOR FACTORS – TRIBAL, COUNTY, STATE

- Health and wellness programs
- Nutrition programs
- Safety programs
- Tobacco prevention programs
- Injury prevention programs
- Maternal and child health programs – WIC

ENVIRONMENT

- Environmental services
- Housing
- Transportation
- Sanitation services – tribal and municipal

MORBIDITY AND MORTALITY

- Vital Statistics
- Cancer, diabetes and stroke registries

ADDITIONAL DATA RESOURCES

- Tribal epidemiology centers
- Centers for Disease Control and Prevention
- National Institutes of Health
- National Center for Health Statistics
- American Community Survey
- Fatal Accidents Reporting System
- Web-based Injury Statistic Query and Reporting System
- National Cancer Database
- Bureau of Indian Affairs

PUBLICALLY AVAILABLE DATA

Public data resources are open to the public and available in the public domain. This type of data has already been analyzed. Tribal specific data may not be available. It is published and reported in journals and websites. Examples include the CDC website, US Census and local public health district website health profiles.

Protected/private data resources tend to be population sub group specific. This type of data is sometimes also called suppressed data. Permission to obtain this data must be obtained and it can take weeks to months to receive the data once permission has been granted. Examples include Indian Health Service and tribal health data.

Both types of data are beneficial in completing a thorough secondary data assessment.

COLLECTING THE PRIMARY DATA

Primary data is new data collected through surveys, interviews, focus groups, and observation. It is typically the most up-to-date data on a topic.

It is important to determine if qualitative, quantitative or both data collection methods will be utilized. Qualitative data is obtained through open-ended questions in interviews and groups. It provides information about perceptions and opinions. Quantitative data provides numbers- counts, percentage, and prevalence rates. It answers questions about who and how many. There are 7 main types of primary data collection methods, which will be explained in more detail in the chart below:

- Surveys
- Interviews
- Focus groups
- Observation
- Forums
- Measurement
- Record/chart review

SURVEYS			
Use	**Pros**	**Cons**	**Tribal considerations**
Can be qualitative or quantitative in design, provides a sample of the community's information.	Can be qualitative, quantitative or both, which provides flexibility in the type of information gathered; potential for fast turnaround time if offered electronically or online	Response rates can be low; responses are only as good as the questions; should use a validated, reliable survey tool; if developing your own survey questions, be sure to ask the right questions and pilot it before implementing	Questions need to be culturally American Indian-specific; dissemination method needs to match the tribal community's capacity – for instance, if it's a web-based survey, do tribal members have access to a computer?
INTERVIEWS			
Use	**Pros**	**Cons**	**Tribal considerations**
A qualitative method, asking key informants or those very knowledge-able on the topic, predetermined questions, interviews should be recorded and transcribed as they generate large amounts of detail.	Provide rich information about the community, giving a true sense of values, attitudes and beliefs.	Time consuming in term of collecting, summarizing, synthesizing and reporting the information; the "right" questions need to be asked so pilot the questions before conducting the interviews	Be respectful; when wanting to work with a tribal nation, secure permission to do so from their identified tribal leadership; ask tribal leadership for their recommendations of who to interview and how to do so i.e. use of tape recorder, written summary, etc.
FOCUS GROUPS			
Use	**Pros**	**Cons**	**Tribal considerations**
A qualitative method, groups are asked open-ended questions by a trained monitor, participants need not be experts, as focus groups seek information about beliefs, perceptions and opinions.	Provides detailed information about personal and group beliefs that you may not learn through other methods; can save time and money compared to individual interviews;	Time consuming in term of collecting, summarizing, synthesizing and reporting the information; can cause "group think" where a few ideas drive the group's thinking as a whole.	Be respectful; when wanting to work with a tribal nation, secure permission to do so from their identified tribal leadership; ask tribal leadership for their recommendations of who to interview and how to do so i.e. use of tape recorder, written summary, etc.

OBSERVATION			
Use	**Pros**	**Cons**	**Tribal considerations**
Qualitative or quantitative in design, an observer at an event looks for behavior defined in the plan and documents how often it happens and if there is anything in the environment encouraging or discouraging it from happening.	Provides specific information directly related to a targeted behavior	Requires significant amount of time; only gathers information from those engaging/not engaging in the behavior at the event, so it doesn't tell you which behavior people not at the event would chose	Be respectful; when wanting to work with a tribal nation, secure permission to do so from their identified tribal leadership; ask for recommendations on who can help conduct observations – an "outsider" conducting this very personal information gathering may be viewed as intrusive
FORUMS			
Use	**Pros**	**Cons**	**Tribal considerations**
Qualitative in design, they are a collective discussion of community members to obtain perceptions, beliefs and experiences	Can create community engagement supporting an issue; can provide an opportunity for education about a topic	Can create community engagement opposing an issue; can cause "group think" where a few ideas drive the group's thinking as a whole.	Be respectful; when wanting to work with a tribal nation, secure permission to do so from their identified tribal leadership; ask for recommendations on who can help conduct forums, best location, and format
MEASUREMENT			
Use	**Pros**	**Cons**	**Tribal considerations**
Quantitative in design, it is a direct measurement, biological, physical or chemical, by a trained person.	Provides concrete "numbers"	Can be time consuming and expensive (one on one data collection, trained professionals, measuring equipment and lab costs)	Be respectful; make sure participants understand how the data will be used to benefit the tribal nation
CHART REVIEW			
Use	**Pros**	**Cons**	**Tribal considerations**
Quantitative in design, review of medical records for health data such as measurements and disease occurrence.	Provides actual numbers related to a condition	Takes time to obtain permission to review charts, actually reviewing charts takes time	Tribal nations may have several providers in the community (IHS, 638 facility or independent provider). Work with tribal leadership to learn which entities are present in the community

DATA ENTRY AND STORAGE CONSIDERATIONS

Data should be entered accurately and consistently. Keep a log of what data was entered, when it was entered and who entered it. It will be helpful should there be questions about the data. Data coding assigns a value, a number or label, to data; for example, 1= Yes 2=No. Data coding may be helpful in speeding up data processing and preparing for analysis.

Data obtained for the tribal CHA should be protected against damage, tampering and theft. Paper surveys and documents should be stored in a locked file cabinet or file box. Data stored electronically should be stored on a password protected computer with updated anti-virus protection, firewalls should be in place and records should be regularly backed up. Data should be backed up in three difference, secure locations, as a best practice. It is recommended that data be stored in a cloud based system, a server and a removable hardware device.

