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

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American Indian and Alaska Native health status report

Acknowledgments

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Introduction

Federally recognized tribes are acknowledged by the U.S. government as sovereign entities by the U.S. constitution, treaties, legislation, executive orders and supreme court decisions.[1-6] This sovereign status allows tribes to engage with federal and state partners on a government-to-government basis. Utah acknowledges this unique relationship with the 8 tribal nations located within its borders in both statute and executive order.[7-9] Together the state and tribes seek to improve the health status of the American Indian and Alaska Native (AI/AN) population in Utah.

Utah is home to the following tribes (Figure 1):

- Confederated Tribes of the Goshute Reservation
- Navajo Nation
- Northwestern Band of Shoshone Nation
- Paiute Indian Tribe of Utah
- San Juan Southern Paiute
- Skull Valley Band of Goshute
- Ute Indian Tribe of the Uintah and Ouray Reservation
- Ute Mountain Ute Tribe

The terms "American Indian" and "Alaska Native" refer both to a racial and political identity.[10,11] While a person's race is self-identified, their political identity is dependent upon enrollment in 1 of the federally recognized tribes. This political status entitles a person to health services through the Indian Health Service (IHS), tribally owned and operated health facilities (often referred to as a '638 facilities' for PL 93-638 authority), and the Urban Indian Organization (UIO)—collectively referred to as the I/T/U or Indian Health System.[12]
In Utah, the **I/T/U** consists of:

I = Two federal Indian Health Service (IHS) service units
- Ute Mountain Ute service unit
- Uintah-Ouray service unit

T = Five tribally owned and operated facilities (638 facilities) in Utah
- *FourPoints Health* (Paiute Indian Tribe of Utah)
- *Nat-su Healthcare* (Skull Valley Band of Goshute)
- *NWBSN Health and Human Services* (Northwestern Band of Shoshone Nation)
- *Sacred Circle Healthcare* (Confederated Tribes of the Goshute Reservation)
- *Utah Navajo Health System* (Navajo Nation)

U = One Urban Indian Organization (UIO) located in Salt Lake City
- Urban Indian Center of Salt Lake

Introduction cont.

The Utah Indian Health Advisory Board (UIHAB) is a group of health officials appointed by their respective tribes to communicate with state officials on health and public health issues. This group primarily interfaces with Utah Department of Health and Human Services (DHHS) through the Office of American Indian/Alaska Native Health and Family Services (IHFS).

Every other year, UIHAB identifies priority topics to be worked on in the coming 2 years to help improve the health status of AI/AN in Utah. These priorities guide the work of IHFS and UIHAB. The 2022-2023 priorities are:

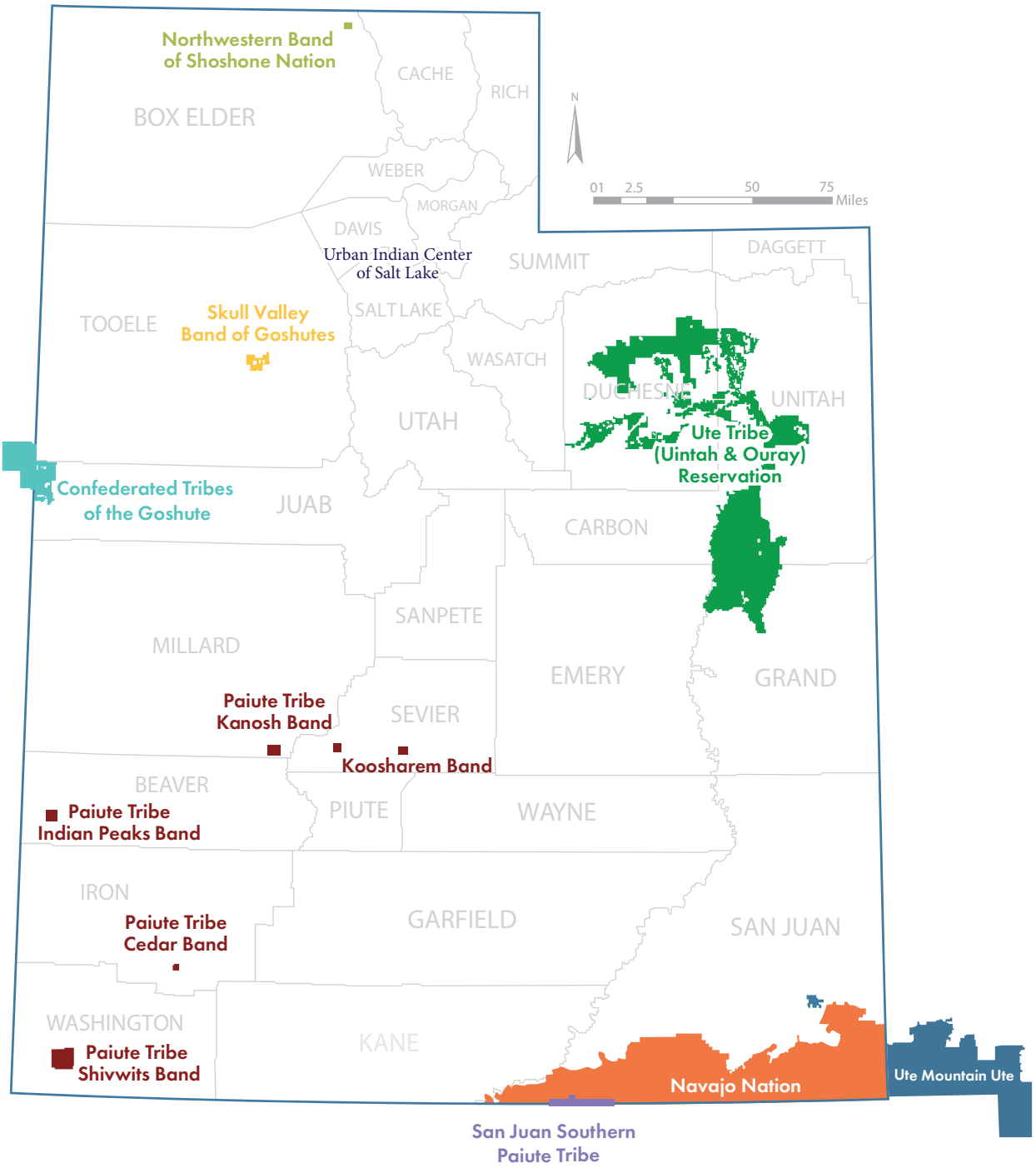
1. Quality health services
2. Mental and behavioral health
3. Diabetes and obesity
4. Data and data sharing
5. Medicaid/Medicaid expansion

Section 1 of this report provides an overview of indicators and policies that are relevant to the UIHAB priorities set in 2022 and other topics of interest. Throughout this section, we will identify disparities between the AI/AN population and the state overall. AI/AN have been subject to many systemic and structural disadvantages including poverty, poor access to resources, and historical trauma from violence, displacement, assimilation, and racism.[13] Any disparities in health outcomes or behaviors identified in this report should be viewed as outgrowths of these underlying inequities, not as inherent vulnerabilities of the AI/AN people.[13]

Additionally, every year IHFS sends out a voluntary survey to UIHAB members and tribal leadership. These surveys offer an opportunity for UIHAB and the tribes to provide feedback on the work that IHFS, DHHS, and the state of Utah do to improve the health status of AI/AN in Utah. Section 2 of this report provides a high-level overview of the survey results.

Map of Utah tribal lands

Figure 1: Utah Tribal Lands Map



Created by P. Perry; Utah Divison of Water Resources S/200
Updated by K.John; Utah Department of Health 11/2019

Data notes

This report pulled data from the Utah Indicator Based Information System for Public Health (IBIS) website, available at https://ibis.health.utah.gov/ibisph-view/, and from the Utah Department of Government Operations Technology Services quarterly reports.

This report discusses all disparities, including those that are statistically significant and non-significant. Non-significant differences are discussed for 2 primary reasons: First, the Utah AI/AN population is small, which makes it difficult for survey based methods to show a statistically significant difference from the overall Utah population. Second, non-significant statistical differences are important when recognizing areas of health disparities. Statistical significance was determined by comparing the confidence intervals provided in IBIS. Statistically significant differences are noted in text and indicated in the figures with an asterisk (*).

The AI/AN population used throughout this report includes those who identify as AI/AN alone and reported being non-hispanic, or did not report an ethnicity.

Issues regarding racial misclassification of AI/AN in death records is well documented.[16] This can result in underestimation of mortality rates.

Section 1:

American Indian/Alaska Native (AI/AN) health status

Priority 1: Quality health services

In the past 10 years, **insurance coverage has improved** in the AI/AN population, growing from 82 to 86%, however, this is consistently about 2% lower than the rest of Utah's population (table 1).

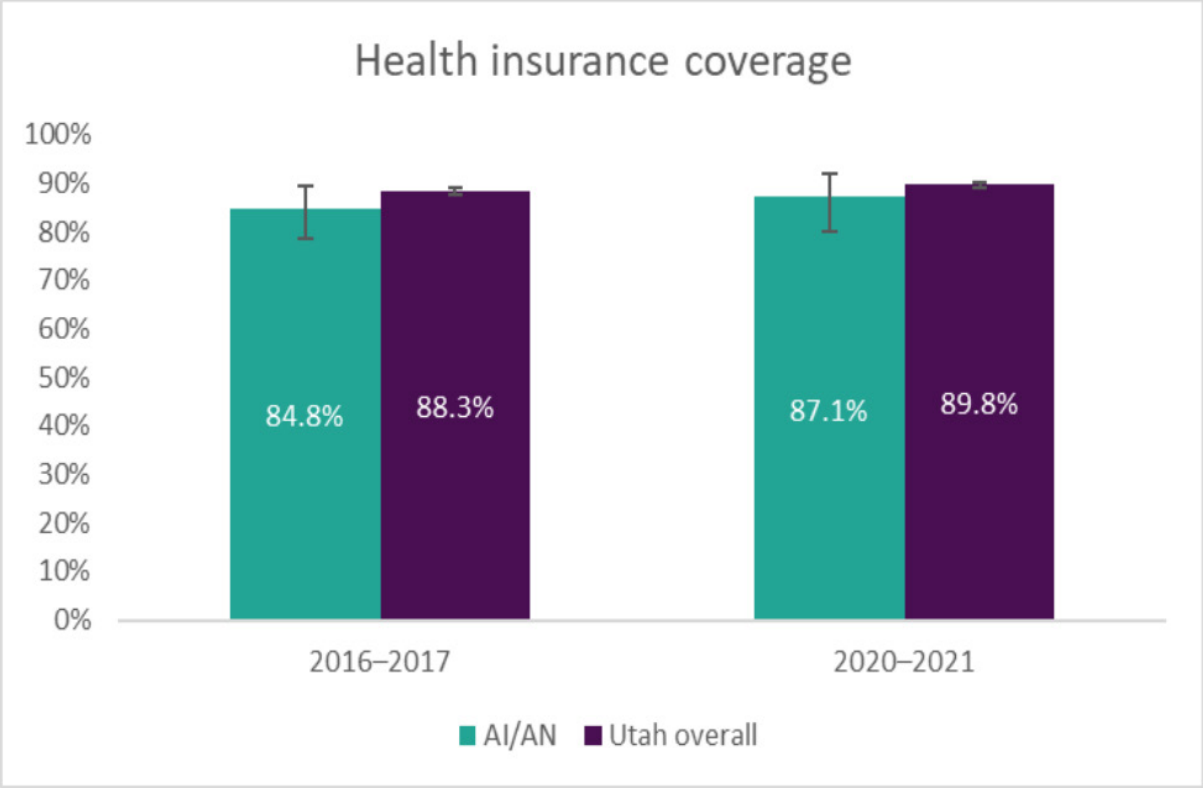
Similarly, fewer AI/AN have a personal doctor compared to the rest of Utah's population, but more do now than they did 10 years ago (table 2).

A higher percentage of AI/AN report difficulty accessing care due to cost compared to the rest of Utah, however the difference between the AI/AN population and the rest of Utah has narrowed in recent years (table 3).

Finally, despite limitations of insurance and cost, **a higher percentage of AI/AN consistently visit a medical provider** in the prior year than other Utahns. The difference between the AI/AN and Utah overall has lessened in recent years (table 4).

