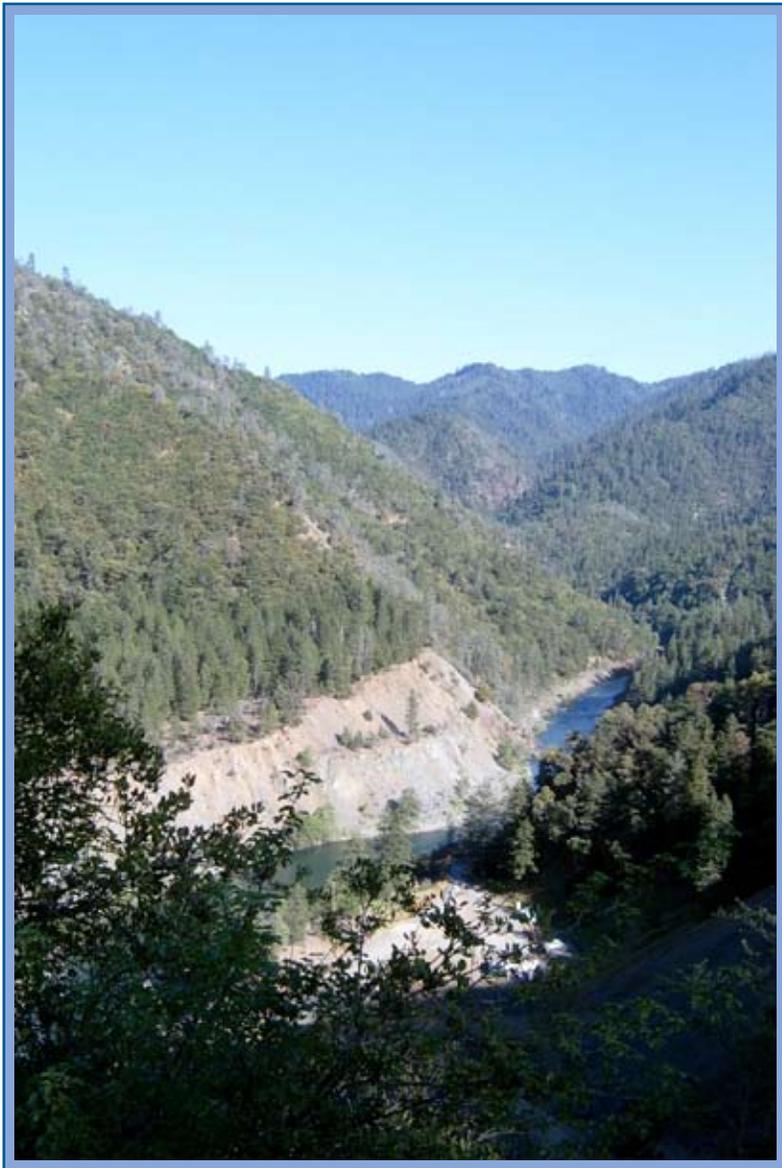


# *Report to Congress*

## *On the Social and Economic Conditions of Native Americans*



*U.S. Department of Health and Human Services  
Fiscal Year 2003 - Fiscal Year 2004*



The U.S. Department of Health and Human Services, Report to Congress, is in accordance with Section 811A (42 U.S.C. 2992-1), to report on the social and economic conditions of American Indians, Alaska Natives, Native Hawaiians, American Samoan Natives and other Native American Pacific Islanders.

## Table of Contents

<i>Introduction from the U.S. Department of Health and Human Services</i>	5
<i>Intradepartmental Council on Native American Affairs</i>	7
<i>Native American Program Highlights</i>	9
<i>Administration for Children and Families</i>	10
<i>Administration for Native Americans</i>	11
<i>Office of Family Assistance</i>	17
<i>Office of Community Services</i>	24
<i>Office of Child Support Enforcement</i>	32
<i>Administration on Developmental Disabilities</i>	35
<i>Administration on Children, Youth and Families</i>	38
<i>Children's Bureau</i>	39
<i>Child Care Bureau</i>	43
<i>Family and Youth Services Bureau</i>	47
<i>Head Start Bureau</i>	56
<i>Indian Health Service</i>	60
<i>Agency for Healthcare Research and Quality</i>	63
<i>Administration on Aging</i>	66
<i>Substance Abuse and Mental Health Services Administration</i>	73
<i>Centers for Disease Control and Prevention</i>	81
<i>Food and Drug Administration</i>	98
<i>Health Resources and Services Administration</i>	102
<i>National Institutes of Health</i>	112
<i>Office of Public Health Emergency Preparedness</i>	116
<i>Agency for Toxic Substances and Disease Registry</i>	117
<i>Assistant Secretary for Planning and Evaluation</i>	121
<i>Office for Civil Rights</i>	124
<i>Office on Disability</i>	129
<i>Center for Faith-Based and Community Initiatives</i>	131
<i>Conclusion</i>	133





# *U. S. Department of Health and Human Services*



The U.S. Department of Health and Human Services (HHS) is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are the least able to help themselves.

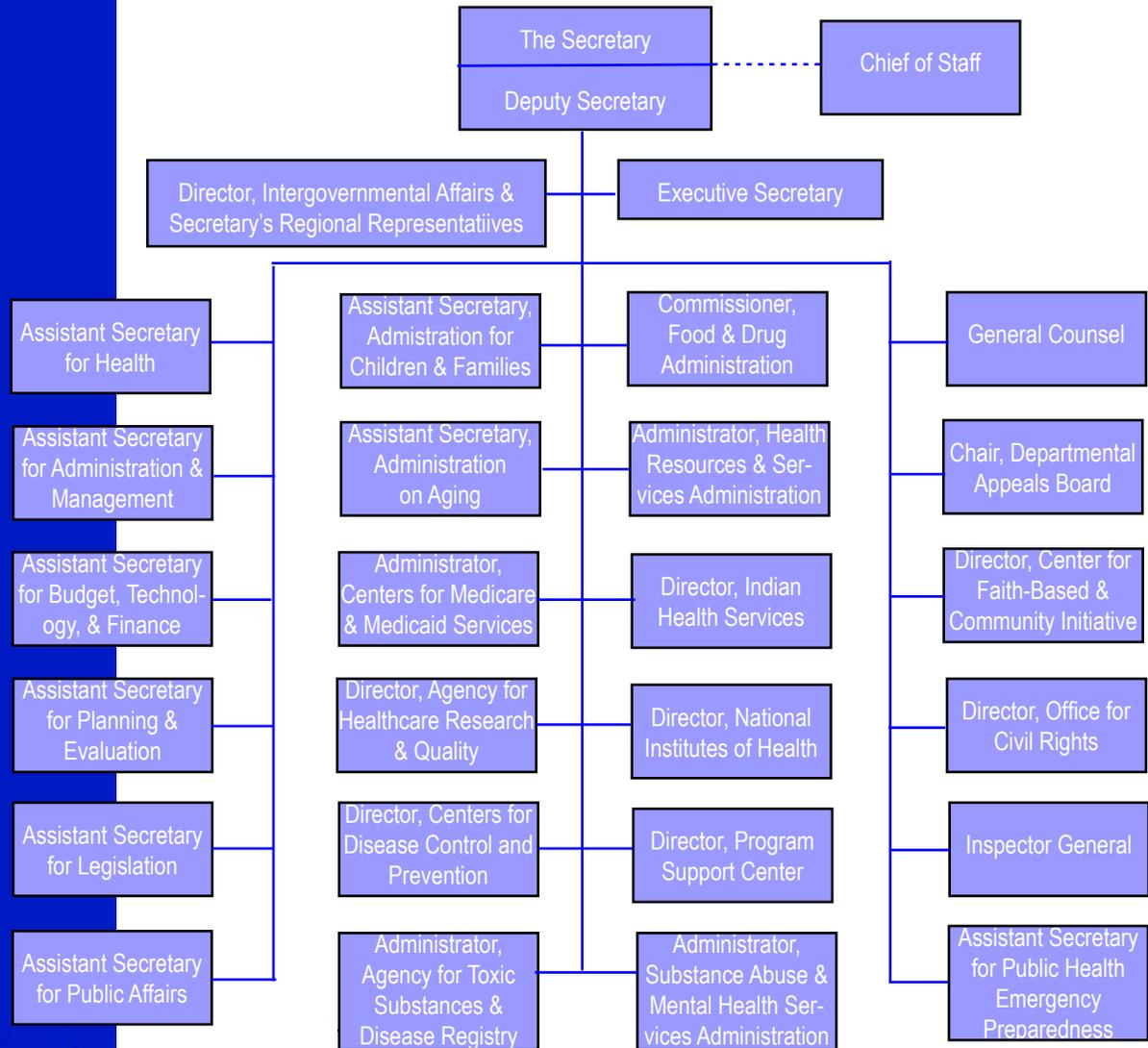
The Department administers more than 300 programs, covering a wide spectrum of services and assistance in:

- Health and social science research;
- Infectious disease prevention, including immunization services;
- Food and drug safety;
- Medicare (health insurance for elderly and disabled Americans) and Medicaid (health insurance for low-income people);
- Health information technology;
- Financial assistance and services for low-income families;
- Maternal and infant health;
- Head Start (pre-school education and services);
- Faith-based and community initiatives;
- Child abuse and domestic violence prevention;
- Substance abuse treatment and prevention;
- Services for older Americans, including home delivered meals;
- Comprehensive health services for Native Americans; and
- Medical preparedness for emergencies, including potential terrorism.

HHS is the largest grant-making agency in the Federal Government. With a budget in FY 2004 of \$542 billion and 64,244 employees, HHS administers more grant dollars than all other federal agencies combined, providing some 60,000 grants per year, representing \$255.7 million in grant funding for FY 2004. HHS works closely with state, local and tribal governments, and many HHS-funded services are provided at the local level by state, county or tribal agencies, or through private sector grantees. The Department has 11 HHS operating divisions including eight agencies in the U.S. Public Health Service and three human service agencies that administer the programs. In addition to the services they deliver, the HHS programs provide for equitable treatment of beneficiaries nationwide and enable the collection of national health and other data. The following is the operational chart for HHS.

# U. S. Department of Health and Human Services

HHS Operational Chart



## *Intradepartmental Council on Native American Affairs*



The Intradepartmental Council on Native American Affairs (ICNAA) is authorized by the Native American Programs Act of 1974, as amended, and serves as the focal point within HHS for coordination and consultation on health and human services issues affecting Native Americans. Late in FY 2002, Secretary Thompson elevated the Intradepartmental Council on Native American Affairs (ICNAA) to the immediate Office of the Secretary. The Council brings together all health and human services operating divisions and staff divisions to help develop logical and effective HHS policy and initiatives for American Indians, Alaska Natives, and Native Hawaiians.

This coordination of HHS leadership ensures consistency on policy and maximizes limited resources. The Council is chaired by Quanah Crossland Stamps, Commissioner of the Administration for Native Americans. The Vice-Chair is Mr. Robert G. McSwain, Acting Director of Indian Health Service. The Council is comprised of the heads of each HHS Division.

In 2003 the Council authorized a “Grants Access Validation Study” to inventory HHS programs and the accessibility to programs by Tribes. The study found that there are 315 HHS programs offering grant funding, 125 of which Tribes are eligible to access. However, out of the 125 eligible programs, Tribes only accessed 85, or about 68 percent.

The study was reported in April 2004, and the Council then took the next step to determine what is preventing Tribes from accessing the other 40 grant programs and to determine why Tribes are not applying.

At the end of FY 2004, the Assistant Secretary for Planning and Evaluation, the Council, the Administration for Native Americans, and the Assistant Secretary for Budget, Technology and Finance supported the hiring of a contractor to conduct a 13-month study to assess the regulatory and policy barriers that exist for Tribes. There was considerable agreement among study respondents on barriers and on strategies to reduce those barriers. Within HHS, there are currently initiatives underway at the department level or within specific agencies that are similar to several of the suggested strategies. Some of these efforts include: increased training and technical assistance, increased use of AI/AN/NA grant reviewers and those familiar with this population, acceptance of applications that are not submitted electronically for applicants with limited Internet access, and increased time-frames between the announcement of grant opportunities and submission deadlines.

In addition to this important study, the work of the ICNAA in FY 2003 and FY 2004 has been to continue its key role in developing HHS Tribal Consultation policy and HHS Tribal Budget Consultation policy. The Council developed the ACF White House Initiative on Tribal Colleges and Universities Plan in FY 2003 and took

## *Intradepartmental Council on Native American Affairs*

---

the lead role in producing an ACF Tribal Consultation Plan and organizing an ACF Tribal Consultation in FY 2004, which is now conducted annually.



# *Native American Program Highlights*

## *FY 2003 and FY 2004*



This Report to Congress summarizes the accomplishments of the U.S. Department of Health and Human Services agencies in the delivery of programs and technical assistance to meet the needs of Native American communities in the United States, Guam, the Commonwealth of Northern Mariana Islands and American Samoa.

Under the One Department Initiative that requires all HHS program offices to work together to effectively coordinate programs, services, and health care resources and funding for Native American communities, the HHS program agencies have made great strides to work collaboratively to improve socio-economic conditions in Indian Country. ICNAA has provided leadership to bring agencies together on behalf of American Indians, Alaska Natives, and Native Americans. Under its Charter, ICNAA coordinates and encourages the cooperation of the Department's and other federal agencies' resources for Native people. It also develops and implements a meaningful policy on Native American affairs for the entire Department. It ensures that this policy will be applied consistently throughout the Department and, where possible, throughout the Federal Government.

The increased coordination among the agencies is partly due to the membership of the Secretary's Intradepartmental Council on Native American Affairs. With this Council as the steering point, HHS has fundamentally realigned support to address the delivery of health, economic and social development programs and services in Native American communities.

In FY 2003 and FY 2004, HHS agencies funded numerous programs throughout Indian Country.

Dollars Provided for Native Americans K=Thousands M=Millions B=Billions		
HHS Agency	FY 2003	FY 2004
Administration on Aging	\$34.7M	\$34.6M
Administration for Children and Families	\$489.2M	\$527.3M
Agency for Toxic Substances and Disease Registry	\$1.2M	\$872K
Centers for Disease Control	\$14.7M	\$25.5M
Health Resources and Services Administration	\$33.5M	\$38.4M
Indian Health Service	\$3.5B	\$3.7B
National Institutes of Health	\$108M	\$111M
Substance Abuse and Mental Health Services Administration	\$55M	\$49.3M

## *Administration for Children and Families*

The Administration for Children and Families (ACF), within the Department of Health and Human Services (HHS), is responsible for federal programs that promote the economic and social well-being of families, children, individuals, and communities. ACF's budget was \$45.4 billion in FY 2003 and \$46.6 billion in FY 2004.\*

The goals of ACF are to:

- Support projects that empower families and individuals to increase their own economic independence and productivity;
- Strengthen and sustain strong, healthy, supportive communities that have a positive impact on the quality of life and the development of children;
- Establish partnerships with individuals, front-line service providers, communities, American Indian tribes, Native communities, states, and Congress that promote solutions that transcend traditional agency boundaries;
- Implement services that are planned, reformed, and integrated to improve community access through community ownership; and
- Strengthen our commitment to working with people with developmental disabilities, refugees, and migrants to address their needs, strengths, and abilities.

ACF works in partnership with American Indian tribes, Alaska Native Villages, state and local governments, community organizations, non-profit and for-profit organizations, the U.S. Territories of Guam and American Samoa, as well as other Native peoples in the United States and with other HHS agencies including Administration on Aging; Centers for Medicare and Medicaid Services; Agency for Healthcare Research and Quality; Centers for Disease Control and Prevention; Agency for Toxic Substances and Disease Registry; Food and Drug Administration; Health Resources and Services Administration; Indian Health Service; National Institutes of Health; Substance Abuse and Mental Health Services, and Office of Public Health Emergency Preparedness.

Offices within ACF work collaboratively to meet these needs. The ACF offices include: Administration for Native Americans; Administration on Developmental Disabilities; Administration on Children, Youth and Families; Office of Community Services; Office of Family Assistance; and Office of Child Support Enforcement.

---

\*The Report reflects organizational structure in FY 2003 and 2004, and supplemental changes made since.



## *Administration for Native Americans*



The Administration for Native Americans (ANA) promotes the goal of social and economic self-sufficiency of American Indians, Alaska Natives, Native Hawaiians and other Native American Pacific Islanders, including Native Samoans. The Commissioner of the Administration for Native Americans is nominated by the President of the United States and confirmed by the United States Senate.

ANA is the only Federal agency serving all Native Americans, including over 556 federally recognized Tribes, 60 Tribes that are state recognized or seeking federal recognition, Indian organizations, all Indian and Alaska Native organizations, Native Hawaiian communities and Native populations throughout the Pacific Basin, including American Samoa, Guam and the Northern Mariana Islands. (Note: By legislative statute, ANA funds grants to Native Hawaiians and other Pacific Islanders.) ANA provides grants, training and technical assistance to eligible Tribes and Native American organizations representing 2.2 million individuals. The major goals of ANA are:

- 1) To assist Tribal and village governments, Native American organizations, and local leadership to exercise control and decision-making over their resources;
- 2) To foster the development of stable, diversified local economies and economic activities that will provide jobs and promote economic well-being to reduce dependency on public funds and social services; and
- 3) To control, coordinate, and support local access to services and programs which safeguard the health and well-being of people that are essential to a thriving and self-sufficient community.

To meet these goals, ANA administers three grant programs: (1) Language Preservation and Maintenance; (2) Environmental Regulatory Enhancement and (3) Social and Economic Development Strategies. ANA also funds Interagency Collaborations.

ANA was appropriated \$45,457,000 in FY 2003 and \$45,157,000 in FY 2004 to fund these grant programs. ANA partnered with American Indian Tribes, Alaska Native Villages and Corporations and non-profit Native American organizations and other government agencies to support projects in Language Preservation and Maintenance, Environmental Regulatory Enhancement, Social and Economic Development Strategies and Interagency Collaborations.

Grant funds were allocated throughout the United States and the Pacific Basin in each of the four areas. The chart on the next page shows specific dollar amounts by state.