DATA COLLECTION CHECKLIST

The following checklist provides an overview of the data collection process for easy tracking (Inter Tribal Council of Arizona, Inc.: Tribal Epidemiology Center, 2013):

- ❑ Refer to the health indicators to determine what data should be collected
- ❑ Finalize the list of what specific indicators will be studied in the CHA
- ❑ Search for relevant and reliable data sources with available data
- ❑ Identify what existing data sources can be found for each health indicator
- ❑ Review and obtain data from secondary or publically available sources
- ❑ Determine who will conduct secondary data collection
- ❑ Compile data for the tribal CHA report
- ❑ Determine how it will be stored
- ❑ If primary data collection needs to occur, draft possible questions
- ❑ Determine what methods to use to collect primary data
- ❑ Develop the tools
- ❑ Test your questions and revise based upon feedback received
- ❑ Administer the tool (i.e. conduct the survey, perform the review).
- ❑ Enter, store and protect the data.
- ❑ Determine who will enter primary data into the data collection spreadsheet/software
- ❑ Determine how and where hard copies of data collection tools will be stored
- ❑ Determine if electronic records and data will be protected and who will have the password(s)
- ❑ Process the data by using cleaning and coding techniques
- ❑ Determine if the source is credible and complete, if there are duplicates, missing data, missing values or variables, if it makes sense and what the limitations of the data are.
- ❑ Archive and destroy the data as planned.
- ❑ Determine where data will be stored and for how long after the tribal CHA has been completed
- ❑ Determine when and who will destroy data records after tribal CHA has been completed

Analyze Data

A data analysis plan should be developed for identifying key information in the assessments that have been done. The following are common elements to include (Inter Tribal Council of Arizona, Inc.: Tribal Epidemiology Center, 2013):

- Purpose of the tribal CHA and analysis
- Variables for analysis
- Software and computer applications that will be used for the analysis and generation of graphs
- Methods used to analyze the data
- Data presentation such as tables, charts, figure and graphs
- Persons responsible
- Select who will be responsible for each task related to data analysis
- Timeline for data analysis

If the tribal nation conducting the CHA does not have staff trained in data analysis, the CHA should be contracted out to professionals. Entities able to assist in data analysis include university and independent epidemiologists or biostatisticians and technical assistance centers. In North Dakota, the American Indian Public Health Resource Center at North Dakota State University (NDSU) and the Center for Rural Health at University of North Dakota (UND) can provide data analysis services, technical assistance in analyzing data, and preparing community health profiles and community health improvement plans.

NDSU American Indian Public Health
Resource Center
NDSU Dept. 2662 PO Box 6050
Fargo, ND 58108-6050

Phone: 701-231-6269

www.ndsu.edu/centers/american_indian_health

Technical Assistance Requests: www.ndsu.edu/centers/american_indian_health/tech_assist

UND Center for Rural Health
501 N Columbia Rd
Grand Forks, ND 58203

Phone: 701-777-3848

https://ruralhealth.und.edu

COMMUNITY HEALTH PROFILE

A community health profile is a way to visually summarize information in specific health indicator categories studied in the tribal CHA. It include various sections and display data in tables, bar charts, pie charts and/or line graphs.

The following are sections that can be included in a Community Health Profiles:

Executive Summary

- Main findings of the community health profile.

Background

- Tribal history.
- Tribal background (government, location, economy, culture, etc.).
- Community resources.
- Additional tribal information.
- Map of tribal lands, or jurisdiction of the tribal public health program.

Methodology

- Identification of health priorities.
- Data collection and data sources.
- Methods of data analysis.

Limitations of data and analysis

- Address the data limitations.
- Describe how the findings are affected.

Summary of Findings

- Overview of the key results.

Data on the health indicators

- Key findings.
- Tables, graphs and charts.
- A listing or description of the health asserts and resources.

Discussion

- Health indicator findings.
- Description of contributing causes of health issues.

Appendix

- Additional relevant information.

The North Dakota Department of Health's Community Health Profile (2012) is included in this toolkit as an appendix.

Identify Health Priorities

A community health improvement plan identifies health priority for improving the health of a community. The CHA is the tool for developing the plan. Once the CHA has been completed reassess the health priorities identified in the CHA and the CHP. This will pinpoint any changes in health priorities. At this point in the process, it is a good time to meet with the community and discuss the CHA findings and next steps.

Topics to consider discussing at the community meeting include:

- Introduction of the working group members and process partners
- Why a CHA was completed in the community
- Explain what a CHA is and the steps to its finishing point
- Data collection methods used
- Data Key findings and any data limitations
- Explain the CHA findings
- Discuss the next step- a Tribal Community Health Improvement Plan
- Ask the community for feedback on the findings and next steps

TRIBAL COMMUNITY HEALTH IMPROVEMENT PLAN

A Tribal Community Health Improvement Plan (TCHIP) a map to guide the tribal community towards reaching its health goals. The TCHIP pulls together the CHA, CHIP and community feedback. It describes the step or activities that will be taken to improve health priorities, how improvement will be measured and who will be leading each effort.

A TCHIP should (Inter Tribal Council of Arizona, Inc.: Tribal Epidemiology Center, 2013):

- Outline measurable objectives aimed at community health improvement.
- Describe strategies to achieve the community health improvement objectives.
- Identify performance measures, or specific targets.
- Describe the implementation process for reporting, monitoring, or evaluating progress.
- Assign individuals and organizations responsible for tasks.
- Outline the time frame for implementation of each strategy, and when each objective will be achieved.
- Typically covers a three- to five-year span.
- Align with tribal, state, and/or national priorities (such as Healthy People 2020).
- Employ continuous stakeholder and community engagement.
- Propose policy changes needed to accomplish objectives.

A sample community health improvement plan from the Wisconsin CHIPP Infrastructure Improvement Project is included on the next page.

IMPLEMENTATION PLAN

Date Created:_____ **Date Reviewed/Updated:** _____

PRIORITY AREA: Nutrition and Physical Activity
GOAL: ABC County will implement policies that support residents in achieving a healthy diet and increased physical activity.

