NOVEMBER 2018

COMMUNITY HEALTH PROFILE

Individual Site Report | Indianapolis Service Area

Urban Indian Health Institute
A Division of the Seattle Indian Health Board

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The report contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

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The Urban Indian Health Institute would like to thank the staff at the urban Indian health and social service organizations nationwide for the excellent work they do daily on behalf of their communities.

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The mission of UIHI is to decolonize data, for indigenous people, by indigenous people.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Urban Indian Health Institute (UIHI) analyzes data from the American Community Survey and the National Vital Statistics System to estimate proportions for 33 health indicators. With this data, UIHI creates Community Health Profiles for service areas throughout the United States.

This Community Health Profile contains sociodemographic, mortality, and maternal and child health data on American Indians and Alaska Natives (AI/ANs) that has been aggregated over a five-year period from the Indianapolis service area, which includes Marion County. The sociodemographic data as well as the mortality data are from 2010-2014, and the maternal and child health data are from 2008-2012.

The county data shows that urban Indians living in the Indianapolis service area frequently experience higher proportions of poverty and disparities in education and food security when compared to their Non-Hispanic White (NHW) counterparts. As this profile may show, there is still work to be done from local, state, and federal entities to collect quality, accurate data. Urban Indian Health Programs should work closely with their local and state health jurisdictions to access the most current data and, where possible, urge better tracking of demographics to inform care.

KEY FINDINGS:

Compared to NHW, urban AI/AN in these counties are:

- **Approximately 74% less likely to have a bachelor's degree or higher,**
- **Twice as likely to have no health insurance, and**
- **One and a half times more likely to participate in food assistance programs**

INDIANAPOLIS SERVICE AREA

INTRODUCTION

The health needs of America's urban Indian population present unique challenges. Across the U.S., an examination of the health outcomes of urban Indians show disproportionately high incidence of disease, co-morbidity, and mortality, particularly for urban Indian mothers. This is significant because, of the 5.2 million Americans who identify as American Indian/Alaska Native (AI/AN), 71% live in urban areas. To meet their health needs, numerous health and social service programs are providing culturally appropriate and holistic care. Many offer services that are grounded in indigenous knowledge and bring Western and traditional medicine together.

As Urban Indian Health Programs and Native health organizations strive to provide the highest-quality care to urban Indians, relevant data are needed. Since 2000, UIHI has created Community Health Profiles for 35 cities where urban Indian people reside, and, in 2018, nine cities were added. This individual Community Health Profile details the data for the Indianapolis service area, which includes Marion County.

What is an urban Indian?

Urban Indians are tribal members who are currently living outside of federally-defined tribal lands in U.S. cities.[1] For many AI/AN communities, systemic issues such as racism, poverty, and poor education have given rise to health disparities.[2, 3] For urban Indians in particular, government policies that forced relocation in the 1950s and termination policies that forced assimilation into non-Native culture, have had long-term health effects.[2] Today, AI/ANs come to the city for educational, employment or housing opportunities, and health-care needs, resulting in an indigenous urban population that is diverse and inter-tribal.

71% of American Indians and Alaska Natives live in urban areas

SERVING THE HEALTH NEEDS OF URBAN INDIANS

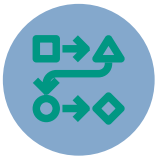
Programs across the United States are providing holistic health care to urban Indians, including private, non-profit corporations receiving partial funding from the Indian Health Service as well as social- and faith-based organizations. UIHI defines the service areas of these programs as Urban Indian Health service areas and are illustrated below in Map 1.

Map 1. Urban Indian Health Service Areas

HOW TO USE THIS REPORT

Improving community health through effective planning and decision making requires good information about the factors that influence the health status of community members.[2] While limited in scope and restricted to available and usable data, this report provides valuable information for service providers serving an urban Indian population with unique needs and greater risk factors. The information provided here is intended to supplement other local data available to your organization.

Program Planning



Data in this report can be used by urban Indian organizations to identify health priorities, allocate resources, and guide the development of innovative programs.

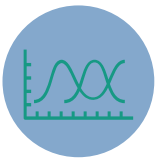
Funding

Data and figures help tell the story of existing health disparities in the AI/AN population compared to NHWs. This report may be useful to include as information for grant applications and other funding opportunities. It can also be cited as a reference.

Identifying Gaps in Data

This report may reveal the need to close current gaps in nationally-collected data. Providers may want to consider pushing their jurisdictions to link other relevant data to help correctly classify AI/ANs in state death records.[4, 5] Another way to improve data collection is by oversampling AI/ANs in national surveys, which provides sufficient statistical power to allow for more stable estimates.

Research



Data in this report can be used to generate additional hypotheses for future studies, evaluations, or assessments.

METHODS AND DATA

This report includes information from residents of Marion County as well as data from the 2010 U.S. Census, American Community Survey, and National Vital Statistics System. There are limitations to this data particularly due to variations in how race is defined and collected.

Analysis

A list of indicators for the community health profile were selected after an analysis of the available data sources. For each indicator, prevalence or incidence was calculated for the AI/AN population and compared with the NHW population. Since NHWs are the racial/ethnic majority, this population was chosen as the comparison group. The AI/AN population was defined as AI/AN only, and in combination with other races, unless otherwise indicated. The NHW population was defined as White only and excluded the Hispanic population unless otherwise indicated. Results were calculated using aggregated data over a five-year period which added stability to estimates and protected individual privacy.

In some instances, confidence intervals—ranges of numbers used to assess the accuracy of a point estimate and measure the variability in data—were calculated and used to show differences in outcomes for specific indicators. The point estimate may be a rate, such as a death rate, or a frequency, such as a percent of individuals living in poverty. Confidence intervals account for the uncertainty that arises from the natural variation inherent in the world around us.

Confidence intervals also account for the difference between a sample from a population and the population itself. For analyses included in this report, confidence intervals were calculated at a p-value of <0.05, which is a 95 percent confidence level. This means that 95 times out of 100 the confidence interval captures the true value for the population. Differences in outcomes were called statistically significant if confidence intervals of the study group (AI/AN) did not overlap with the comparison group (NHW). Data analysis for indicators were analyzed using the statistical software SAS version 9.4.

Data Limitations

Although data analysis and assessment of results were conducted for 33 indicators, data limitations were found. In some instances, the number of cases or sample size was limited, data collection excluded AI/AN in combination, or there was possible racial misclassification of AI/ AN. These limitations impact the analysis and prevent or limit the reporting of results.

Frequently, data were only available for AI/ANs alone and not inclusive of AI/ANs who also identify with another race or ethnicity. Therefore, the estimates provided in this report may be an underestimation of the true value of the outcome or risk factor for any indicator analyzed.

Racial misclassification, particularly for mortality data, can greatly underestimate the true rate of disease, risk factor, or outcome. AI/ANs are especially likely to experience problems of incorrect racial classification on death certificates. Therefore, true mortality rates among AI/ANs are assumed to be higher than reported.[5, 6]

DATA SOURCES

2010 U.S. Census

The U.S. Census takes place every 10 years and provides official population counts for individuals living in the United States. It also presents information on age, race, Hispanic origin, and sex. In 2010, the U.S. Census allowed individuals to self-report belonging to more than one racial group.

When determining a population count, this report considers people to be AI/AN if they report AI/AN as their only race or if they report being AI/AN in combination with other races. Some Census statistics are not easily accessible when including individuals who report multiple races, so, for these indicators, only individuals who report AI/AN alone are included.

For more information about the U.S. Census, visit: www.census.gov.

American Community Survey

The American Community Survey (ACS) is a nationwide, continuous survey that collects demographic, housing, social, and economic data every year. To provide reliable estimates for small counties, neighborhoods, and population groups, the ACS provides 1-, 3-, and 5-year aggregate estimates. Estimates for this report are from aggregated data from 2010-2014.

Race is self-reported in ACS, with similar race categories as the U.S. Census. However, some ACS data are not easily accessible for multiple racial groups. Therefore, ACS data are reported for AI/AN alone in this report. ACS estimates in this profile are not adjusted for age. Observed differences in estimates may be due to a true difference in rates or due to differences in age distribution in the population.

For more information about the ACS, visit: www.census.gov/acs.

National Vital Statistics System

Mortality data from the National Vital Statistics System (NVSS) are generated from death certificates. The five most recent years for which complete mortality data were available was from 2010-2014. The five most recent years for which complete infant mortality data were available was from 2008-2012. All mortality data are age-adjusted to the U.S. population for the year 2000. Age-adjusted death rates are useful when comparing different populations because they remove the potential bias that can occur when comparing populations with different age distributions. For example, AI/ANs historically are a younger population than other race groups.