# ACF-Administration for Native Americans

## Language Preservation and Maintenance

FY 2003: \$2,559,581  
 FY 2004: \$3,968,102

## Interagency Collaborations

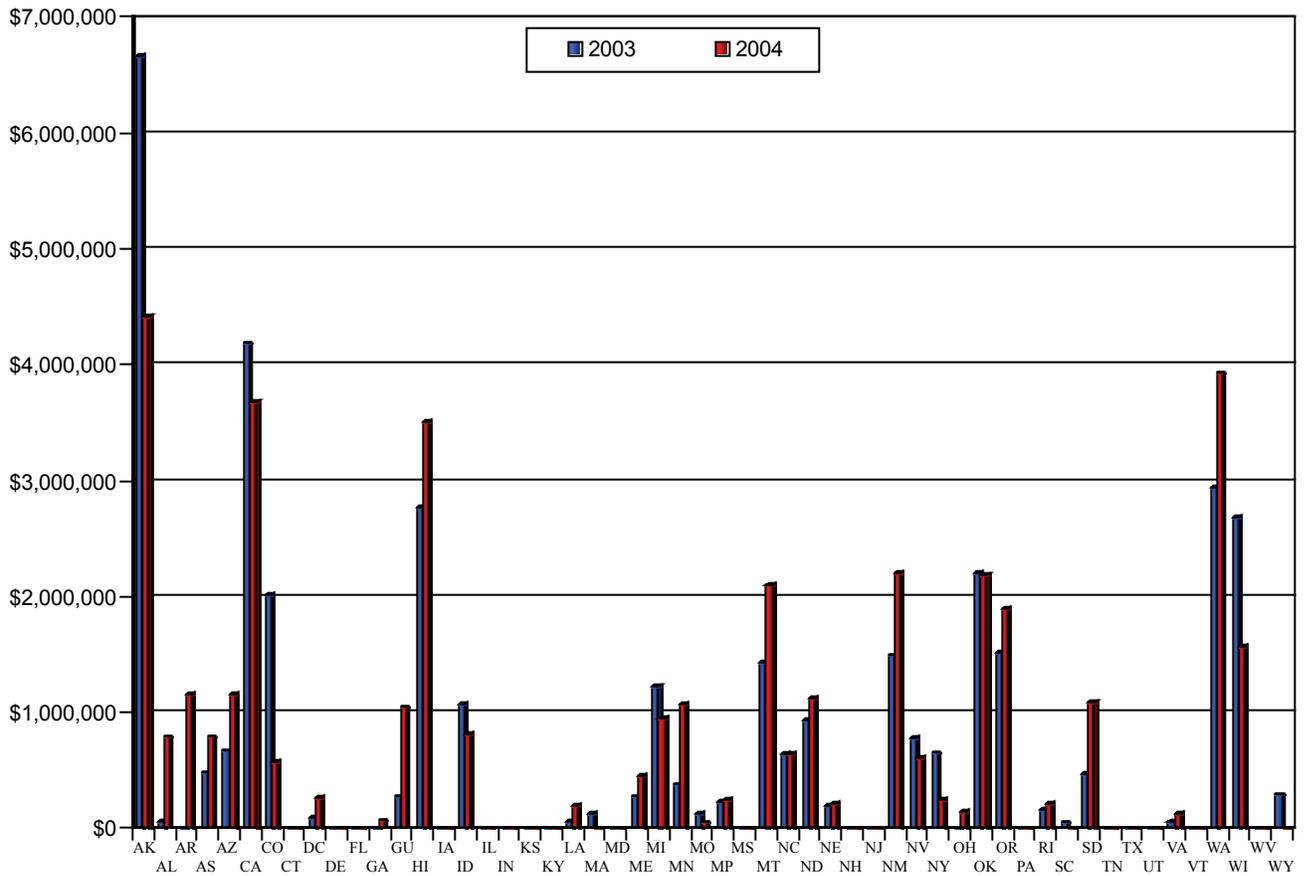
FY 2003: \$2,302,725  
 FY 2004: \$1,602,462

## Environmental Regulatory Enhancement

FY 2003: \$2,498,540  
 FY 2004: \$1,416,499

## Social and Economic Development Strategies

FY 2003: \$13,925,761  
 FY 2004: \$19,083,020



Projects that received funding from ANA helped build the social and economic capacity of Native American communities, increased opportunities for language and cultural preservation and developed environmental laws and regulations. These activities created new businesses and expanded employment options and opportunities for Native Americans.

ANA was also busy making improvements to internal processes and

# ACF-Administration for Native Americans

procedures to streamline support to ANA grantees. The following summary highlights ANA's improvements:

## Publication of New Program Announcements

The ANA program announcement had not been updated since 1984. In FY 2003, ANA began the process of streamlining and standardizing the application submission process. The work in this area began in FY 2003 and became effective with the 2004 Grant Application process. The following summarizes the changes that were made to the Grant Application process.

- **Standardized Application Submission** The format of the ANA program announcement now clarifies the type of information and data required to support project proposals. This modification focuses applicants on the process of project development and implementation and allows ANA to monitor and document the success of a grantee's project. This standardization corresponds to a universal format that supports the federal government's initiative on electronic grant application submissions (E-grants).

- **Community Based Projects** The new program announcement emphasizes community-based projects in order to increase economic activity and build governance, management and technical capacities at the local level. The effect of this change is to increase the number of grants to local community based organizations, expand partnerships, and leverage ANA dollars.

- **Performance Indicators** The new program announcements now require ANA applicants to identify performance indicators (also known as Impact Indicators) to be used to evaluate the success of a funded project. ANA has never consistently collected quantitative data to track the success of grantees. This lack of data hinders ANA's ability to inform Congress on the effectiveness of the ANA program and its effect in Native communities. The new performance indicators will allow ANA to document the number of people trained; the number of jobs created and retained; the number of children, youth and families served; the amount of non-government investment in each project; the transference of language and fluency; the number of businesses retained or expanded; the dollars invested in community infrastructure; and the number and type of new tribal codes and ordinances developed and implemented.

- **Funding Thresholds** The preservation of Native Languages is important to ANA's constituency. The new program announcement increases the cap amount of funding for Category I Planning Grants from \$60,000 to \$100,000 and Category II Design and Implementation Grants from \$150,000 to \$175,000. This increase will support and expedite the preservation of indigenous languages.

- **Budget Change** In the Social and Economic Development Strategies (SEDS)



## *ACF-Administration for Native Americans*

program announcement, the maximum grant award is now \$500,000 per budget period. This modification will increase the number of new grants awarded, and allow ANA to deploy more funding into Native American community-based organizations.

- **Project Areas of Interest Complement ACF and HHS Programs** In the FY 2004 Program Announcement, ANA included project areas of interest to complement other HHS and ACF programs. For example, under Social Development, ANA's project areas of interest support families, elders, youth development and individuals with disabilities. Under Governance, ANA funding may be used for leadership and management training or to assist eligible applicants in the development of laws, regulations, codes, policies and practices that support and promote community based activities and revenues. ANA's Economic Development project areas of interest support activities to teach financial literacy; develop and coordinate emergency response services; develop community transportation services to support the needs of the elderly, the disabled, and the local workforce; and develop and implement community based activities that increase international tourism and trade.

- **Program Announcement Clarifications** Previously, under each competitive program area, ANA only accepted and funded one application that served a reservation, Tribe or Native American community. In FY 2004, ANA began accepting applications from multiple organizations and Tribes in the same geographic area. The reason for this program modification is to expand and support large rural and urban communities that need a variety of services in the same geographic area. In addition to Tribes being able to have three simultaneous ANA grants (SEDS, Language and Environmental) at any one time, this clarification allows other community based organizations to apply for and receive ANA funding, provided the objectives and activities do not duplicate currently funded projects.

Additionally, ANA clarified many areas that had prompted numerous questions from applicants and included a comprehensive definition section.

### **Consolidated Program Competitions**

During FY 2004, ANA released three separate program announcements (one for SEDS, including Alaska SEDS, one for Language Preservation and Maintenance and one for Environmental Regulatory Enhancement). Each announcement had one closing date. Previously, ANA had two to three competitions per fiscal year for SEDS, one for Language, and one for Environmental Regulatory Enhancement. Closing dates were staggered over a four-week period to allow Tribes and Native organizations the opportunity to apply to all program areas. The new application closing process will allow ANA to release all funding to communities earlier in the fiscal year. It will also provide additional time for applicants to receive training and



## *ACF-Administration for Native Americans*



technical assistance in project development and application preparation. In addition, it will allow ANA grantees the opportunity to implement projects in a timely manner, recruit personnel necessary to support the grantee's objectives and decrease the number of requests for grant extensions. The results of this consolidation have allowed ANA to decrease the administrative costs associated with multiple closings and use the cost savings to award additional grants.

### **Restructuring of the Peer Panel Review Process**

ANA is required by statute to provide a peer panel review for each eligible application. Application reviewers are selected nationally for their education, experience and working knowledge in ANA program areas. In FY 2003, ANA began the process of expanding and rotating the pool of application panel reviewers. The peer panel review process now ensures that each application for funding will be scored by professionals who have the expertise to analyze projects in ANA program areas. For example, readers with education and work experience in Environmental Regulatory Enhancement will review environmental applications. Readers with education and work experience in Language Preservation and Maintenance will review language applications.

### **Automation and Implementation of a Data Collection Process**

In compliance with the Paperwork Reduction Act of 1995 and in accordance with the federal government's E-Grants initiative, ANA began automating its application receipt and panel review process. The new automation and document management system has provided significant program and cost efficiencies. It has allowed ANA to: collect program data such as the type of projects to be funded; track grantee progress and project expenditures; identify non-federal project investments; provide effective and timely comments to unsuccessful applicants; track the effectiveness of technical assistance providers; and ensure that ANA does not duplicate grant projects that may have been funded in prior years.

### **Restructured Training and Technical Assistance**

ANA is required by statute to provide training and technical assistance (T/TA) to help eligible entities plan, develop, conduct and administer ANA projects. ANA's T/TA providers teach pre-application training and post-award grant administration training through cluster trainings, electronic T/TA and on-site one-on-one technical assistance. Additional technical assistance in application development is offered to unsuccessful applicants.

Prior to FY 2003, ANA was unable to fully evaluate the effectiveness of ANA T/TA providers. In FY 2003, ANA implemented a T/TA tracking system that monitors which applicants received ANA T/TA services. ANA specifically reviews the effectiveness of the training, where the application scored in the funding process,

## *ACF-Administration for Native Americans*

---

what comments are provided to the applicant through the panel review process and the type and expense associated with TA services. This change has been positive and successful across the board. Other HHS and ACF organizations now use ANA T/TA providers to provide T/TA in Native communities in other HHS and ACF program areas.

### **Program Monitoring**

In FY 2004, ANA started to implement a program monitoring system to effectively and efficiently manage ANA's grant portfolio. ANA staff is now in contact with each grantee, and grantee progress reports and financial draw downs are being reviewed to ascertain the grantees progress. If a grantee is struggling with the implementation of a project, ANA will provide the necessary technical assistance to support the grantee and the successful completion of the project. If a grantee is unable to recover from the delay, or is not meeting the requirements of the grant, ANA will re-program the associated funds to other grants and projects. The new program monitoring system will help ANA accurately report to Congress on the expenditure and impact of ANA funding.

### **Program Evaluation**

ANA is required to evaluate its projects no less frequently than at 3-year intervals. In FY 2004, ANA began to develop an evaluation tool that would rigorously assess the effectiveness of ANA-funded projects. This evaluation tool will be used to collect data from 1/3 of ANA's grant portfolio each year and will also assess how well the ANA program and its services meet the needs of the communities they serve.



## ACF-Office of Family Assistance



The Office of Family Assistance (OFA) is located in the Department of Health and Human Services, Administration for Children and Families, and oversees the Temporary Assistance for Needy Families (TANF) program, which includes Tribal TANF. The TANF program was created by the welfare reform law of 1996 – the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). OFA also oversees the Native Employment Works (NEW) program, which also was created by PRWORA.

The Division of Tribal TANF Management is responsible for assisting in the implementation and coordination of the Tribal provisions in title IV-A of the Social Security Act, as amended by PRWORA. The purposes of the TANF program are:

1. To encourage needy families to care for their children in a home environment;
2. To reduce the dependency on public benefits by promoting job preparation;
3. To prevent and reduce the incidence of out-of-wedlock pregnancies; and
4. To encourage the formation of two-parent families.

TANF became effective July 1, 1997, and replaced what was then commonly known as welfare: Aid to Families with Dependent Children (AFDC) and the Job Opportunities and Basic Skills Training (JOBS) programs. TANF provides assistance and work opportunities to needy families by providing states and tribal grantees the federal funds and wide flexibility to develop and implement their own welfare programs. Federally-recognized American Indian Tribes and certain Alaska Native organizations may elect to operate their own TANF programs to serve eligible Tribal families. As of October 1, 2005, there were 51 Tribal TANF programs serving 237 Tribes and Alaska Native villages in 15 States. The average monthly number of Indian families on Tribal TANF programs is approximately 11,000.

The following charts depict Tribal TANF Programs and their allocations for FY 2003 and FY 2004. The amount shown in the last column is the full annual grant awarded, without adjustment. Note, if a program starts other than at the beginning of the federal fiscal year, the first year's allocation is prorated.

New FY 2003 Tribal TANF Grants			
TRIBE or ORGANIZATION (state)	NUMBER OF TRIBES SERVED	PROGRAM IMPLEMENTATION, CONTINUATION/RENEWAL, & AMENDMENT DATES	TRIBAL FAMILY ASSISTANCE GRANT (TFAG)
Washoe Tribe of Nevada and California (CA)	2 tribes plus the non-reservation Indian population of Alpine, El Dorado, Sacramento, Nevada, Placer, Santa Clara, Alameda, San Francisco, Santa Cruz, San Mateo, and part of San Joaquin counties in California and Carson City and Douglas counties in Nevada	originated 1/1/03 amended 7/1/05 to add Nevada, Placer, Santa Clara, Alameda, San Francisco, Santa Cruz, San Mateo, and part of San Joaquin counties amended 9/1/05 to add Douglas and Carson City Counties in Nevada	\$13,940,901

## ACF-Office of Family Assistance

New FY 2003 Tribal TANF Grants			
Spokane Tribe of Indians (WA)	1 plus the non-reservation Indian populations of Adams, Lincoln, Pend Oreilles, Spokane, Stevens and Whitman Counties	originated 3/1/03	\$8,403,229
Oncida Tribe of Wisconsin (WI)	1 plus the non-reservation Indian population of Brown and Outagamie Counties	originated 5/1/03	\$835,924
California Tribal TANF Partnership - Robinson Rancheria (CA)	19 tribes plus the non-Rancheria/reservation Indian population of Lassen, Yuba, Napa, Sutter, Solano, Plumas, Glenn, Amador, Butte, Lake, Modoc, Colusa, Humboldt, Trinity, and Del Norte counties	originated 7/1/03 with 3 tribes and the non-reservation/rancheria Indian population of Lassen, Yuba, Napa, Sutter, Solano, Plumas, and Glenn counties amended 7/1/2003 to add Ione Miwok, Moretown Rancheria, Berry Creek Rancheria, Robinson Rancheria, Upper Lake Rancheria, Scotts Valley Rancheria, Elem Rancheria, Big Valley Rancheria, Fort Bidwell Rancheria, Cortina Rancheria, Big Lagoon Rancheria, Bear River Band of Rohnerville Rancheria, and Resighini Rancheria and the non-reservation/rancheria Indian population of Amador, Butte, Lake, Modoc, Colusa, Humboldt, Trinity, and Del Norte counties	\$4,581,606

New FY 2004 Tribal TANF Grants			
TRIBE or ORGANIZATION (state)	NUMBER OF TRIBES SERVED	PROGRAM IMPLEMENTATION, CONTINUATION/RENEWAL, & AMENDMENT DATES	TRIBAL FAMILY ASSISTANCE GRANT (TFAG)
North Fork Rancheria (CA)	1 tribe plus the non-Rancheria/reservation Indian population of Madera, Merced, and Mariposa counties	originated 11/1/03	\$787,882
Menominee Indian Tribe of Wisconsin (WI)	1 including trust lands in Shawano County	originated 4/1/04	\$1,267,930
South Puget Inter-tribal Planning Agency (WA)	3 including non-reservation members in Thurston, Pierce, Mason, and Kitsap Counties	originated 9/1/04	\$4,743,962

Each eligible Tribe or Alaska Native organization that wants to administer its own TANF program must submit a Tribal TANF Family Assistance Plan (TFAP) to the Department of Health and Human Services (HHS) for review and approval. Although no specific format is required, a TFAP must contain elements specified in the law and regulations, such as how Tribes will promote work and the stability and health of families, work activities and support services, time-limited assistance, sanctions for non-compliance with work requirements and personal responsibility. Unlike State TANF plans, which are reviewed to certify only that they are complete, HHS must approve Tribal TANF plans.

Tribes administering their own TANF program have great flexibility in program design and implementation. They can define such elements of their programs as the service area, service population (e.g., all Indian families in the service area or only enrolled members of the Tribe), time limits, benefits and services, the definition of "family," eligibility criteria and work and work activities. Tribes have the ability to establish, through negotiation with HHS, program work participation rate targets and required work hours. Also, they can establish what



## ACF-Office of Family Assistance



benefits and services will be available and develop their own strategies for achieving program goals, including how to help recipients move off welfare and become self-sufficient.

An important factor in successful administration of Tribal programs has been communication, collaboration and coordination with States and locally administered programs. In addition, Tribes can enter into partnerships with States and local governments to ensure that Tribal families continue to receive the support services necessary to become self-sufficient, such as food stamps and Medicaid. New relationships are being forged, and existing ones are being strengthened. Research conducted by the Washington University School of Social Work and funded by HHS found that Tribal TANF implementation on reservations has “strengthened coordination, communication, and collaboration at all levels – among Tribal social service providers, between Tribes and States, and Tribes and the Federal government.”

American Indian and Alaska Native families not served by Tribal TANF programs continue to be served by State TANF programs.

The purpose of the Native Employment Works (NEW) program is to make work activities available to grantees’ designated service populations and service areas. By law, only federally-recognized Indian Tribes and Alaska Native organizations that operated a Tribal Job Opportunities and Basic Skills Training (JOBS) program in FY 1995 are eligible for NEW program funding.



Annual NEW program funding amounts are set by law at the FY 1994 Tribal JOBS funding levels for each eligible Tribe/organization. Total annual funding available is \$7,633,287. FY 2003 NEW funds were awarded to 79 grantees, and FY 2004 NEW funds were awarded to 78 grantees. See chart on the following pages for specific dollar amounts allotted per state to each NEW grantee in FY 2003 and FY 2004.