PERFORMANCE MEASURES **How We Will Know We are Making a Difference**		
Short Term Indicators	**Source**	**Frequency**
By DATE, decrease the percentage of adults engaging in no physical activity from x% to y%	BRFS	Annual
By DATE, decrease the percentage of adults eating less than five servings of fruits and vegetables daily from x% to y%	BRFS	Annual
By DATE, increase the percentage of WIC infants ever breastfed from x% to y%	DHS (PedNSS)	Annual
Long Term Indicators	**Source**	**Frequency**
By DATE, decrease the percentage of overweight adult from x% to y%	BRFS	Annual
By DATE, decrease the percentage of obese adults from x% to y%	CHR	Annual

OBJECTIVE #1:
By DATE, increase the number of ABC County municipalities that are working towards adopting local complete street policies from # to #

BACKGROUND ON STRATEGY
Source: Complete Streets Program http://www.completestreets.org/
Evidence Base: "Urban design and land use policies" recommended by The Guide to Community Preventive Services
Policy Change (Y/N): Yes

ACTION PLAN

Activity	**Target Date**	**Resources Required**	**Lead Person/ Organization**	**Anticipated Product or Result**	**Progress Notes**
Attend training on state's complete street legislation and assess expected impact on ABC County by discussing with Highway Dept.	12/31/17	Staff time Travel	Amy Adams, ABC Health Department	Increased knowledge Written resources Assessment of impact	
Find at least 1 street/road in each community and graphically design a complete street.	4/30/17	Staff time	Amy Adams	Graphic presentation of desired design for each community's selected street	
Conduct walkability/ bikeability checklists in those communities.	5/31/17	Staff time Volunteer time Travel	Amy Adams and Physical Activity Team Volunteers	Completed assessment for each community	
Create a presentation for city councils about the new state law, using photovoice and complete street pictures.	8/30/17	Staff time	Susie Smith, ABC Health Officer Terri Thomas, ABC Hospital	PowerPoint presentation and packet of materials	
Present to city councils and invite to go on a walk audit.	10/31/17	Staff time	Susie Smith Terri Thomas	Presentation and walk audit completed	
Follow up with city council chair after meeting	11/30/17	Staff time	Susie Smith	Discussed next steps	
Announce approved policy to the community collaboratively with the city council (if approved)	12/31/17	Staff time	Terri Thomas	Press release Press coverage	

OBJECTIVE #2: By DATE, increase the number of schools participating in a comprehensive Farm to School Program from # to #
BACKGROUND ON STRATEGY Source: HealthinPractice.org: toolkits, communication tools Evidence Base: Farm to School programs indicated to be effective based on "expert opinion" in "What Works for Health" Policy Change (Y/N): Yes
ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes

OBJECTIVE #3: By DATE, increase the number of early care and education providers who have adopted the Ten Steps to Breastfeeding-Friendly Child Care Centers from # to #.
BACKGROUND ON STRATEGY Source: 10 Steps Resource Kit Evidence Base: Breastfeeding promotion programs indicated to be "scientifically supported" in "What Works for Health'" Policy Change (Y/N): Yes
ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes

ALIGNMENT WITH STATE/NATIONAL PRIORITIES			
Obj #	**Healthiest (Insert State) 2020**	**Healthy People 2020**	**National Prevention Strategy**
1	Design communities to encourage activity	Increase legislative policies for the built environment that enhance access to and availability of physical activity opportunities (PA-15)	Encourage community design and development that support physical activity
2	Make healthy foods available for all Increase access to healthy foods and support breastfeeding		Increase access to healthy and affordable foods in communities
3	Increase access to healthy foods and support breastfeeding	Increase the proportion of infants who are breastfed (MICH-21)	Support policies and programs that promote breastfeeding
DESCRIBE PLANS FOR SUSTAINING ACTION			
(added for CHA/CHIP Project)			

Communicate the Results

If the reason the tribal public health program completed a CHA was application for accreditation, the CHA results must be shared with the Public Health Accreditation Board. In addition, two examples of how the results will be shared with the community should be included.

Before the assessment has started, consideration should be paid to whom will use the information once the assessment is completed. Some tribes may ask for the information to be shared in a private document where only a few people have access to the data. Others may prefer to have the assessment made public and allow all community members to see the health data.

A CHA's results can best serve in assisting and improving the community's health. Consult the CHA work team, your tribal key stakeholders and other within the community to determine the most appropriate and effective methods for sharing the information collected through the CHA. Share the results with the community, key tribal leaders, and tribal program directors. This may be through a tribal council presentation, community event, department meetings and the media. Utilize graphics and pictures to help with relaying technical and data-heavy information. Know your audience and match their reading level.

The ITCA Epidemiology Center (2013) has created the following outline for CHA presentation:

- Provide an introduction of the leaders, staff, community members involved.
- Provide a brief background on the project including the purpose and the partnerships.
- Define "Tribal CHA" and explain the overall process.
- Describe how the data was collected.
- Explain data key findings.
- Address the limitations.
- Explain "the story" or what the findings mean.
- Propose how to utilize the information and describe the next steps.
- Encourage and receive feedback from the audience.

Resources

American Indian Public Health Resource Center (AIPHRC)
North Dakota State University
1805 Research Park Dr
Fargo, ND 58102
Mailing Address:
NDSU Dept. 2662
PO Box 6050
Fargo, ND 58108-6050
Phone: 701.231.6666
www.ndsu.edu/centers/american_indian_health

Center for Rural Health
501 N Columbia Rd
Grand Forks, ND 58203
Phone: 701.777.3848
ruralhealth@med.und.edu
www.ruralhealth.und.edu

Fargo Cass Public Health
1240 25th St S.
Fargo, ND 58103
Phone: (701) 241 – 1360
www.fargocasspublichealth.com

Indian Health Service (IHS) Headquarters
5600 Fishers Lane
Rockville, MD 20857
www.ihs.gov
Great Plains Tribal Chairmen's Health Board (GPTCHB)
1770 Rand Road
Rapid City, SD 57702
Phone: 605.721.1922
Toll Free: 1.800.745.3466
info@gptchb.org
www.gptchb.org

National Congress of American Indians (NCAI)
Embassy of Tribal Nations
1516 P Street NW
Washington, DC 20005
Phone: (202) 466-7767
Fax: (202) 466-7797
www.ncai.org

National Indian Health Board (NIHB)
910 Pennsylvania Ave, SE
Washington, DC 20003
Phone: 202-355-5494
www.nihb.org

North Dakota Department of Health
600 East Boulevard Avenue
Bismarck, ND 58505
Phone: (701) 328 – 2372
health@nd.gov
www.ndhealth.gov

North Dakota Indian Affairs Commission
State Capitol Building
600 East Boulevard Avenue
1st Floor, Judicial Wing - Room #117
Bismarck, ND 58505
Phone: (701) 328-2428
www.nd.gov/indianaffairs

Public Health Accreditation Board (PHAB)
1600 Duke Street, Suite 200
Alexandria, VA 22314
Phone: (703) 778 - 4549
www.phaboard.org

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North Dakota Health Profile

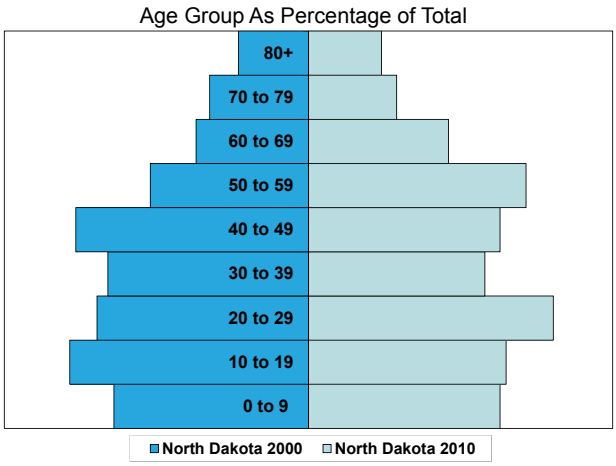
POPULATION

The Demographic Section of this report comes from the US Census Bureau (www.census.gov). Most tables are derived either from the full (100%) census taken in 2010 or from the Community Population Survey for 2010. The table showing percent population change uses census data from 2000 and 1990 also. Tables present number of persons and percentages which in almost all circumstances represent the category specific percentage of all persons referenced by the table (e.g., percentage of persons age 15 and older who are married). Age specific poverty rates represent the percentage of each age group which is in poverty (e.g., percentage of children under five years in poverty).