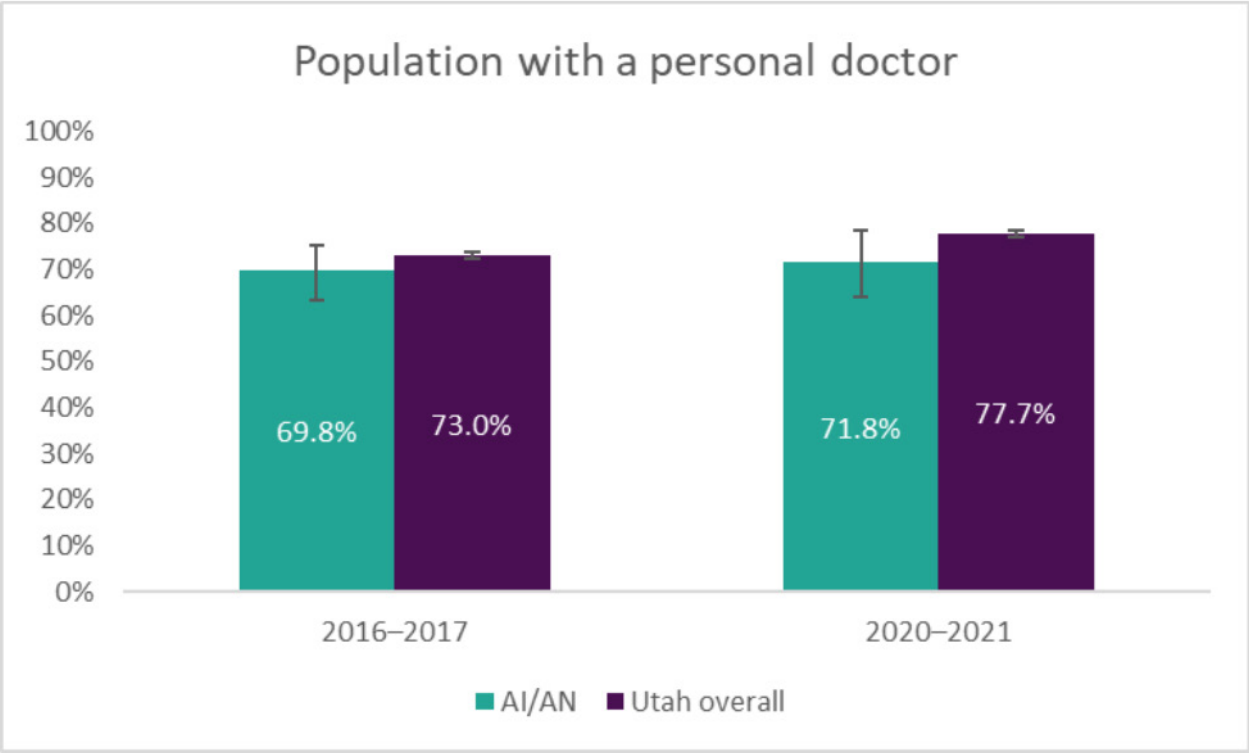
IHFS works to support this priority and links UIHAB representatives to grant opportunities, connects them with DHHS professionals, and advocates for more equitable reimbursement rates for I/T/U facilities.

Table 1: Age-adjusted percentage of population with health insurance coverage



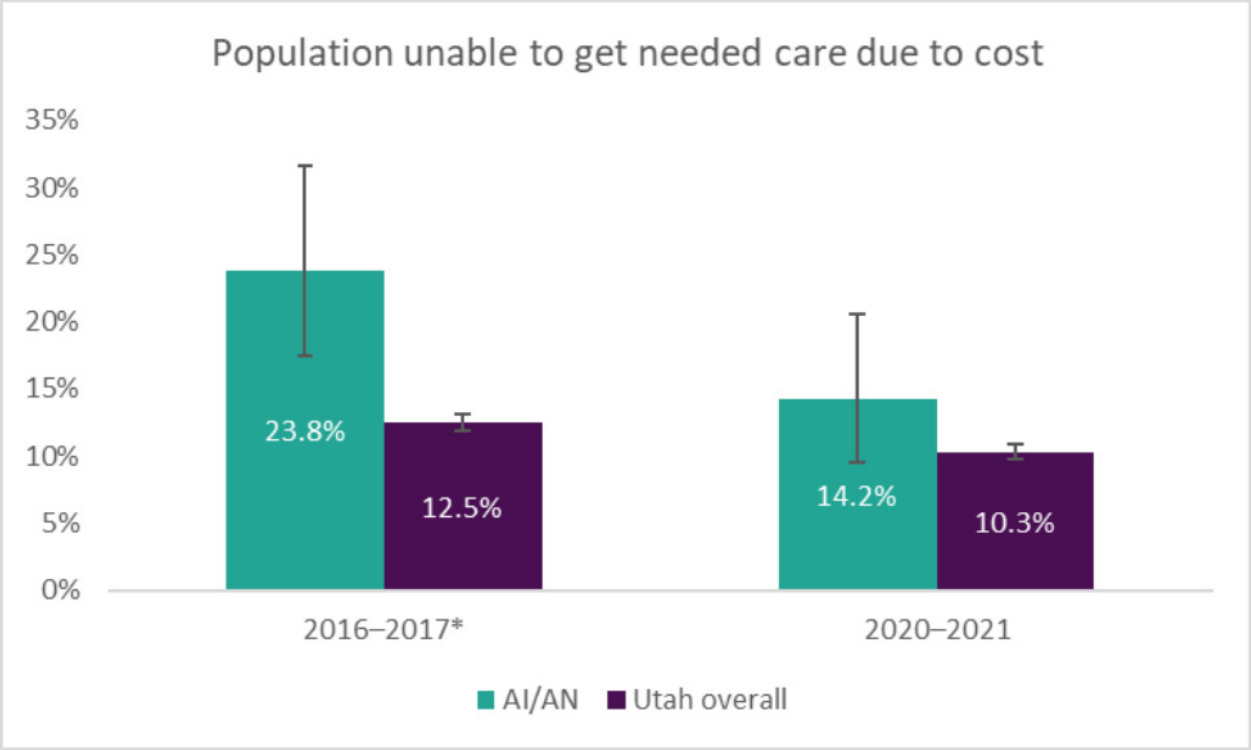
Source: Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health and Human Services.

Table 2: Age-adjusted percentage of the population with a personal doctor



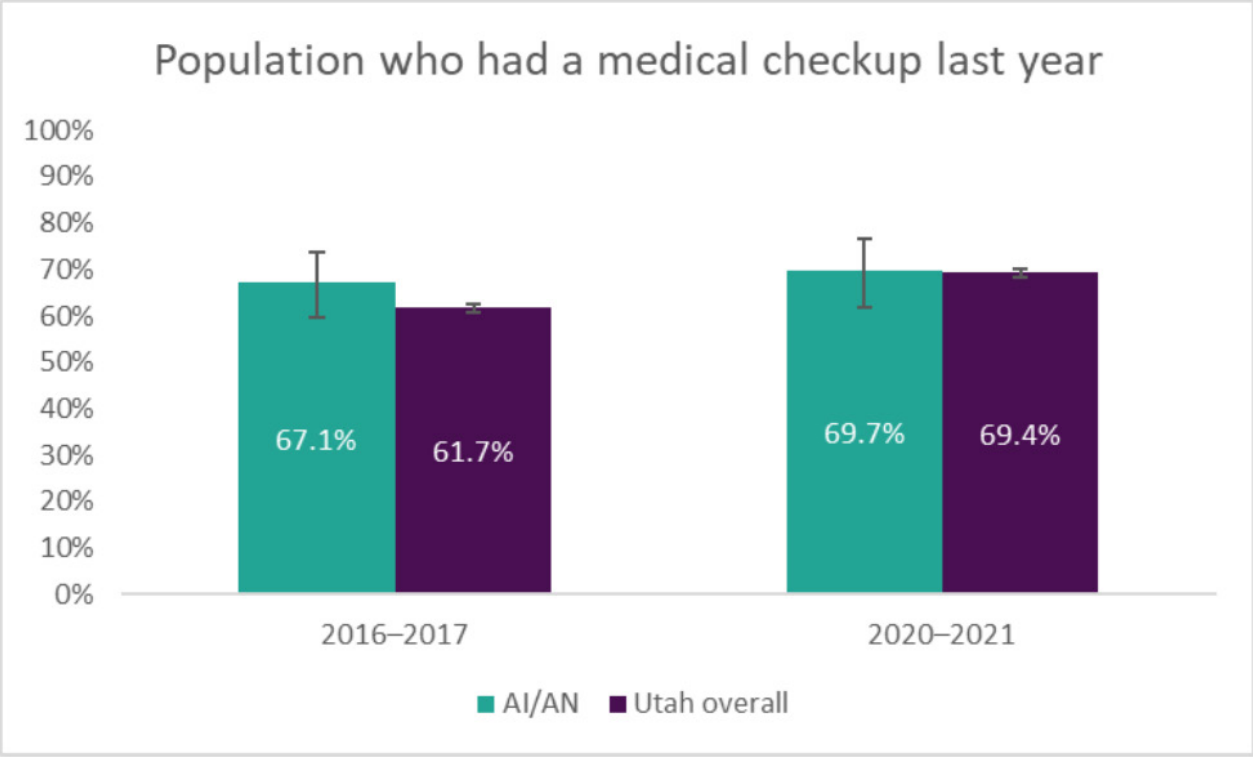
Source: Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health and Human Services.

Table 3: Age-adjusted percentage of the population unable to get needed care due to cost



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

Table 4: Age-adjusted percentage of population who had a medical checkup in the past year



Source: Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health and Human Services.

Priority 2: Mental/behavioral health

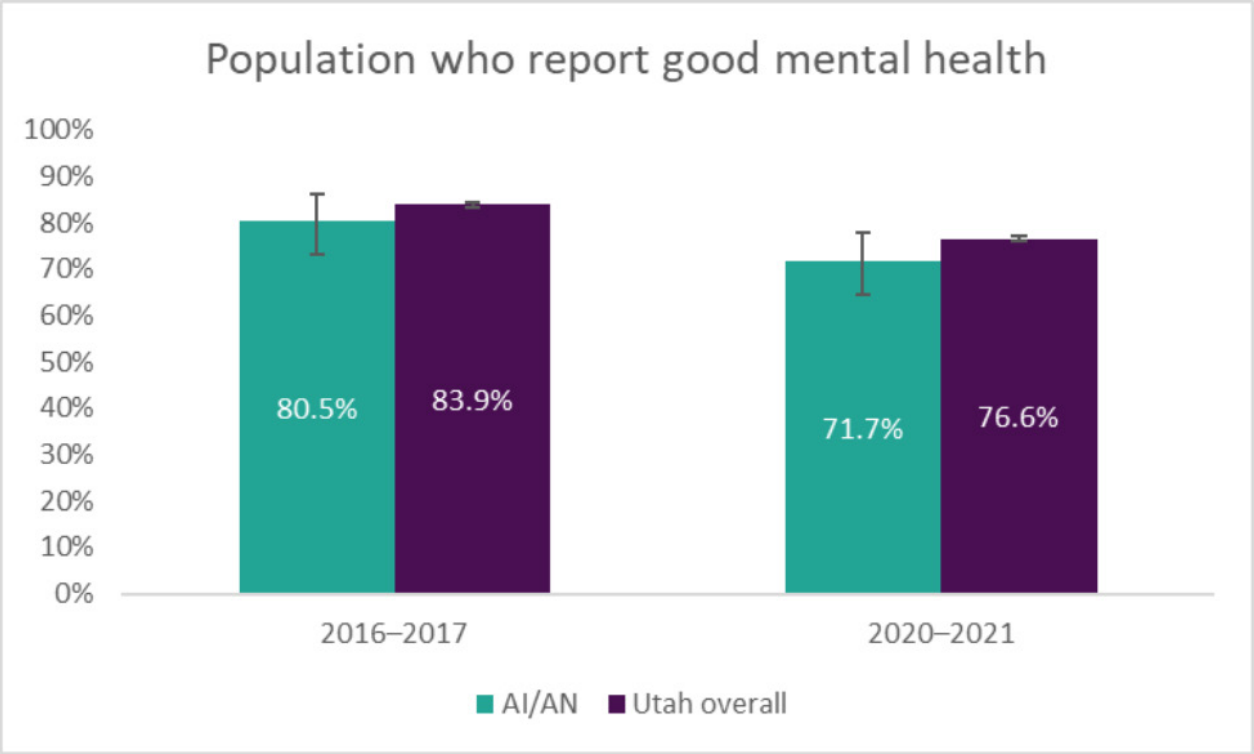
The percentage of all Utah residents who reported having good mental health decreased dramatically from 2017–2021. This drop in mental health status coincides with the onset of the COVID-19 pandemic (Table 5).

Self-reported rates of depression varied in the past 10 years, but in 2020/2021 there was no significant difference between the AI/AN population and the rest of Utah (Table 6). While there was no difference between AI/AN and the state overall, rates of depression-related emergency department (ED) visits increased since 2017 (Table 7).

AI/AN consistently have higher rates of anxiety and stress-related ED visits compared to the rest of the state but have a lower rate of bipolar-related ED visits (Tables 8,9,10). The most dramatic increase is seen in stress-related disorders which include post-traumatic stress disorder and acute stress reactions. Since 2017, **the AI/AN population has seen an 87% increase in ED visits related to stress disorders while the rest of the state increased 39%**. This may be due in part to the lack of outpatient mental health services available to AI/AN resulting in mental health crises initially presenting at the ED instead of being routed through outpatient services.