Birth certificate data from NVSS data files include all documented births occurring within the United States as filed in each state. These data include demographic information about parents, information on the infant, the mother's risk factors, and information on the birth. The five most recent years for which complete natality data were available was from 2008-2012.

Since not all states allow individuals to identify as more than one race, National Center for Health Statistics (NCHS) releases bridged-race population estimates for calculation of rates. As a result, estimates in this report may not match local and county estimates because of differing projection methods.

For more information about NVSS, visit: http://www.cdc.gov/nchs/nvss.htm

SOCIODEMOGRAPHICS

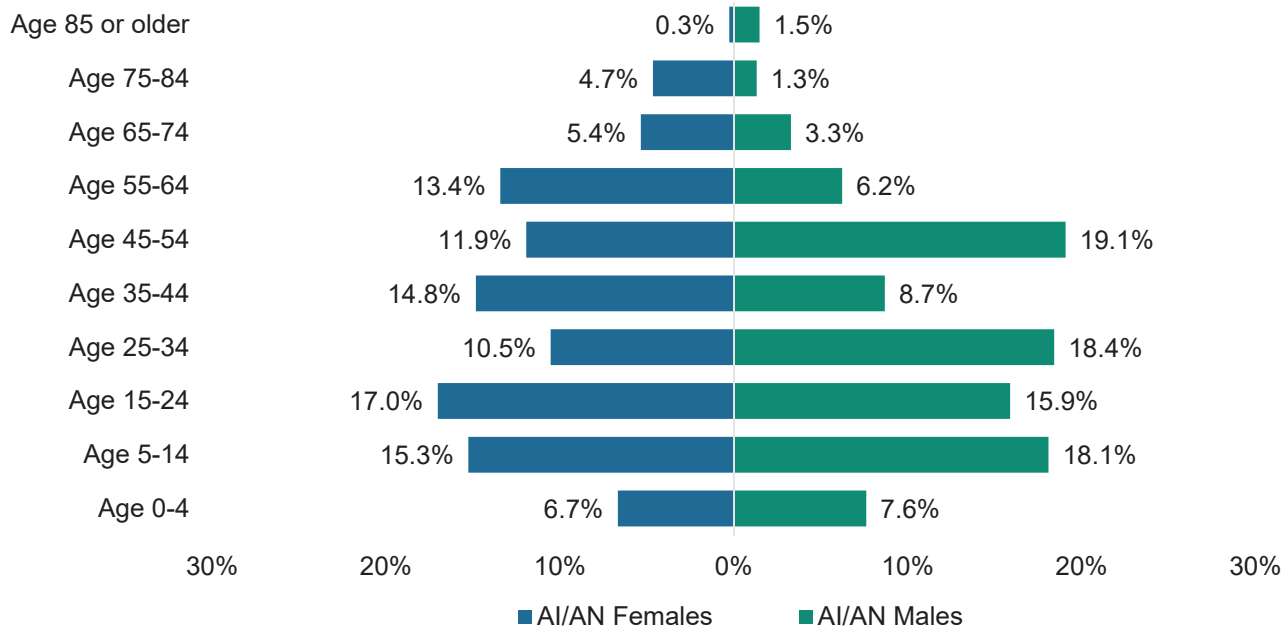
Introduction

The health of an individual or a population is largely determined by where they live, work, play, and learn. Race and economic status also play key roles.[7, 8] Decades of research show a relationship between greater social disadvantage and poorer health. Race, lack of access to education, unemployment, poverty, and housing all create inequities between urban Indian and Non-Hispanic White populations.[7] This section presents data on measures of demographics and social determinants of health to illustrate the disparities between AI/ANs and NHWs.

Age and Gender

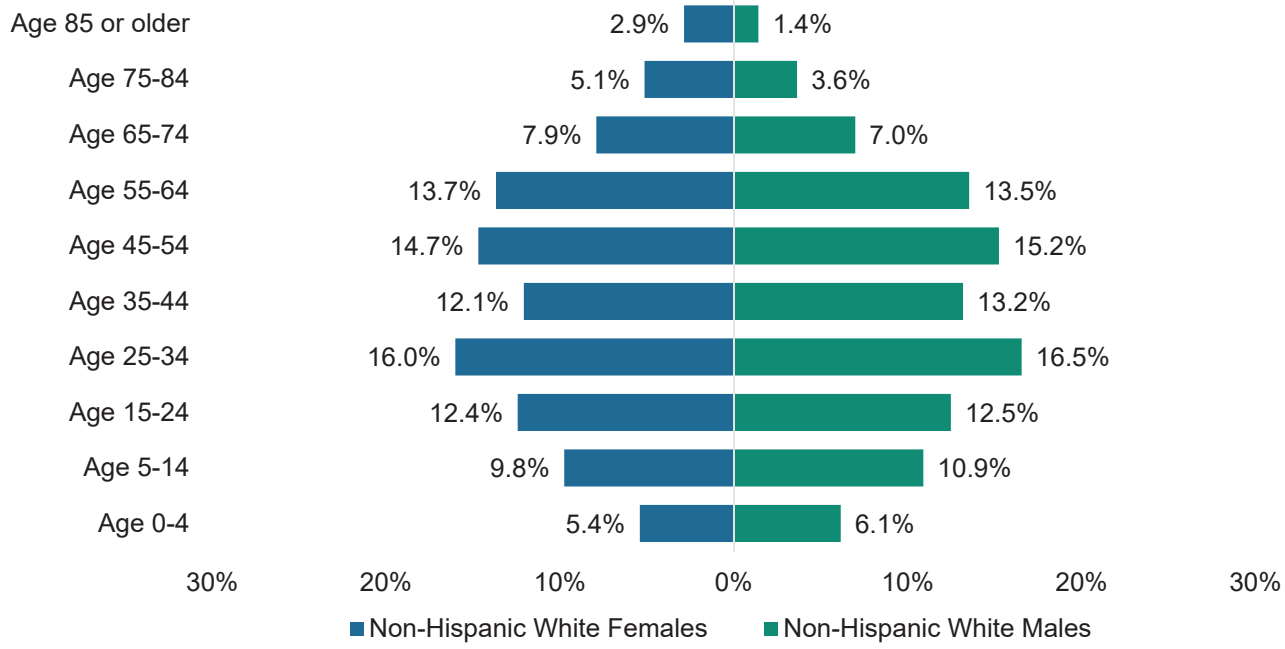
Relative to the NHW population, the AI/AN population in the Indianapolis service area was younger (Figure 1; Figure 2). In this service area, 40.3% of AI/ANs were under the age of 25 years, compared with 28.6% of NHWs. In contrast, 8.3% of AI/ANs were over the age of 65 years, compared with 14.0% of NHWs.

Figure 1. AI/AN Population by Age and Gender, Indianapolis Service Area, 2010-2014



Source: American Community Survey, 2010-2014

Figure 2. NHW Population by Age and Gender, Indianapolis Service Area, 2010-2014

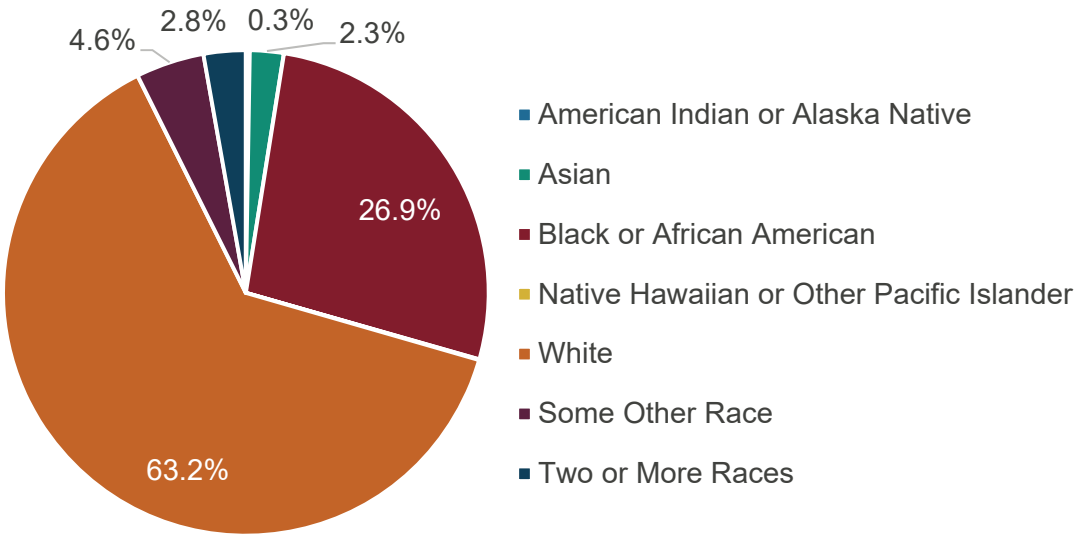


Source: American Community Survey, 2010-2014

Race

As shown in Figure 3, an estimated 2,361 (0.3%) individuals identified as AI/AN alone in the Indianapolis service area, and an estimated 8,287 (0.9%) individuals identified as AI/AN alone or in combination with one or more races (data not shown). Those who identified as White alone comprised the largest proportion (63.2%) of the total population (919,336) in the Indianapolis service area. In addition, Black or African American was the second largest population identified in the Indianapolis service area, making up 26.9% of the total population.