NEW Program Grantees, by State		
STATE/TRIBE	FY 2003	FY 2004
Alaska		
Aleutian/Pribilof Islands Association, Inc.	\$7,600	\$7,600
Association of Village Council Presidents	\$326,075	\$326,075
Bristol Bay Native Association	\$54,427	\$54,427
Central Council of the Tlingit and Haida Indian Tribes	\$124,791	\$124,791
Chugachmiut	\$17,652	\$17,652

## ACF-Office of Family Assistance

NEW Program Grantees, by State		
Cook Inlet Tribal Council, Inc.	\$285,377	\$285,377
Kawerak, Inc.	\$80,415	\$80,415
Kodiak Area Native Association	\$19,123	\$19,123
Maniilaq Manpower, Inc.	\$75,267	
Metlakatla Indian Community	\$16,917	\$16,917
Tanana Chiefs Conference, Inc.	\$159,115	\$159,115
<b>Arizona</b>		
Cocopah Indian Tribe	\$5,187	\$5,187
Gila River Indian Community	\$126,512	\$126,512
Hualapai Nation	\$6,089	\$6,089
Navajo Nation (Arizona, New Mexico, and Utah)	\$1,752,666	\$1,752,666
Pascua Yaqui Tribe	\$55,025	\$55,025
Salt River Pima-Maricopa Indian Community	\$51,868	\$51,868
Tohono O'odham Nation	\$150,868	\$150,868
<b>California</b>		
California Indian Manpower Consortium	\$447,885	\$447,885
<b>Idaho</b>		
Coeur D'Alene Tribe of Idaho	\$6,568	\$6,568
Nez Perce Tribe	\$34,752	\$34,752
<b>Kansas</b>		
Kickapoo Tribe in Kansas	\$27,269	\$27,269
<b>Maine</b>		
Penobscot Nation	\$23,915	\$23,915
<b>Michigan</b>		
Sault Ste. Marie Tribe of Chippewa Indians	\$113,011	\$113,011
<b>Minnesota</b>		
Leech Lake Band of Chippewa Indians	\$168,176	\$168,176
Mille Lacs Band of Chippewa Indians	\$61,723	\$61,723
Minnesota Chippewa Tribe	\$396,575	\$396,575
Red Lake Band of Chippewa Indians	\$134,691	\$134,691
White Earth Band of Chippewa Indians	\$192,415	\$192,415
<b>Mississippi</b>		
Mississippi Band of Choctaw Indians	\$42,598	\$42,598
<b>Montana</b>		
Assiniboine and Sioux Tribes of the Fort Peck Reservation	\$64,671	\$64,671
Blackfeet Tribe	\$116,825	\$116,825
Chippewa-Cree Tribe of the Rocky Boy's Reservation	\$24,512	\$24,512
Confederated Salish and Kootenai Tribes of the Flathead Reservation	\$60,238	\$60,238
Crow Tribe of Montana	\$69,365	\$69,365
Northern Cheyenne Tribe	\$59,456	\$59,456
<b>Nebraska</b>		
Omaha Tribe of Nebraska	\$39,606	\$39,606
Santee Sioux Nation	\$12,576	\$12,576
Winnebago Tribe of Nebraska	\$19,389	\$19,389
<b>Nevada</b>		
Shoshone-Paiute Tribes of the Duck Valley Reservation (Nevada & Idaho)	\$5,257	\$5,257
<b>New Mexico</b>		
Mescalero Apache Tribe	\$22,244	\$22,244
Pueblo of Zuni (Zuni Tribe)	\$54,474	\$54,474



## ACF-Office of Family Assistance



NEW Program Grantees, by State		
New York		
Seneca Nation of New York	\$74,616	\$74,616
North Carolina		
Eastern Band of Cherokee Indians	\$90,972	\$90,972
North Dakota		
Spirit Lake Sioux Tribe	\$55,904	\$55,904
Standing Rock Sioux Tribe (North Dakota and South Dakota)	\$75,312	\$75,312
Three Affiliated Tribes of the Fort Berthold Reservation	\$38,279	\$38,279
Turtle Mountain Band of Chippewa Indians	\$207,368	\$207,368
Oklahoma		
Cheyenne and Arapaho Tribes of Oklahoma	\$53,288	\$53,288
Chickasaw Nation	\$29,960	\$29,960
Comanche Nation	\$34,991	\$34,991
Inter-Tribal Council, Inc.	\$7,776	\$7,776
Sac and Fox Nation	\$10,063	\$10,063
Oregon		
Confederated Tribes of the Grande Ronde Community	\$54,426	\$54,426
South Dakota		
Cheyenne River Sioux Tribe	\$69,415	\$69,415
Lower Brule Sioux Tribe	\$8,184	\$8,184
Oglala Sioux Tribe	\$219,158	\$219,158
Rosebud Sioux Tribe	\$164,596	\$164,596
Sisseton-Wahpeton Sioux Tribe	\$41,831	\$41,831
Washington		
Colville Confederated Tribes	\$111,945	\$111,945
Confederated Tribes and Bands of the Yakama Nation	\$131,731	\$131,731
Lummi Tribe	\$57,274	\$57,274
Makah Indian Tribe	\$12,496	\$12,496
Nooksack Indian Tribe	\$45,819	\$45,819
Puyallup Tribe	\$22,910	\$22,910
Sauk-Suiattle Indian Tribe	\$11,455	\$11,455
South Puget Inter-Tribal Planning Agency (SPIPA)	\$57,274	\$57,274
Stillaguamish Tribe	\$14,319	\$14,319
Swinomish Indian Tribal Community	\$17,182	\$17,182
Tulalip Tribes	\$28,637	\$28,637
Upper Skagit Indian Tribe	\$45,819	\$45,819
Wisconsin		
Forest County Potawatomi Community	\$13,185	\$13,185
Ho-Chunk Nation	\$52,217	\$52,217
Lac Courte Oreilles Band of Chippewa Indians	\$58,483	\$58,483
Menominee Indian Tribe of Wisconsin	\$114,615	\$114,615
Oneida Tribe of Wisconsin	\$19,320	\$19,320
Sokaogon Chippewa Community	\$13,184	\$13,184
Wyoming		
Eastern Shoshone Tribe (Shoshone Tribe of the Wind River Reservation)	\$22,447	\$22,447
Northern Arapahoe Tribe (Arapahoe Tribe of the Wind River Reservation)	\$33,671	\$33,671

NEW programs provide work activities and supportive and job retention services to help clients prepare for and obtain permanent, unsubsidized employment.

## *ACF-Office of Family Assistance*

NEW grantees have the flexibility to design their programs to meet their needs, to select their service population and service area and to determine the work activities and related services they will provide. In designing their NEW programs, Tribes consider the unique economic and social conditions in their communities and the needs of individual clients. Clients generally have low levels of education and job skills and often face serious shortages of job opportunities and support services. Working with related programs, NEW programs help Tribes address these problems, bridge service gaps, and provide coordinated employment, training, and related services. Primary coordination linkages are with Tribal and State TANF programs, other employment and training programs (for example, the Department of Labor's Workforce Investment Act program), Head Start and child care programs, Tribal and community colleges and local businesses.

NEW work activities include (but are not limited to):

- Educational activities, including remedial, post-secondary and alternative education;
- Training and job readiness activities, including job skills training, on-the-job training (OJT), entrepreneurial training and management training, and
- Employment activities, including job search, job development and placement, unsubsidized and subsidized public and private sector employment and community work experience.

NEW program supportive and job retention services are work and family self-sufficiency-related services that enable a client to participate in the program. They include transportation, child care, counseling, medical services and services such as providing eyeglasses, equipment, tools and uniforms needed for jobs. NEW program activities also may include labor/job market assessments, job creation and economic development leading to job creation.

NEW programs coordinated education, training, work experience, job search and job referral with other Tribal programs and with local educational institutions and employers. They provided intensive case management, behavioral and health counseling and life skills training. Many Tribes with NEW programs located training, employment and social services in "one-stop" centers where staff assessed clients' needs and then provided targeted activities and services to meet those needs. Information/resource centers and learning centers containing resource materials, classrooms and computer labs provided job preparation services, including individual needs assessments, case management and classroom instruction.

Many NEW grantees helped clients achieve educational goals to prepare for employment, such as receiving their GED or AA degree. Grantees provided GED preparation classes and enrolled clients in nearby colleges, including Tribal



## *ACF-Office of Family Assistance*

---

colleges, where the clients took courses in nursing, child care, accounting, business, management, etc. Grantees helped clients take vocational courses to pursue careers as certified nursing assistants, office workers, fire fighters, auto mechanics, bus drivers, construction workers and more.

NEW programs established OJT and work experience placements for clients and helped them locate and apply for permanent employment. Funding was also used to provide vans and other transportation to take clients with work experience to classes and training to conduct job searches. The funding was used by clients to purchase clothing and equipment needed for employment, pay bills, and other necessary situations. The funding also provided child care and other needed supportive and job retention services and to operate programs to help clients overcome barriers including substance abuse and domestic violence.



## *ACF-Office of Community Services*

The Office of Community Services (OCS) is a component of the Administration for Children and Families within the Department of Health and Human Services. The mission of the Office of Community Services is to increase the capacity of individuals and families to become more self-sufficient and assist them to build, revitalize and strengthen their communities. The vision is to provide leadership to address the causes and effects of poverty and to empower low-income individuals and families to thrive in safe and healthy communities.

OCS's objectives are to increase its understanding of the problems and needs of its constituents; improve access to resources; strengthen partnerships with other federal agencies, state, tribal and local governments, nonprofit agencies, community-based organizations, national associations and the private sector; and foster stability, self-sufficiency, safety and economic opportunities to help create upward mobility and increased well being.

OCS is headed by a Director and Deputy Director of four divisions: Division of State Assistance; Division of Community Discretionary Programs; Division of Community Demonstration Programs and Division of Energy Assistance. Within each division there are several programs or discretionary funding opportunities available to tribes and/or Native American organizations.

In FY 2003 and FY 2004, tribes and/or tribal Native American organizations received direct funding grant awards from the following OCS programs: Assets for Independence (AFI) Demonstration Program, Community Economic Development Program, Community Food and Nutrition Program, Community Services Block Grant (CSBG), Low Income Home Energy Assistance Program (LIHEAP) and Rural Community Facilities Program.

### **Assets for Independence Program (Individual Development Accounts)**

The Assets for Independence Demonstration (AFI/IDA) provides competitive grants to nonprofit organizations (and state, local and tribal governments applying jointly with nonprofit organizations) to manage individual development account (IDA) projects for low-income working families. IDAs are dedicated savings accounts that participants may use to pay for post-secondary education, purchase a first home and/or start a business. IDAs include participant savings from earned income, matched by deposits of up to eight dollars for each dollar saved. In FY 2003, one tribal IDA was funded:

Cook Inlet Tribal Council (Alaska)

Project period: 9/2003 – 9/2008

FY 2003 funding: \$625,000 (for the entire 5-year project period)



# ACF-Office of Community Services

## Community Economic Development Program

Community Economic Development competitive grants support community development corporation (CDC) projects that provide employment and business development opportunities for low income people in disinvested communities.

The Following CDC grants were awarded in FY 2003 and FY 2004:

Four Directions Development Corporation (Maine)

Project period: 9/30/2003 – 6/30/2005

Total funding amount: \$75,000

Ho-Chunk Community Development Corporation (Nebraska)

Project period: 9/30/2004 – 9/29/2009

FY 2004 funding: \$128,777

Total funding amount: \$688,885

Native Opportunity Way Community Development Corporation, Inc.  
(North Carolina)

Project period: 5/1/2004 – 4/30/2007

Total funding amount: \$349,580

Passamaquoddy Development and Supply Company (Maine)

Project period: 9/30/2004 – 9/29/2005

Total funding amount: \$75,000

Tohono O'odham Community Action, Inc. (Arizona)

Project period: 9/30/2003 – 9/29/2008

Total funding amount: \$700,000

White Earth Investment Initiative (Minnesota)

Project period: 9/30/2004 – 9/29/2007

Total funding amount: \$350,000

## Community Food and Nutrition Program

Community Food and Nutrition Program competitive grants assist public and private nonprofit agencies to coordinate existing food assistance resources, identify sponsors of child nutrition programs, initiate new programs in unserved and under-served areas and develop innovative approaches to help low income people meet their nutrition needs. In FY's 2003 and 2004 there were a total of three tribal projects:



## ACF-Office of Community Services

Fort Peck Community College (Montana)

Project period: 9/30/2003 – 9/29/2004

Total funding amount: \$50,000

Northern Cheyenne Food Bank (Montana)

Project period: 9/30/2003 – 9/29/2004

Total funding amount: \$48,061

Stone Child College (Montana)

Project period: 9/1/2004 – 8/31/2005

Total funding amount: \$50,000

### Community Services Block Grant (CSBG)

The CSBG program addresses the causes and conditions of poverty. State and tribal grantees use CSBG funds to support a wide variety of services for low-income people. CSBG services typically include: assisting with employment, education and adequate housing; providing nutrition, child care, transportation, youth development and emergency health services; solving problems that block the achievement of self-sufficiency; helping people make better use of their income and coordinating resources. In FY 2003, a total of 67 tribal grantees received a total of \$4,066,217 in direct CSBG funding; and in FY 2004, a total of 65 tribal grantees received a total of \$4,116,323 in direct CSBG funding. (See the following charts for specific allocations).

COMMUNITY SERVICES BLOCK GRANT TRIBAL ALLOCATIONS -- FY 2003	
Grantee	Allocation Amount
<b>ALABAMA</b>	
MOWA BAND OF CHOCTAW INDIANS	\$56,041
POARCH BAND OF CREE INDIANS	\$16,815
<b>ALASKA</b>	
BRISTOL BAY NATIVE ASSOCIATION	\$96,475
CENTRAL COUNCIL OF THE TLINGIT AND HAIDA INDIAN TRIBES	\$218,013
COOK INLET TRIBAL COUNCIL	\$268,411
EIIBANKS NATIVE ASSOCIATION	\$39,691
SHOONAQ TRIBE OF KODIAK	\$42,676
SITKA TRIBE OF ALASKA	\$41,507
TANANA CHIEFS CONFERENCE, INC.	\$200,855
VILLAGE OF OLD HARBOR	\$6,267
<b>ARIZONA</b>	
NAVAJO NATION (AZ) (NM) (UT)	\$1,177,435
QUECHAN TRIBE (AZ) (CA)	\$8,713
SAN CARLOS APACHE TRIBE	\$55,388
WHITE MOUNTAIN APACHE TRIBE	\$65,596
<b>COLORADO</b>	
SOUTHERN UTE INDIAN TRIBE	\$6,818



# ACF-Office of Community Services



COMMUNITY SERVICES BLOCK GRANT TRIBAL ALLOCATIONS -- FY 2003	
Grantee	Allocation Amount
<b>IDAHO</b>	
NEZ PERCE TRIBE	\$22,397
SHOSHONE-BANNOCK TRIBES OF THE FT. HALL RESERVATION	\$36,814
<b>KANSAS</b>	
UNITED TRIBES OF KANSAS AND SOUTHEAST NEBRASKA	\$309
<b>MAINE</b>	
PASSAMAQUODDY TRIBE - PLEASANT POINT	\$3,053
<b>MICHIGAN</b>	
INTER-TRIBAL COUNCIL OF MICHIGAN	\$32,498
SAULT STE. MARIE TRIBE OF CHIPPEWA INDIANS	\$5,571
<b>MONTANA</b>	
ASSINIBOINE AND SIOUX TRIBES OF THE FT. PECK RESERVATION	\$65,982
BLACKFEET TRIBE	\$80,065
CHIPPEWA-CREE TRIBE OF THE ROCKY BOYS RESERVATION	\$24,958
NORTHERN CHEYENNE TRIBE	\$46,417
<b>NEW JERSEY</b>	
NANTICOKE LENNI-LENAPE INDIANS OF NEW JERSEY, INC.	\$21,568
<b>NEW MEXICO</b>	
FIVE SANDOVAL INDIAN PUEBLOS, INC.	\$30,693
JICARILLA APACHE TRIBE	\$14,010
PUEBLO OF ZUNI	\$49,623
<b>NEW YORK</b>	
ST. REGIS BAND OF MOHAWK INDIANS	\$12,606
<b>NORTH CAROLINA</b>	
COHARIE INTRA-TRIBAL ASSOCIATION	\$9,188
HALIWA-SAPONI INDIAN TRIBE	\$16,391
LUMBEE TRIBE	\$232,849
<b>NORTH DAKOTA</b>	
SPIRIT LAKE SIOUX TRIBE	\$44,478
THREE AFFILIATED TRIBES OF THE FT. BERTHOLD RESERVATION	\$53,986
TURTLE MOUNTAIN BAND OF CHIPPEWA INDIANS	\$116,468
<b>OKLAHOMA</b>	
APACHE TRIBE OF OKLAHOMA	\$3,131
CHEROKEE NATION	\$45,278
CHEYENNE-ARAPAHO TRIBES OF OKLAHOMA	\$6,007
CHICKASAW NATION	\$13,995
CHOCTAW NATION	\$20,964
CITIZEN POTAWATOMI NATION	\$1,948
COMMANCHE INDIAN TRIBE	\$9,820
DELAWARE NATION	\$1,044
MUSCOGEE (CREEK) NATION	\$27,686
OSAGE TRIBE	\$42,807
PAWNEE NATION	\$2,728
SAC AND FOX NATION OF OKLAHOMA	\$5,325
SEMINOLE NATION OF OKLAHOMA	\$14,694
WICHITA AND AFFILIATED TRIBES	\$2,030
<b>OREGON</b>	
CONFEDERATED TRIBES OF THE GRAND RONDE RESERVATION	\$10,743
CONFEDERATED TRIBES OF THE SILETZ RESERVATION	\$2,564
KLAMATH INDIAN TRIBE	\$12,617

## ACF-Office of Community Services

COMMUNITY SERVICES BLOCK GRANT TRIBAL ALLOCATIONS -- FY 2003	
Grantee	Allocation Amount
<b>RHODE ISLAND</b>	
NARRAGANSETT INDIAN TRIBE	\$26,176
<b>SOUTH DAKOTA</b>	
OGLALA SIOUX TRIBE	\$207,309
ROSEBUD SIOUX TRIBE	\$119,392
SISSETON-WAHPETON SIOUX TRIBE (SD) (ND)	\$47,943
YANKTON SIOUX TRIBE	\$27,311
<b>WASHINGTON</b>	
COLVILLE CONFEDERATED TRIBES	\$23,546
LUMMI TRIBE	\$7,983
MUCKLESHOOT INDIAN TRIBE	\$9,528
NOOKSACK INDIAN TRIBE	\$3,702
PUYALLUP TRIBE	\$83,559
SOUTH PUGET INTERTRIBAL PLANNING AGENCY	\$23,724
SWINOMISH INDIANS	\$2,581
TULALIP TRIBES	\$5,077
YAKAMA NATION	\$34,380
<b>FY 2003 TOTAL</b>	<b>\$4,066,217</b>

COMMUNITY SERVICES BLOCK GRANT TRIBAL ALLOCATIONS -- FY 2004	
Grantee	Allocation Amount
<b>ALABAMA</b>	
MOWA BAND OF CHOCTAW INDIANS	\$55,709
POARCH BAND OF CREEK INDIANS	\$16,715
<b>ALASKA</b>	
BRISTOL BAY NATIVE ASSOCIATION	\$95,904
CENTRAL COUNCIL OF THE TLINGIT AND HAIDA INDIAN TRIBES	\$216,723
COOK INLET TRIBAL COUNCIL	\$266,824
FAIBANKS NATIVE ASSOCIATION	\$39,456
SHOONAQ TRIBE OF KODIAK	\$42,424
SITKA TRIBE OF ALASKA	\$41,261
TANANA CHIEFS CONFERENCE, INC.	\$199,667
VILLAGE OF OLD HARBOR	\$6,230
<b>ARIZONA</b>	
NAVAJO NATION (AZ) (NM) (UT)	\$1,170,458
QUECHAN TRIBE (AZ) (CA)	\$17,890
SAN CARLOS APACHE TRIBE	\$55,060
WHITE MOUNTAIN APACHE TRIBE	\$65,207
<b>COLORADO</b>	
SOUTHERN UTE INDIAN TRIBE	\$6,778
<b>IDAHO</b>	
NEZ PERCE TRIBE	\$22,265
SHOSHONE-BANNOCK TRIBES OF THE FT. HALL RESERVATION	\$36,597
<b>MAINE</b>	
PASSAMAQUODDY TRIBE - PLEASANT POINT	\$3,035
<b>MICHIGAN</b>	
INTER-TRIBAL COUNCIL OF MICHIGAN	\$33,370
SAULT STE. MARIE TRIBE OF CHIPPEWA INDIANS	\$32,613