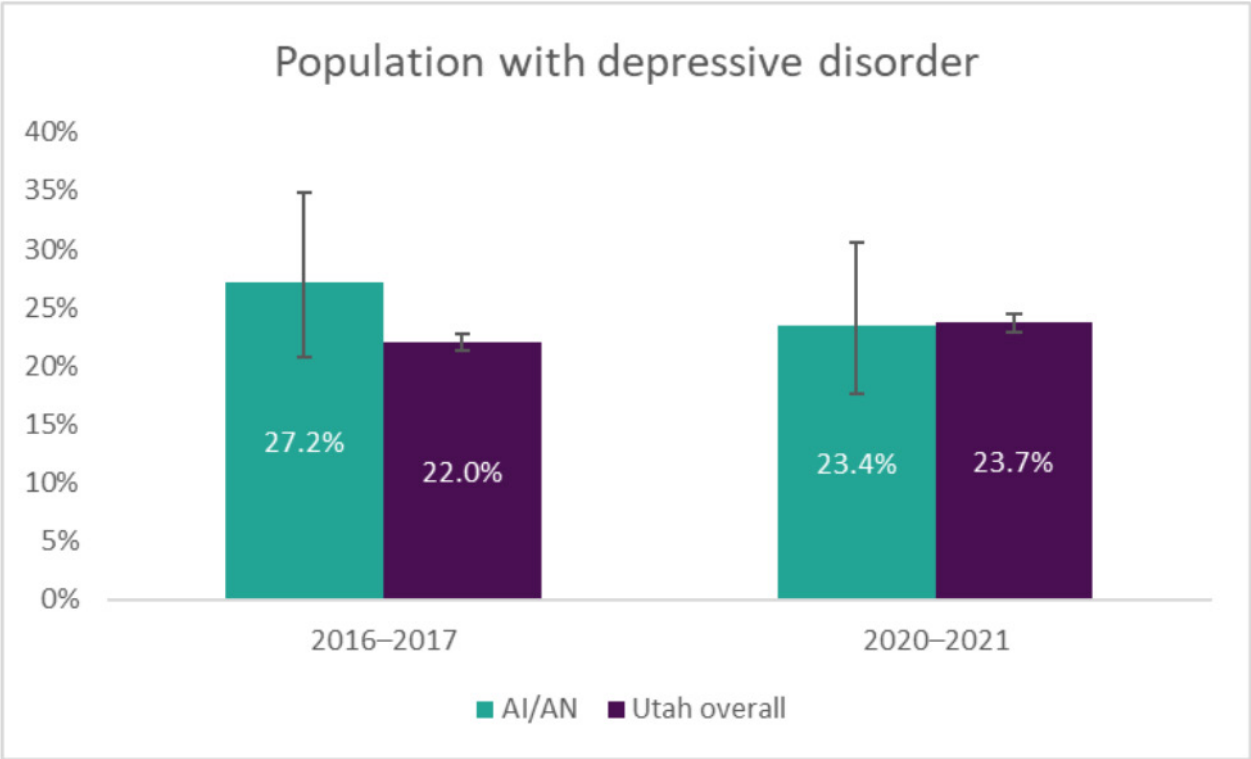
Compared with Utah overall, AI/AN have higher rates of ED visits relating to alcohol, opioid, and stimulant related abuse or dependency disorders. **In 2021, AI/AN were 5 times as likely to present at the ED with alcohol-related disorders, 2.4 times as likely for stimulant disorders, and 1.3 times as likely for opioid disorders when compared to the entire Utah population.** (Tables 11,12,13).

Table 5: Age-adjusted percentage of population who report good mental health



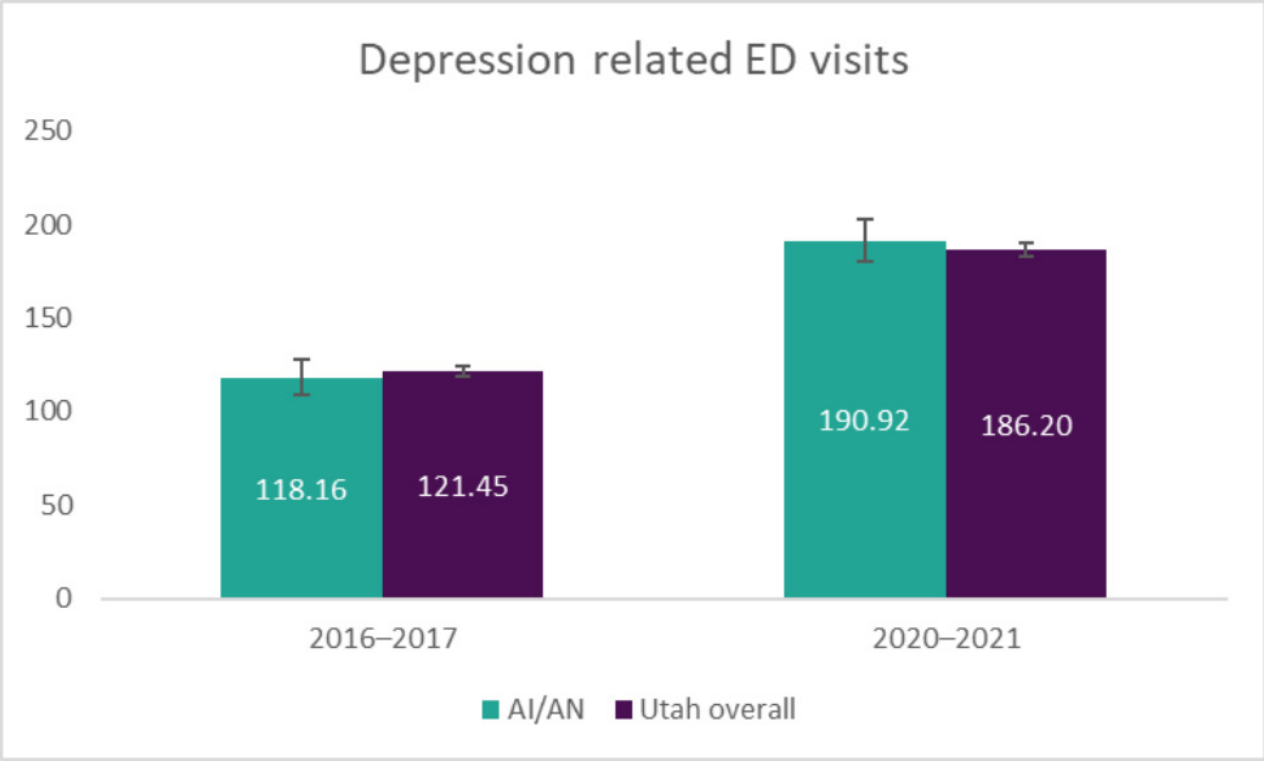
Source: Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health and Human Services.

Table 6: Age-adjusted percentage of the population told by doctor they have a depressive disorder



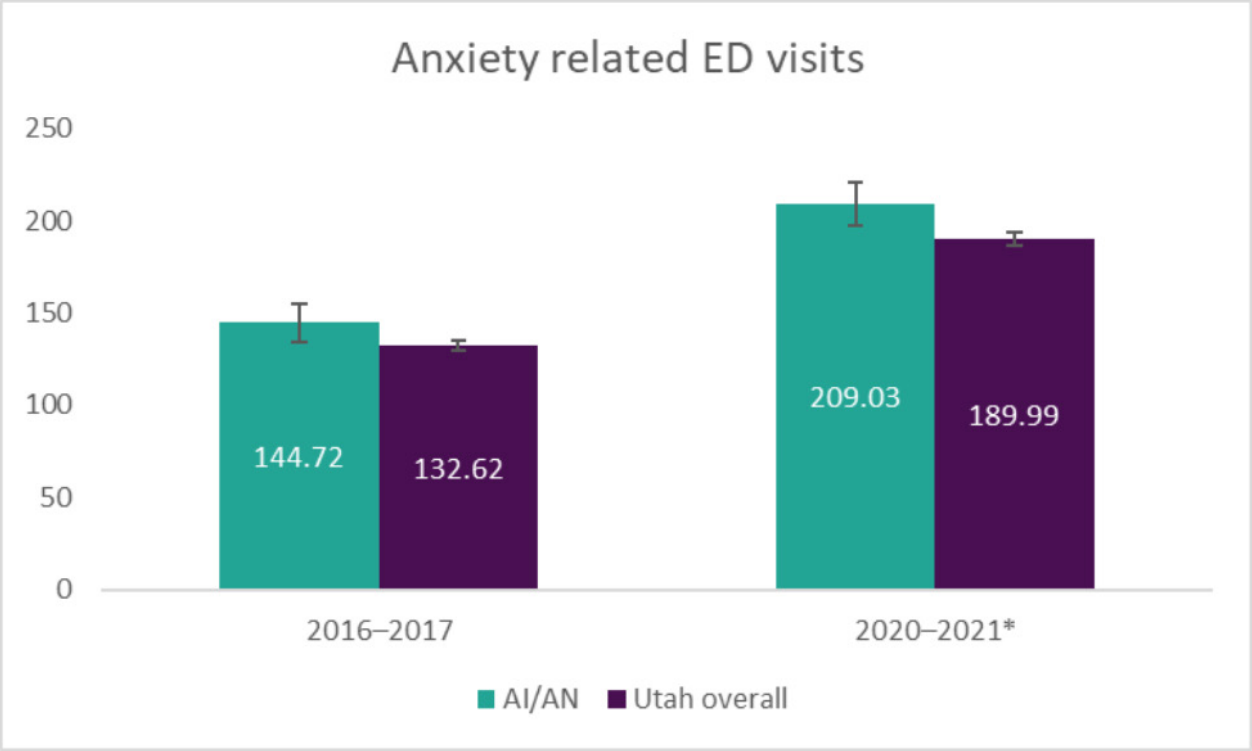
Source: Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health and Human Services.

Table 7: Age-adjusted rate of depression related emergency department (ED) visits per 10,000 population



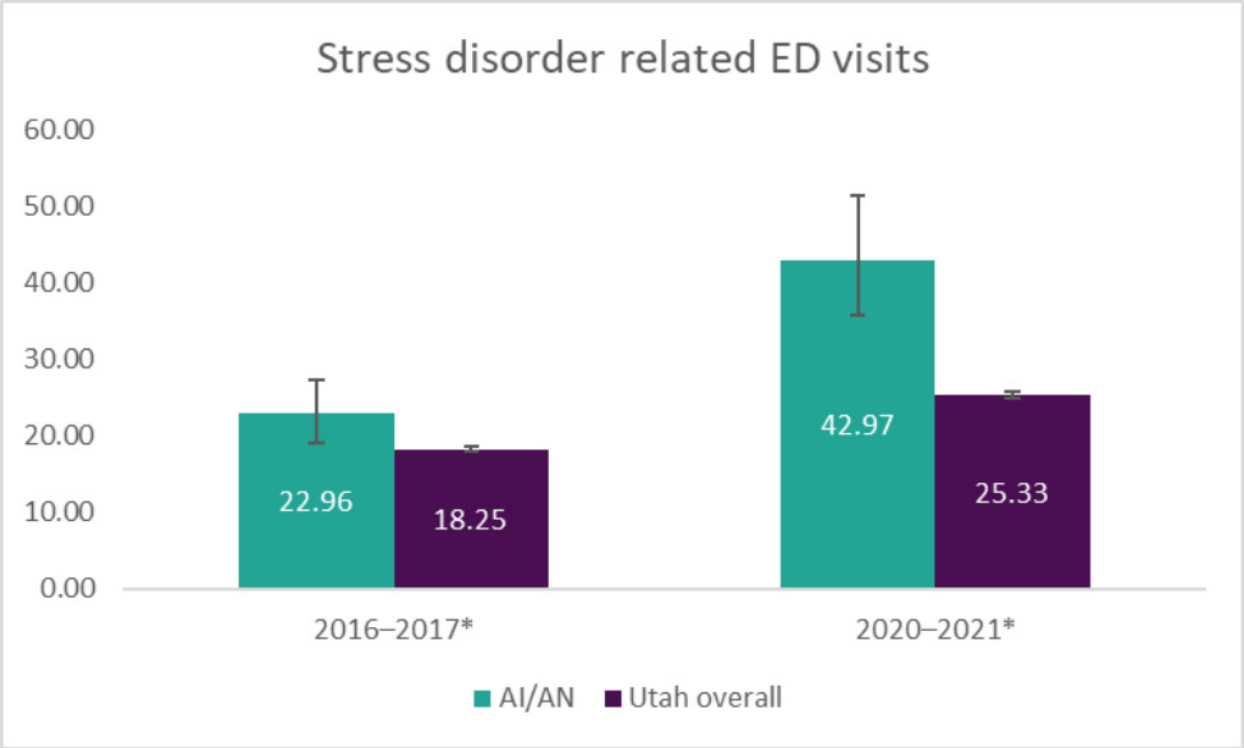
Source: Utah Emergency Department Encounter Database, NCHS population estimates.