Figure 3. Population by Race, Indianapolis Service Area, 2010-2014

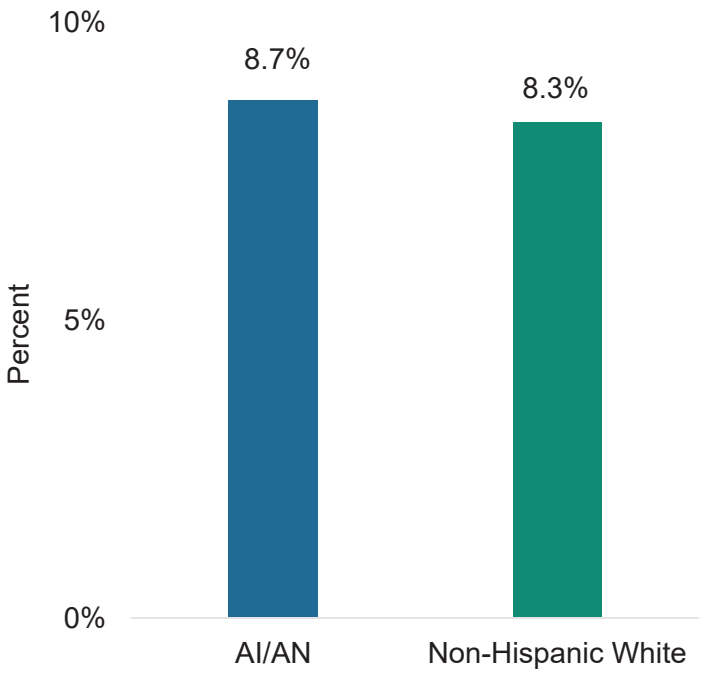


Source: American Community Survey, 2010-2014

Unemployment

Extensive evidence has shown that unemployment has a negative effect on health.[9] Unemployed individuals may experience financial insecurity and are more likely to lack health insurance coverage.[10] In the Indianapolis service area, the percent of unemployed AI/ANs and NHWs over 16 years of age was similar (8.7% vs 8.3%; Figure 4).

Figure 4. Civilian Labor Force, Indianapolis Service Area, 2010-2014



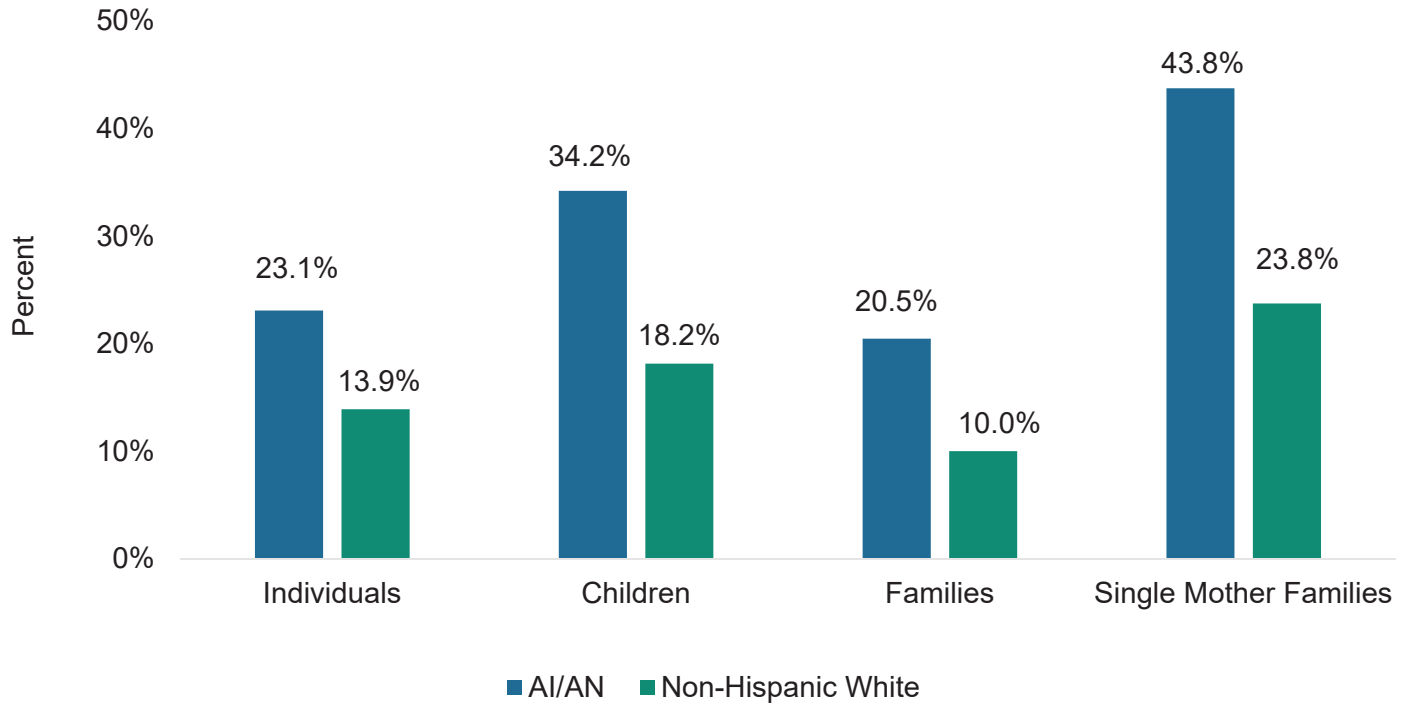
Source: American Community Survey, 2010-2014

Poverty

Poverty limits access to healthy foods, quality housing, economic opportunities, and adequate health care.[11, 12] These foundational social and economic factors are inextricably connected to health outcomes. The impacts of poverty on a child's health and well-being can be detrimental, including negative effects on early childhood and secondary academic achievement.[13, 14] In this report, poverty is defined as annual income less than 100% of the federal poverty level. For example, in 2017, 100% of the federal poverty level for a family of four was no more than $24,600.[15]

In the Indianapolis service area, nearly a quarter of AI/AN individuals lived in poverty (23.1%), compared to 13.9% for NHWs (Figure 5). The percentage of AI/AN children experiencing poverty was higher than NHW children. Over one-third of AI/AN children aged 17 and under (34.2%) lived in households with an income below the federal poverty level. This proportion is 1.9 times that of the NHW population (18.2%). In addition, over one in five AI/AN families in the Indianapolis service area (20.5%) lived in households with an income below the federal poverty level. This is 2.1 times higher than the proportion of NHWs (10.0%). Finally, among those AI/AN families in households headed by single mothers, 43.8% lived in poverty, 1.8 times higher than the proportion of NHW families headed by single mothers (23.8%).