# ACF-Office of Community Services



COMMUNITY SERVICES BLOCK GRANT TRIBAL ALLOCATIONS -- FY 2004	
Grantee	Allocation Amount
<b>MONTANA</b>	
ASSINIBOINE AND SIOUX TRIBES OF THE FT. PECK RESERVATION	\$65,591
BLACKFEET TRIBE	\$79,592
CHIPPEWA-CREE TRIBE OF THE ROCKY BOY'S RESERVATION	\$24,810
CONFEDERATED SALISH AND KOOTENAI TRIBES	\$69,502
NORTHERN CHEYENNE TRIBE	\$46,142
<b>NEW JERSEY</b>	
NANTICOKE LENNI-LENAPE INDIANS OF NEW JERSEY, INC.	\$21,440
<b>NEW MEXICO</b>	
FIVE SANDOVAL INDIAN PUEBLOS, INC.	\$30,511
JICARILLA APACHE TRIBE	\$13,927
PUEBLO OF ZUNI	\$49,329
<b>NEW YORK</b>	
ST. REGIS BAND OF MOHAWK INDIANS	\$12,343
<b>NORTH CAROLINA</b>	
COHARIE INTRA-TRIBAL ASSOCIATION	\$9,134
HALIWA-SAPONI INDIAN TRIBE	\$16,294
LUMBEE TRIBE	\$231,469
<b>NORTH DAKOTA</b>	
SPIRIT LAKE SIOUX TRIBE	\$44,215
THREE AFFILIATED TRIBES OF THE FT. BERTHOLD RESERVATION	\$53,666
TURTLE MOUNTAIN BAND OF CHIPPEWA INDIANS	\$115,779
<b>OKLAHOMA</b>	
APACHE TRIBE OF OKLAHOMA	\$3,112
CHEROKEE NATION	\$45,012
CHEYENNE-ARAPAHO TRIBES OF OKLAHOMA	\$5,972
CHICKASAW NATION	\$13,912
CHOCTAW NATION	\$20,840
CITIZEN POTAWATOMI NATION	\$1,936
COMMANCHE INDIAN TRIBE	\$9,762
DELAWARE NATION	\$1,037
MUSCOGEE (CREEK) NATION	\$27,522
OSAGE TRIBE	\$42,553
PAWNEE NATION	\$2,712
SAC AND FOX NATION OF OKLAHOMA	\$5,294
SEMINOLE NATION OF OKLAHOMA	\$14,607
WICHITA AND AFFILIATED TRIBES	\$2,018
<b>OREGON</b>	
CONFEDERATED TRIBES OF THE GRAND RONDE RESERVATION	\$10,680
CONFEDERATED TRIBES OF THE SILETZ RESERVATION	\$2,548
KLAMATH INDIAN TRIBE	\$12,542
<b>RHODE ISLAND</b>	
NARRAGANSETT INDIAN TRIBE	\$26,021
<b>SOUTH DAKOTA</b>	
OTLALA SIOUX TRIBE	\$206,083
ROSEBUD SIOUX TRIBE	\$118,686
SISSETON-WAHPETON SIOUX TRIBE (SD) (ND)	\$47,660
<b>WASHINGTON</b>	
COLVILLE CONFEDERATED TRIBES	\$23,407
LUMMI TRIBE	\$7,935

## ACF-Office of Community Services

COMMUNITY SERVICES BLOCK GRANT TRIBAL ALLOCATIONS -- FY 2004	
Grantee	Allocation Amount
WASHINGTON	
MUCKLESHOOT INDIAN TRIBE	\$9,472
NOOKSACK INDIAN TRIBE	\$3,680
PUYALLUP TRIBE	\$83,064
SOUTH PUGET INTERTRIBAL PLANNING AGENCY	\$23,583
SWINOMISH INDIANS	\$2,566
YAKAMA NATION	\$34,177
<b>FY 2004 TOTAL</b>	<b>\$4,116,323</b>

### Compassion Capital Fund

Compassion Capital Fund competitive grants help faith-based and community organizations increase their effectiveness and enhance their ability to provide social services to those most in need. In FY 2004, there were three tribal grantees:

Central Council of the Tlingit and Haida Indian Tribes (Alaska)

Project period: 8/1/2004 - 7/31/2005

Total funding amount: \$50,000

Kaw Nation (Oklahoma)

Project period: 8/1/2004 - 7/31/2005

Total funding amount: \$50,000

Kenaitze Indian Tribe (Alaska)

Project period: 8/31/2004

Total funding amount: \$49,419

### Low Income Home Energy Assistance Program (LIHEAP)

LIHEAP assistance and services are provided through the LIHEAP block grant, the leveraging incentive program for LIHEAP grantees and the Residential Energy Assistance Challenge Option (REACH) Program for LIHEAP grantees. The LIHEAP block grant helps low income households meet the costs of home energy (home heating and cooling). State and tribal grantees use LIHEAP block grant funds to provide heating assistance, cooling assistance, energy crisis intervention (crisis assistance), weatherization and services that encourage and enable households to reduce their home energy costs. The LIHEAP leveraging incentive program rewards grantees that leverage nonfederal home energy resources. REACH grants support innovative projects to demonstrate the long term cost-effectiveness of supplementing energy assistance benefits with non-monetary benefits that increase the ability of eligible households to meet home energy costs and achieve energy self-sufficiency.



## *ACF-Office of Community Services*



Each year in the LIHEAP program, approximately 65,000 – 75,000 American Indian households are served by tribal grantees that receive direct LIHEAP funding from HHS. The number of households served each year by tribal grantees is affected by variables including LIHEAP appropriation amounts and funding levels, the number of tribal grantees, weather conditions, home energy prices and economic conditions. State LIHEAP programs serve American Indian households that are not in the service population of direct tribal grantees. Data on the number of American Indian households served by state LIHEAP programs are not available.

In FY 2003, 138 tribal grantees received a total of \$22,207,434 in direct LIHEAP funding, including regular LIHEAP block grant, emergency contingency, leveraging incentive fund and Residential Energy Assistance Challenge Option (REACH) funding and in FY 2004, 138 tribal grantees received a total of \$21,258,540.

### **Rural Community Facilities Program (Rural Community Development Activities Program)**

Rural Community Facilities grants support private nonprofit groups that provide training and technical assistance to low income rural communities to develop expertise needed to establish and/or maintain safe water and wastewater treatment facilities. The following 3-year Rural Community Facilities Program grant project was initially funded in FY 2002.

Inter-Tribal Council of Arizona, Inc. (Arizona)  
Project period: 9/30/2002 – 9/29/2005  
Total funding amount: \$1,796,103

### **Training and Technical Assistance**

OCS and its training and technical assistance providers provide technical assistance to tribes in conferences and meetings, on site and by telephone, correspondence and printed material. Printed material includes the Low Income Home Energy Assistance Program (LIHEAP) tribal manual, which provides in-depth information for tribes on applying for LIHEAP funds and operating a LIHEAP program.

## *ACF-Office of Child Support Enforcement*

The Office of Child Support Enforcement (OCSE) is located in the Administration for Children and Families (ACF) in Washington, D.C. The Child Support Enforcement Program was established in 1975 under title IV-D of the Social Security Act. The goals of the Child Support Enforcement Program (also known as the title IV-D program) are to ensure that children have the financial support of both parents, to foster responsible behavior towards children, to emphasize that children need to have both parents involved in their lives and to reduce welfare costs.

The IV-D program locates noncustodial parents, establishes parentage, establishes and enforces support orders and collects child support payments from parents who are legally obligated to pay. Since 1996, Title IV-D has authorized direct funding of Tribes and Tribal organizations to operate child support enforcement programs. The direct Federal funding provides Tribes with an opportunity to design their own child support programs to meet the needs of the Tribes' children and their families. The Child Support Enforcement Program is a joint partnership involving federal, state, tribal and local cooperative efforts. The States, Tribes and territories run their own CSE programs, each with their own unique laws and procedures.

Accordingly, the mission of the Office of Child Support Enforcement is to enhance the well-being of children by assuring that assistance in obtaining support, including financial and medical, is available to children through locating parents, establishing parentage, establishing support obligations, and monitoring and enforcing those obligations. The vision for the future is that children can count on their parents for the financial, medical and emotional support they need to be healthy and successful.

OCSE provides Federal oversight of the program. The specific responsibilities of this office include the development of policies, procedures, guidance and technical assistance for State and Tribal programs. Primary responsibility for the oversight, monitoring and overall management of the Tribal Child Support Enforcement Program rests with the OCSE Division of Special Staffs, along with the ACF Regional Offices.

### **Tribal Child Support Enforcement Program**

Final regulations for Tribal Child Support Enforcement Program, published March 30, 2004, implement funding to Indian Tribes and Tribal organizations under section 455(f) of the Social Security Act, by authorizing direct funding of Tribal Child Support Enforcement programs meeting requirements contained in the statute and regulation. To receive funding, Tribes must meet the objectives of the program, including establishment of parentage; establishment, modification and enforcement of support orders and location of custodial and noncustodial parents. For the



## ACF-Office of Child Support Enforcement



first three years of full operation, the Federal government will pay 90 percent of reasonable and necessary costs of the programs. During that time, Tribes and Tribal organizations will be required to make contributions of 10 percent. Thereafter, the Federal and Tribal shares become 80 and 20 percent, respectively.

Nine Tribal Child Support Enforcement Programs have been implemented thus far, and projections are for up to 50 Tribal Child Support Enforcement Programs by FY 2007. The budget information and recipients for Tribal Child Support Enforcement Programs for FY 2003 and FY 2004 are listed in the chart below.

Tribal Child Support Enforcement Programs		
Name & Location of Grantee	FY 2003 Dollar Amounts	FY 2004 Dollar Amounts
Chickasaw Nation, Oklahoma	\$1,780,749	\$3,803,987
Navajo Nation, N.M./Arizona/Colorado	\$4,367,849	\$5,725,454
Puyallup Tribe, Washington	\$691,218	\$791,883
Sisseton-Wahpeton Sioux Tribe, South Dakota	\$360,141	\$489,161
Lac du Flambeau Tribe, Wisconsin	\$196,863	\$229,713
Menominee Tribe, Wisconsin	\$494,960	\$830,805
Port Gamble S'Klallam, Washington	\$636,211	\$670,558
Lummi Tribe, Washington	\$79,545	\$458,187
Forest County Potawatomi, Wisconsin	17 month grant	\$156,522

The final regulation also provides for up to \$500,000 in start-up funding to Tribes and Tribal Organizations for the reasonable and necessary costs of developing a Tribal IV-D program that meets Federal requirements. Tribes are not required to share in the start-up costs.

In FY 2004, OCSE provided \$500,000 in start-up funding to the Central Council of Tlingit Haida Indian Tribes of Alaska (CCTHIA).

## *ACF-Office of Child Support Enforcement*

### **Technical Assistance**

Technical assistance is available to Tribes from OCSE and ACF Regional Offices, including workshops and conferences providing technical assistance to potential applicants. OCSE engaged in an extensive roll-out program since issuance of the new regulations with briefings including:

- HHS Tribal Budget Consultation meeting;
- Joint National Congress of American Indians-American Public Human Services Association;
- National Conference of State Legislatures (NCSL);
- National Tribal Child Support Enforcement Association; and
- Workshops at various child support conferences.

### **Outreach Projects**

Special Improvement Project Grants are available to design and carry out special projects of regional and national significance relating to the improvement of child support enforcement efforts. These activities must be consistent with the goals of the national child support mission to ensure all children receive financial and medical support from both parents and must also advance the purposes of Title IV-D. Also, while only State Title IV-D agencies (or state umbrella agencies) are eligible to apply for Child Support Enforcement demonstration project grants under Section 1115 of the Social Security Act, we note that Tribes and Tribal organizations, including faith and community-based organizations, may be collaborators with the States in the proposed projects, as appropriate.

A Special Improvement Project Grant was given to the Nat'l American Indian Court Judges Association, Boulder, Colorado, for their Nat'l Tribal Justice Resource Center (FY-03/04; \$199,887) to conduct a needs assessment and provide technical assistance and models of child support services to help tribal courts and agencies implement successful and effective child support programs.

### **OCSE Success Stories**

Since FY 2002, the Tribal IV-D caseload has increased from 21,720 to 26,425 – an increase of nearly 22 percent. Over that same time, Tribal IV-D program collections tripled, from \$3,897,597 to \$12,420,354.



# *ACF-Administration on Developmental Disabilities*



The Administration on Developmental Disabilities (ADD) is part of the Administration for Children and Families, of the U.S. Department of Health and Human Services. ADD ensures that individuals with developmental disabilities and their families participate in the design of, and have access to, culturally competent services, supports and other assistance and opportunities that promote independence, productivity, integration, and inclusion into the community.

Three goals of ADD are:

**1. Making a difference through self-advocacy;**

ADD programs and services emphasize empowerment of people with developmental disabilities and their families.

**2. Making a difference through inclusion;**

ADD programs foster community integration of children and adults who have disabilities in jobs, education, housing, and society.

**3. Making a difference through you.**

ADD works through all people by increasing awareness, improving communities and promoting a society in which people are valued for their unique contributions and talents.

ADD programs are at work in every state and U.S. territory. ADD does not provide direct consumer support or financial assistance. ADD provides funding, monitoring and policy guidance to its programs nationwide.

## **The Native American Protection & Advocacy Project**

The Native American Protection & Advocacy Project (NAPAP) provides legal representation to Native Americans with disabilities. As the only legal advocacy organization of this type in the United States, NAPAP also provides extensive information, training and advice to other disability advocacy groups across the Nation regarding Native American issues. The ADD allotment to NAPAP for Fiscal Year 2003 was \$184,802 and Fiscal Year 2004 was \$195,775.

The Native American Protection and Advocacy Project (NAPAP) with three state grantees (AZ, NM and UT) provided trainings to allow parents of children with disabilities to expand their knowledge about Special Education Law under IDEA.

## **Projects of National Significance**

Under the Developmental Disabilities Assistance and Bill of Rights Act of 2000, the Administration on Developmental Disabilities awarded grants and contracts for Projects of National Significance (PNS) to enhance the independence,

## *ACF-Administration on Developmental Disabilities*

productivity and inclusion of individuals with developmental disabilities. PNS grants are awarded on a competitive basis to public and private non-profit entities for wide applicability and effect. ADD annually solicits funding applications from non-profits, institutions of higher learning, State and local governments and Tribal governments.

In Fiscal Year 2003, the University of New Mexico, Health Science Center received one year of funding to plan and design a One-Stop Center to assist unserved and underserved families of individuals with developmental disabilities. In Fiscal Year 2004, the grantee's plan was selected to proceed with implementation and will be funded for five years. In collaboration with the Five Sandoval Indian Pueblos, Inc., this project is implementing a Family Support 360 Center in each of the five Pueblos to provide a comprehensive array of culturally appropriate services and supports for families who have a son or daughter with a developmental disability. A steering committee of families, tribal members and key agencies are overseeing the implementation of the five Centers.

### **Native American Disability Summit**

The South Dakota Council conducted the Native American Disability Summit in May 2003. The Summit is an annual event held to provide a forum to share information about services available to Native Americans. ADD provided \$6,000 in funds, and other funding totaled \$44,373.

### **The University Centers for Excellence in Developmental Disabilities Education, Research and Service**

The University Centers for Excellence in Developmental Disabilities Education, Research and Service (UCEDD) are components of a university system or are public or not-for-profit entities associated with universities. The UCEDDs of AZ, CO, NM and UT focus on health as they provide services under the Indian Children's Program.

### **The Mississippi Governor's Council on Developmental Disabilities**

The Mississippi Governor's Council on Developmental Disabilities awarded a competitive grant to the Mississippi Band of Choctaw Indians for a project entitled "Career Exploration Curriculum" that resulted in development of seventeen units with a training video. This curriculum has been presented to approximately 22 Native American Tribes throughout the United States. Although the Council funded project has ended, training using the video and curriculum continues on the Choctaw Reservation in Mississippi.



## *ACF-Administration on Developmental Disabilities*

---

### **Native American Self-Employment Conference for People with Disabilities**

The NAPAP sponsored their 1st Annual Native American Self-Employment Conference for People with Disabilities on July 13, 2004 in Farmington, New Mexico. This conference was a collaborative project with many other sponsors. The topics discussed were: Independent Living Skills, Benefits, Marketing and Networking, Business Plans, Grant Writing and Website Development.



## *ACF-Administration on Children, Youth and Families*

**T**he Administration on Children, Youth and Families (ACYF) administers the major Federal programs that support social services programs that promote the positive growth and development of children and youth and their families; protective services programs and shelter for children and youth in at-risk situations; child care programs for working families and families on public assistance and adoption programs for children with special needs. These programs provide financial assistance to States, community-based organizations, and academic institutions to provide services, carry out research and demonstration activities and undertake training, technical assistance and information dissemination.

The Administration on Children, Youth and Families is a part of the Administration for Children and Families (ACF), under the Department of Health and Human Services, and is administered by a Commissioner who is a Presidential appointee and confirmed by the United States Senate. In FYs 2003 and 2004, ACYF was divided into four bureaus, each of which was responsible for different issues involving children, youth and families and a cross-cutting unit responsible for research and evaluation. An Associate Commissioner heads each ACYF Bureau. In addition, the United States and its territories are divided into 10 geographic regions, each having an office responsible for administering some of ACYF's programs located in that region.

The four Bureaus of the Administration on Children, Youth and Families are the Children's Bureau, Child Care Bureau, Family and Youth Services Bureau and Head Start Bureau. Each Bureau in the ACYF department is discussed in detail in this Report. Note that there was a reorganization of ACF since FY 2004; however the descriptions in this report reflect organizational arrangements during the fiscal years that are the subject of this report.



## *ACYF-Children's Bureau*

The Children's Bureau (CB) is the oldest federal agency for Children within ACF. It is responsible for assisting States in the delivery of child welfare services—services designed to protect children and strengthen families. With an annual budget of over \$6.7 billion, CB works with State and local agencies to develop a number of programs, including child protective services (child abuse and neglect), family preservation and support, foster care, adoption and independent living, that focus on preventing the abuse of children in troubled families, protecting children from abuse and finding permanent placements for those who cannot safely return to their homes.

The Children's Bureau seeks to provide for the safety, permanency and well being of children through leadership, support for necessary services, oversight and review and productive partnerships with States, Tribes and communities.

Beyond the technical assistance available through the Regional Offices' child welfare specialists, additional technical assistance is provided through the Children's Bureau's array of training and technical assistance (T/TA). This includes support resources funded through grants, contracts, cooperative agreements, Clearinghouses and technical support projects.

The Children's Bureau is composed of four departments: the Office of Child Abuse and Neglect, Division of Policy, Division of Program Implementation, Division of Research and Innovation and Division of Child Welfare Capacity Building. Throughout these divisions, the Children's Bureau administers several programs to provide support to Tribes.

### **Title IV-B, subpart 1 (Child Welfare Services)**

The Title IV-B, subpart 1, Child Welfare Services program helps State and Tribal public welfare agencies improve their child welfare services with the goal of keeping families together. States and Tribes operate programs under the following broad purposes:

- Protecting and promoting the welfare of all children, including handicapped, homeless, dependent or neglected children;
- Preventing, remedying or assisting in the solution of problems, which may result in the neglect, abuse, exploitation or delinquency of children;
- Preventing the unnecessary separation of children from their families by identifying family problems, assisting families in resolving their problems, and preventing breakup of the family where the prevention of child removal is desirable and possible;
- Restoring to their families children who have been removed, by the



## ACYF-Children's Bureau

provision of services to the child and the families;

- Placing children in suitable adoptive homes, in cases where restoration to the biological family is not possible or appropriate; and
- Assuring adequate care of children away from their homes, in cases where the child cannot be returned home or cannot be placed for adoption.

### Title IV-B, subpart 2 (Promoting Safe and Stable Families)

The Title IV-B, subpart 2, **Promoting Safe and Stable Families** program provides funds to states to provide family preservation, community-based family support programs, time-limited family reunification services and services to promote and support adoptions. These services are primarily aimed at preventing the risk of abuse and promoting nurturing families, assisting families at risk of having a child removed from their home, promoting the timely return of a child to his/her home and if returning home is not an option, placement of a child in a permanent setting with services that support the family.

Funding to Tribes for the Title IV-B, subparts 1 and 2 were provided through formula grants as follows:

	FY 2003 Allocation	FY 2004 Allocation
Title IV-B, subpart 1 (Child Welfare Services)	\$5,837,137	\$5,829,560
Title IV-B, subpart 2 (Promoting Safe and Stable Families)	\$5,037,000	\$5,037,278
	\$10,874,137	\$10,866,838

The Children's Bureau also targets some discretionary funds towards Tribes. Funding in FY 2003 and FY 2004 included the following grants:

### Community-Based Family Resource and Support (CBFRS) Grants

(The name is now changed to Community-Based Child Abuse Protection Program (CBCAP)).