Table 8: Age-adjusted rate of anxiety related emergency department (ED) visits per 10,000 population



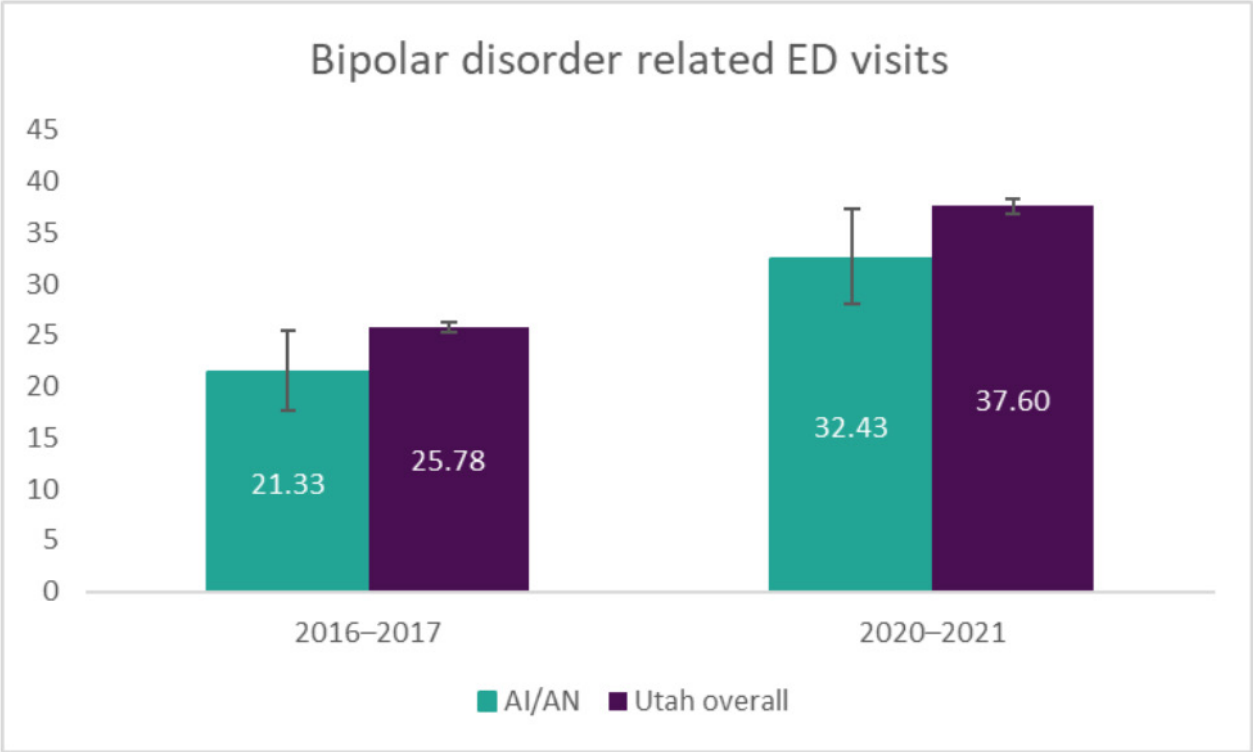
Source: Utah Emergency Department Encounter Database, NCHS population estimates.
*Statistically significant difference between AI/AN and the general population.

Table 9: Age-adjusted rate of stress disorder related emergency department (ED) visits per 10,000 population



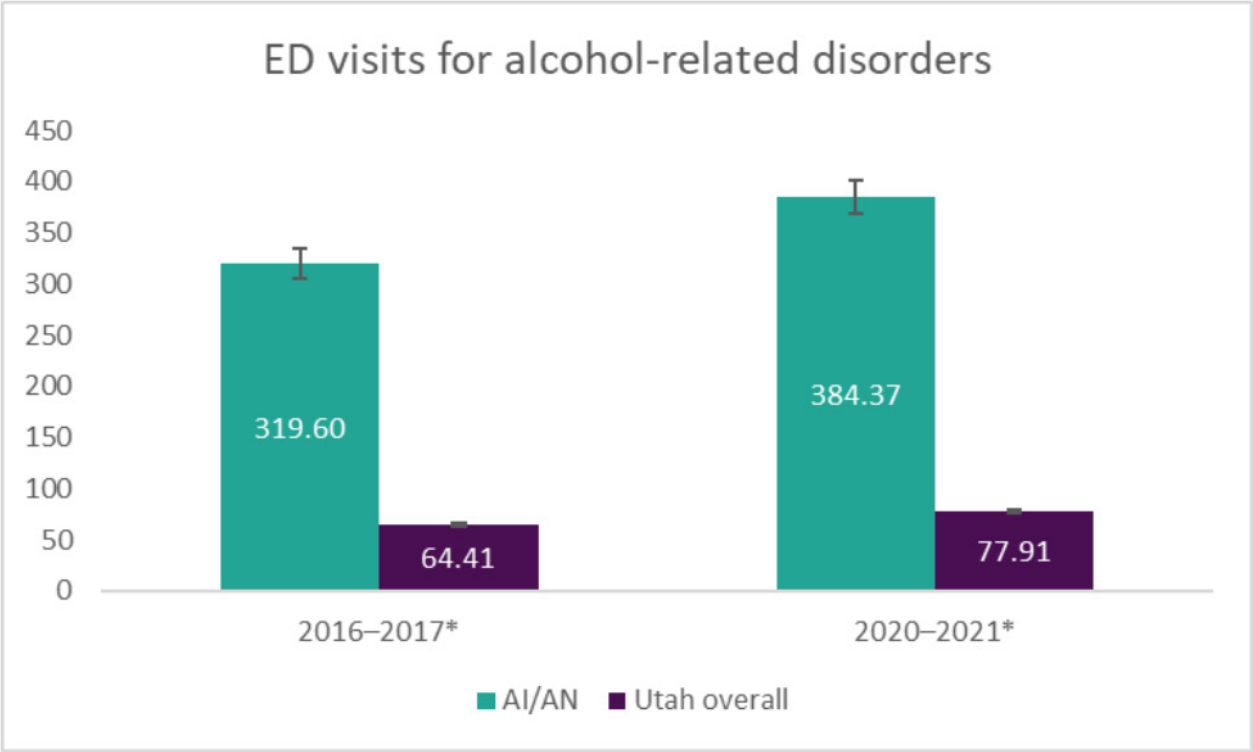
Source: Utah Emergency Department Encounter Database, NCHS population estimates.
*Statistically significant difference between AI/AN and the general population.

Table 10: Age-adjusted rate of bipolar disorder related emergency department (ED) visits per 10,000 Population



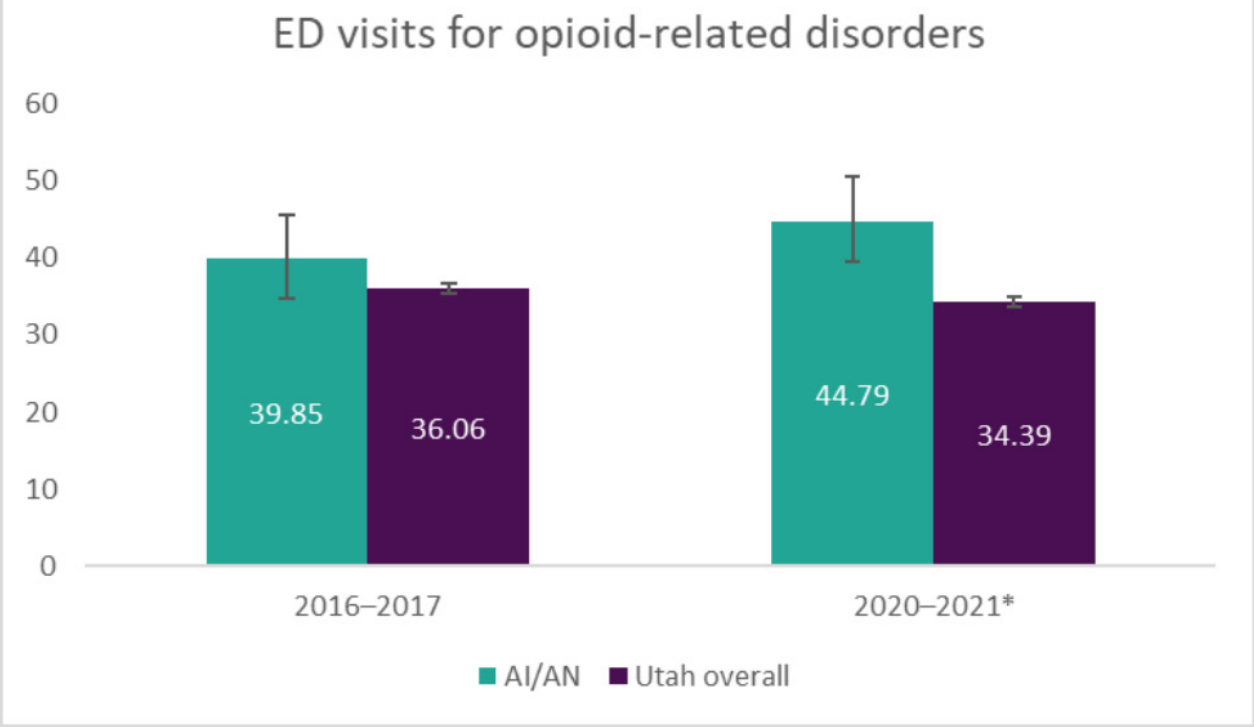
Source: Utah Emergency Department Encounter Database, NCHS population estimates.

Table 11: Age-adjusted rate of emergency department (ED) visits for alcohol-related disorders per 10,000 Population



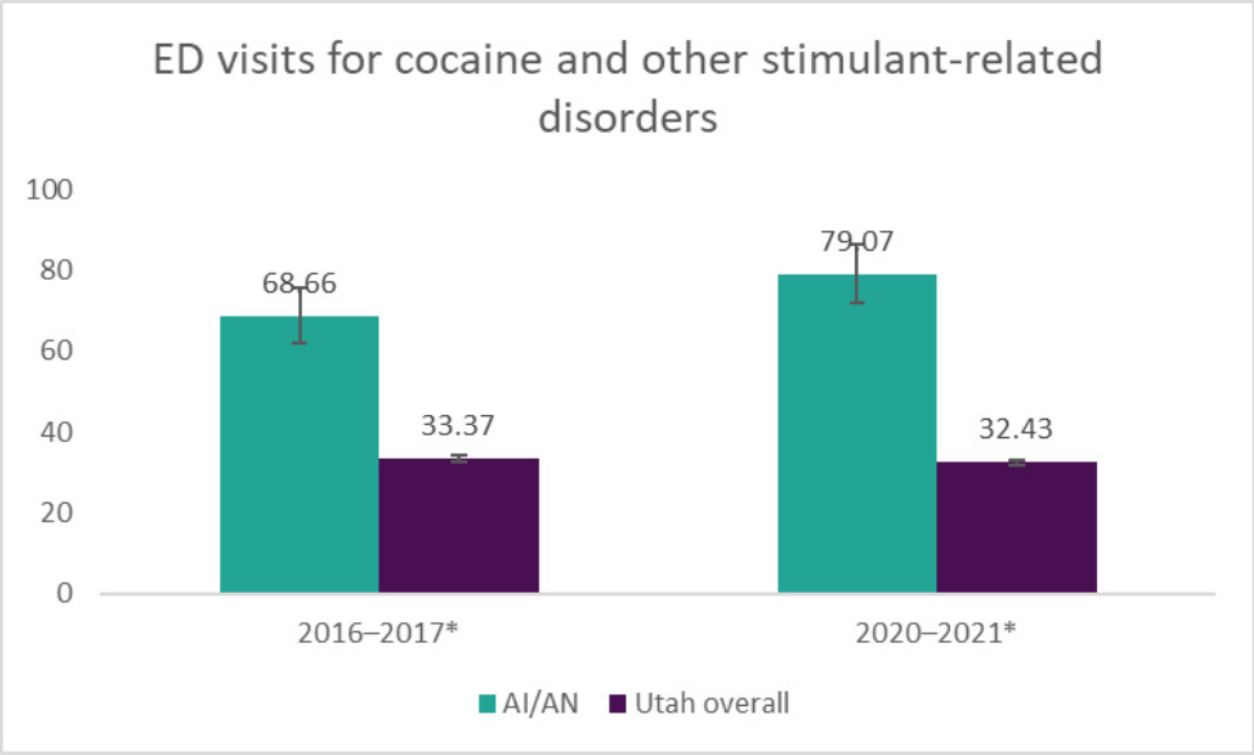
Source: Utah Emergency Department Encounter Database, NCHS population estimates.
*Statistically significant difference between AI/AN and the general population.