Figure 5. Income Below the Federal Poverty Level in Past Year, Indianapolis Service Area, 2010-2014

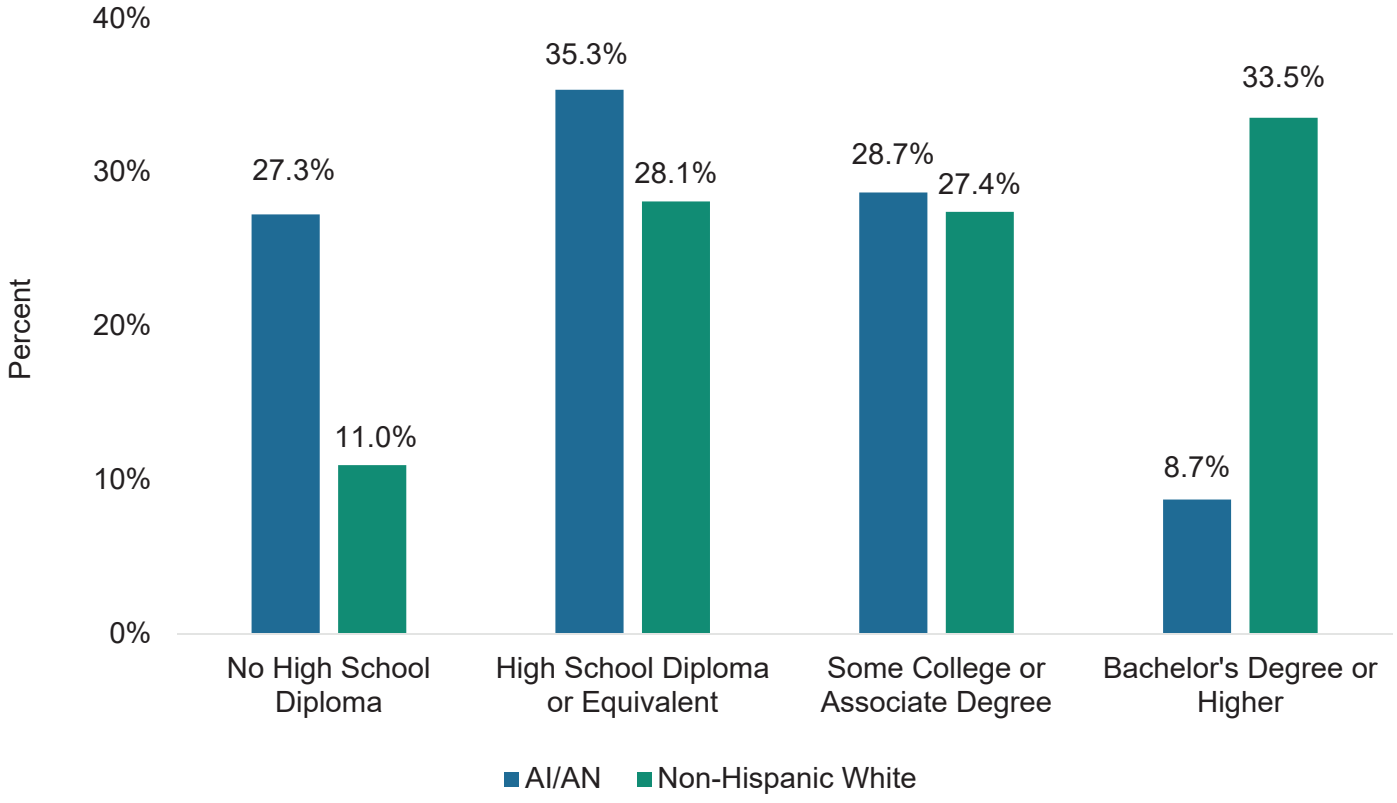


Source: American Community Survey, 2010-2014

Educational Attainment

The relationship between education and health is well documented.[16, 17] Disparities in life expectancy by level of education are found among all demographic groups and are arguably increasing over time.[17] In the Indianapolis service area, a higher proportion of AI/ANs aged 25 and older had not completed high school or passed the General Educational Development (GED) exam (27.3%) compared with the NHW population (11.0%; Figure 6). A lower percentage of AI/ANs (8.7%) reported a Bachelor's degree or higher as their highest level of education compared with the NHW population (33.5%). The proportion of AI/ANs that reported a Bachelor's degree or higher in the Indianapolis service area was 74.0% lower than NHWs.

Figure 6. Educational Attainment for the Population 25 Years and Older, Indianapolis Service Area, 2010-2014

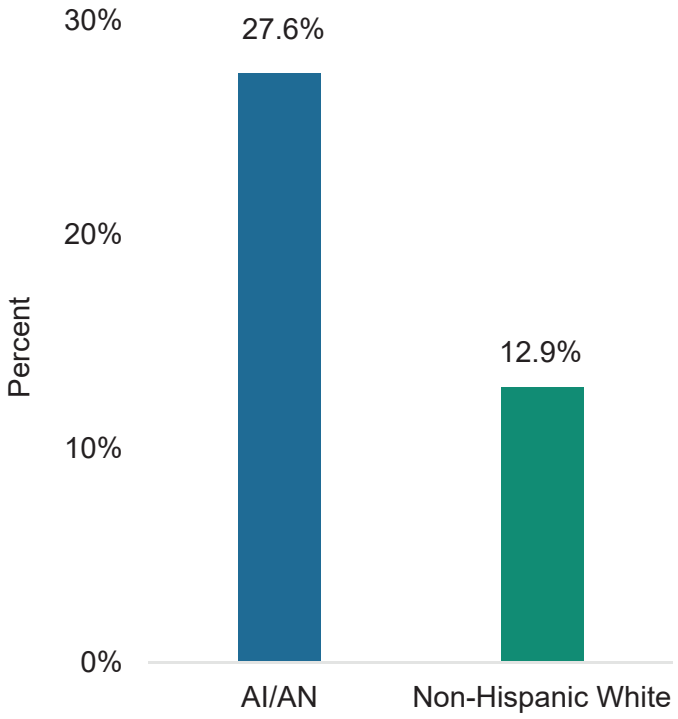


Source: American Community Survey, 2010-2014

Health Insurance Coverage

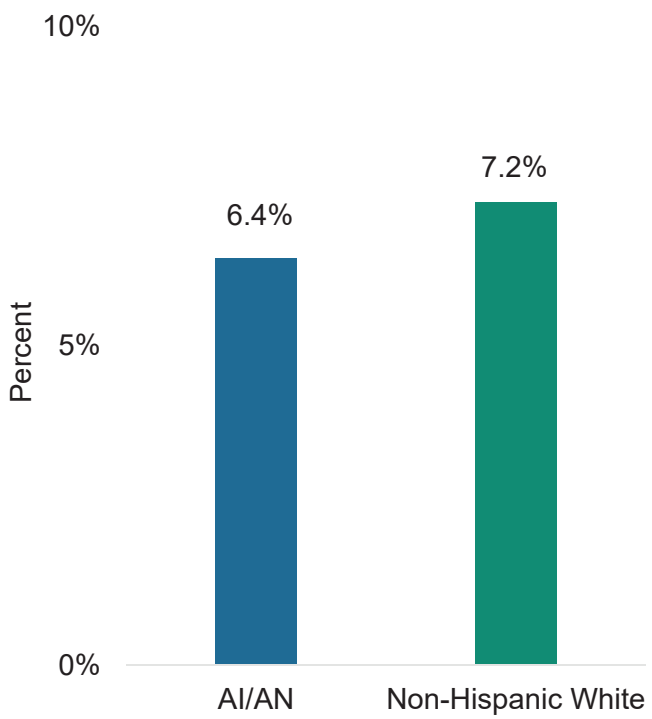
Those without health insurance coverage have higher mortality rates than those with coverage.[18] Individuals without health insurance are also less likely to receive care and take longer to return to health after an unintentional injury or the onset of a chronic disease than those with health insurance.[19] In the Indianapolis service area, over one-quarter of AI/ANs under age 65 (27.6%) reported having no health insurance, a proportion 2.1 times higher than that of NHWs (12.9%; Figure 7). The proportion of uninsured AI/AN children under the age of 18 (6.4%) in the Indianapolis service area was 11.1% lower than their NHW counterparts (7.2%; Figure 8).

Figure 7. Population Under 65 with No Health Insurance Coverage, Indianapolis Service Area, 2010-2014



Source: American Community Survey, 2010-2014

Figure 8. Population Under 18 with No Health Insurance Coverage, Indianapolis Service Area, 2010-2014



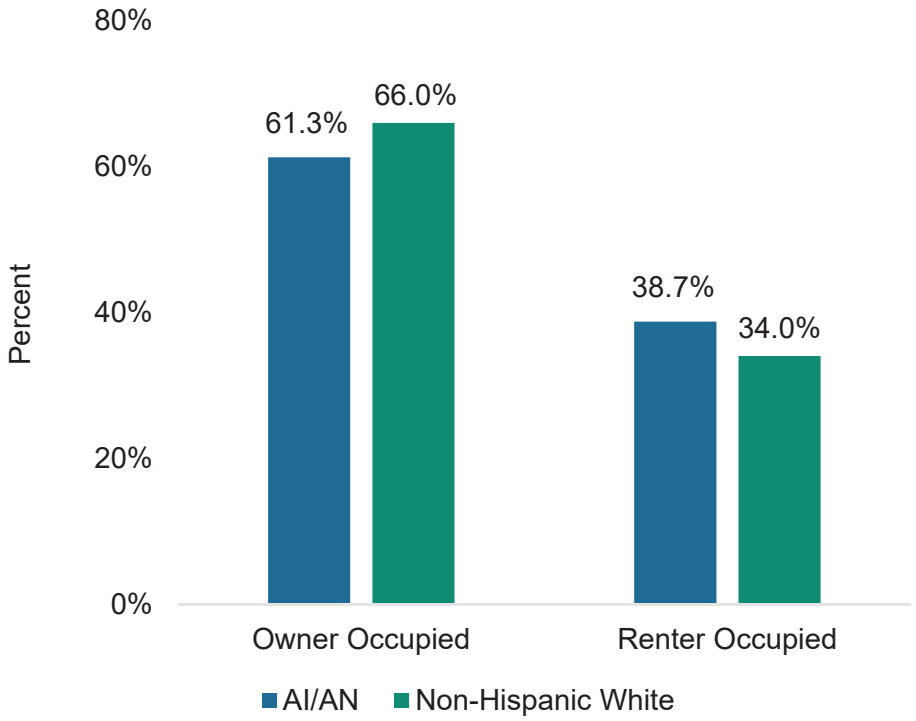
Source: American Community Survey, 2010-2014