1

Population by Age Group, 2010 Census				
Age Group	North Dakota		United States	
	Number	Percent	Number	Percent
0-9	84,671	12.6%	40,550,019	13.1%
10-19	87,264	13.0%	42,717,537	13.8%
20-29	108,552	16.1%	42,687,848	13.8%
30-39	77,954	11.6%	40,141,741	13.0%
40-49	84,577	12.6%	43,599,555	14.1%
50-59	96,223	14.3%	41,962,930	13.6%
60-69	61,901	9.2%	29,253,187	9.5%
70-79	39,213	5.8%	16,595,961	5.4%
80+	32,236	4.8%	11,236,760	3.6%
Total	672,591	100.0%	308,745,538	100.0%
0-17	149,871	22.3%	74,181,467	24.0%
65+	97,477	14.5%	40,267,984	13.0%

2



3

Female Population and Percentage Female by Age, 2010 Census				
Age Group	North Dakota		United States	
	Number	Percent	Number	Percent
0-9	41,330	48.8%	19,840,954	48.9%
10-19	42,277	48.4%	20,834,009	48.8%
20-29	50,571	46.6%	21,038,081	49.3%
30-39	37,144	47.6%	20,103,219	50.1%
40-49	41,499	49.1%	21,996,493	50.5%
50-59	47,283	49.1%	21,506,008	51.3%
60-69	30,699	49.6%	15,323,140	52.4%
70-79	21,453	54.7%	9,169,601	55.3%
80+	20,471	63.5%	7,152,707	63.7%
Total	332,727	49.5%	156,964,212	50.8%
0-17	73,083	48.8%	36,236,331	48.8%
65+	55,050	56.5%	22,908,024	56.9%

North Dakota Health Profile

POPULATION

4

Race, 2010 Census	North Dakota		United States	
Race	Number	Percentage	Number	Percentage
Total	672,591	100.0%	308,745,538	100.0%
White	605,449	90.0%	223,553,265	72.4%
Black	7,960	1.2%	38,929,319	12.6%
American Indian	36,591	5.4%	2,932,248	0.9%
Asian	6,909	1.0%	14,674,252	4.8%
Pacific Islander	320	0.0%	540,013	0.2%
Other	3,509	0.5%	19,107,368	6.2%
Multirace	11,853	1.8%	9,009,073	2.9%
Hispanic	13,467	2.0%	50,477,594	16.3%

5

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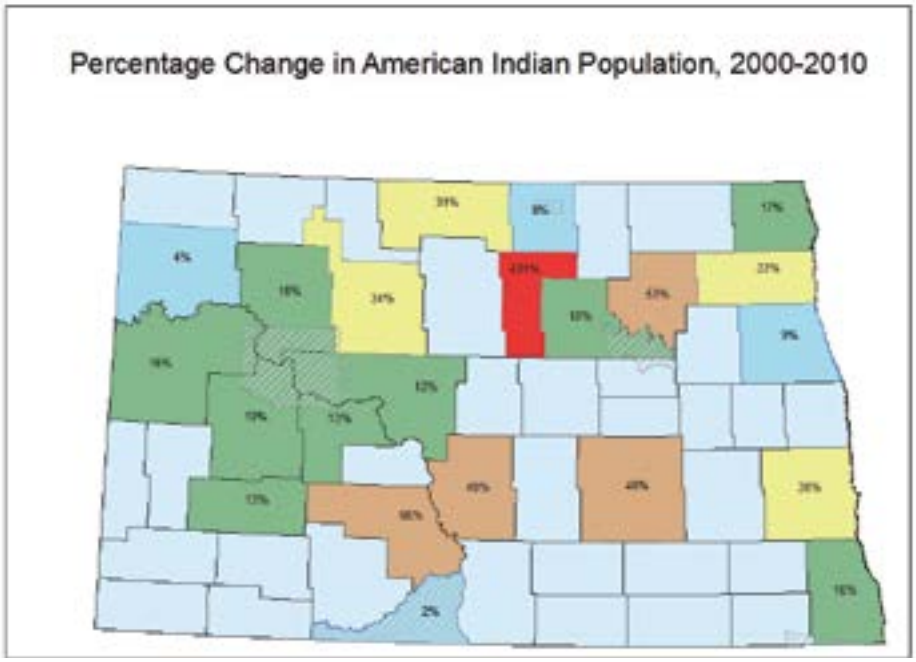
6



North Dakota Health Profile

POPULATION

7

Decennial Population Change, 1990 to 2000, 2000 to 2010				
Census	North Dakota	10 Year Change (%)	United States	10 Year Change (%)
1990	638,800		248,709,873	
2000	642,200	0.5%	281,421,906	13.2%
2010	672,591	4.7%	308,745,538	9.7%

8

Household Populations, 2010	North Dakota		United States	
Household Type	Number	Percentage	Number	Percentage
Total	659,858	100.0%	309,349,689	100.0%
In households	634,679	96.2%	301,362,366	97.4%
In family households:	504,148	76.4%	252,364,729	81.6%
In nonfamily households:	130,531	19.8%	48,997,637	15.8%
In group quarters	25,179	3.8%	7,987,323	2.6%
Institutionalized population	9,675	1.5%	3,993,659	1.3%
Noninstitutionalized population	15,504	2.3%	3,993,664	1.3%

9

Marital Status of Persons Age 15 and Older, 2010 ACS	North Dakota		United States	
Marital Status	Number	Percent	Number	Percent
Total Age 15+	549,738	100.0%	248,055,976	100.0%
Never Married	172,068	31.3%	79,625,968	32.1%
Now Married	290,262	52.8%	121,051,316	48.8%
Separated	3,848	0.7%	5,457,231	2.2%
Widowed	32,984	6.0%	14,883,359	6.0%
Divorced	51,126	9.3%	27,038,101	10.9%