One percent of the total CBCAP allocation is reserved for Tribal and migrant programs. Tribes compete for three-year grants. The following Tribes received grants totaling approximately \$329,000 per year in FY 2003 and 2004:

- Cook Inlet Tribal Council, Inc., Anchorage, Alaska
- Indian Township Tribal Government, Princeton, Maine
- Southern California Indian Center, Inc., Los Angeles, California



# ACYF-Children's Bureau

## Child Welfare Training Grants

In FY 2003, this included an initiative called "Professional Education for Prospective and Current American Indian and/or Alaskan Native Public Child Welfare Staff." These grants were awarded to universities to serve Tribal staff who are currently enrolled or plan to enroll in undergraduate or graduate social work programs (awarding BSW and /or MSW Degrees). The following universities were each awarded, in FY 2003, up to \$75,000 each year for five years.

- The Regents of The University of Minnesota, Minneapolis, MN
- University of Kansas, Center for Research, Inc., Lawrence, KS
- University of Maine, Orono, ME
- University of Washington, Seattle, WA
- University of Wisconsin-Green Bay, Green Bay, WI

Other discretionary grants are open to governmental, non-profit or other organizations. Tribal organizations, which received funding in FY 2003 and FY 2004, included the following:

### "Improving Child Welfare Outcomes through Systems of Care" Grants

Up to \$500,000 per year for five years was awarded in FY 2003 to the **Native American Training Institute**, Bismarck, ND. 'Systems of Care' is an approach that facilitates partnerships to create a broader, more seamless array of services and supports for children and families. This approach is based on the development of a strong infrastructure of interagency collaboration, individualized care practices, culturally competent services and supports and child and family involvement in all aspects of the system. The expected end result is better outcomes for children and families.

### Field Initiated Service Demonstration Projects in the Adoption Field

One award, of up to \$400,000 per year for 4 years, was awarded to the **National Indian Child Welfare Association**, Portland, OR. The grant, beginning in September 2004, proposes to expand and improve adoption services provided by at least 20 rural reservation-based American Indian tribes by helping those tribes reclaim adoption as a culturally relevant practice.

### CB Success Story

The "Systems of Care" grant, **Medicine Moon Initiative**, includes the Spirit Lake Nation, the Three Affiliated Tribes of Mandan, Hidatsa and Arikara, the Turtle Mountain Band of Chippewa and Standing Rock Sioux Tribe in North and South Dakota. One positive accomplishment of the grant is the acquisition of



## *ACYF-Children's Bureau*

---

management information systems (MIS) for all four tribes for case management and data collection. The project is now able to track such things as length of placement, recidivism and other outcome measures needed to identify strengths and weaknesses of service delivery.



## ACYF-Child Care Bureau



The Child Care Bureau is dedicated to enhancing the quality, affordability and availability of child care for all families. Through the Child Care and Development Fund (CCDF), the Child Care Bureau administers federal funds to states, territories and tribes to assist low-income families in accessing quality child care for children when the parents work or participate in education or training. The Child Care Bureau has three divisions: Policy Division, Program Operations and Technical Assistance.

In FY 2003, 18,490 families and 33,159 children were served with CCDF funds according to data reported by Tribes (with 200 of the 259 tribal grantees reporting). In FY 2004, 17,078 families and 23,604 children were served according to tribal reports (with 199 of the 263 Tribes reporting). In these reports, Tribes are instructed to count each family/child only once, regardless of the number of times a family/child has exited and re-entered the program during a fiscal year. Due to the lack of complete reporting and some concerns about data quality, ACF is providing technical assistance, support, and data reporting tools to increase the number of Tribes reporting and to improve the quality of the data.

In FY 2004, Tribes reported that 84 percent of children received CCDF subsidies because their parents were working, while 12 percent had parents attending training or education. Four percent of children were in protective services. Of all children served, 35 percent were infants or toddlers (birth through age 2); 33 percent were preschoolers or kindergarteners (ages 3 through 5); and 32 percent were school-aged (ages 6 and older). The children received care in a range of settings: 57 percent in centers; 37 percent in family child care homes or group homes; and 5 percent in the child's own home.

Native American Children and Families Who Received CCDF Funds		
<i>Fiscal Year</i>	<i>Number of Families Served</i>	<i>Number of Children Served</i>
<i>FY 2001</i>	<i>15,851</i>	<i>27,735</i>
<i>FY 2002</i>	<i>16,689</i>	<i>29,932</i>
<i>FY 2003</i>	<i>18,490</i>	<i>33,159</i>
<i>FY 2004</i>	<i>17,078</i>	<i>23,604</i>

*\*ACF is examining whether this unexpected drop in the number of children served between FY2003 and 2004 is due to data reporting issues or some other cause.*

### Technical Assistance

Since 1998, Tribes have received specialized technical assistance in administering their Child Care and Development Fund (CCDF) programs through Native American Management Services, Inc. (NAMS), a Native American woman-owned contractor, which operates a Tribal Child Care Technical Assistance Center (TriTAC).

## *ACYF-Child Care Bureau*

TriTAC assists tribal grantees in child care capacity building efforts through: a tribal child care webpage (<http://nccic.org/tribal>); a toll-free information and referral line; a database of “Effective Program Strategies,” Tribal Cluster Trainings; an annual National American Indian/Alaska Native (AI/AN) Child Care Conference and an annual New Administrators Training.

### **Child Care and Development Fund Grants**

Public Law 104-193 amended the Child Care and Development Block Grant Act to reserve “not less than 1 percent and no more than 2 percent” of the aggregate Child Care and Development Fund (CCDF) funds for Indian Tribes. The Secretary elected to reserve the full 2 percent set-aside. Over 500 Federally recognized Indian Tribes, Alaska Native Villages and a Native Hawaiian organization receive CCDF funds directly or through consortium arrangements.

Current estimates are that in FY 2003, 18,401 families and 33,040 children were served with CCB Child Care and Development Funds (CCDF), in the 196 (out of 259) grantees that reported. The families and children are counted once, regardless of the number of times a family/child has exited and re-entered the program during a fiscal year.

In FY 2003, 259 Tribal grantees were awarded \$96,066,881 in CCDF funds.

In FY 2004, 263 Tribal grantees were awarded \$96,086,196 in CCDF funds.

### **Early Learning Opportunities Act Grants**

Grant award amounts range from \$250,000 to \$1,000,000. In any fiscal year, 1 percent of the total amount appropriated will be reserved for allotment to Indian Tribes, regional corporations, and Native Hawaiian entities, of which 0.5 percent shall be available to Indian Tribes and 0.5 percent shall be available to Regional Corporations and Native Hawaiian entities.

In FY 2003, Illisagvik College, Barrow, Alaska, on behalf of the Community Child Care Council of the Artic Slope Native Association was awarded an ELOA grant for \$999,000.

In FY 2004, the Bristol Bay Native Association, Dillingham, Alaska, was awarded an ELOA grant for \$991,365.



# *ACYF-Child Care Bureau*

## **Tribal Research Project**

In FY 2004, a research contract for nearly \$100,000 was awarded to the Oklahoma Child Care Resource and Referral Agency to work in a partnership with five Oklahoma Tribes (Cherokee Nation, Choctaw Nation, Delaware Tribe, Eastern Shawnee Tribe and United Keetoowah Band) on a 24-month research project focusing on tribal child care.

## **CCB Success Stories**

### **Bay Mills Indian Community – Collaboration with Boys and Girls Club**

In 2003, Bay Mills Indian Community (BMIC), Brimley, Michigan, embarked on a creative path to serve the after-school care needs of its school-age children. The Tribe once operated an after-school program, but the opening of a Boys and Girls Club on the reservation reduced interest in the CCDF-funded school-age care program.

With attendance dwindling, BMIC was concerned that operating its own school-age center was an inefficient use of scarce child care resources. Bay Mills parents noted that their older children were already spending time at the Boys and Girls Club and that it would be helpful for the Club to accept their younger children so all the children could attend together. The Tribe decided that a more efficient use of its CCDF grant would be to use most of the direct service dollars to support the services of the Boys and Girls Club. The Club in turn lowered the minimum age for Club membership from 8-years-old to 5-years-old to accommodate BMIC's youngest school-agers.

Most of the Club's activities rely on Boys and Girls Club curricula that have been adapted specifically for Native American and younger children. The Club provides computer labs, reading labs, nutrition programs and other resources to which the Bay Mills children wouldn't otherwise have access.

As a direct result of the lowering of the Club's age membership requirement, there is a waiting list for the 5- to 8-year-olds program. The program has also attracted a highly educated director and teachers. Through this unique arrangement, BMIC is providing higher quality after-school opportunities for its young children and more efficiently meeting the needs of its school-age children and their families. CCDF quality funds and CCDF school-age earmarked funds are used to sustain this project.

### **Port Gamble S'Klallam Tribe—Caseworker Training**

In February 2003, the Port Gamble S'Klallam Tribe, Kingston, Washington,



## *ACYF-Child Care Bureau*

---

initiated a two-year Touchpoints implementation project based on the Touchpoints training model, developed by pediatrician and researcher T. Berry Brazelton, which is centered on key points in a young child's development. The focus of the Port Gamble Touchpoints initiative is to provide training to all child and health care providers and caseworkers who work with the families of young children, to support providers through reflective techniques, to educate the entire community about the strength-building model of Touchpoints and to value and respect families in all of the community's services and activities.

In May 2003, team members revised the Touchpoints Quick Reference Guide to include information specific to the S'Klallam community. The guides were distributed to all early childhood classrooms, tribal clinic rooms, maternal/child health caseworkers and Indian child welfare caseworkers.

Children, families and the providers who work with them have all benefited from the positive interactions brought about through this strength-based model. Child care and other service providers now strive to understand families' particular circumstances and to interact with them based on their strengths. This approach to meeting families' needs has had the effect of expanding opportunities for exploring and understanding community needs.

Funds from CCDF, Tribal TANF and the Tribe's other partnering social and health service agencies were used to support this initiative. A one-time supplement from the Head Start Bureau's American Indian/Alaskan Native Branch supported the core team training in Boston, as well as two on-site training visits.



## *ACYF-Family and Youth Services Bureau*



**F**amily and Youth Services Bureau (FYSB), is a part of Administration on Children, Youth and Families (ACYF), Administration for Children and Families (ACF). FYSB administers a number of programs: Runaway and Homeless Youth Programs (Street Outreach, Basic Centers and Transitional Living Programs); Family Violence Prevention and Services Program; Mentoring Children of Prisoners Program and the Abstinence Education Program.

The mission of the Family and Youth Services Bureau is to provide national leadership on youth issues and to assist individuals and organizations in providing effective, comprehensive services for youth in at-risk situations and their families. FYSB programs are designed to provide youth with positive alternatives, ensure their safety and maximize their potential to take advantage of available opportunities. FYSB encourages communities to support young people through Positive Youth Development. This approach suggests that the best way to prevent risky behavior in young people is to promote youth leadership, skills building, and community involvement. Strengthening families and communities is also essential.

### **Runaway and Homeless Youth (RHY) Programs**

**Street Outreach Program** The Street Outreach Program (SO) funds local youth service providers in conducting street-based education and outreach and offering emergency shelter and related services to young people who have been, or are at risk of being, sexually abused or exploited. The goal of these efforts is to help young people leave the streets.

**Basic Center Program** FYSB provides financial assistance to establish or strengthen community and Tribal programs that address the immediate needs of runaway and homeless youth and their families. The central purpose of this program is to provide youth with emergency shelter, food, clothing, counseling, and referrals for health care. Basic Centers (BC) attempt to reunite young people with their families whenever possible or locate appropriate alternative placements.

**Transitional Living Program** Transitional Living Program (TLP) grantees assist older, homeless youth (including pregnant and parenting teens) in developing skills and resources to promote their independence and prevent future dependency on social services. TLPs provide housing and a range of services for up to 18 months to youth ages 16-21 who are unable to return to their homes. RHY tribal grantees are listed on pages 52 and 53.

### **Family Violence Prevention and Services Program**

FVPSA funds State agencies, Territories and Indian Tribes to provide shelter to victims of family violence and their dependents and for related services, such as emergency transportation and child care. Grantees use FYSB resources to

## ACYF-Family and Youth Services Bureau

expand current service programs and to open new centers in rural and underserved area, on Indian Reservations and in Alaska Native villages. The program also supports technical assistance and training for local domestic violence programs and disseminates research and information through five resource centers. The following chart shows the tribal grantees for FY 2003 and 2004 by state and tribe.

### FVPSA GRANTS TO TRIBAL ORGANIZATIONS FY 2002-2004

TRIBAL ORGANIZATION	FY03	FY04
<i>Alabama</i>		
Poarch Band of Creek Indians	\$25,731	\$24,710
<i>Alaska</i>		
Alatna Traditional Council	\$25,731	\$24,709
Aleutian/Pribilof Island Association	\$109,356	\$105,015
Allakaket Tribal Council	\$25,731	\$24,710
Anvik Tribal Council	\$25,731	\$24,709
Arctic Village Traditional Council	\$25,731	
Beaver Traditional Council		\$24,709
Bristol Bay	\$83,625	\$80,306
Chalkyitsik Traditional Council		\$24,710
Chitina Traditional Indian Village Cnsl.		\$24,709
Chugachmiut	\$45,029	\$43,242
Circle Traditional Council	\$25,731	\$24,710
Dendu Gwich'in Tribal Council		\$24,710
Dot Lake Tribal Council	\$25,731	\$24,709
Eagle Village Council	\$25,731	\$24,710
Eastern Aleutian Tribes, Inc.	\$25,731	\$24,709
Evansville Traditional Council	\$25,731	
Fairbanks Native Association	\$57,894	\$55,596
Grayling IRA Council		\$24,710
Gwichyaa Zhee Gwich'in Tribal Gov't	\$25,731	\$24,710
Healy Lake Traditional Council		
Holy Cross Tribal Council	\$25,731	\$24,710
Hughes Village Council	\$25,731	\$24,710
Huslia Village Council	\$25,731	\$24,710
Kaltag Tribal Council	\$25,731	\$24,710
Kodiak Area Native Association	\$45,029	\$43,242
Koyukuk Tribal Council	\$25,731	\$24,710
Louden Village Council	\$25,731	
McGrath Native Village Council	\$25,731	\$24,710
Minto Tribal Council	\$25,731	\$24,710
Nenana Native Council	\$25,731	\$24,710
Nikolai Edzeno Village Council	\$25,731	\$24,710



## ACYF-Family and Youth Services Bureau



Northway Village Council		
Nulato Tribal Council	\$25,731	\$24,710
Rampart Village Council		\$24,710
Ruby Tribal Council	\$25,731	\$24,710
Shageluk Tribal Council		\$24,710
South Central Foundation	\$295,905	\$284,159
Stevens Village Tribal Council	\$25,731	\$24,710
Takotna Tribal Council	\$25,731	\$24,710
Tanacross Village Council	\$25,731	\$24,710
Telida Native Village Council	\$25,731	\$24,710
Tetlin IRA Council	\$25,731	\$24,710
Tlingit and Haida	\$218,712	\$210,031
Tok Native Association	\$25,731	\$24,710
Venetie Native Village	\$25,731	\$24,710
<b>Arizona</b>		
Hulapai Tribal Council	\$25,731	\$24,710
Navajo Nation	\$2,251,451	\$2,162,081
Pascua-Yaqui Tribe	\$57,894	\$55,596
Salt River Pima-Maricopa Indian Comm.		
Tohono O'odham		\$129,725
Yavapai Prescott Indian Tribe	\$25,731	\$24,710
<b>California</b>		
Inter-Tribal Council of California, Inc.	\$334,503	\$444,780
Mojava	\$25,731	\$24,710
Smith River Rancheria	\$25,731	\$24,710
Southern Indian Health Council, Inc.	\$154,386	\$172,970
<b>Colorado</b>		
Southern Ute Indian Tribal Council	\$25,731	\$24,710
<b>Florida</b>		
<b>Idaho</b>		
Coeur D'Alene	\$25,731	\$24,709
The Shoshone-Bannock Tribes	\$57,894	\$55,596
<b>Kansas</b>		
IOWA Tribe of Kansas and Nebraska	\$25,731	\$24,710
Kickapoo Tribe of Kansas	\$25,731	\$24,710
Native American Family Services, Inc.	\$25,731	\$24,710
<b>Maine</b>		
Aroostook Band of Micmacs	\$25,731	\$24,710
Houlton Band of Maliseet Indians	\$25,731	\$24,710
Passamaquoddy Tribe at Pleasant Point	\$25,731	\$24,710
<b>Massachusetts</b>		
Wampanoag Tribe of Gay Head (Aquinnah)	\$25,731	\$24,710
<b>Michigan</b>		
Bay Mills Indian Community	\$25,731	\$24,710

## ACYF-Family and Youth Services Bureau

Grand Traverse	\$25,731	\$24,710
Hannahville Indian Community	\$25,731	\$24,710
Lac Vieux Desert Band of Chippewa Indians		\$24,710
Little River Band of Ottawa Indians of Michigan	\$25,731	\$24,710
Sault St. Marie Chippewa	\$25,731	\$24,710
<b>Minnesota</b>		
Boise Forte Reservation Tribal Council	\$25,731	\$24,710
Fond Du Lac Reservation Business Committee	\$25,731	\$24,710
Grand Portage Reservation	\$25,731	\$24,710
Leech Lake Reservation	\$70,760	\$67,951
Red Lake Band Chippewa	\$83,625	\$80,306
White Earth Reservation	\$57,894	\$55,596
<b>Mississippi</b>		
Mississippi Band of Choctaw Indians	\$70,760	\$67,951
<b>Montana</b>		
Blackfeet Tribe	\$122,222	\$117,370
Flathead Res.	\$96,491	\$92,661
Fort Belknap Community Council	\$45,029	\$43,242
Northern Cheyenne Tribal Council	\$70,760	\$67,951
<b>Nebraska</b>		
Omaha Tribe of Nebraska		
Ponca Tribe of Nebraska	\$45,029	\$43,242
<b>Nevada</b>		
Elko Band Council	\$25,731	\$24,710
Inter-Tribal Council of Nevada, Inc.	\$205,848	\$172,970
Reno-Sparks Indian Colony	\$25,731	\$24,710
Te-Moak Tribe of Western Shoshone		
Washoe Tribe of Nevada and California		
<b>New Mexico</b>		
Eight Northern Indian Pueblos Council	\$205,848	\$197,677
Jicarilla Apache Tribe		
Pueblo of Isleta	\$45,029	\$43,242
Pueblo of Laguna	\$57,894	\$55,596
Pueblo of Santo Domingo Tribe	\$57,894	\$55,596
Pueblo of Zuni	\$109,356	\$105,015
<b>New York</b>		
<b>North Carolina</b>		
Eastern Band of Cherokee Indians	\$96,491	\$92,661
<b>North Dakota</b>		
Fort Berthold Reservation	\$57,894	\$55,596
Spirit Lake of Fort Totten	\$70,760	\$67,951
Turtle Mountain Band of Chippewas	\$122,222	\$117,370
<b>Oklahoma</b>		
Absentee Shawnee Tribe		\$92,661
Apache Tribe of Oklahoma	\$45,029	\$43,242