Housing

Several studies have found that home ownership is associated with many health benefits.[20, 21] These benefits may be explained by the fact that homeowners likely experience higher socioeconomic status, fewer problems of overcrowding, and lower exposure to neighborhood violence. In contrast, renters are more likely to experience poorer self-reported health, higher proportions of coronary heart disease, and more risk factors, such as smoking.[22]

In the Indianapolis service area, the proportion of AI/AN households that were owner occupied was similar to that of NHW households (Figure 9). The proportion of home ownership among AI/ANs (61.3%) was slightly lower than NHWs (66.0%). Additionally, there was a similar proportion of AI/AN households that were renter occupied compared with NHW households. The proportion of renter occupation among AI/ANs (38.7%) was slightly higher than NHWs (34.0%).

Figure 9. Housing Tenure, Indianapolis Service Area, 2010-2014



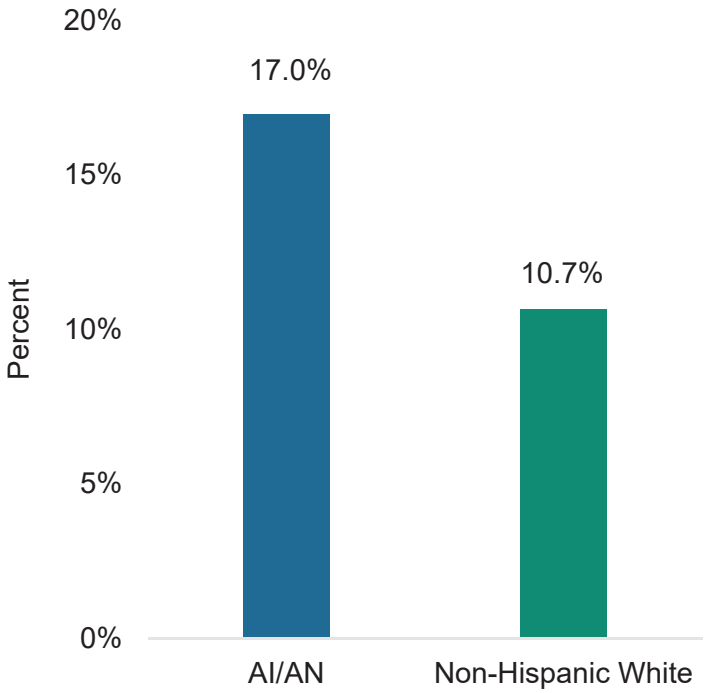
Source: American Community Survey, 2010-2014

Food Stamps

Households experiencing poverty are more likely to be food insecure.[23] As the largest food assistance program in the United States, the Supplemental Nutrition Assistance Program (SNAP), formerly known as the federal Food Stamp program, is a crucial part of the social safety net.[24] In most states, many households with an income below 130% of the federal poverty level are eligible to receive SNAP benefits.

In the Indianapolis service area, 17.0% of AI/AN households received SNAP benefits in the past year (Figure 10). The proportion of SNAP participation among AI/ANs in this area was 1.6 times higher than NHWs (10.7%).

Figure 10. SNAP Use, Indianapolis Service Area, 2010-2014



Source: American Community Survey, 2010-2014

MORTALITY

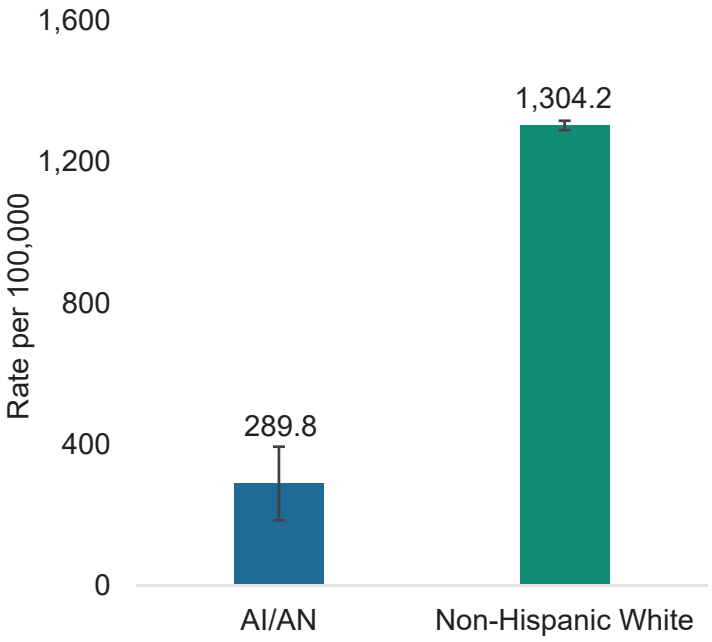
Introduction

Mortality data provide an indication of a community's or population health and socioeconomic development status. Mortality data are also a key component to understanding population size, future growth, and change. Examining mortality data is one way to measure the burden of disease in a community or population. Tracking death rates may identify groups that are at an increased risk for premature death and may identify specific underlying causes of death that are more prevalent in certain populations. In addition, high mortality rates may indicate an issue with environmental, risk, and/or socioeconomic factors as well as communicable diseases. Relevant and accurate data are needed on the health of urban Indians. UIHI recommends local, state, and national organizations work to improve the quality and availability of data to serve this diverse and unique population.

All-Cause Mortality Rate

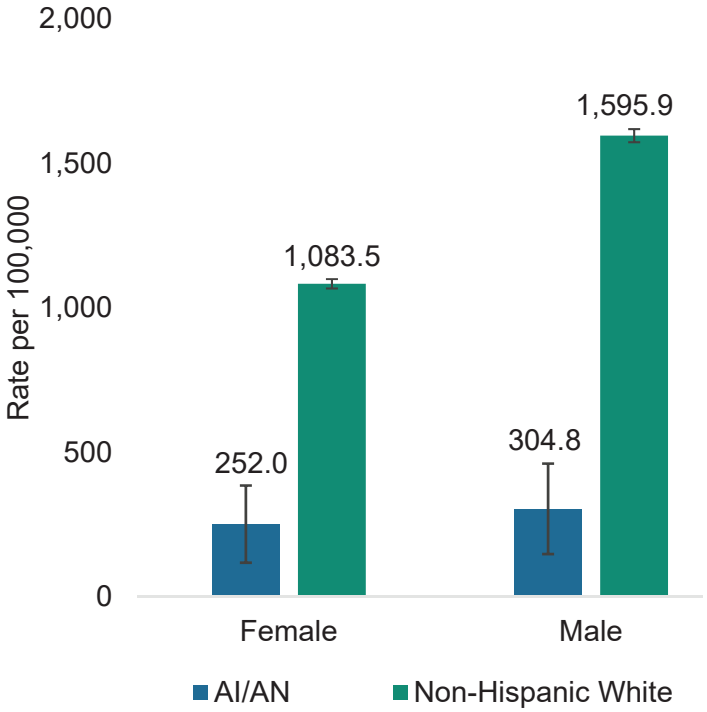
The all-cause mortality rate in the Indianapolis service area was 77.8% lower for the AI/AN population than for the NHW population, which is a significant difference (Figure 11). The mortality rates were 80.9% lower among AI/AN males compared to their NHW counterparts and 76.7% lower for AI/AN females when compared to NHW females (Figure 12).