10

Educattional Attaiment, 2010, ACS	North Dakota		United States	
	Estimate	Percent	Estimate	Percent
Population 25 years and over	442,946	100.0%	204,288,933	100.0%
Less than 9th grade	21,704	4.9%	12,461,625	6.1%
9th to 12th grade, no diploma	20,818	4.7%	16,955,981	8.3%
High school graduate or GED	119,595	27.0%	58,222,346	28.5%
Some college, no degree	106,307	24.0%	43,513,543	21.3%
Associate's degree	51,825	11.7%	15,525,959	7.6%
Bachelor's degree	87,260	19.7%	36,159,141	17.7%
Grad degree or prof degree	34,993	7.9%	21,246,049	10.4%

North Dakota Health Profile

POPULATION

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Income and Poverty Status by Age Group, 2010, ACS	North Dakota		United States	
Median Household Income	$48,670		$50,046	
Per Capita Income	$26,021		$26,059	
	Number	**Percent**	**Number**	**Percent**
Below Poverty Level	84,895	13.0%	46,215,956	15.3%
Under 5 years	8,373	19.0%	4,961,524	25.0%
5 to 11 years	9,748	17.2%	6,125,463	21.7%
12 to 17 years	5,995	12.5%	4,662,142	18.7%
18 to 64 years	49,610	12.1%	26,929,254	14.2%
65 to 74 years	3,931	8.5%	1,750,344	8.1%
75 years and over	7,238	15.8%	1,787,229	10.2%
Total Known Children in Poverty (0-17)	24,116	16.2%	15,749,129	21.6%
Total Known Age 65+ in Poverty	11,169	12.1%	3,537,573	9.0%

12

Family Poverty and Childhood and Elderly Poverty, 2010, ACS	North Dakota		United States	
	Number	**Percent**	**Number**	**Percent**
Total Families	171,945	100.0%	76,089,045	100.0%
Families in Poverty	13,412	7.8%	8,598,062	11.3%
Families with Related Children	76,535	44.5%	37,416,697	49.2%
Families with Related Children in Poverty	10,485	6.1%	6,697,589	8.8%
Families with Related Children and Female Parent Only	16,219	9.4%	9,970,534	13.1%
Families with Related Children and Female Parent Only in Poverty	7,104	4.1%	3,948,331	5.2%

13

Disability Status by Age, 2007-2010	North Dakota		United States	
	Number	**Percent***	**Number**	**Percent***
Total	649,963	100.0%	301,501,772	100.0%
Under 18	147,774		73,981,918	
With a disability	3,998	2.7%	2,948,493	4.0%
Without a disability	143,776	97.3%	71,033,425	96.0%
18-64	411,489		189,239,988	
With a disability	35,295	8.6%	18,984,266	10.0%
Without a disability	376,194	91.4%	170,255,722	90.0%
65 and older	90,700		38,279,866	
With a disability	32,470	35.8%	14,247,365	37.2%
Without a disability	58,230	64.2%	24,032,501	62.8%

*Within age group

Vital Statistics Data

BIRTHS AND DEATHS

Vital Statistics Data comes from the birth and death records collected by the State of North Dakota for 2010. All births and deaths represent the state of residence not the state of occurrence. Formulas for calculating rates and ratios are as follows:

Birth Rate = Resident live births divided by the total resident population x 1000.
Pregnancies = Live births + Fetal deaths + Induced termination of pregnancy.
Pregnancy Rate = Total pregnancies divided b the total resident population x 1000.
Fertility Rate = Resident live births divided by female population (age 15-44) x 1000.
Teenage Birth Rate = Teenage births (age <20) divided by female teen population x 1000.
Teenage Pregnancy Rate = Teenage pregnancies (age<20) divided by female teen population x 1000.
Out of Wedlock Live Birth Ratio = Resident OOW live births divided by total resident live births x 1000.
Out of Wedlock Pregnancy Ratio = Resident OOW pregnancies divided by total pregnancies x 1000.
Low Weight Ratio = Low weight births (birth weight < 2500 grams) divided by total resident live births x 1000.
Infant Death Ratio = Number of infant deaths divided by the total resident live births x 1000.
Childhood & Adolescent Deaths = Deaths to individuals 1 - 19 years of age.
Childhood and Adolescent Death Rate = Number of resident deaths (age 1 - 19) divided by population (age 1 - 19) x 100,000.
Crude Death Rate = Death events divided by population x 100,000.
Age-Adjusted Death Rate = Death events with age specific adjustments x 100,000 population.

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Births, 2006-2010 (ND) and 2008 (US)	North Dakota		United States	
	Number	Rate	Number	Rate
Live Births	44,427	13	4,130,665	13
Pregnancies	48,818	15	-	21
Fertility Ratio		71	-	67
Teen Births	3,337	19	414,831	29
Teen Pregnancies	4,062	23		53
	Number	Ratio	Number	Ratio
Out of Wedlock Births	14,506	327	1,693,658	410
Out of Wedlock Pregnancies	18,103	371	-	-
Low Birth Weight Births	2,919	66	336,747	82

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Deaths, 2006-2010 (ND) and 2009 (US)	North Dakota		United States	
	Number	Ratio	Number	Ratio
Infant Deaths	281	6	26,412	6
	Number	Rate	Number	Rate
Child and Adolescent Deaths	285	35	21,621	27
Total Deaths	28,984	862	2,437,163	789

Vital Statistics Data

BIRTHS AND DEATHS

16

Deaths and Age Adjusted Death Rate by Cause, 2006-2010 (ND) and 2009 (US)	North Dakota Number (Adj. Rate)	United States Number (Adj. Rate)
All Causes	28,985 (689)	2,437,163 (741)
Heart Disease	7,122 (162)	599,413 (180)
Cancer	6,544 (162)	567,628 (173)
Stroke	1,696 (38)	128,842 (39)
Alzheimers Disease	1,936 (40)	79,003 (24)
COPD	1,607 (39)	137,353 (42)
Unintentional Injury	1,545 (42)	118,021 (37)
Diabetes Mellitus	1,072 (26)	68,705 (21)
Pneumonia and Influenza	702 (15)	53,692 (16)
Cirrhosis	289 (8)	30,558 (9)
Suicide	462 (14)	36,909 (12)

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Leading Causes of Death by Age Group for North Dakota, 2006-2010			
Age	1	2	3
0-4	Congenital Anomaly 69	Prematurity 44	SIDS 40
5-14	Unintentional Injury 26	Cancer 10	Congenital Anomaly 6
15-24	Unintentional Injury 184	Suicide 109	Cancer 20
25-34	Unintentional Injury 166	Suicide 91	Heart 32
35-44	Unintentional Injury 173	Heart 94	Cancer 88
45-54	Cancer 493	Heart 335	Unintentional Injury 194
55-64	Cancer 1001	Heart 579	Unintentional Injury 137
65-74	Cancer 1562	Heart 843	COPD 313
75-84	Cancer 1992	Heart 1797	COPD 626
85+	Heart 3421	Alzheimer's Dz 1391	Cancer 1352