## ACYF-Family and Youth Services Bureau



Cherokee Nation of Oklahoma	\$1,608,180	\$1,544,343
Choctaw Nation of Oklahoma	\$1,608,180	\$1,544,344
Citizen Band Potawatomi Indians of Oklahoma	\$96,491	\$92,661
Comanche Indian Tribe	\$167,251	\$160,612
Fort Sill Apache Tribe	\$25,731	\$24,710
IOWA	\$25,731	\$24,710
Muscogee Creek Nation	\$244,443	\$234,740
Osage Tribal Council	\$96,491	\$92,661
Otoe-Missouria Council.	\$25,731	\$24,710
Sac and Fox Nation	\$83,625	\$80,306
The Chickasaw Nation	\$321,636	\$308,869
Wichita and Affiliated Tribes	\$25,731	\$24,710
<b>Oregon</b>		
Burns Paiute Tribe	\$25,731	
Grand Rhonde	\$57,894	\$55,596
The Klamath Tribe	\$45,029	\$43,242
Warm Springs Res.	\$57,894	
<b>Rhode Island</b>		
Narrangansett Indian Tribe	\$25,731	\$24,710
<b>South Carolina</b>		
Catawba Indian Nation		\$24,709
<b>South Dakota</b>		
Cheyenne River Sioux Tribe	\$96,491	\$92,661
Crow Creek Res.	\$45,029	\$43,242
Flandreau Santee Sioux	\$25,731	\$24,710
Lower Brule Sioux Tribe	\$25,731	\$24,710
Oglala Lakota Nation	\$192,982	\$185,321
Rosebud Sioux Tribe	\$135,087	\$129,725
Sisseton-Wahpeton	\$57,894	\$55,596
The Paiute Indian Tribe of Utah		
<b>Washington</b>		
Lummi Nation	\$57,894	\$55,596
Makah Tribal Council		
Muckleshoot Tribe of Washington	\$25,731	
Puyallup Tribe of Indians	\$25,731	\$24,710
Quileute Tribal Council		
South Puget Intertribal Planning Agency	\$128,655	\$123,550
Spokane Tribe of Indians	\$45,029	\$43,242
Swinomish Tribal Community	\$25,731	\$24,710
Yakama Indian Nation	\$122,222	\$105,015
<b>Wisconsin</b>		
Bad River Band of Lake Superior	\$25,731	\$24,709
Ho-Chunk Nation	\$25,731	\$24,710
Lac Du Flambeau Band of Lake Superior Chippewa Indiana	\$45,029	\$43,242

## ACYF-Family and Youth Services Bureau

Menominee Indian Tribe	\$57,894	\$55,596
Red Cliff Band of Lake Superior Chippewas	\$25,731	\$24,710
Sokaogon Chippewa Community	\$25,731	\$24,710
St. Croix Band of Lake Superior Chippewa		
<b>Wyoming</b>		
Shoshone-Arapahoe (Wind River)	\$96,491	\$92,661
<b>Total:</b>	<b>\$12,640,301</b>	<b>\$12,540,118</b>

### Mentoring Children of Prisoners Program

FYSB awards grants to community-based organizations, Tribes and Tribal consortia that provide mentoring services to children (ages 4-15) of incarcerated parents. The goals of the Mentoring Children of Prisoners Program are to establish one-on-one mentoring relationships, enabling these children to meet once a week with a caring adult who provides support, encouragement and advice. Mentors also serve as guides and role models for their mentees. FYSB first awarded MCP grants in FY 2003 and by FY 2004 had funded over 200 grants.

### Abstinence Education Program

Under the Abstinence Education program, FYSB awards grants to State agencies that fund abstinence education, as well as mentoring, counseling and adult supervisory services that promote abstinence from sexual activity. The goal of the program is to influence the youth most likely to bear children out of wedlock. The community-based abstinence education program funds projects directly in communities and locations throughout the country. A broad array of organizations are eligible to compete for these funds, including Native American tribes.

Funding to Tribes for the Runaway and Homeless Youth Programs (Street Outreach, Basic Centers, and Transitional Living Programs), Family Violence Prevention and Services Program and Mentoring Children of Prisoners Program were provided through formula grants. The distribution of the funding for FY 2003 and FY 2004 are shown in the following charts.

Fiscal Year 2003	Award Amount	Total 2003
Street Outreach (SO) Ain Dah Yung (MN)	\$100,000	\$100,000
Basic Centers (BC) Cherokee Nation (OK) Ain Dah Yung (MN) Ute Mountain Tribe (CO)	\$75,000 \$200,000 \$115,000	\$390,000



## ACYF-Family and Youth Services Bureau



Transitional Living Programs (TLP)		\$592,634
Southcentral Foundation (AK)	\$200,000	
Cherokee Nation (OK)	\$150,000	
Chickasaw Nation (OK)	\$200,000	
Ain Dah Yung (MN)	\$42,634	
Family Violence Prevention (FVP)*		\$12,640,301
Mentoring Children of Prisoners Program (MCP)	No funds allocated	No funds allocated

Fiscal Year 2004	Award Amount	Total 2004
Street Outreach (SO)		\$100,000
Ain Dah Yung (MN)	\$100,000	
Basic Centers (BC)		\$300,000
Oglala Sioux Tribe (SD)	\$100,000	
Ain Dah Yung (MN)	\$200,000	
Transitional Living Programs (TLP)		\$592,634
Cherokee Nation (OK)	\$150,000	
Chickasaw Nation (OK)	\$200,000	
Ain Dah Yung (MN)	\$42,634	
Southcentral Foundation (AK)	\$200,000	
Family Violence Prevention (FVP)*		\$12,564,828
Mentoring Children of Prisoners Program		\$1,689,000
Wakanyeja Pawicayapi, Inc. (SD)	\$500,000	
Blackfeet Tribal Business Council (MT)	\$354,000	
Dry Creek Rancheria (CA)	\$34,000	
Menominee Indian Tribe of Wisconsin (WI)	\$61,000	
Navajo Nation (AZ)	\$740,000	

*\*FVPSA awarded in FY 2003 and FY 2004 respectively, under legislation which provides that 10% of the FVPSA appropriation for grants to Indian Tribes, tribal organizations and nonprofit organizations approved by the Indian Tribe for the operation of family violence shelters on Reservations or projects designed to prevent family violence and provide immediate shelter and related assistance for victims of family violence and their dependents. Grants are awarded to all federally recognized tribes who apply and meet the criteria. Grant amounts are determined on a formula basis. Funding for tribes and tribal entities, which meet application requirements, are granted minimum base amounts based on population. After the distribution of base amounts, the remaining funds are allocated in proportional amounts based on the ratio of the tribes population to the total population of all tribes who have applied. Tribes are also encouraged to apply as consortia.*

### Technical Assistance

Technical Assistance is also available to Tribes and Native communities in the following areas:

- Runaway and Homeless Youth – Technical assistance providers are available to grantees (potential and current) and are assigned to work with specific federal regions.
- Mentoring – Current grantees have been provided with technical assistance at two major FYSB-sponsored conferences on mentoring.

## *ACYF-Family and Youth Services Bureau*

· Family Violence Prevention and Services Assistance (FVPSA) – Technical assistance on the prevention of family violence is provided to Native women through Sacred Circle, a resource center that is part of the Domestic Violence Resource Center Network. These services are provided in the context of the unique set of historical, cultural and jurisdictional issues faced by American Indian/Alaska Native women. Sacred Circle was established through a FVPSA grant to Cangleska, Inc., the tribal chartered non-profit organization that provides domestic violence service to the Oglala Sioux in South Dakota. The expertise of the other members of the Resource Center Network is also available to Native communities.

### **FYSB Success Stories**

Battered Families, Inc. of Gallup, NM is a sub-grantee of the Navajo Nation. Battered Families, Inc. provides services for Navajo women who reside both on the reservation and in adjacent communities. This organization provides immediate emergency shelter, separate transitional shelter and job training and employment through the operation of a resale store and production of herbal bath and beauty products. Battered Families, Inc. has managed to involve and commit the City of Gallup in supporting the efforts of the shelter activities. Further, they have forged an excellent working relationship between the police enforcement and legal entities of the city and the Reservation thereby minimizing jurisdictional problems when providing services to battered Native women.

Ain Dah Yung of St. Paul, MN is a grantee that has demonstrated success in all of the RHY programs – Basic Center, Street Outreach and Transitional Living. They have a very integrated approach and often hire youth who, in the past, may have been “on the streets” and who have personal experience with FYSB RHY programs. Ain Dah Yung also is very active in establishing partnerships in the community and coordinates across numerous community-based organizations throughout the St. Paul area to provide comprehensive services.

A FVPSA demonstration project that has proven effective and been replicated throughout Indian Country is the Cell Phone Program. Due to the isolation of many Indian Reservations, effective and rapid communication and transportation are major problems. Under this program Native women considered at risk for domestic violence are given donated cell phones for use in the case of emergencies that are programmed to summon help and provide a location.

### **FYSB Special Initiatives**

For the past several years FYSB has funded a State-based demonstration project on Positive Youth Development (PYD). The first round of funding



## *ACYF-Family and Youth Services Bureau*

---

supported selected States in their efforts to infuse the concept of PYD throughout the State government, thereby increasing the likelihood that state and local programs would incorporate positive youth outcomes and asset-based approaches in all of their services. The current phase of this demonstration project is a community-based approach, choosing a number of local communities to work with the selected States on PYD. The Nebraska State Collaboration project selected a Tribal community in the panhandle as their local entity. This current project is still underway and no evaluative data is available at this time.

In FY 2003, FYSB and Head Start collaborated to fund a joint initiative to promote Positive Youth Development through the participation of youth in local Head Start programs. The program centered on family literacy, enabling the youth to invest in their communities while benefiting Head Start programs and their families. In FY 2003, this program was funded at \$3,000,000. In total \$10,000,000 was made available for this Initiative in FY 2004.



## ACF-Head Start Bureau

The Head Start Bureau is housed in the Administration for Children, Youth and Families, under the Administration for Children and Families, in the Department of Health and Human Services. Head Start promotes school readiness through the provision of education, health, nutrition and other services to low income children and their families (Head Start Act, Sec. 635). Head Start was established in 1965 to serve primarily preschool age children from three to five years of age. It was expanded in 1994 to include infants and toddlers from birth to the age of three years through the Early Head Start program.

Grants are awarded by the Administration for Children and Families to local agencies for the purpose of operating Head Start programs at the local level. While most Head Start grants are awarded through the ten regional offices representing Federally designated regions, the Head Start Bureau directly funds grants to tribal grantees and to grantees enrolling the children of migrant and seasonal agricultural workers.

An Associate Commissioner, assisted by a Deputy Commissioner, leads the Head Start Bureau. The Bureau is comprised of three divisions: the Program Management Division, the Program Support Division and the Program Operations Division. American Indian Alaska Native (AI/AN) and the Migrant and Seasonal Program Branch are housed in the Program Operations Division, which is overseen by a Division Director. AI/AN Branch includes a Branch Chief and twelve Program Specialists.

### American Indian/Alaska Native Head Start

This program includes Head Start and Early Head Start programs. The budget amount appropriated for FY 2003 for Head Start was \$156,927,290 and for Early Head Start \$26,460,978. For FY 2004, \$159,438,133 was budgeted for Head Start and \$26,884,356 for Early Head Start.

Head Start Bureau FY 2003	Budget Amount
DHHS/ACF/ACYF/Head Start Bureau/Head Start Programs	\$156,927,290
DHHS/ACF/ACYF/Head Start Bureau/Early Head Start Programs	\$26,460,978
Total	\$183,388,268

Head Start Bureau FY 2004	Budget Amount
DHHS/ACF/ACYF/Head Start Bureau/Head Start Programs	\$159,438,133
DHHS/ACF/ACYF/Head Start Bureau/Early Head Start Programs	\$26,884,356
Total	\$186,322,489



# ACF-Head Start Bureau



## Comprehensive Services

The American Indian Alaska Native (AI/AN) Branch of the Head Start Bureau provides grants totaling over \$186 million dollars to 155 tribal grantees, consortiums, Alaska Native corporations or other agencies that administer AI/AN Head Start programs. Over 23,000 children are enrolled in AI/AN Head Start programs. Of these, 21,714 were identified as being American Indian or Alaska Native. The Head Start regulations require that grantees assess their communities and provide comprehensive services based on the unique needs and strengths of the communities and families served. Some of these comprehensive services provided to American Indian Head Start Families include:

- Child Health—Health Screenings;
- Dental Health—Dental Screenings;
- Mental Health—Grantees benefited from the services of mental health providers for an average of 19 hours per month. These services included child evaluation, referral and treatment; and staff and parent training; and
- Disabilities—Through screenings, the majority of children identified with a disability, typically a speech or language impairment, received special education or related services during their Head Start enrollment.

## Outreach Projects

AI/AN Head Start grantees have participated in several important initiatives since 2003. They continued working to improve children's literacy and other cognitive outcomes through implementation of a mentor coach model and more intentional teaching practices. They also assessed enrolled four and five years olds through the National Reporting System (NRS). The first year results show that AI/AN children are similar to other Head Start children when they begin the program and that they make similar progress.

The Head Start Bureau funded several additional initiatives in FY 2004 to support identified outcomes for Head Start children. American Indian/Alaska Native grantees participated in all of these opportunities.

## Father Involvement

The importance of the father's active participation in raising a young child has been increasingly recognized. The Head Start Father Involvement supplement allowed grantees to initiate new efforts to ensure their programs were welcoming to fathers and that fathers have the opportunity to make meaningful contributions

## *ACF-Head Start Bureau*

---

to their children's development. Programs launched fatherhood education groups, support groups, training opportunities and volunteer opportunities. It is expected that these activities will lead to increased father involvement and related improved child outcomes.

### **Youth Mentor Programs**

Youth grants were provided competitively to a relatively small number of grantees. The programs funded will work to train and support youth in acting as mentors to Head Start children.

### **Governance Training**

Head Start programs are required to operate through a system of shared governance that includes the governing body (Tribal Council for AI/AN grantees), parent Policy Council and staff. This area is frequently identified as out of compliance during monitoring reviews and a frequent contributor to program deficiencies. The Head Start Bureau provided funds to all interested grantees to obtain customized local training in the governance of a Head Start program. It is expected that this investment will lead to improved grantee operations and a decrease in the number and severity of non-compliances in this area.

### **Targeted Technical Assistance**

Targeted technical assistance was provided to several grantees who agreed to host others in their geographic area who had been identified with program deficiencies.

### **Parent Mentor Training**

The funds for parent mentor training were used to support the participation of Head Start parents in training events that instructed parents in how to support the developing literacy of their young children. Parents were encouraged to model the approaches learned when they returned to their home communities.

### **Health and Safety Improvements**

Limited one time supplemental grants were provided to grantees to make health and safety improvements in their programs. Nearly \$5 million was available. The funds were awarded in accordance with the criteria established by the Head Start Bureau. They were used for building repairs, new school buses, child safety restraints (car seats), play ground fences, etc.

A summary of the total amount of money funded in each category and



## *ACF-Head Start Bureau*

number of grantees that received the special funds is as follows:

Head Start Bureau FY 2004 Supplemental Grant Programs	Number of Grantees	Total Funded
Father Involvement	47	\$95,572
Youth Mentor Programs	5	\$229,458
Governance Training	83	\$329,747
Targeted Technical Assistance	3	\$270,000
Parent Mentor Training	10	\$23,940
One Time Funding for Health and Safety Improvements	44	\$4,739,031
Total		\$5,687,748



## *HHS-Indian Health Service*

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.

The Mission of IHS is to raise the physical, mental, social and spiritual health of American Indians and Alaska Natives to the highest level, and the goal of IHS is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people. The IHS currently provides health services to approximately 1.5 million American Indians and Alaska Natives who belong to more than 557 federally recognized tribes in 35 states.

IHS services are provided directly and through tribally contracted and operated health programs. Health services also include health care purchased from more than 9,000 private providers annually. The Federal system consists of 36 hospitals, 61 health centers, 49 health stations and 5 residential treatment centers. In addition, 34 urban Indian health projects provide a variety of health and referral services.

The IHS clinical staff consists of approximately 2,700 nurses, 900 physicians, 350 engineers, 450 pharmacists, 300 dentists, 150 sanitarians and 83 physician assistants. The IHS also employs various allied health professionals, such as nutritionists, health administrators, engineers and medical records administrators. The IHS has a vacancy rate of about 12% for health professional positions, ranging from a vacancy rate of 5% for sanitarians to 23% for dentists.

Through P.L. 93-638 self-determination contracts, American Indian tribes and Alaska Native corporations administer 13 hospitals, 158 health centers, 28 residential treatment centers, 76 health stations and 170 Alaska village clinics.

IHS Headquarters is located in Rockville, MD. There are 12 IHS administrative units, called Area Offices, which are located in: Aberdeen, S.D.; Anchorage, AK; Albuquerque, NM; Bemidji, MN; Billings, MT; Nashville, TN; Oklahoma City, OK; Phoenix, AZ; Portland, OR; Sacramento, CA; Window Rock, AZ and Tucson, AZ.

The IHS employs approximately 15,000 people, including members of





## *HHS-Indian Health Service*

virtually every discipline involved in providing health care, social and environmental health services. Virtually all of the IHS senior executive service staff are of American Indian or Alaska Native descent. Excluding medical professionals, approximately 88% of all IHS staff is of American Indian or Alaska Native descent. Individuals who have health related degrees have the option of joining the IHS as civil servants or as commissioned officers in the Public Health Service (PHS). (<http://www.ihs.gov/>)

Annual resources for IHS totaled \$3.5 billion (03) and \$3.7 billion (04), which included collection of health insurance, as well as budget authority. Approximately 78% of the FY 2003 and FY 2004 IHS budgets were appropriated specifically in “line items” to support direct care delivery, other health-related expenditures and the administrative

costs of the Agency itself. Also included in the budgets were resources appropriated to expand Indian health service; build, renovate and maintain medical facilities and equipment; support the Tribal Self-Governance programs and increase the number of Indian health care professionals through academic scholarships and loan repayment programs.



### **IHS Accomplishments**

Most IHS funds are appropriated for American Indian tribal members and persons closely affiliated with tribes who live on or near reservations. IHS also provides health care and preventive measures involving environmental, educational and outreach activities in traditional medicine, elder care, women’s health, children and adolescent care, injury prevention, domestic violence and child abuse, health care financing, state health care, sanitation facilities and oral health.

Throughout the Department, many effective behavioral health promotion and disease prevention partnerships and co-operative efforts have been established in recent years. The following are some governmental interagency partnerships:

- Substance Abuse and Mental Health Services Administration

## *HHS-Indian Health Service*

(SAMHSA) - Alcohol and substance abuse prevention;

- Administration for Children and Families – Head Start program;
- Administration for Native Americans – Resulting in IHS issuing 20 grants for developing long-term care services for the elderly;
- Centers for Disease Control Prevention – Diabetes research and prevention;
- National Institutes of Health – Diabetes research and prevention.

Other partnerships created in FY 2003 and FY 2004 with IHS to address health promotion and disease prevention in Native American communities include:

- helping the National Congress of American Indians and the National Boys & Girls Clubs of America to reach their goals of increasing to 200 the number of Boys & Girls Clubs on Indian Reservations by 2005.

· working with the CJ Foundation, a national SIDS (Sudden Infant Death Syndrome) prevention organization, and the Office for Minority Health in the Office of the Secretary/Office of Public Health Service, which resulted in \$200,000 in grant funding award to two tribal organizations - one organization serving tribes in the IHS Aberdeen Area and the other serving tribes in the IHS Bemidji Area.

· partnering with NIKE corporation to focus on the promotion of healthy lifestyles and healthy choices for all Native Americans.

· continuing to support to United National Indian Tribal Youth organization, which focuses on helping develop leadership qualities in Native American youth and young adults.