Figure 11. All-Cause Mortality, Indianapolis Service Area, 2010-2014



Source: National Vital Statistics, Death Certificates, 2010-2014

Figure 12. Mortality Rate by Gender, Indianapolis Service Area, 2010-2014



Source: National Vital Statistics, Death Certificates, 2010-2014

Top Cause of Mortality

Table 1. Top Cause of Mortality, Indianapolis Service Area, 2010-2014

AI/AN			NHW		
RANK	CAUSE	RATE (PER 100,000)	RANK	CAUSE	RATE (PER 100,000)
1	Vascular disease	186.2	1	Vascular disease	750.1

Source: US Center for Health Statistics, Death Certificates, 2010-2014

Table 1 summarizes the top cause of mortality for both AI/AN and NHW.

MATERNAL AND CHILD HEALTH

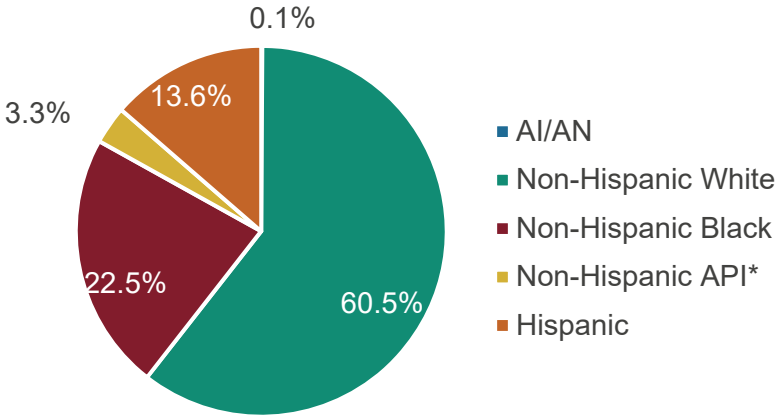
Introduction

Understanding the state of maternal and child health (MCH) for urban Indians is key to creating the foundation for healthy children, mothers, and future generations. Tracking maternal smoking, gestational diabetes, prenatal care, and premature births can help urban Indian health organizations make the best decisions regarding programs for pregnant mothers and infants. As UIHI found in the Indianapolis service area, disparities exist in most key indicators for MCH. The data in this section can be used to further examine why these health disparities exist and to consider programs to eliminate them.

Total Births

From 2008 to 2012, there were a total of 90,368 births in the Indianapolis service area. Among those births, 0.1% were identified as Non-Hispanic AI/AN alone (Figure 13). The largest proportions of births among the racial/ethnic groups were from NHW women (60.5%) and Non-Hispanic Black women (22.5%). Hispanics were 13.6% of all births while Non-Hispanic Asians and Pacific Islanders were 3.3% of all births.

Figure 13. Births by Race/Ethnicity, Indianapolis Service Area, 2008-2012

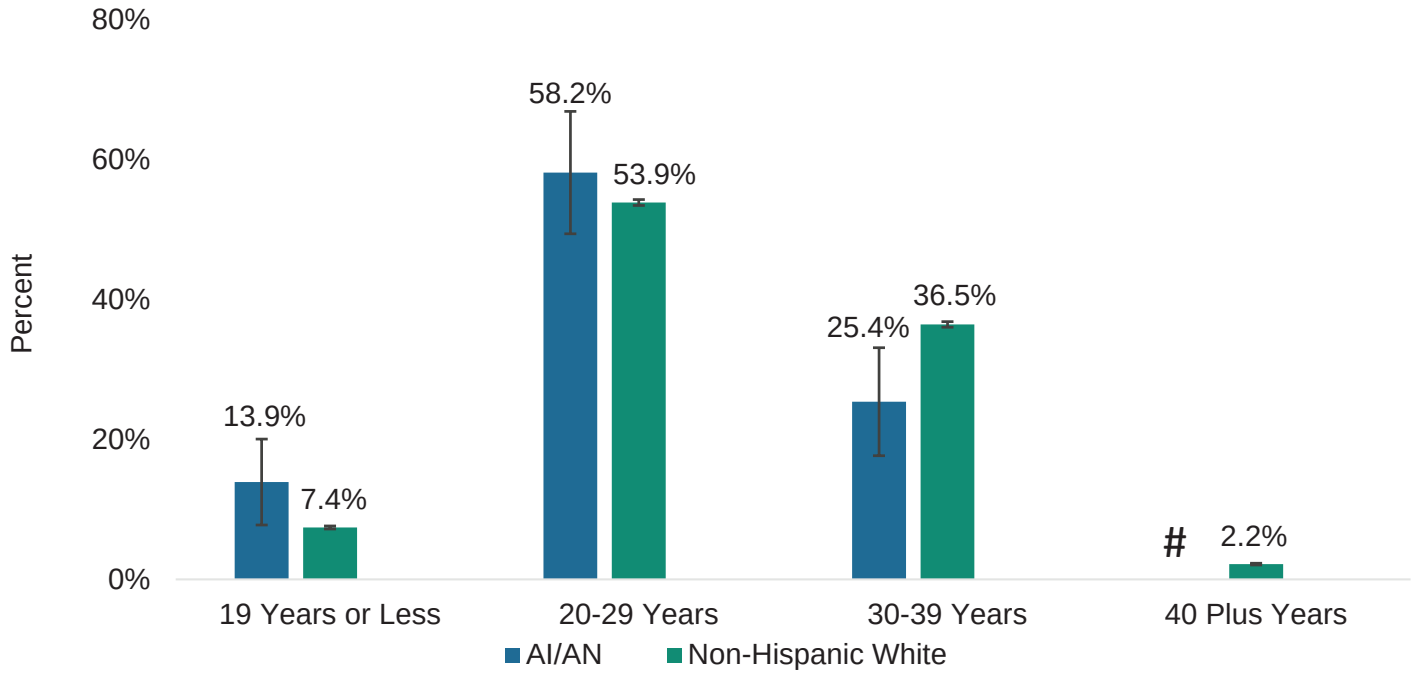


*API: Asian-Pacific Islander
Source: National Vital Statistics, Birth Certificates, 2008-2012

Age

In general, AI/AN women tend to give birth at younger ages than their NHW counterparts (Figure 14). In the Indianapolis service area, 13.9% of all births among AI/AN women were to teenage women (less than 19 years of age) compared to 7.4% of NHW births. The proportion of births to teenage women was 1.9 times higher in AI/ANs compared to NHWs. In addition, the proportion of births to women in their 20s was similar between AI/ANs and NHWs, at 58.2% and 53.9%, respectively. Conversely, NHW women had more children in their 30s compared to AI/AN women (36.5% vs. 25.4%).

Figure 14. Births by Maternal Age Group, Indianapolis Service Area, 2008-2012



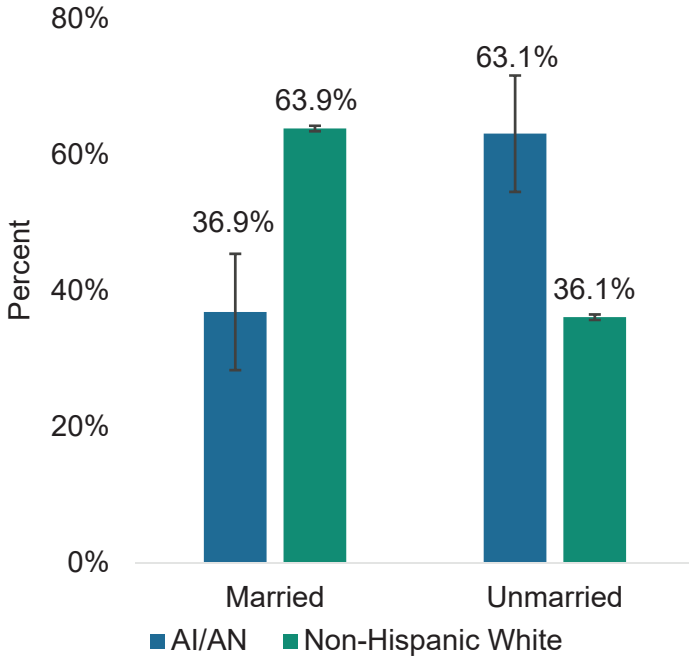
#: Data Suppressed
Source: National Vital Statistics, Birth Certificates, 2008-2012

INDIANAPOLIS SERVICE AREA

Marital Status

In the Indianapolis service area, 36.9% of all births to AI/ANs were to women who were married and 63.1% were to women who were not married (Figure 15). This was significantly different compared to NHWs in which 63.9% of births were to married mothers and 36.1% of births were to unmarried mothers. The proportion of births to unmarried women was 1.7 times higher in AI/ANs compared to their NHW counterparts.