Table 12: Age-adjusted rate of emergency department (ED) visits for opioid-related disorders per 10,000 population



Source: Utah Emergency Department Encounter Database, NCHS population estimates.
*Statistically significant difference between AI/AN and the general population.

Table 13: Age-adjusted rate of emergency department (ED) visits for cocaine and stimulant-related disorders per 10,000 population



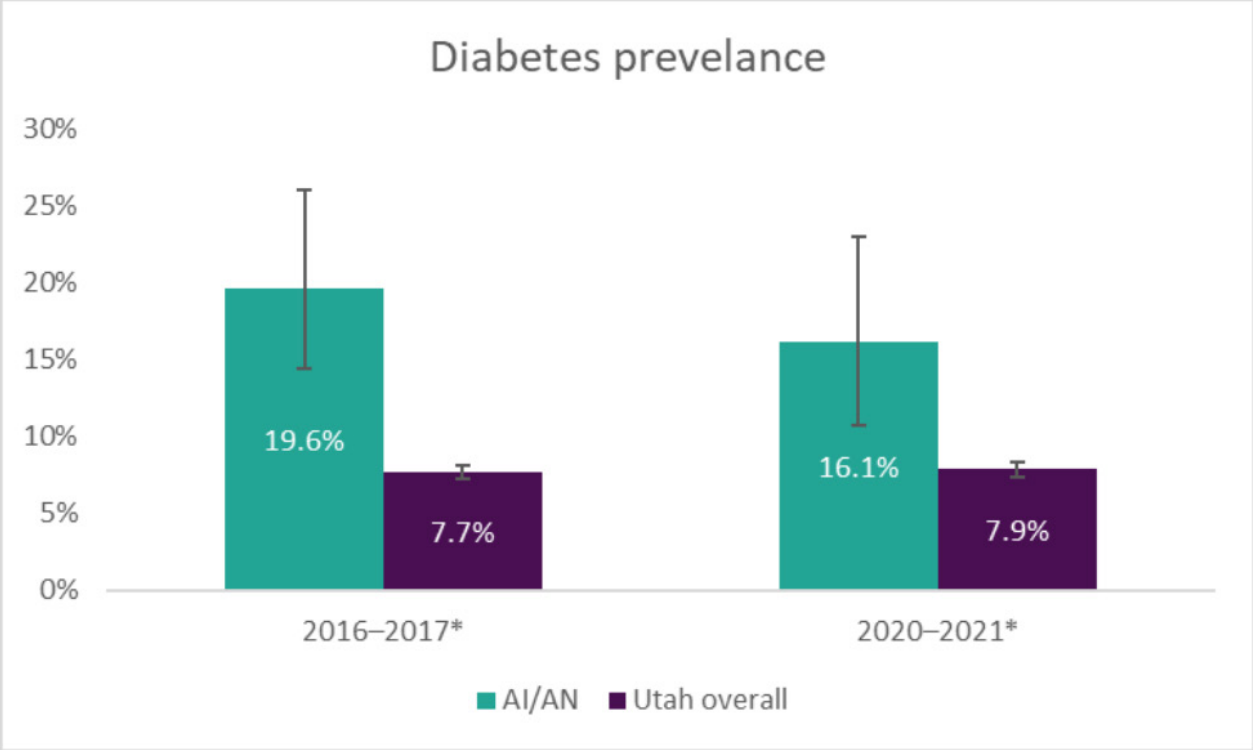
Source: Utah Emergency Department Encounter Database, NCHS population estimates.
*Statistically significant difference between AI/AN and the general population.

Priority 3: Diabetes and obesity

Compared to Utah overall, **AI/AN have more than double the prevalence of diabetes** (Table 14). This has led to higher rates of diabetes-related ED visits and mortality (Tables 15,16). AI/AN also have a higher prevalence of obesity (Table 17).

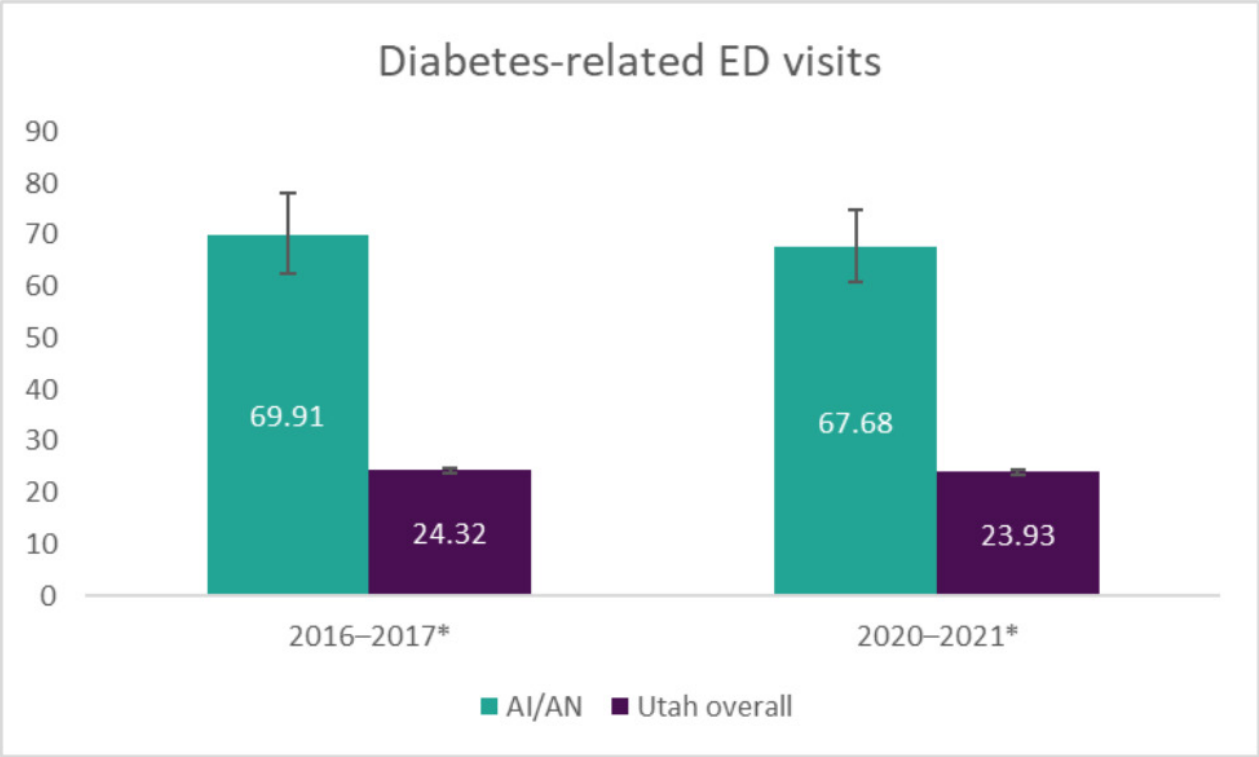
Lifestyle factors including diet and physical activity play an important role in the prevention of type 2 diabetes and obesity. More AI/AN reported they didn't engage in physical leisure activity in the past month compared to the state overall and more than 80% of AI/AN reported they didn't eat the recommended number of fruit and vegetables per day in 2021 (Tables 18,19).

Table 14: Age-adjusted percentage of population with diabetes



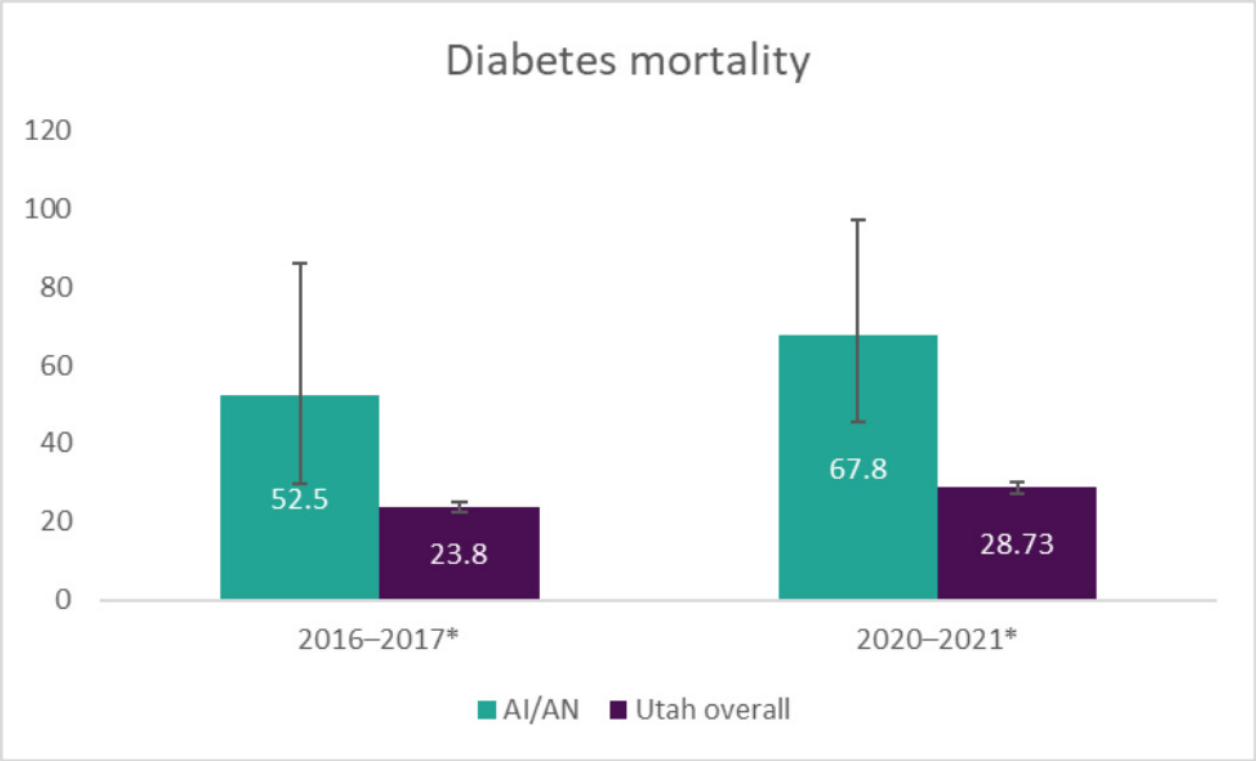
Source: Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health and Human Services. *Statistically significant difference between AI/AN and the general population.

Table 15: Age-adjusted rate of diabetes-related emergency department (ED) visits per 10,000 population



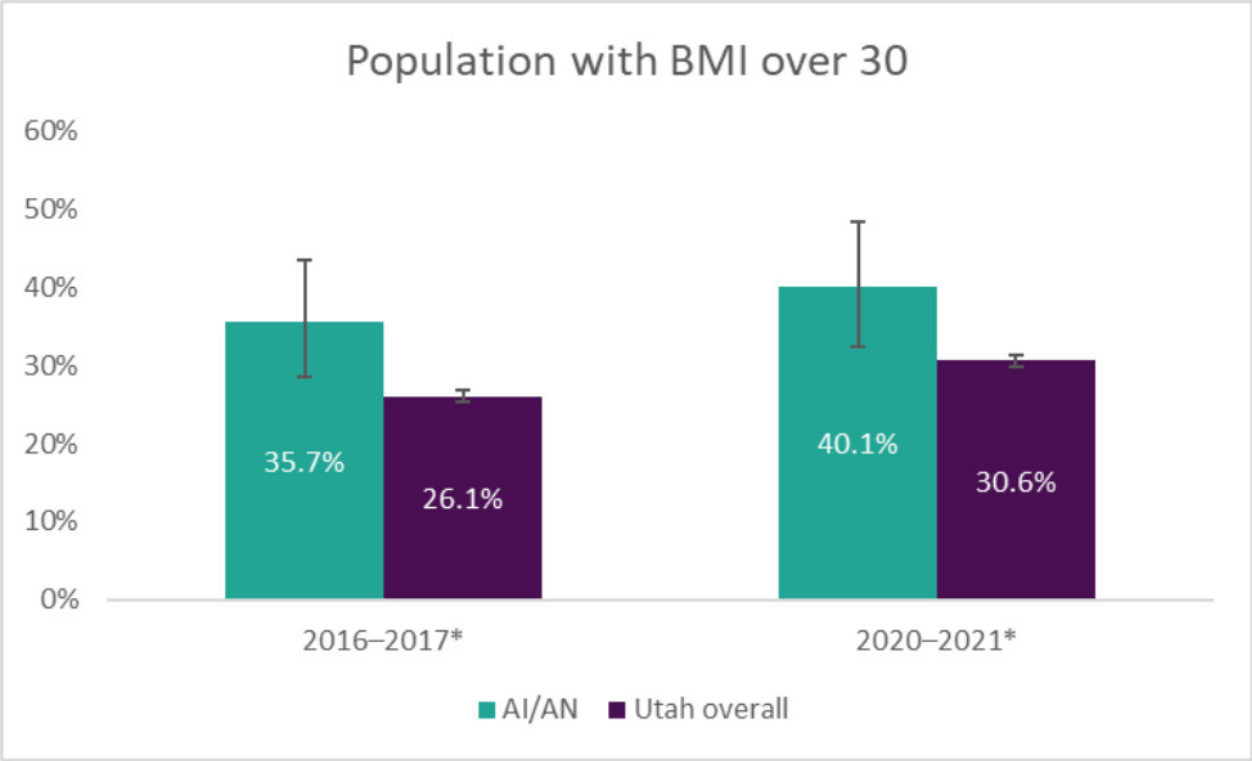
Source: Utah Emergency Department Encounter Database, NCHS population estimates.
*Statistically significant difference between AI/AN and the general population.