ADULT BEHAVIORAL RISK FACTORS, 2009 or 2010

Adult Behavioral Risk Factor data are derived from data from 2010 when available, or 2009 otherwise. The survey is continuously collected by telephone survey from persons 18 years and older. All data is self-reported data. Numbers given are point estimate percentages followed by 95% confidence intervals. Statistical significance can be determined by comparing confidence intervals between two geographic areas. To be statistically significant, confidence may not overlap. For example the confidence intervals 9.3 (8.3-10.2) and 10.8 (10.0-11.6) overlap (see picture below) so the difference between the two numbers is not statistically significant. That means that substantial uncertainty remains whether the apparent difference is due to chance alone (due to sampling variation) rather than representing a true difference in the prevalence of the condition in the two populations. The less they overlap, the more likely it is that the point estimates represent truly different prevalences in the two populations.

	ALCOHOL	North Dakota 2009 or 2010 %	United States 50 State Median 2009 or 2010 %
Binge Drinking	Respondents who reported binge drinking (5 drinks for men, 4 drinks for women) one or more times in the past 30 days.	18.7 (17.0-20.5)	15.1
Heavy Drinking	Respondents who reported heavy drinking (more than 2 drinks per day for men, more than 1 drink per day for women) during the past 30 days	4.1 (3.3-5.0)	5.0
Drunk Driving	Respondents who reported driving when they had too much to drink one or more times during the past 30 days	6.3 (4.8- 7.7)	1.8
	ARTHRITIS		
Chronic Joint Symptoms	Respondents who reported pain, aching of stiff in a joint during the past 30 days which started more than 3 months ago	33.2 (26.6-39.8)	NA
Activity Limitation Due to Arthritis	Respondents who reported being limited in any usual activities because of arthritis or joint symptoms.	42.4 (39.6-45.3)	NA
Doctor Diagnosed Arthritis	Respondents who reported ever have been told by a doctor or other health professional that they had some form or arthritis.	27.4 (25.9-29.0)	NA
	ASTHMA		
Ever Asthma	Respondents who reported ever having been told by a doctor, nurse or other health professional that they had asthma.	10.6 (9.1-12.1)	13.8
Current Asthma	Respondents who reported ever having been told by a doctor, nurse or other health professional that they had asthma and who still have asthma.	6.0 (4.0- 8.0)	9.1

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ADULT BEHAVIORAL RISK FACTORS, 2009 or 2010

	BODY WEIGHT	North Dakota 2009 or 2010 %	United States 50 State Median 2009 or 2010 %
Overweight But Not Obese	Respondents with a body mass index greater than or equal to 25 but less than 30 (overweight)	42.4 (38.0-46.7)	36.2
Obese	Respondents with a body mass index greater than or equal to 30 (obese)	28.0 (23.8-32.1)	27.6
Overweight or Obese	Respondents with a body mass index greater than or equal to 25 (overweight or obese)	70.3 (66.1-74.5)	63.8
	CARDIOVASCULAR		
Heart Attack	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had a heart attack.	5.7 (3.8- 7.6)	4.2
Angina	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had angina.	3.7 (2.2- 5.2)	4.1
Stroke	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had a stroke.	3.3 (1.8- 4.7)	2.7
Cardiovascular Disease	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had any of the following: heart attack, angina or stroke.	9.0 (6.7-11.4)	NA
	CHOLESTEROL		
Never Cholesterol Test	Respondents who reported never having a cholesterol test	20.4 (18.3-22.4)	NA
No Cholesterol Test in Past 5 Years	Respondents who reported never having a cholesterol test in the past five years	25.4 (19.8-31.0)	NA
High Cholesterol	Respondents who reported that they had ever been told by a doctor, nurse or other health professional that they had high cholesterol.	34.8 (33.0-36.5)	NA
	COLORECTAL CANCER		
Fecal Occult Blood	Respondents age 50 and older who reported not having a fecal occult blood test in the past two years.	63.3 (56.4-70.1)	NA
Never Sigmoidoscopy	Respondents age 50 and older who reported never having had a sigmoidoscopy or colonoscopy	36.1 (28.7-43.6)	34.8
No Sigmoidoscopy in Past 5 Years	Respondents age 50 and older who reported not having a sigmoidoscopy or colonoscopy in the past five years.	44.9 (37.8-52.1)	NA

ADULT BEHAVIORAL RISK FACTORS, 2009 or 2010

	DIABETES	North Dakota 2009 or 2010 %	United States 50 State Median 2009 or 2010 %
Diabetes Diagnosis	Respondents who reported ever having been told by a doctor that they had diabetes.	6.1 (3.2- 9.0)	8.7
	FRUITS AND VEGETABLES		
Five Fruits and Vegetables	Respondents who reported that they do not usually eat 5 fruits and vegetables per day	72.2 (66.5-77.9)	NA
	GENERAL HEALTH		
Fair or Poor Health	Respondents who reported that their general health was fair or poor	12.5 (9.6-15.5)	14.9
Poor physical Health	Respondents who reported they had 8 or more days in the last 30 when their physical health was not good	8.8 (6.6-11.0)	NA
Poor Mental Health	Respondents who reported they had 8 or more days in the last 30 when their mental health was not good	7.3 (1.2-13.4)	NA
Activity Limitation Due to Poor Health	Respondents who reported they had 8 or more days in the last 30 when poor physical or mental health kept them from doing their usual activities.	6.0 (5.2- 6.9)	NA
Any Activity Limitation	Respondents who reported being limited in any way due to physical, mental or emotional problem.	18.0 (16.5-19.5)	21.2
	HEALTH CARE ACCESS		
Health Insurance	Respondents who reported not having any form or health care coverage	11.1 (9.4-12.7)	15.0
Access Limited by Cost	Respondents who reported needing to see a doctor during the past 12 months but could not due to cost.	6.5 (5.3-7.7)	NA
No Personal Provider	Respondents who reported that they did not have one person they consider to be their personal doctor or health care provider.	22.5 (20.5-24.5)	NA
	HYPERTENSION		
High Blood Pressure	Respondents who reported ever having been told by a doctor, nurse or other health professional that they had high blood pressure.	31.5 (26.2-36.7)	NA
	IMMUNIZATION		
Influenza Vaccine	Respondents age 65 and older who reported that they did not have a flu shot in the past year	33.6 (31.0-36.1)	32.5
Pneumococcal Vaccine	Respondents age 65 or older who reported never having had a pneumonia shot.	29.1 (26.6-31.6)	31.2