Figure 15. Births by Marital Status, Indianapolis Service Area, 2008-2012



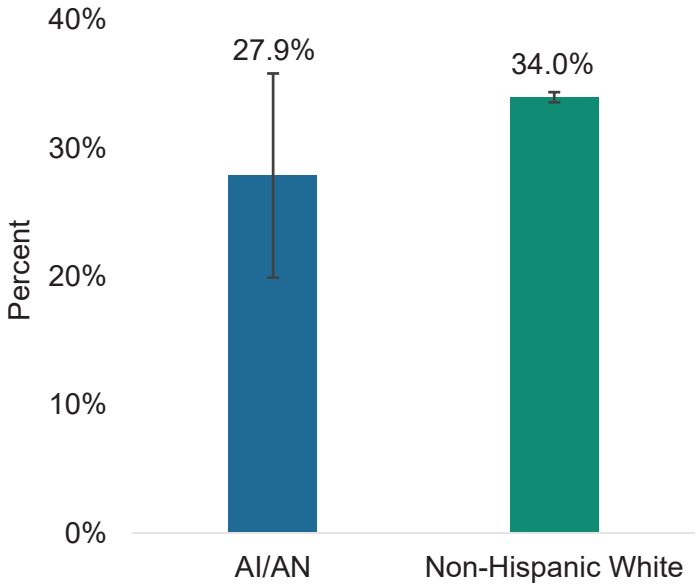
Source: National Vital Statistics, Birth Certificates, 2008-2012

Cesarean Section

While cesarean sections can prevent maternal and infant mortality and morbidity, there is no advantage for women who have the procedure electively.[25, 26] Possible complications of cesarean sections include infection, hemorrhage or increased blood loss, injury to organs, and extended hospital stay.[27, 28]

In the Indianapolis service area, an estimated 27.9% of births were delivered by cesarean section among AI/AN females. This was not statistically different from the proportion among NHW births at 34.0% (Figure 16).

Figure 16. Births by Cesarean Section, Indianapolis Service Area, 2008-2012



Source: National Vital Statistics, Birth Certificates, 2008-2012

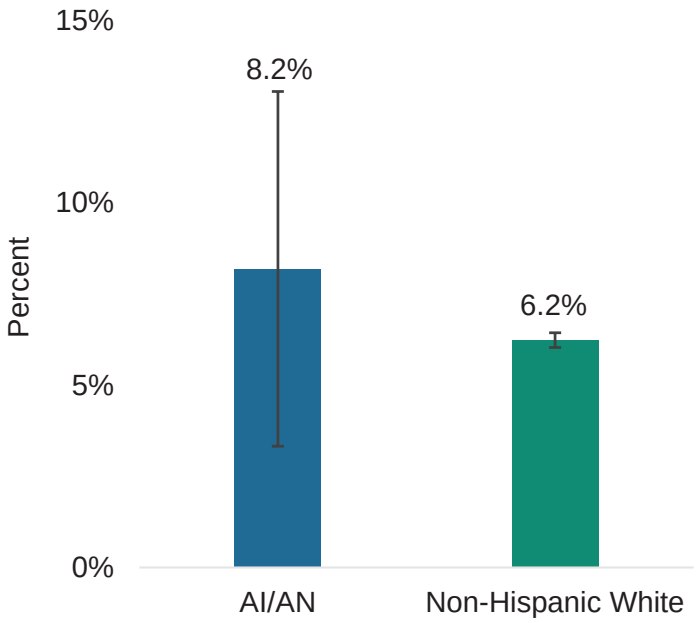
INDIANAPOLIS SERVICE AREA

Gestational Diabetes

A woman with gestational diabetes may have a larger than average baby.[29] Diabetes during a pregnancy leads to the unborn child having a higher-than-normal blood sugar level, which causes an overproduction of insulin in the unborn child. That overproduction produces extra calories that are stored as fat, making the baby larger than average. Due to the size of the child, there may be delivery complications for both the mother and the baby.

In the Indianapolis service area, 8.2% of AI/AN births were to women who were diagnosed with gestational diabetes during their pregnancy (Figure 17). This proportion was not statistically different from their NHW counterparts, where 6.2% were diagnosed with gestational diabetes.

Figure 17. Gestational Diabetes, Indianapolis Service Area, 2008-2012



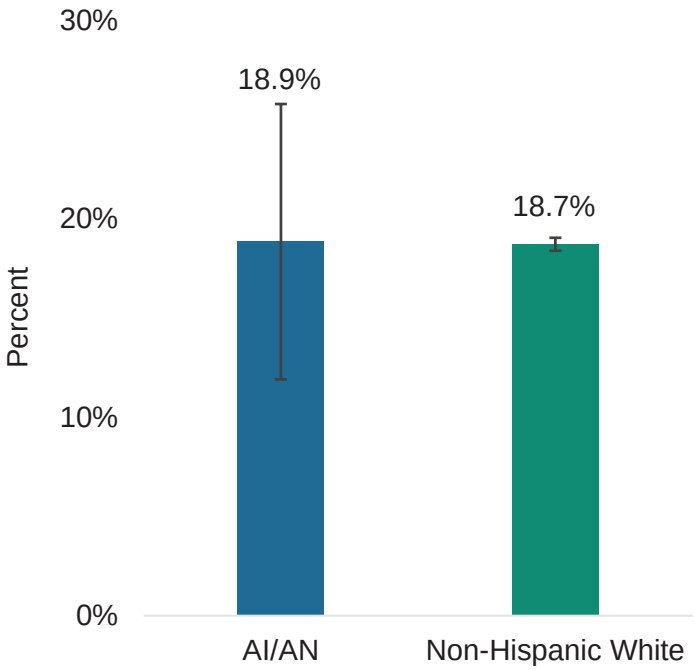
Source: National Vital Statistics, Birth Certificates, 2008-2012

Maternal Smoking

Smoking before and during pregnancy is the single most preventable cause of illness and death among mothers and infants.[30] Maternal smoking can result in complications during delivery for both mother and newborn and may result in adverse outcomes for the infant. Complications include low birth weight, preterm birth, ectopic pregnancy, miscarriage, stillbirths, slow fetal growth, placenta previa and abruption, severe vaginal bleeding, intrauterine growth restriction, sudden infant death syndrome (SIDS), and birth defects.

In the Indianapolis service area, 18.9% of AI/AN women smoked while pregnant, which was similar to NHW women at 18.7% (Figure 18).

Figure 18. Maternal Smoking, Indianapolis Service Area, 2008-2012



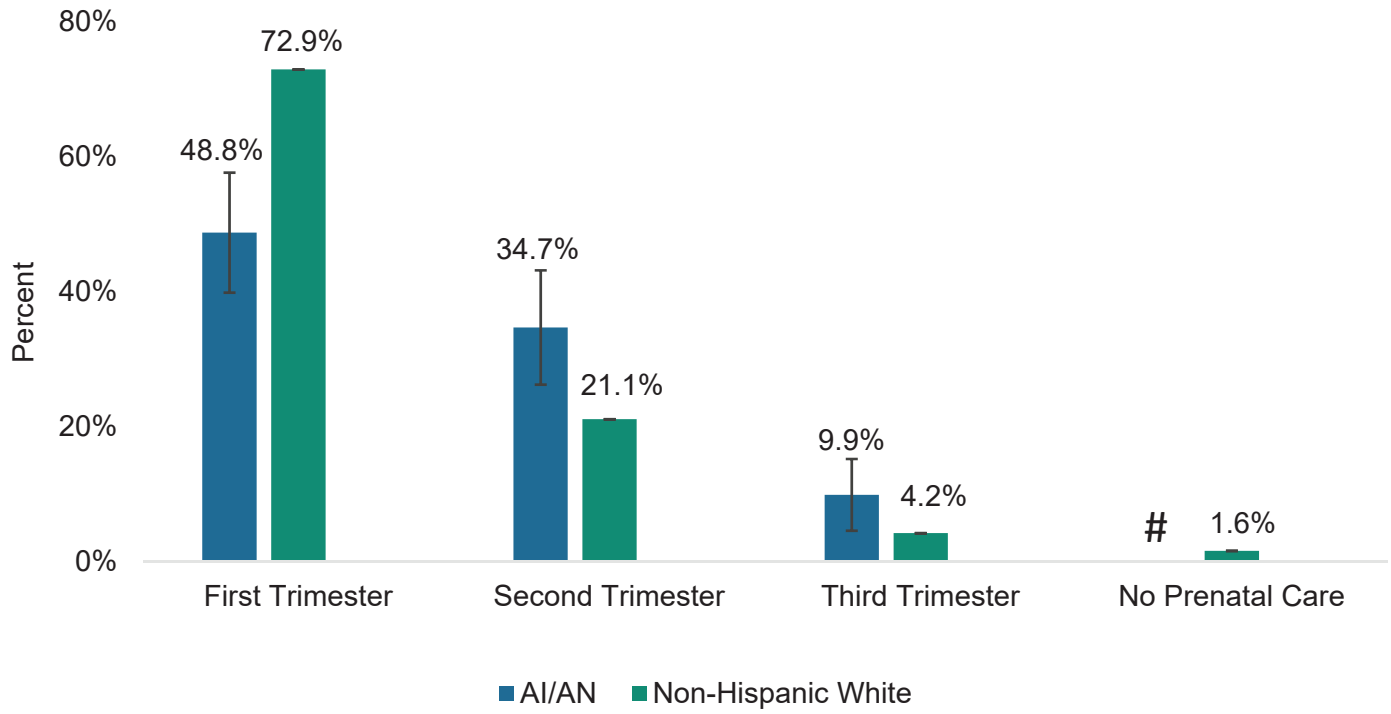
Source: National Vital Statistics, Birth Certificates, 2008-2012