Table 16: Age-adjusted rate of diabetes mortality per 100,000 population



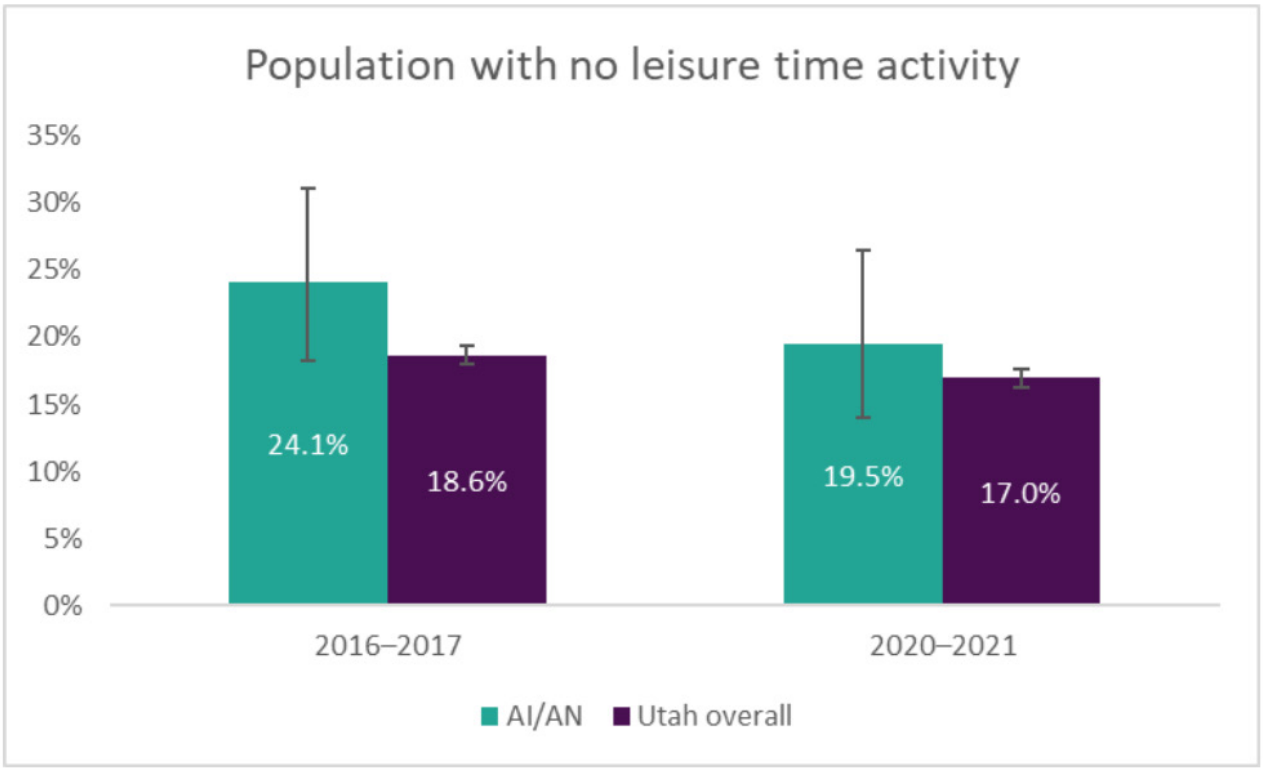
Source: Utah Death Certificate Database, U.S. Census Bureau population estimates.
*Statistically significant difference between AI/AN and the general population.

Table 17: Age-adjusted percentage of population with BMI over 30



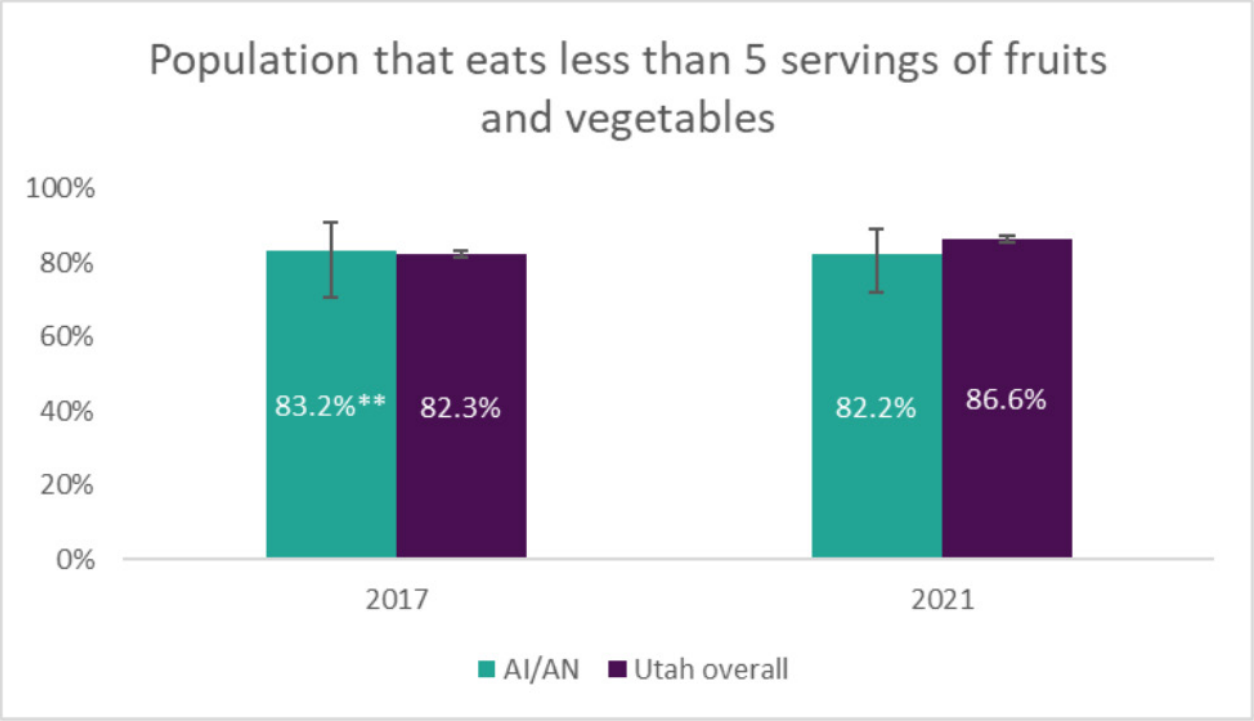
Source: Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health and Human Services.
*Statistically significant difference between AI/AN and the general population.

Table 18: Age-adjusted percentage of population who do not engage in a physical leisure time activity



Source: Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health and Human Services.

Table 19: Age-adjusted percentage of population who eat less than 5 servings of fruits and vegetables per day.



Source: Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health and Human Service.s
**Use caution in interpreting; the estimate has a coefficient of variation > 30% and is therefore deemed unreliable by Utah Department of Health and Human Services standards.

Priority 4: Data/data sharing

In an effort to improve the data sharing processes in place between the tribes and the state of Utah, IHFS worked with the I/T/U facilities to review existing Memorandums of Agreement (MOAs). **Currently the state of Utah has MOAs with most I/T/U facilities** which gives them access to the state infectious disease system EpiTrax.

Throughout the COVID-19 pandemic, IHFS held weekly meetings with I/T/U officials to communicate up-to-date data and policy regarding COVID-19. As the state ramped down its response to COVID-19, the frequency of this meeting was changed to once a month and the scope was expanded to provide an overview of the entire infectious disease landscape in Utah. This meeting is an important piece of IHFS' data sharing strategy and allows collaboration between DHHS departments, tribes, tribal epidemiology centers (TECs), and I/T/U facilities.

At the federal level, a report from the Government Accountability Office found that TECs were often unable to access needed data despite their status as public health authorities.[14] The report made several suggestions to improve the ability of TECs and tribes to get better access to federal data. The implementation of these recommendations has resulted in the creation of a CDC website for tribes and TECs to request data directly from the federal government.[15]

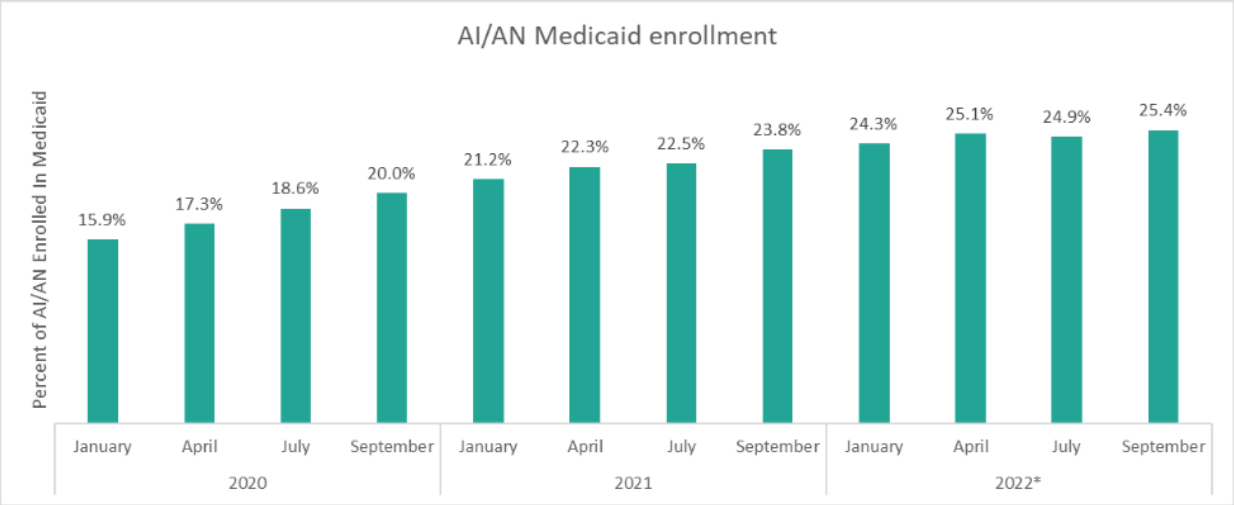
Priority 5: Medicaid/Medicaid expansion

IHFS holds monthly meetings with UIHAB as part of the formal consultation process between the state and the tribes. Each month, time is set aside for Utah Medicaid to present proposed changes and receive feedback from tribal representatives.

Since January 2020, the AI/AN population in Utah has seen an approximate 60% increase in Medicaid enrollment. As of September 2022, approximately a quarter of Utah's AI/AN population were enrolled in Medicaid (Table 20). **The continued increase in AI/AN Medicaid enrollment over the past 3 years can be explained, in part, by the COVID-19 public health emergency** when Medicaid cases were held open and the work of I/T/U facilities to help qualified patients enroll in Medicaid.

With such a large number of AI/AN enrolled in Medicaid, UIHAB representatives have raised concerns that the enrollment process is often difficult to navigate and traditional practices are not listed as billable services.