# *HHS-Agency for Healthcare Research and Quality*



The Agency for Healthcare Research and Quality (AHRQ) is an operating division of the Department of Health and Human Services. AHRQ is committed to improving the quality, safety, efficiency and effectiveness of health care for all Americans. With its focus on supporting and transforming sound research into practice to improve outcomes, AHRQ continues to enhance the health services research knowledge base; develop tools and talent that foster the health services research infrastructure and build relationships with consumers, providers, purchasers and policy makers, including tribal and other American Indian/Alaska Native (AI/AN) organizations, the Indian Health Service (IHS) and other Federal agencies to advance excellence in health care.

AHRQ is led by the Office of the Director which manages the work of eight Centers and Offices: Center for Delivery, Organization, and Markets; Center for Financing, Access, and Cost Trends; Center for Outcomes and Evidence; Center for Primary Care, Prevention, and Clinical Partnerships; Center for Quality Improvement and Patient Safety; Office of Extramural Research, Education and Priority Populations; Office of Communications and Knowledge Transfer and Office of Performance Accountability, Resources and Technology.

AHRQ awards grants and contracts to accomplish its mission. There are no Tribal or Native American dollars set aside for any of the AHRQ programs. Tribes, tribal organizations, and other non-profit groups, as well as governmental entities, are eligible to apply for almost all of AHRQ's grants. AHRQ will provide technical assistance to any groups interested in applying for AHRQ research grants.

AHRQ is striving to make tribes and tribal organizations more aware of grant opportunities. As a result, the agency is receiving more applications from and making more grants to tribes and tribal organizations. Many grants were funded on a variety of research topics in Indian Country during FY 2003 and FY 2004.

## **Infrastructure Development and Research in Montana And Wyoming**

In addition to support for the Montana/Wyoming Tribal Leaders Council, Black Hill State University and the Black Hills Center for American Indian Health to develop a sustainable research infrastructure, this project provides funding for two studies. One is identifying factors that affect breast and cervical cancer screening and follow-up of abnormal findings and developing a pilot program to increase the proportion of American Indian women who receive screening tests. The second aims to design, implement and evaluate the effectiveness of a structured process involving tribal members and IHS providers for jointly developing strategies for performance improvement based on priority issues that are identified through a consumer survey. (Principal Investigator: Gordon Belcourt, Montana/Wyoming Tribal Leaders Council; Grant HS14034, 9/30/03-9/29/06).

# *HHS-Agency for Healthcare Research and Quality*

## **Understanding and Reducing Native Elder Health Disparities**

At one of AHRQ's Excellence Centers to Eliminate Ethnic/Racial Disparities, a team headed by an American Indian researcher is examining health care of older American Indian/Alaska Natives for diabetes, heart disease, cancer and respiratory diseases such as influenza, tuberculosis and pneumonia—chronic conditions for which the American Indian/Alaska Native population is at an increased risk. Individual projects address improving the quality of diabetic care, increasing participation in clinical preventive services, such as immunization and cancer detection/management and smoking cessation, as well as identifying both the barriers and facilitators to improved health status and functioning of older American Indians/Alaska Natives. (Principal Investigator: Spero Manson, University of Colorado; Grant HS10854, 9/30/00-9/29/06)

## **Planning for Health Information Technology (IT) Implementation in Cherokee County, Oklahoma**

This project includes a collaborative partnership among a rural acute care hospital, a large American Indian tribal entity, an IHS hospital, a community health center, a health department and a community consortium. Specific strategies in the plan for health IT implementation include developing both an integrated community health information network to facilitate provider coordination and client access as well as a telephone nurse line service and triage function to improve quality and reduce inappropriate emergency room use. (Principal Investigator: Mark Jones, Tahlequah City Hospital; Grant HS15364, 9/30/04-9/29/05)

## **IT Systems for Rural Indian Clinic Health Care**

Beginning September 2004, the California Rural Indian Health Board partnered with three of its rural tribal health programs that have implemented electronic health records with clinical decision support systems in a coordinated effort to reduce hospitalizations that may be preventable through improving quality of care and reducing medical errors. The IT systems that result will be used in conjunction with local hospitals to support the review of all hospitalizations for their preventability and to detect and track the programs' medical and medication errors, as well as their clinical care performance according to standardized performance guidelines. (Principal Investigator: Susan Dahl, California Rural Indian Health Board; Grant HS15339, 9/20/04-8/31/07)

AHRQ has also initiated or participated in various outreach projects to Native American Communities on a variety of topics of concern. Following are a few of the outreach projects AHRQ sponsored during FY 2003 and FY 2004:



# *HHS-Agency for Healthcare Research and Quality*



## **Addressing Long-term Care Needs of Rural Native Americans**

In 2003 AHRQ held a workshop for tribal and State health officials in the Denver Region, which includes Colorado, Montana, North and South Dakota, Utah and Wyoming. The 3-day workshop was designed to help tribal and State policymakers better understand and assess American Indians' long-term care needs and develop policies, resources, and programs that meet those needs.

## **Reducing Health Care Disparities Among Native American Populations**

AHRQ participated in a 1-day meeting of HHS officials and Tribal College and University (TCU) presidents in 2003 to identify ways in which the TCUs can contribute to the national efforts to address health care disparities and how HHS components can help them in these and other efforts to support and promote the development of TCUs.

## **Assisting in Implementation of a Clinical Prevention Pilot Program**

Following technical assistance training in 2003, the Alaska Department of Health and Social Services has implemented AHRQ's Put Prevention Into Practice (PPIP) program at a pilot site at Iliuliuk Clinic in Unalaska. The purpose of PPIP is to increase the appropriate use of clinical preventive services, such as screening tests, immunizations, and counseling, based on U.S. Preventive Services Task Force recommendations. Eleven of Alaska's community health center sites that receive funding as federally qualified health centers are operated by tribal health organizations. All Alaska centers serve members of the Native American community. Five sites have expressed interest in potential participation in the Alaska PPIP project.

## *HHS-Administration on Aging*

The Administration on Aging (AoA), an agency of the U.S. Department of Health and Human Services, was established by the Older Americans Act (OAA) in 1965.

AoA's mission is to develop a comprehensive, coordinated and cost-effective system of long-term care that helps elderly individuals to maintain their independence and dignity in their homes and communities. Our vision for older people is based on the American value that dignity is inherent to all individuals in our democratic society, and the belief that older people should have the opportunity to fully participate in all aspects of society and community life, be able to maintain their health and independence and remain in their own homes and communities for as long as possible. AoA has developed a 5-Year Strategic Plan that establishes five strategies to advance our mission and our vision for older people:

- Listen to our customers, at the state, tribal and local level, especially our older citizens and their families, and make sure we understand their needs and respond to what they are asking us to do.
- Continue our commitment to educating policymakers and the public about the long-term care needs of older people and the actions our nation should take to respond to those needs.
- Help others to understand the extraordinary value and assets of the Aging Network.
- Expand our technical assistance program to help the Network keep up-to-date on the latest research and best practices.
- Work with other agencies and private sector organizations on initiatives to strengthen the Aging Network's role in health and long-term care.

AoA's Strategic Plan establishes five programmatic priorities to support the HHS Strategic Plan and guide and focus our resources. These include:

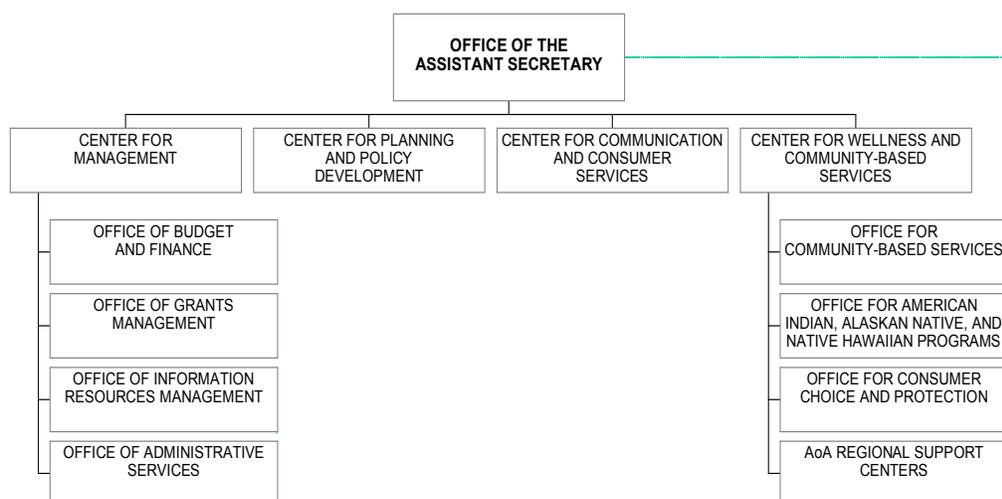
1. Make it easier for older people to access an integrated array of health and social supports.
2. Help older people to stay active and healthy.
3. Support families in their efforts to care for their loved ones at home and in the community.
4. Ensure the rights of older people and prevent their abuse, neglect, and exploitation.
5. Promote effective and responsive management.



## HHS-Administration on Aging

Josephina Carbonelle leads the AoA in the Presidential appointed position of Assistant Secretary. There are four divisions to AoA: Center for Management; Center for Planning and Policy Development; Center for Communication and Consumer Service and Center for Wellness and Community-Based Services. Some of these divisions are further divided into departments.

*AoA Operational Chart*



Within each AoA department, there are opportunities for tribes and Native Americans to receive funding for various programs, technical assistance, research and enhancement of delivery of services.

### **Office for American Indian, Alaskan Native and Native Hawaiian Programs**

Established by the 1989 amendments to the Older Americans Act (OAA), the Director of the Office for American Indian, Alaskan Native and Native Hawaiian Programs (OAIANNHP) serves as the effective and visible advocate on behalf of older Native Americans within HHS and with other departments and agencies of the Federal government on all Federal policies affecting older Native Americans; coordinates activities between other Federal departments and agencies to assure a continuum of improved services; serves as the effective and visible advocate on behalf of older Native Americans in the States to promote the enhanced delivery of services; administers and evaluates OAA grants; collects and disseminates information related to problems experienced by older Native Americans; develops research plans and conducts and arranges for research in the field of Native American aging and develops and provides technical assistance and training programs to grantees under Title VI.

### **Nutrition and Supportive Services (OAA Title VI, Part A and B)**

These are formula grant awards that are made directly to Tribal organizations



## *HHS-Administration on Aging*

representing American Indians and Alaska Natives and organizations representing Native Hawaiians. In FY 2003, \$27,495,000 was awarded to 241 organizations representing nearly 300 Tribes under Title VI, Part A and to two organizations serving Native Hawaiians under Title VI, Part B. FY 2004 funding of \$26,455,000 was awarded to the same 243 grantees.

### **Native American Caregiver Support Program (OAA Title VI, Part C)**

These formula grant awards are also made directly to Tribal organizations. In FY 2003, \$6,209,000 was awarded to 185 Tribal organizations and two organizations serving Native Hawaiians for Native American Caregiver Support Program. FY 2004 funding of \$6,318,000 was awarded to these same 185 grantees.

### **OAA Title IV discretionary grants**

These competitive grants were awarded to the following organizations serving American Indians, Alaska Natives and Native Hawaiians:

- Great Lakes Inter-Tribal Council, Wisconsin, for the Senior Medicare Patrol Project (\$100,000 in both FY 2003 and FY 2004) and a Health Care Fraud and Abuse Integration grant (\$100,000 in FY 2004);
- National Resource Center on Native American Aging, North Dakota, University of North Dakota (\$345,000 in both FY 2003 and 2004);
- National Resource Center on Native American Aging, Alaska, University of Alaska (\$344,145 in both FY 2003 and 2004); and
- National Indian Council on Aging, New Mexico, (\$129,155 in both FY 2003 and 2004) National Indian Council on Aging, New Mexico (\$865,038 in FY 2004 – Congressional earmark).

### **OAA Title VI major disaster grant**

The OAA authorizes the Assistant Secretary on Aging to provide funds to any Tribal organization receiving a Title VI grant for reimbursement for the delivery of supportive services during any major disaster declared by the President. In the summer of 2003, several Indian reservations were devastated by wildfires. In southern California over 30,000 acres of land and 130 houses were destroyed. Two grantees in this area were given disaster assistance awards to purchase emergency services and supplies:

- Southern Indian Health Council, Inc., California – FY 2004 - \$40,000
- California Indian Manpower Consortium, California - FY 2004 -



## HHS-Administration on Aging

\$40,000.

AOA services include congregate meals, home delivered meals, access services and in-home services. The following chart specifies the number of Native Americans served in FY 2003 and FY 2004.

Number of Native Americans Who Received AOA Services		
<i>AOA Service</i>	<i>FY 2003</i>	<i>FY 2004</i>
<i>Congregate Meals</i>	<i>1,536,839</i>	<i>1,532,117</i>
<i>Home Delivered Meals</i>	<i>2,010,557</i>	<i>1,984,642</i>
<i>Access Services, including Transportation</i>	<i>1,476,265</i>	<i>1,725,448</i>
<i>In-Home Services</i>	<i>947,142</i>	<i>996,861</i>

### Success Stories

#### Helping older people have access to an integrated array of health and social supports

The Title VI Elders Program at the Chippewa Cree Tribe in Montana has developed a pilot program to help veterans apply for disability benefits. Judi Houle, the Title VI Director, has been successful in helping Korean War Veterans obtain disability benefits and getting service related injury benefits for veterans, their families and children. Additionally, Ms. Houle has been successful in improving the housing for Tribal elders; this is inclusive of all elders enrolled in the Tribe in need of assistance. Using data from the needs assessment she conducted for her Title VI Elders Program, she convinced the Tribal Council to dedicate \$12,000 of the BIA Home Improvement Program funds to the Elders Program for renovating homes of the elders.

The Chickasaw Nation Division on Aging has continued to grow from one nutrition site funded by their first Title VI grant in 1980 nutrition site to 10 sites in 2004. The Tribe has allocated Tribal funds to allow for the construction, renovation and equipping of these centers to meet all the necessary safety and sanitation requirements. In addition to nutrition and supportive services, the Aging program conducts an annual conference for elders to provide seniors with workshops of interest such as home improvement, transportation, long-term/community-based care, health care issues, benefit updates and Veterans benefits. The Aging and Education Departments purchased computers for each Nutrition center for use by elders. A tutor schedules weekly visits to teach the elders how to use the computers. Elders are involved in several intergenerational activities such as sponsoring a game booth at "Kids Day", tutoring children at Carter Seminary, volunteering at Head Start, and participating in the Foster Grandparents program. During National Volunteer Week, Governor Bill Anoatubby and other Tribal officials presented awards to senior volunteers. Elderly volunteers provided over 26,000 hours of



## *HHS-Administration on Aging*

volunteer service during FY 2004.

On October 29, 2003, the AoA funded the National Resource Center on Native American Aging at the University of North Dakota to convene a meeting between Native elders and health-care experts to discuss the difficulties many elders encounter in health communications. The outcome of the meeting was to promote awareness of health disparities and poor health communication and develop some possible solutions for dealing with low health literacy, thus reducing health disparities. Tips for improving health communications provided by the elders included:

- Be positive –native healers are positive and support the notion that a remedy will work. Often times non-native providers indicate that the elder should try the remedy, and if it doesn't work, come back. That may be contrary to the culture.
- Be respectful of the need for silence.
- Deal with biases such as fear of going to the doctor, not wanting to hear the results and denial.
- Be understanding of other problems. Perhaps an elder needs to care for grandchildren or can only access transportation on certain days.

### **Helping older people to stay active and healthy**

The Salt River Pima-Maricopa Indian Community's Senior Services Division coordinates with all Tribal Department of Health and Human Services programs to assure comprehensive health and social services are provided to elders. Case managers assist elders in accessing services such as medical appointments, home based health care, congregate meals, home delivered meals, social activities, community events and community sponsored excursions. Recreation activities allow elders to socialize among one another while participating in various recreation activities such as gardening, sewing, storytelling and bingo. The program provides in-home exercise therapy by a physical health fitness specialist to allow elders to stay physically fit and be active to the extent of their individual abilities. The Program hosts monthly breakfast meetings to allow elders to access information on a variety of topics, including affordable housing, dentures, hearing aids, how to get help in financial emergencies, and others.

Alu Like's Elders Program is collaborating with the Native Hawaiian Health Care system to help Native Hawaiian elders maintain or improve their health. Because of this collaboration, elders are offered routine health screenings and appropriate follow-up services. Program staff reinforce healthy lifestyles through group physical activities and discussions about nutrition. They developed a



## *HHS-Administration on Aging*

Traditional Foods Cookbook to reinforce the healthy aspects of eating native foods.

The AoA funded National Resource Center for American Indian, Alaska Native, and Native Hawaiian Elders at the University of Alaska is working to reconceptualize the best practices framework into a “healing practices” framework to more accurately respond to the needs of elderly Alaska Natives. The purpose of traditional customs and healing practices is to help people access their own answers and strengths to restore a sense of self-worth and healthy relationships. To date, the Resource Center staff have met with Alaska Native elders throughout the state to provide an opportunity to express their wishes and expectations for services and care that are consistent with their traditional community heritages, Tribal values and customs. Information gathered indicates that elders from all the cultural regions were not primarily concerned with themselves, but were instead principally concerned with the entire group. The overwhelming majority of elders voiced concern, frustration and sense of loss related to the youth’s lack of respect for and interest in learning the ways of the past and for the continuation of their cultural knowledge and ancient ways. The elders related historical experiences that are linked with current negative circumstances, such as chronic social problems. Many elders talked about the negative impact on the community and Tribe when the elders are removed from their community to an urban area for medical care. The issue of elder abuse and neglect was an immediate concern for elders from all regions.

### **Supporting families in their efforts to care for their loved ones at home and in the community**

The Rosebud Sioux Native American Caregiver Support Program delivers services and resources to many grandparents raising their grandchildren on the Rosebud Indian Reservation. Grace Broken Leg, a 78-year-old great-grandmother, is raising her thirteen great-grandchildren and participates in the Native American Caregiver Support Program. She wants the best for her great-grandchildren and encourages their education. Ms. Broken Leg stresses the importance of a traditional education and wants her great-grandchildren to understand their culture. She speaks her native Lakota language to the children and stresses the Lakota cultural values. She demonstrates the importance of staying active, spending time outdoors and using the land to help feed the family. She plants and cares for her one-half acre garden and cans the vegetables to eat with dried meat that she prepares herself. Another program participant, 79 year old Loretta Hollow Horn Bear-Iyotte, is raising her five grandchildren. Never having learned to drive, Ms. Hollow Horn Bear-Iyotte walks everywhere and teaches her grandchildren their native language as they accompany her. She says this keeps her healthy. She wants her grandchildren to grow up knowing the values and traditions of the Sicangu. She feels it is vital for the younger generation to respect their land and carry on their Lakota culture since understanding and knowing their own history will help them to live long, happy, self-sufficient lives.



## *HHS-Administration on Aging*

---

The wild fires in southern California in October 2003 were devastating to several Tribal communities. The Barona Band of Mission Indians lost 35-40 homes as the Cedar fire burned all 6,296 acres of the reservation. Many residents were evacuated, and most of the reservation was without electricity for over a week. Because elders live in an isolated, rural area and only infrequently get a chance to do grocery shopping, they generally purchase a month's food supply at one time. Consequently, nearly every elder lost a substantial amount of food with the prolonged power outage that followed the fires. Staff of the Southern Indian Health Council's Senior Program provide much needed transportation for elders to access medical services, apply for assistance, shop and do other activities related to recovering from the fires. Staff provided assistance on a daily basis to help elders deal with their personal crises of absent caretakers, fire-related health problems, emotional reactions to the disaster, and a host of other needs related to the disaster. A total of 132 elders received assistance.