Prenatal Care

Prenatal care refers to the medical attention received by women before or during their pregnancy. The goal of prenatal care is to detect potential problems early in the pregnancy and to prevent potential complications. Early prenatal care is a significant component in ensuring a good pregnancy outcome and it is recommended for women to begin prenatal care during the first trimester.[31] Women who receive late or no prenatal care are at risk for having undetected complications during their pregnancy that can result in severe maternal morbidity and mortality, and serious consequences to the unborn infant including low birth weight, premature birth, morbidity, and mortality.

Among pregnant women in the Indianapolis service area, 48.8% of AI/AN women began prenatal care in the first trimester compared to 72.9% of NHW women, a significant difference (Figure 19). The proportion of women beginning prenatal care in their first trimester was 33.1% lower in AI/AN women compared to NHW women. In addition, 9.9% of AI/AN pregnant women began prenatal care in the third trimester compared to 4.2% of NHW pregnant women. The proportion of women beginning prenatal care in their third trimester was 2.4 times higher in AI/AN women compared to NHW women.

Figure 19. Prenatal Care Initiation by Trimester, Indianapolis Service Area, 2008-2012



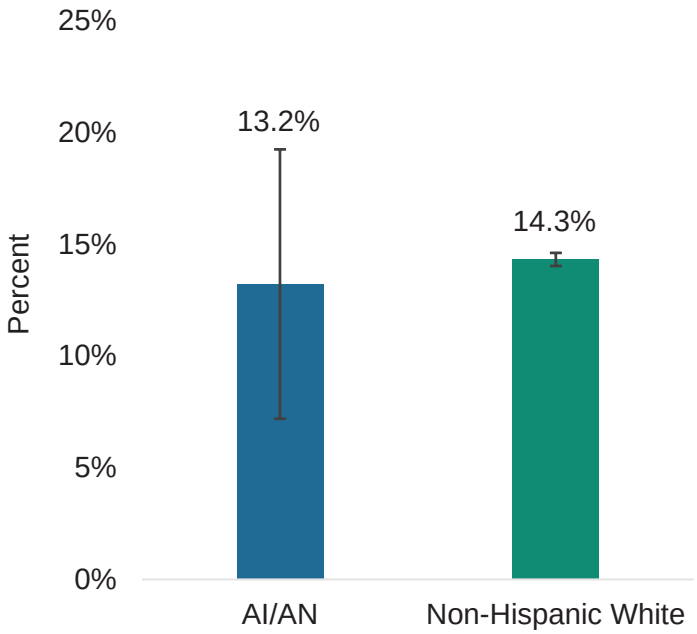
Data Suppressed
Source: National Vital Statistics, Birth Certificates, 2008-2012

Premature Births

A premature birth is defined as, "childbirth occurring between 20 and 37 completed weeks of pregnancy".[32] Infants born prematurely have an increased risk of health complications, including infant mortality, and are at a greater risk of developing long-term disabilities.[33] The risk of adverse outcomes is directly related to the length of a woman's pregnancy. The shorter the pregnancy, the greater the risk of complications and disabilities in the newborn.

In the Indianapolis service area, 13.2% of all infants born to AI/AN women were born prematurely, which was not statistically different from all infants born prematurely to NHW women at 14.3% (Figure 20).

Figure 20. Premature Birth Rate, Indianapolis Service Area, 2008-2012



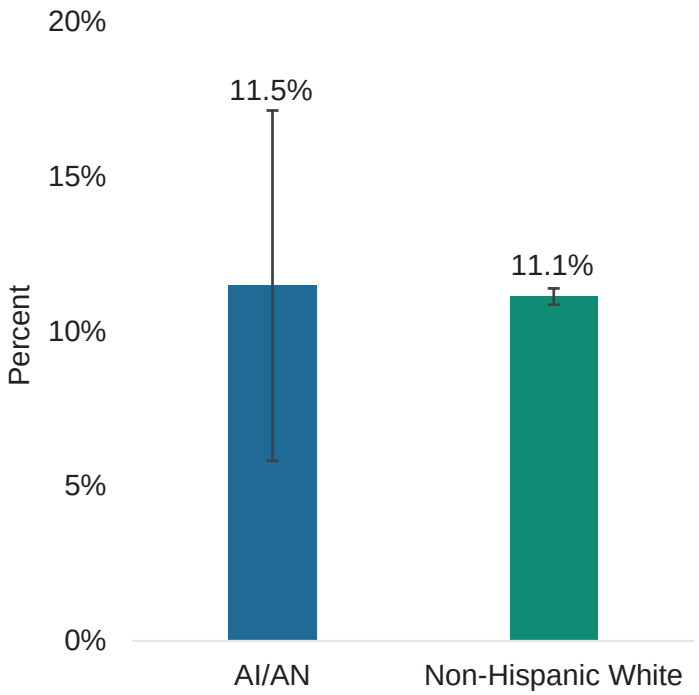
Source: National Vital Statistics, Birth Certificates, 2008-2012

Low Birth Weight

Low birth weight is defined as less than 2,500 grams (5.5 pounds).[34] Low birth weight infants have higher rates of subnormal growth, and adverse health conditions.[35]

In the Indianapolis service area, 11.5% of all infants born to AI/AN women were low birth weight, which was similar to their NHW counterparts at 11.1% (Figure 21).

Figure 21. Low Birth Weight, Indianapolis Service Area, 2008-2012



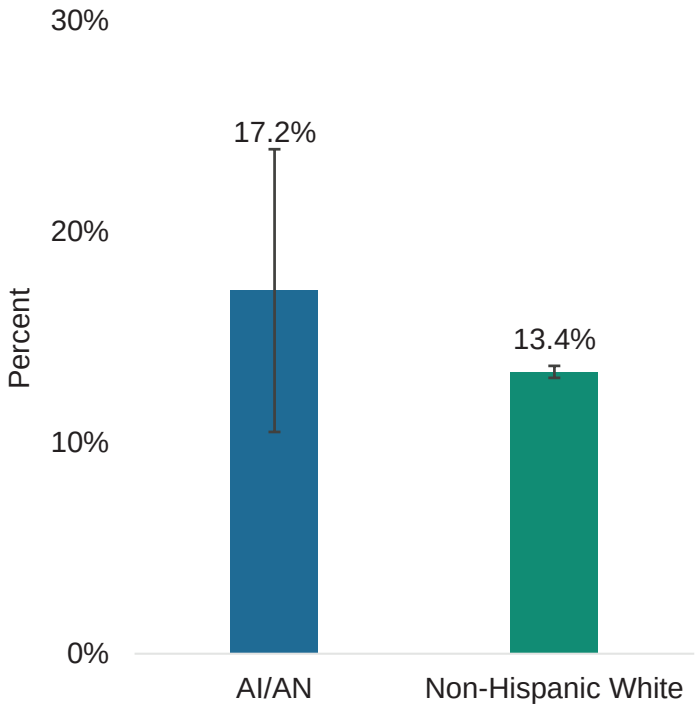
Source: National Vital Statistics, Birth Certificates, 2008-2012

Neonatal Intensive Care Unit Admission

Most babies admitted to the neonatal intensive care unit (NICU) are premature, have low birth weight, or have a medical condition that requires special care. Babies with medical conditions such as heart problems, infections or birth defects are also cared for in the NICU.[36, 37]

There was no significant difference in the proportion of AI/AN and NHW infants who were admitted to the NICU in the Indianapolis service area (Figure 22). An estimated 17.2% of AI/AN newborns were admitted to the NICU compared to 13.4% of NHW newborns.

Figure 22. Newborns Admitted to the NICU, Indianapolis Service Area, 2008-2012



Source: National Vital Statistics, Birth Certificates, 2008-2012

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