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ADULT BEHAVIORAL RISK FACTORS, 2009 or 2010

21

	INJURY	North Dakota 2009 or 2010 %	United States 50 State Median 2009 or 2010 %
Fall	Respondents 45 years and older who reported that they had fallen in the past 3 months	16.5 (15.1-17.8)	NA
Seat Belt	Respondents who reported not always wearing their seatbelt	37.7 (35.5-39.8)	14.8
	ORAL HEALTH		
Dental Visit	Respondents who reported that they have not had a dental visit in the past year	28.9 (27.0-30.8)	30.3
Tooth Loss	Respondents who reported they had lost 6 or more permanent teeth due to gum disease or decay.	13.6 (12.6-14.6)	NA
	PHYSICAL ACTIVITY		
Recommend Physical Activity	Respondents who reported that they did not get the recommended amount of physical activity	48.7 (42.7-54.6)	NA
	TOBACCO		
Current Smoking	Respondents who reported that they smoked every day or some days	17.4 (15.7-19.1)	17.3
	WOMEN'S HEALTH		
Pap Smear	Women 18 and older who reported that they have not had a pap smear in the past three years	17.0 (14.6-19.4)	18.7
Mammogram Age 40+	Women 40 and older who reported that they have not had a mammogram in the past two years	24.8 (22.9-26.8)	24.8

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ADULT BEHAVIORAL RISK FACTORS, 2001-2005, 2006-2010 Time Trend

	ALCOHOL	North Dakota 2001-2005 %	North Dakota 2006-2010 %
Binge Drinking	Respondents who reported binge drinking (5 drinks for men, 4 drinks for women) one or more times in the past 30 days.	20.9 (20.1-21.7)	21.2 (20.4-22.0)
Heavy Drinking	Respondents who reported heavy drinking (more than 2 drinks per day for men, more than 1 drink per day for women) during the past 30 days	5.2 (4.7-5.7)	4.8 (4.3-5.2)
Drunk Driving	Respondents who reported driving when they had too much to drink one or more times during the past 30 days	4.3 (3.7- 5.0)	7.1 (6.3-8.0)
	ASTHMA		
Current Asthma	Respondents who reported ever having been told by a doctor, nurse or other health professional that they had asthma and who still have asthma.	7.2 (6.8- 7.7)	7.8 (7.3-8.3)
	BODY WEIGHT		
Overweight But Not Obese	Respondents with a body mass index greater than or equal to 25 but less than 30 (overweight)	39.1 (38.2-40.0)	38.2 (37.4-39.1)
Obese	Respondents with a body mass index greater than or equal to 30 (obese)	23.5 (22.7-24.3)	27.3 (26.5-28.1)
Overweight or Obese	Respondents with a body mass index greater than or equal to 25 (overweight or obese)	62.6 (61.7-63.6)	65.5 (64.6-66.4)
	CARDIOVASCULAR		
Cardiovascular Disease	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had any of the following: heart attack, angina or stroke.	7.3 (6.7- 7.8)	7.5 (7.1- 7.8)
	CHOLESTEROL		
No Cholesterol Test in Past 5 Years	Respondents who reported never having a cholesterol test in the past five years	29.4 (28.4-30.4)	25.9 (24.4-27.3)
High Cholesterol	Respondents who reported that they had ever been told by a doctor, nurse or other health professional that they had high cholesterol.	32.9 (31.9-34.0)	35.9 (34.7-37.2)
	COLORECTAL CANCER		
Never Sigmoidoscopy	Respondents age 50 and older who reported never having had a sigmoidoscopy or colonoscopy	46.1 (43.3-48.8)	41.5 (40.3-42.6)
No Sigmoidoscopy in Past 5 Years	Respondents age 50 and older who reported not having a sigmoidoscopy or colonoscopy in the past five years.	58.7 (56.9-60.4)	51.7 (50.5-52.9)

ADULT BEHAVIORAL RISK FACTORS, 2001-2005, 2006-2010 Time Trend

	DIABETES	North Dakota 2001-2005 %	North Dakota 2006-2010 %
Diabetes Diagnosis	Respondents who reported ever having been told by a doctor that they had diabetes.	6.3 (5.7- 6.9)	7.1 (6.7- 7.4)
	FRUITS AND VEGETABLES		
Five Fruits and Vegetables	Respondents who reported that they do not usually eat 5 fruits and vegetables per day	78.8 (77.8-79.7)	77.8 (76.7-78.9)
	GENERAL HEALTH		
Fair or Poor Health	Respondents who reported that their general health was fair or poor	12.7 (12.1-13.3)	12.4 (11.9-12.9)
Any Activity Limitation	Respondents who reported being limited in any way due to physical, mental or emotional problem.	15.5 (14.9-16.2)	16.5 (15.9-17.1)
	HEALTH CARE ACCESS		
Health Insurance	Respondents who reported not having any form or health care coverage	11.5 (10.9-12.1)	11.4 (10.7-12.5)
Access Limited by Cost	Respondents who reported needing to see a doctor during the past 12 months but could not due to cost.	6.9 (6.3-7.4)	6.7 (6.2-7.2)
No Personal Provider	Respondents who reported that they did not have one person they consider to be their personal doctor or health care provider.	23.5 (22.7-24.4)	23.5 (22.7-24.4)
	HYPERTENSION		
High Blood Pressure	Respondents who reported ever having been told by a doctor, nurse or other health professional that they had high blood pressure.	24.1 (23.2-25.0)	26.4 (25.3-27.4)
	IMMUNIZATION		
Influenza Vaccine	Respondents age 65 and older who reported that they did not have a flu shot in the past year	27.7 (26.1-29.4)	29.4 (28.2-30.6)
Pneumococcal Vaccine	Respondents age 65 or older who reported never having had a pneumonia shot.	30.0 (28.3-31.7)	30.0 (28.8-31.2)
	INJURY		
Seat Belt	Respondents who reported not always wearing their seatbelt	47.6 (45.5-49.7)	40.0 (38.9-41.2)
	ORAL HEALTH		
Dental Visit	Respondents who reported that they have not had a dental visit in the past year	30.7 (29.6-31.8)	28.4 (27.4-29.4)
	PHYSICAL ACTIVITY		
Recommend Physical Activity	Respondents who reported that they did not get the recommended amount of physical activity	52.1 (51.0-53.1)	47.5 (46.1-49.0)
	TOBACCO		
Current Smoking	Respondents who reported that they smoked every day or some days	20.8 (20.1-21.6)	18.9 (18.2-19.6)

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ADULT BEHAVIORAL RISK FACTORS, 2001-2005, 2006-2010 Time Trend

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	WOMEN'S HEALTH	North Dakota 2001-2005 %	North Dakota 2006-2010 %
Pap Smear	Women 18 and older who reported that they have not had a pap smear in the past three years	12.5 (11.1-13.8)	15.1 (13.8-16.3)
Mammogram Age 40+	Women 40 and older who reported that they have not had a mammogram in the past two years	25.4 (23.5-27.3)	23.6 (22.4-24.7)

= Statistical Significance

CANCER INCIDENCE AND MORTALITY, 2008

Cancer incidence data is derived from high quality state cancer registries, including North Dakota. Mortality of specific cancers is derived from vital statistics data. Data is shown for common cancers for which a preventive action exists to prevent disease or death.