Table 20: AI/AN Medicaid enrollment, 2020–2023

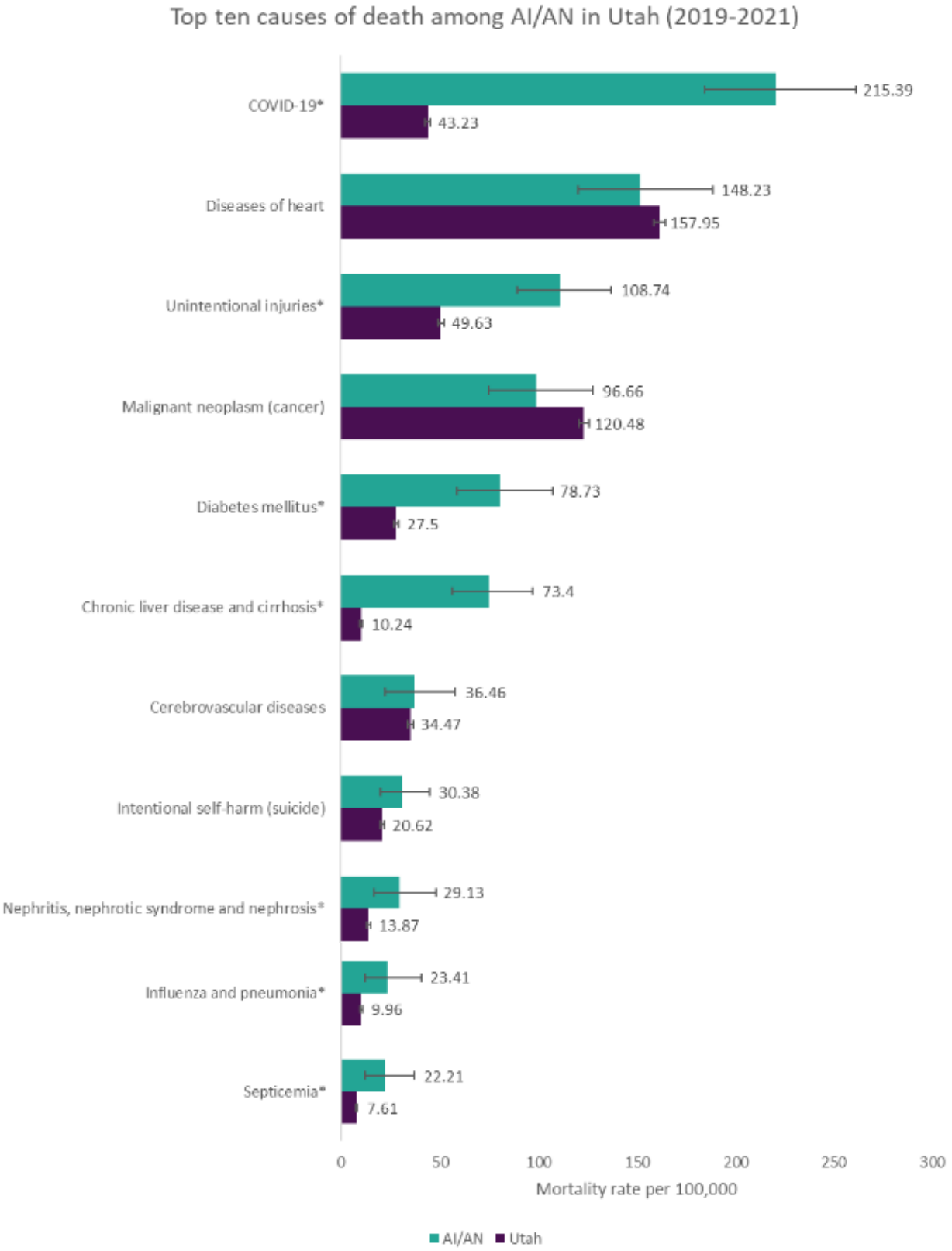


Source: Utah Medicaid, U.S. Census Bureau population estimates.
*2022 population estimates have not been released, 2022 percentages were calculated using the 2021 AI/AN population.

Top causes of death and emergency department (ED) visits

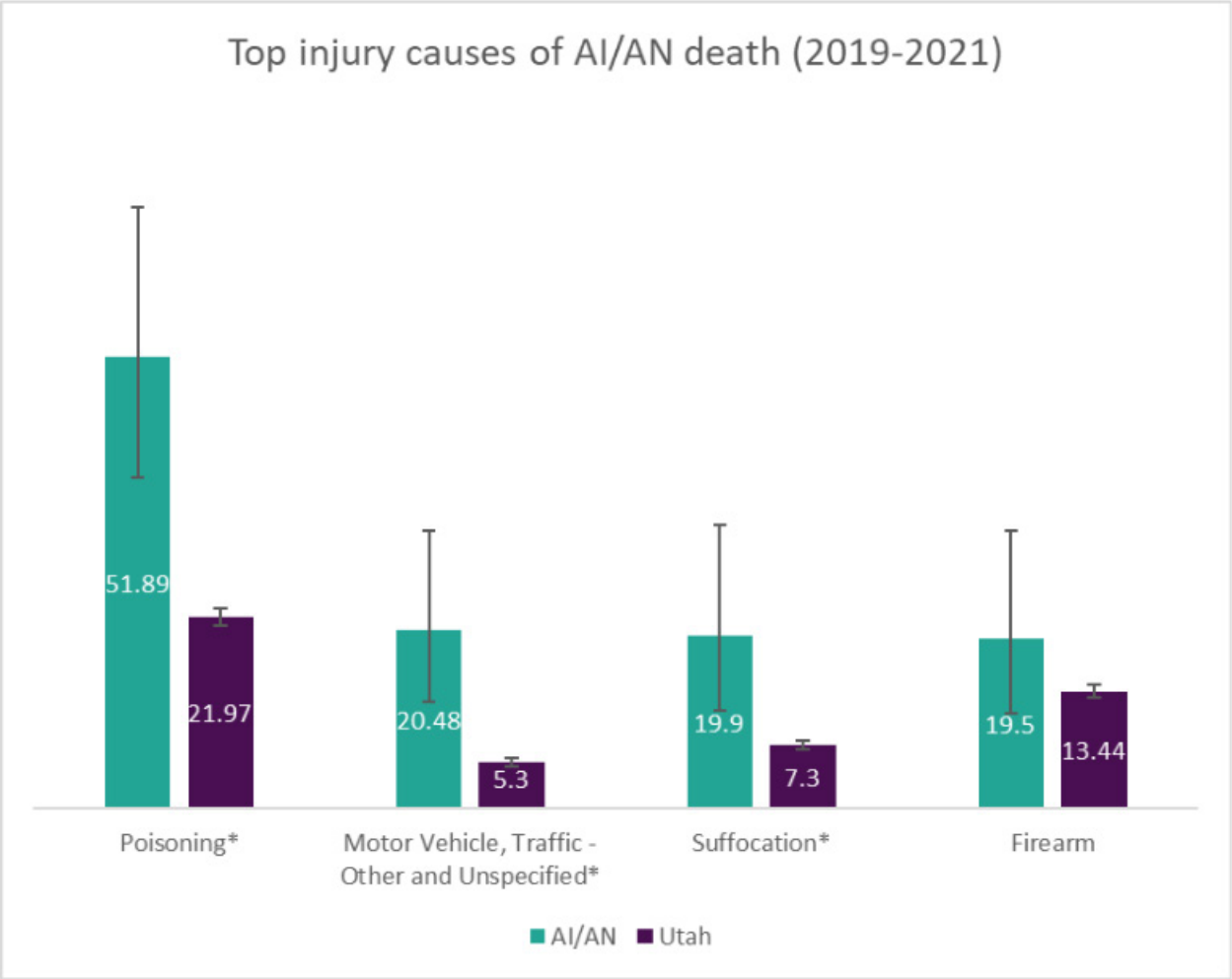
Significant disparities in morbidity and mortality exist between the AI/AN population and the rest of Utah. Between 2019 to 2021, **AI/AN were 7 times more likely to die from liver disease, 5 times more likely to die from COVID-19, 3 times more likely to die from diabetes, 2 times more likely to die from unintentional injuries** (including poisonings, traffic accidents, and firearm-related deaths) than the average Utahn (Tables 21,22). Similar disparities can be seen in ED visits with AI/AN seeing higher rates of influenza and pneumonia, falls, diabetes, bronchitis, lower respiratory diseases, and other injury causes (Table 23, 24).

Table 21: Age-adjusted mortality rate for top 10 causes of death among AI/AN per 100,000 population



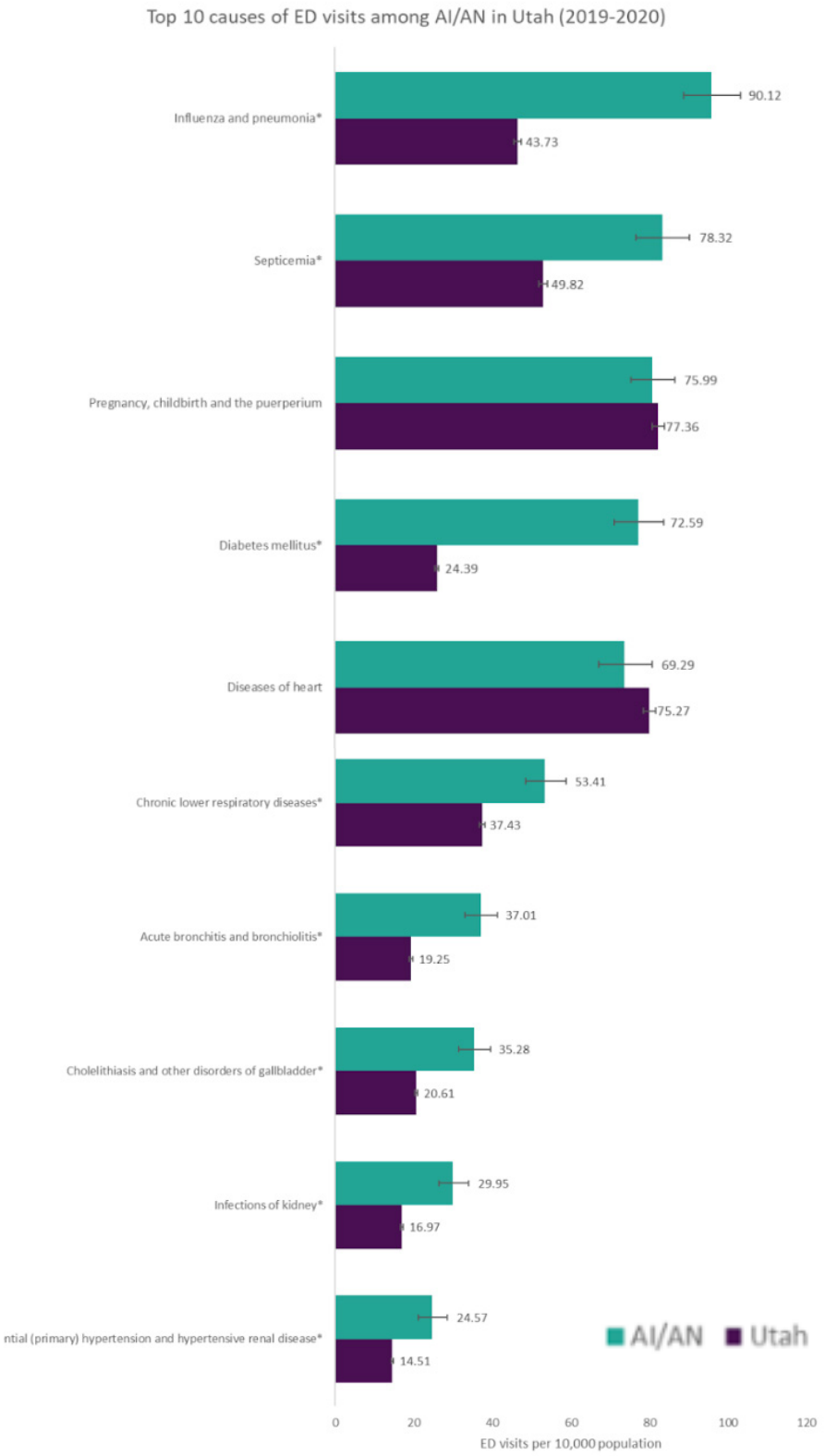
Source: Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health and Human Services. *Statistically significant difference between AI/AN and the general population.

Table 22: Age-adjusted mortality rates for top causes of injury-related deaths among AI/AN per 100,000 population



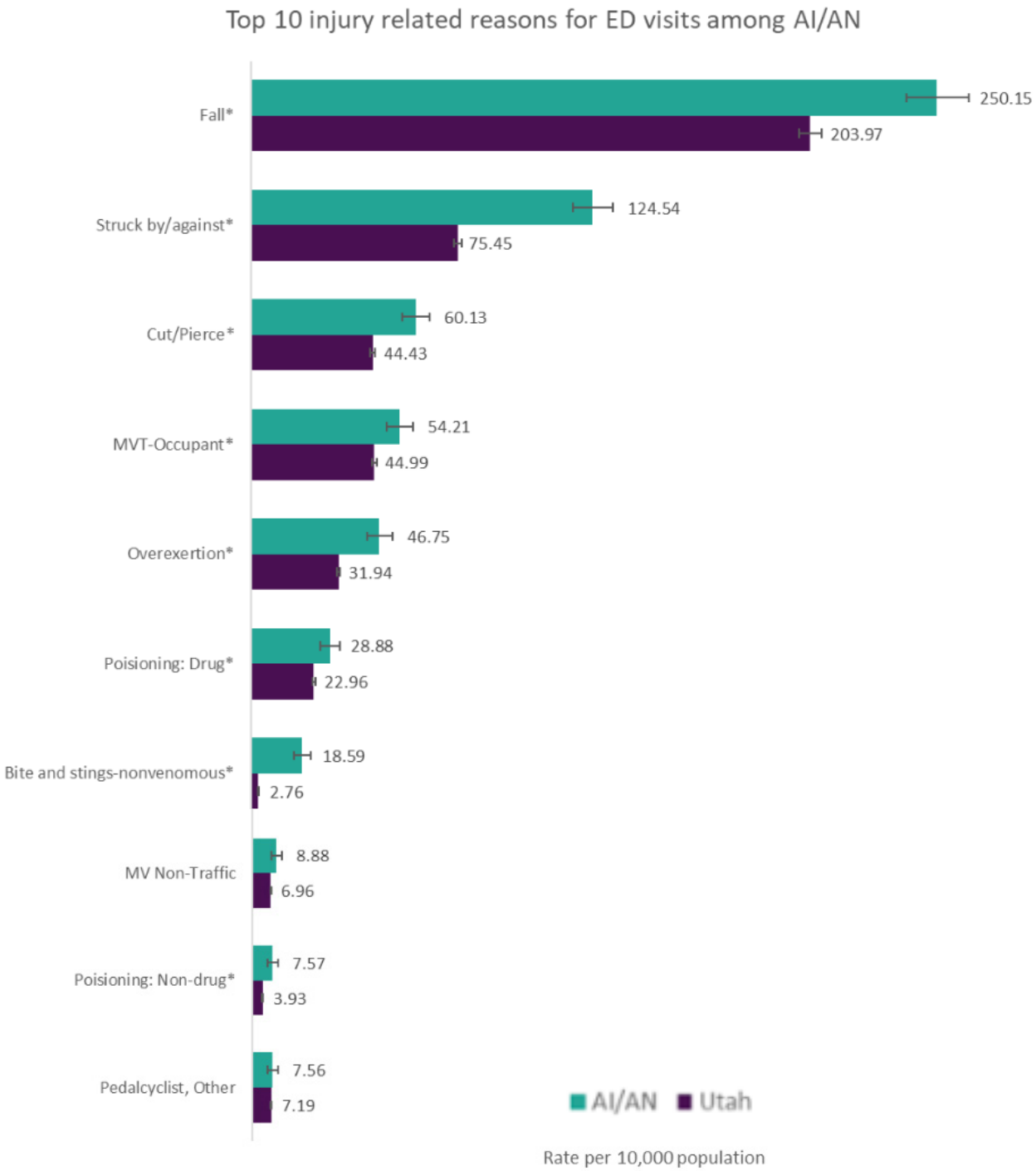
Source: Utah Death Certificate Database, U.S. Census Bureau population estimates.
*Statistically significant difference between AI/AN and the general population.

Table 23: Age-adjusted rates of non-injury related emergency department (ED) visits among AI/AN per 10,000 population



Source: Utah Emergency Department Encounter Database, NCHS population estimates.
*Statistically significant difference between AI/AN and the general population.

Table 24: Age-adjusted rates of injury-related emergency department (ED) visits among AI/AN per 10,000 population

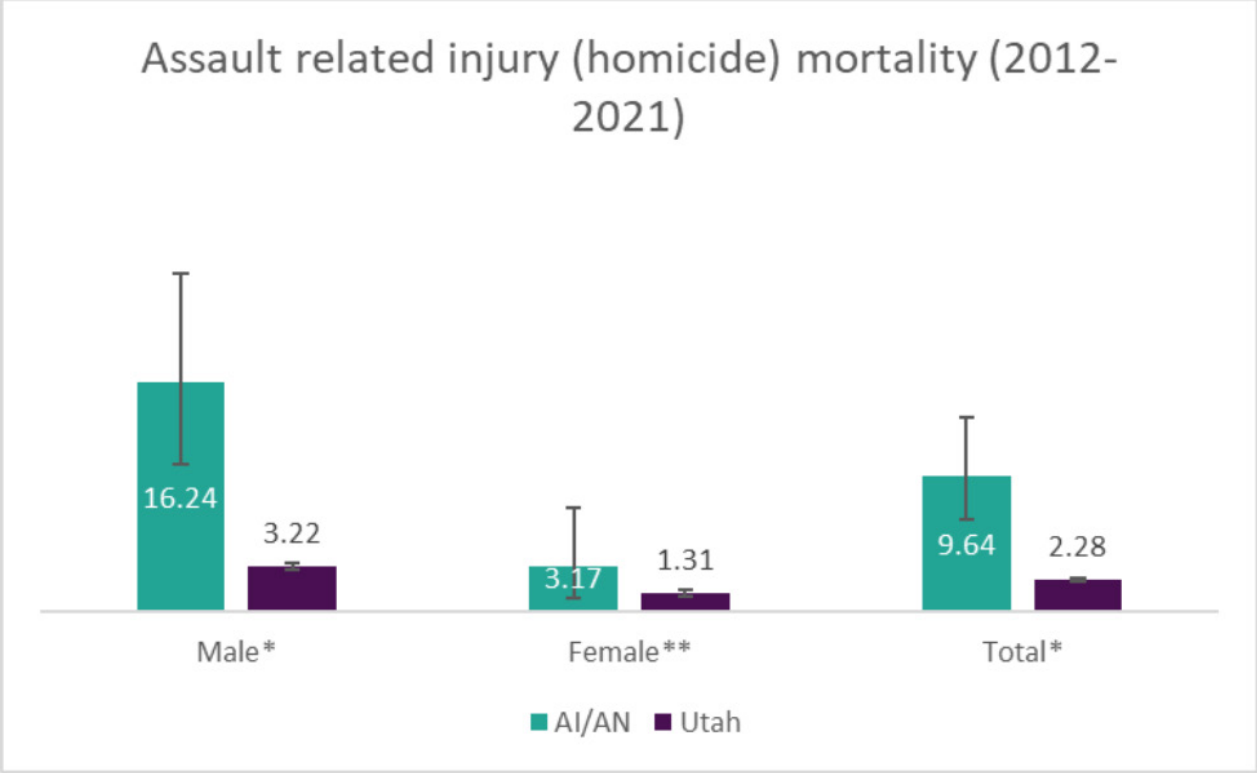


Source: Utah Emergency Department Encounter Database, NCHS population estimates.
*Statistically significant difference between AI/AN and the general population.

Violence and homicide

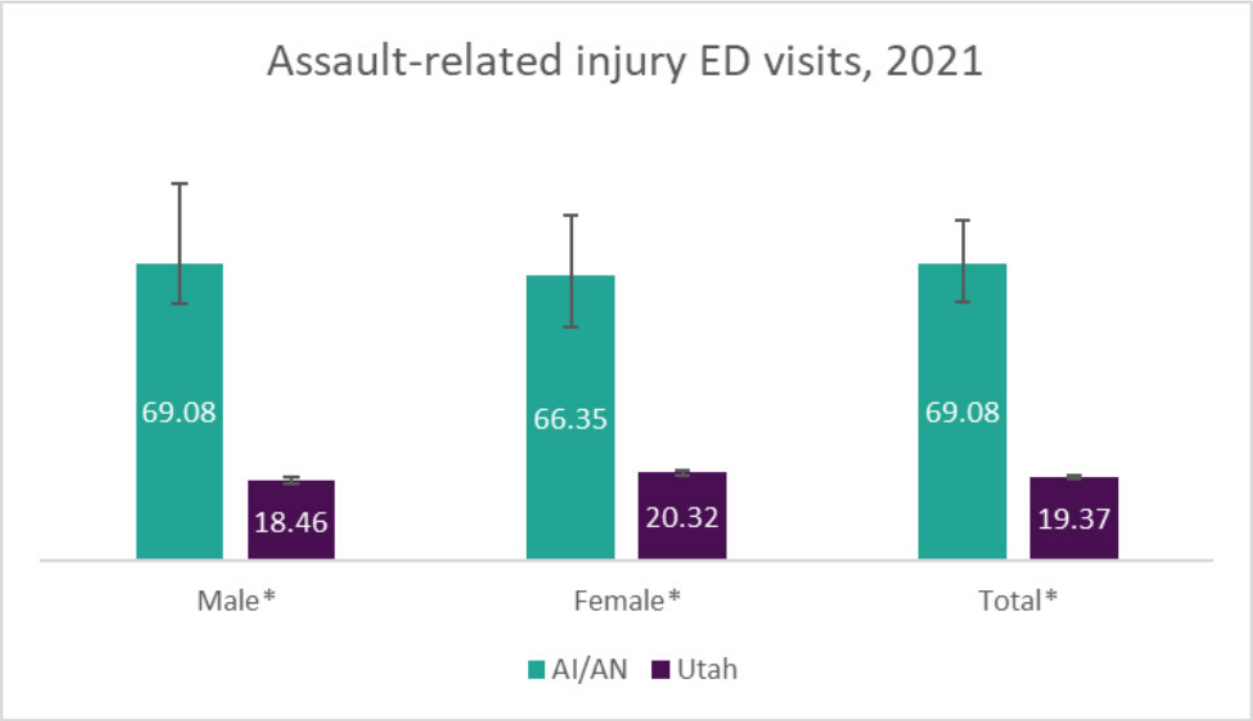
From 2012–2021, **AI/AN were about 4 times as likely to die from homicide than the average Utahn**. Both male and female AI/AN are more likely to die from homicide (Table 25). This disparity is also seen in ED visits where **violence-related injuries are seen at a higher rate for AI/AN regardless of gender** (Table 26).

Table 25: Age-adjusted rates of homicide mortality among AI/AN per 100,000 population, 2012-2021



Source: Utah Death Certificate Database, U.S. Census Bureau population estimates.
*Statistically significant difference between AI/AN and the general population.
**Use caution in interpreting; the estimate has a coefficient of variation > 30% and is therefore deemed unreliable by Utah Department of Health and Human Services standards.

Table 26: Age-adjusted rates of assault-related emergency department (ED) visits among AI/AN per 10,000 Population, 2021



Source: Utah Emergency Department Encounter Database, NCHS population estimates.
*Statistically significant difference between AI/AN and the general population.

Section 2:

Office of American Indian/Alaska Native Health and Family Services (IHFS) survey results

Priority 1: Quality health services

The UIHAB is a small group of health officials appointed by their respective tribes or the Urban Indian Center of Salt Lake. **They serve as the first point of contact for tribal consultation between the state of Utah and the tribes on health-related issues.** The UIHAB primarily interfaces with the Utah Department of Health and Human Services (DHHS) through the Office of American Indian/Alaska Native Health and Family Services (IHFS).

IHFS sent a survey to UIHAB members in December 2022 to assess their views on the work done by IHFS, the state, and IHFS's local partners. Eleven UIHAB members who represented the Urban Indian Center and 7 tribal jurisdictions responded to the survey.

When asked about the work done by IHFS, the survey responses provided the following information:

- **63%** of the respondents agreed that IHFS is responsive to their needs.
- **72%** of the respondents agreed that IHFS respected tribal sovereignty and shared data effectively.
- **81%** of the respondents agreed that IHFS was effective in communicating policy-relevant health policy.
- 1 respondent disagreed with each statement on the survey.
- Overall, these results indicate that IHFS works effectively with UIHAB to support the Utah tribes.

When asked about the collaboration between the UIHAB and local health departments (LHDs), the survey responses provided the following information:

- **55%** of respondents agreed the LHDs are effective partners and that LHDs treat the tribal jurisdictions as equals.
- 45% either disagreed or were neutral about this topic.

When asked about state leadership, the survey responses provided the following information:

- **64%** of survey respondents indicated they believed state leadership respected tribal sovereignty.
- **27%** of survey respondents indicated they felt state leadership does not understand tribal health concerns.

Tribal leadership survey

Each year, IHFS sends Utah tribal leaders a survey. In 2023, only 5 of the 8 tribes responded for a total of 6 completed surveys. The lack of survey responses from the tribes severely limits the interpretation of the 2023 survey results. The survey responses provided the following information:

- **50%** of respondents disagreed with statements regarding the effectiveness of IHFS' efforts to provide up-to-date information on ICWA, consult with tribes in a timely manner, share data, and communicate policy.
- **17%** (1 response) felt that county leadership respected tribal sovereignty.
- **67%** of respondents indicated they disagreed with or were neutral about statements regarding the effectiveness of the efforts undertaken by state leadership to engage in consultation, support ICWA, and understand tribal health issues.

One possible contributor to the poor response rate and the number of respondents who had negative views about IHFS, county leadership, and state leadership is the time period when the survey was sent out. **The survey was sent out during the 2023 legislative session, during which the Indian Child Welfare Act (ICWA) draft bill was not passed**. Regardless, survey results indicate that respectful and timely communication with tribal leadership is needed.

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