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Cancer Incidence per 100,000, North Dakota and United States, 2008	North Dakota	United States
Prostate (Male)	166.4	144.8
Breast (Female)	118.7	121.9
Lung and Bronchus	53.5	65.1
Colon and Rectum	53.0	44.4
Melanoma	18.6	18.8

Age Adjusted Cancer Death Rate per 100,000, North Dakota and United States, 2008	North Dakota	United States
Lung and Bronchus	45.5	49.6
Prostate (Male)	26.0	22.8
Breast (Female)	22.5	22.5
Colon and Rectum	18.2	16.4

HIGH SCHOOL BEHAVIORAL RISKS, 2011

High school risk behavior data is collected by the Youth Risk Behavior Survey. The survey uses randomly selected schools and is collected every other year.

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	North Dakota Percent	United States Percent
Ride with drinking driver past 30 days	25	24
Text while driving	58	-
Bullied at school	25	20
Hit, slapped or physically hurt by boyfriend of girlfriend	7	9
Ever physically forced to have sexual intercourse	6	8
Feeling sad or hopeless prevented usual activity for 2+ weeks in past year	24	29
Seriously considered suicide in past 12 mo	15	16
Smoked cigarettes on at least one day in past 30 days	19	18
Any tobacco use at least one day in past 30 days	28	23
Drank alcohol at least one day in past 30 days	39	39
5 or more drinks within a couple of hours at least once in past 30 days	26	22
Took prescription drug without prescription at least once in past 30 days	16	21
Ever sexual intercourse	45	47
4+ lifetime sex partners	13	15
Obese	11	13
Overweight not obese	15	15
Physically active 60 minutes on 5 of 7 days	46	51
Leisure comp/video game use 3+ hours/day	25	31
TV 3+ hours per day	25	32
Had dental visit past year	76	-
Daily tooth brushing	72	-
No trusted adult for personal problem	14	-
	=statistical significance	

CHILD HEALTH INDICATORS

Child Health Indicators are selected from Kid's Count data reported on the web.

Child Indicators: Education 2010	North Dakota	United States
Teens 16-19 not in school and not high school graduates	4%	6%
High school dropouts (Dropouts per 100 persons ages 16-24)	2.2%	7.4%
Average ACT composite score	21.5	21.1
Average expenditure per student in public school	$9,812	$11,665

Child Indicators: Economic Health 2010	North Dakota	United States
TANF Recipients Ages 0-19 (Percent of persons ages 0-19)	4.7%	4%
Percent of Eligible Persons who Participate in SNAP	76%	72%
Children living in crowded housing	6%	14%
Children living in a household that was food insecure at some point during the year	11%	22%
Median Income for Families with Children Ages 0-17 *	$61,035	$54,900
Percentage of children Ages 0-17 Living in Extreme Poverty	8%	10%

Child Indicators: Families and Health	North Dakota	United States
Children in single parent families	25%	34%
Children living with neither parent	3%	5%
Children 0-18 without health insurance	8%	10%
Children who have received preventive dental care in the past year. (2007)	77%	82%
Children who have one or more emotional, behavioral or developmental conditions. (2007)	16%	15%
Children in foster care	0.7%	0.5%
Youth residing in correctional facilities per 100,000 (2006)	355	295

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CRIME

North Dakota crime data is obtained from the North Dakota web site for the North Dakota Bureau of Criminal

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North Dakota

	2006	2007	2008	2009	2010	5 year	5-Year Rate
Murder	8	16	4	15	11	54	1.7
Rape	184	202	222	206	222	1,036	32.3
Robbery	69	68	71	102	85	395	12.3
Assualt	525	599	738	795	847	3,504	109.2
Violent crime	786	885	1,035	1,118	1,165	4,989	155.5
Burglary	2,364	2,096	2,035	2,180	1,826	10,501	327.4
Larceny	8,884	8,672	8,926	8,699	8,673	43,854	1367.2
Motor vehicle theft	966	878	854	825	763	4,286	133.6
Property crime	12,214	11,646	11,815	11,704	11,262	58,641	1828.2
Total	13,000	12,531	12,850	12,822	12,427	63,630	1983.8

United States

	2006	2007	2008	2009	2010	5 year	5-Year Rate
Murder	17,309	17,128	16,465	15,399	14,748	81,049	5.3
Rape	94,472	92,160	90,750	89,241	84,767	451,390	29.7
Robbery	449,246	447,324	443,563	408,742	367,832	2,116,707	139.2
Assualt	847,096	866,358	843,683	812,514	778,901	4,148,552	272.9
Violent crime	1,408,123	1,422,970	1,394,461	1,325,896	1,246,248	6,797,698	447.1
Burglary	2,194,993	2,190,198	2,228,887	2,023,313	2,159,878	10,797,269	710.2
Larceny	6,626,363	6,591,542	6,586,206	6,338,095	6,185,867	32,328,073	2126.4
Motor vehicle theft	1,198,245	1,100,472	959,059	795,652	737,142	4,790,570	315.1
Property crime	10,019,601	9,882,212	9,774,152	9,157,060	9,082,887	47,915,912	3151.7
Total	11,427,724	11,305,182	11,168,613	10,482,956	10,329,135	54,713,610	3598.9

INFECTIOUS DISEASES

North Dakota infectious disease data are derived primarily from case reports and laboratory reports. It does not represent all cases which occurred in the state, but only those recognized and reported. Only selected infectious agents are presented here.

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Infectious Disease Rates, North Dakota and US

		Years	North Dakota		United States
			Number	Rate/100K	Rate/100K
Vaccine Preventable	Pertussis	2,010	30	5	102
	Hib	2010	10	2	1
Sexually Transmitted	Gonorrhea	2010	204	31	112
	Chlamydia	2010	2,405	370	408
	HIV/AIDS	2010	39	6	12
Enteric (intestinal)	Salmonella	2010	59	9	18
	Shigella	2010	9	1	1
Antibiotic Resistance	Enterococcus, Vancomycin resistant	2010	328	50	NA