## *HHS-Substance Abuse and Mental Health Services Administration*



The mission of the Substance Abuse and Mental Health Services Administration (SAMHSA) is: “A Life in the Community for Everyone,” a vision that is manifested by building resilience and facilitating recovery for people with or at risk for mental or substance use disorders. Underlying this mission is SAMHSA’s belief that all people seek and deserve lives with jobs, homes and meaningful relationships – all of which contribute to a sense of stability and fulfillment. This belief is the guiding principle for all of SAMHSA’s programs.

Improving services for all populations, from older adults to the youngest citizens, is the driving force that fuels SAMHSA’s program priorities. These priorities, which are independent yet interconnected, are clearly outlined in the SAMHSA Matrix. Among the program priorities in the Matrix, the top three program areas are: Substance Abuse Treatment Capacity, Strategic Prevention Framework and Mental Health System Transformation. Significant emphasis is placed on principles that cut across all SAMHSA’s programs, particularly important is Cultural Competence and Eliminating Disparities.

Discretionary grant funds are awarded competitively in accordance with the mission and purpose of SAMHSA. Discretionary grants are made available by SAMHSA’s three Centers: the Center for Mental Health Services (CMHS), the Center for Substance Abuse Prevention (CSAP), and the Center for Substance Abuse Treatment (CSAT).

SAMHSA also administers the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Mental Health Services Block Grant, which provide Federal funding directly to States for substance abuse treatment and prevention programs and mental health services, respectively. The block grant mechanism was established to give States flexibility in controlling resources and addressing high priority needs at the local level.

SAMHSA has a strong commitment to enable and empower American Indians and Alaska Natives (AI/AN) and other Native Americans to respond to the substance abuse prevention and treatment and mental health needs of their communities. In FY 2004, SAMHSA’s Administrator reaffirmed this commitment and clarified policy on the eligibility of tribes and tribal organizations to apply for SAMHSA grants. In principle, tribal entities are to be eligible for all grants for which States are eligible unless there is compelling reason to the contrary. Any reason for excluding tribal entities requires justification and the approval of the Administrator. This policy became effective for the 2005 grant cycle, and subsequently, AI/AN tribes and tribal organizations experienced increased access to SAMHSA programs and grant opportunities.

# HHS-Substance Abuse and Mental Health Services Administration

SAMHSA's significant efforts providing training and technical assistance to AI/AN populations are highlighted in the following section.

- American Indian/Alaska Native National Resource Center** Jointly funded by CSAT and CSAP, the “One Sky Center” in Portland, Oregon was established by the Oregon Health and Science University. The Center identifies and fosters effective, culturally appropriate substance abuse prevention and treatment programs and systems to support American Indian/Alaska Native populations. In FY 2003, it served 3,192 AI/ANs. The Center provides technical assistance, training, dissemination and communication to increase substance abuse prevention and treatment knowledge and skills among service providers, policy makers, tribal communities, funding organizations and consumers. A key example is One Sky’s provision of assistance to several tribes applying for SAMHSA’s Access to Recovery grants, including the successful tribal grantee, California Rural Indian Health Board.

SAMHSA Priorities: Programs & Principles		Cross-Cutting Principles									
		Science to Services/ Evidence-based Practices	Data for Performance Measurement & Management	Collaboration with Public & Private Partners	Recovery: Reducing Stigma & Barriers to Services	Cultural Competency/ Eliminating Disparities	Community and Faith-Based Approaches	Trauma & Violence (e.g., Physical & Sexual Abuse)	Financing Strategies & Cost-effectiveness	Rural & Other Specific Settings	Workforce Development
Programs/Issues	Co-Occurring Disorders										
	Substance Abuse Treatment Capacity										
	Seclusion & Restraint										
	Strategic Prevention Framework										
	Children & Families										
	Mental Health System Transformation										
	Disaster Readiness & Response										
	Homelessness										
	Aging										
	HIV/AIDS and Hepatitis										
	Criminal Justice										

- Grant-related TA**  
 Under SAMHSA’s Children’s Mental Health Initiative, CMHS conducts technical assistance sessions not only for grantees but for potential American Indian and Alaska Native applicants. The system of care related to tribes has unique qualities (cultural and intergovernmental aspects), thus this special emphasis. An Inter-Agency Agreement with the Indian Health Service for TA to tribal grantees and prospective tribal grantees is maintained with the National Indian Child Welfare Association. The roles of each agency in this Inter-Agency Agreement were as follows: SAMHSA’s CMHS transferred funds to IHS’ Behavioral Health Program who contracted with the National Indian Child Welfare Association to provide technical assistance to tribal grantees in SAMHSA’s Child Mental Health Initiative (Systems of Care Program) and the Circles of Care grant program.

- Indian Country Child Trauma Center** Located at the University of Oklahoma, the Center is available to provide culturally adaptable treatment protocols, outreach



## *HHS-Substance Abuse and Mental Health Services Administration*



materials and service delivery guidelines. The director of the project is Dolores Bigfoot, Ph.D., a member of the Caddo Nation.

- **Ute Mountain Tribe** In April 2004, at the specific request of the Deputy Secretary, SAMHSA provided technical assistance to the Ute Mountain Tribe of Towaoc, Colorado. The Deputy Secretary had visited the tribe in late 2003 and was informed of tribal members' very low average life expectancy, which in part was directly caused by alcohol abuse. SAMHSA provided a two-day grant writing training in April 2004. Training included an overview of SAMHSA; identifying resources for funding, including Federal, State, foundation and corporate; understanding the grant announcement and application process; developing partnerships and collaborations and hands-on practice in developing specific sections of a proposal.

- **Tribal visit related TA** During the Deputy Secretary's and SAMHSA Administrator's visits to Northern Plains tribes in August 2004, tribal leaders of the Crow Tribe and the Northern Cheyenne Tribe identified methamphetamine use as a major health concern among their tribal communities. SAMHSA followed up soon afterwards up with conference calls to both tribes to discuss their concerns and offer assistance. Specific information on methamphetamine use was provided, as well as assistance related to SAMHSA's latest Targeted Capacity Expansion grant opportunity for FY 2005, which for the first time focuses on AI/ANs as a target population (as opposed to racial/ethnic minority populations in general) and also has a focus on methamphetamine use. Specifically regarding the Crow Tribe, SAMHSA also worked in close collaboration with the IHS Area Office in Billings, Montana, regarding the tribe's Seven Hills Healing Center. The Office had received a draft proposal from the Center for IHS funding, on which SAMHSA's input was requested in order to refine the proposal. SAMHSA's AI/AN resource center, "One Sky," reviewed the proposal and provided suggestions, which the tribe adopted.

- **Grant writing TA series** In the area of assisting tribes and tribal organizations to increase their access to SAMHSA's programs, SAMHSA in FY 2004 held a series of conferences, workshops and technical assistance meetings throughout the country to help remove unnecessary barriers that may prevent community and faith-based organizations from receiving Federal funding and participating as viable substance abuse treatment, prevention and mental health service providers. (A second series was offered in FY 2005.) All the sessions of the Faith-Based and Community Initiative for Grant Writing Training and Technical Assistance were open to tribal attendees, and SAMHSA offered two tribal-specific sessions: (1) As part of the 27th Annual American Indian School on Alcohol and Drug-related Issues in Albuquerque, New Mexico, SAMHSA provided grant writing technical assistance from February 28 through March 5, 2004. Topic areas included: proposal development, alcohol and drug abuse recovery issues, coalition building, capacity building, fiscal accountability and diversified funding; (2) The Wellbriety Plan

## *HHS-Substance Abuse and Mental Health Services Administration*

Technical Assistance Meeting for Native Americans was held in Denver, Colorado, April 13-15, 2004. Representatives from Urban Community Indian Centers across the United States addressed AI/AN strategies for prevention, treatment, intervention, and recovery from alcohol and other addictions, as well as from co-occurring disorders.

- CAPT's TA is also provided by CSAP's Centers for the Application of Prevention Technology, which constitute a technical assistance program serving State Incentive Grant sub-recipients, many of whom are Native American entities. Examples follow:

- **January 2003**  
**Western CAPT**  
**Pacific Islands Prevention Newsletter**

CSAP's Western CAPT staff has developed a Pacific Island Prevention Newsletter which has been receiving Pacific Island and national attention and support. The purpose behind this newsletter is to provide the Pacific Island entities an avenue from which to gain valuable information on science based prevention that may be relevant to their cultural settings and needs. It also provides these island entities the opportunity to be recognized for the successful prevention programs and activities they are implementing in their respective communities. This newsletter is published on a quarterly basis, and currently, there are five issues now on CSAP's Western CAPT web site at <http://www.unr.edu/westcapt/productlist.htm>.

- **June 24, 2003**  
**Central CAPT**  
**Fourth Annual Native American Conference**

The Fourth Annual Native American Prevention Program Sharing Conference was held in Minnesota, June 24-26, 2003, with approximately 165 elder, youth and adult prevention professionals and volunteers attending. Post conference evaluation indicated 100% of participants were somewhat or very satisfied with the conference, and 91% said the conference was relevant to their work. These numbers are supported by comments, such as: (1) "I have gained a lot of information that I plan to take back and share with staff so that we can enhance our programs!" and (2) "Principles of prevention are universal, but the application to Native communities is specific; good application in this conference."

Examples of AI/AN-focused TA activities by CSAT's State Systems Technical Assistance Project (SSTAP):

- SSTAP covered the fees and expenses for the subcontractor to assess cultural competence of 30 accredited AI/AN-related programs in South Dakota. The TA took place between October 2002 and July 2003. The State now has an ability to



## *HHS-Substance Abuse and Mental Health Services Administration*



gauge the cultural appropriateness of providers and to give the providers feedback to help improve services.

- Between December 2003 and July 2004, SSTAP covered the fees and expenses for the South Dakota Urban Indian Health Program to participate in a study to determine the feasibility of establishing a statewide Native American Case Management Assessment and Referral Center in South Dakota. Tribal substance abuse programs (N = 9) and State-supported core agencies (N = 13) were invited to complete survey instruments. The survey instruments were designed to collect information on the following: (1) satisfaction levels regarding the process of accessing State-funded substance abuse treatment services; (2) satisfaction levels regarding services provided by State-supported core agencies; (3) need for a Native American Assessment and Referral Case Management Center; (4) need for a Web-based Native American Assessment and Referral Case Management Center; (5) procedures for the tribal programs to invoice for services; and, (6) opinions from tribal programs and core agencies as to which type of tribal, State, or service agency would be the preferred manager of a case management center.

All 9 tribal groups and all 13 core agencies were contacted to complete a survey instrument. Six of the 9 tribal groups initially responded, but 2 later chose not to participate. Four of 9 tribal groups and 12 of 13 core agencies completed the survey instruments.

According to the survey results, both the tribal and the core agency respondents indicated that they believe that there was a need for a statewide, Native American Case Management Assessment and Referral Center in South Dakota. On the question of which agency should manage a center if such a center was established, core agency respondents ranked Native American nonprofit organizations as their first choice. Tribal programs, on the other hand, ranked Tribal Charter, Non-Profit organizations as their first choice. Collectively, the tribal and the core agency respondents' choice to manage a center would be a Native American nonprofit organization.

# HHS-Substance Abuse and Mental Health Services Administration

BUDGET SUMMARY FOR FY 2003 AND FY 2004  
SAMHSA (CMHS, CSAP, and CSAT)  
FUNDING FOR NATIVE AMERICANS  
(\$ in thousands)

Program or Budget Activity <sup>1</sup>	FY 2003 Award	FY 2004 Award
<b>American Indians/Alaska Natives</b>		
Programs of Regional and National Significance (PRNS)	\$44,102	\$ 35,413
Children's Mental Health Services	\$3,160	\$ 5,191
Protection and Advocacy Program	\$214	\$ 220
PATH Formula Grant - Alaska	---	---
Mental Health Block Grant Program	---	---
Substance Abuse Block Grant - Chippewa Nation <sup>2</sup>	\$537	\$ 539
<b>Subtotal, American Indians/Alaska Natives</b>	<b>\$48,013</b>	<b>\$ 41,363</b>
<b>Native Hawaiians</b>		
PRNS <sup>3</sup>	\$4,081	\$ 4,106
Protection and Advocacy Program	\$72	\$ 73
PATH Formula Grant	\$289	\$ 348
Mental Health Block Grant Program	\$319	\$ 309
Substance Abuse Block Grant <sup>2</sup>	---	---
<b>Subtotal, Native Hawaiians</b>	<b>\$4,761</b>	<b>\$ 4,836</b>
<b>Pacific Islanders</b>		
PRNS <sup>4</sup>	\$1,462	\$1,816
Protection and Advocacy Program	\$64	\$659
PATH Formula Grant	---	---
Mental Health Block Grant Program	\$673	\$669
Substance Abuse Block Grant <sup>2</sup>	---	---
<b>Subtotal, Pacific Islanders</b>	<b>\$2,199</b>	<b>\$ 3,144</b>
<b>TOTAL, CMHS, CSAP, &amp; CSAT</b>	<b>\$54,973</b>	<b>\$ 49,343</b>

FOOTNOTES

1. Excludes funding for the Drug Free Communities Support Program, administered by SAMHSA, for the Office of National Drug Control Policy.
2. Excludes Substance Abuse Block Grant funding that States and Territories may provide to AI/AN, Native Hawaiians and Pacific Islanders. SAMHSA does not collect this funding data.
3. The Native Hawaiian category reflects funding provided to grantees in the State of Hawaii and may include other races in addition to Native Hawaiians.
4. The Pacific Islander category reflects funding provided to grantees in the US Pacific Island Territories and may include other races in addition to Pacific Islanders.



# *HHS-Substance Abuse and Mental Health Services Administration*



## **Success Stories**

SAMHSA grant funds have provided community-based substance abuse prevention and treatment and mental health services to AI/AN populations across the United States. Successful programs are profiled below.

Cook Inlet Tribal Council, Inc., located in Anchorage, Alaska received SAMHSA funding during FY 2001-2004 to provide substance abuse services. Individualized treatment plans, “village community” support, and peer networking are hallmarks of this program. Clients enter a “Village of Care” and are connected to a community that maintains contact and support beyond treatment into recovery. Program graduates often return to the program and assume leadership roles in activities that support others, such as facilitating relapse prevention groups. The program integrates cultural identity and connectivity to achieve positive client outcomes. Work therapy is utilized in treatment to successfully transition to full time employment and career development.

Eagle Wing Recovery Services in Hoopa, California received SAMHSA grant funds during the period from June 2003 to February 2005 to serve the Hoopa Valley Indian Tribe in Humboldt County, CA. Eagle Wing is unique in that it has been providing the only sweat lodge ceremonies in the Hoopa Valley as a holistic approach to treating substance abuse and mental health disorders. Eagle Wing will partner with the K’ima:w (Hupa word for good medicine) Medical Center to begin the process of community-based strategic planning around the issue of delivering culturally appropriate treatment and other related services. The process will involve community stakeholders such as: tribal leadership, the Director of Human Services, the Chief of Police, the Chief Judge of the Tribal Court and service providers. This will be done to develop a community-based plan and implement a model program that will link tribal policy-making with prevention, substance abuse treatment, mental health and primary medical care, including HIV/AIDS prevention.

McKinley County Juvenile Substance Abuse Crisis Center in Gallup, New Mexico used SAMHSA grant funds (received during September 2002 to September 2004) to create a regional eight-bed juvenile substance abuse crisis center facility within the county’s existing juvenile detention center. The program provided detoxification (social) and initial treatment services (early intervention) to juveniles under the influence of alcohol and/or other substances; offered assessment of additional treatment needs; and provided referrals to a wide range of programs within an effective continuum of care. The majority of youth served by the center are Navajo and Zuni, although the center also served rural youth who are Apache, Hopi, Laguna-Acoma and Ute. Youth are brought to the center mainly by law enforcement. The center holds the belief that youth are entitled to know the truth about drugs and alcohol; that youth are entitled to a safe and healthy environment that contributes to their success in life; and, that there is a possibility of mental, spiritual and physical

## *HHS-Substance Abuse and Mental Health Services Administration*

---

balance. With help, they can achieve and sustain that harmony. Using the national cross-site evaluation and the Government Performance and Results Act (GPRA) questionnaire, data collected from this project will be used to determine long term performance.



# *HHS-Centers for Disease Control and Prevention*



The Centers for Disease Control and Prevention (CDC) is recognized as the lead federal agency for protecting the health and safety of people—at home and abroad, providing credible information to enhance health decisions and promoting health through strong partnerships. CDC serves as the national focus for developing and applying disease prevention and control, environmental health and health promotion and education activities designed to improve the health of the people of the United States. CDC works hard to make people safer and healthier. By charting decisive courses of action, collecting the right information and working closely with other health and community organizations, CDC has been putting science into action to tackle important health problems since 1946. With more than 9,500 employees across the country, CDC plays a critical role in protecting the public from the most widespread, deadly and mysterious threats against our health today and tomorrow.

CDC's mission is to promote health and quality of life by preventing and controlling disease, injury and disability. CDC seeks to accomplish its mission by working with partners throughout the nation and world to monitor health; detect and investigate health problems; conduct research to enhance prevention; develop and advocate sound public health policies; implement prevention strategies; promote healthy behaviors; foster safe and healthful environments and provide leadership and training.

In May 2004, CDC Director Dr. Julie Gerberding announced new goals and integrated operations that will allow this federal public health agency to have greater impact on the health of people around the world. This announcement evolved from an ongoing strategic development process called the Futures Initiative, which began in 2003 and has included hundreds of employees, other agencies, organizations, and the public. Dr. Gerberding announced that CDC will align its priorities and investments under two overarching health protection goals:

- 1) **Preparedness** All people in all communities will be protected from infectious, environmental and terrorists threats.
  
- 2) **Health Promotion and Prevention of Disease, Injury and Disability** All people will achieve their optimal lifespan with the best possible quality of health in every stage of life.

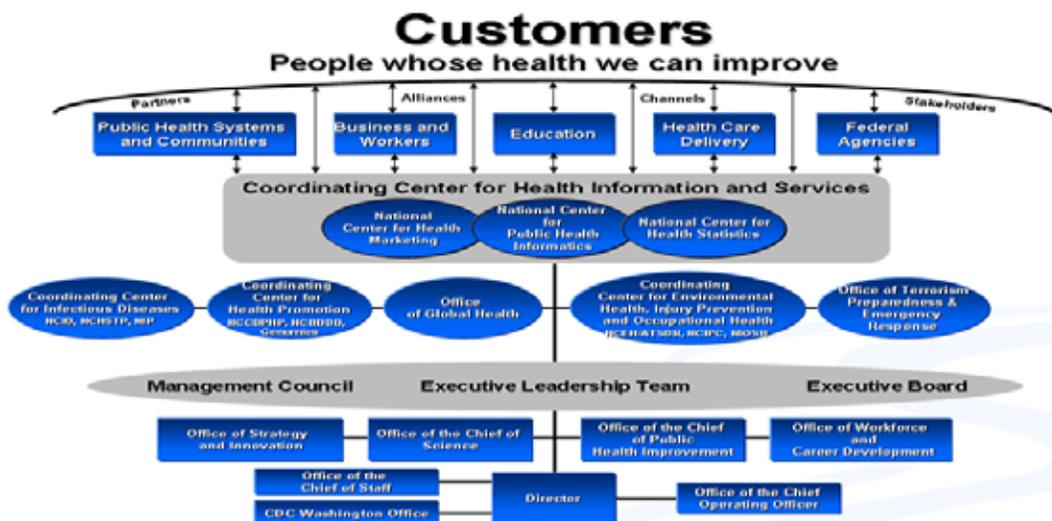
CDC is changing to meet the challenges of public health in the 21st century, including terrorism preparedness and response; America's aging population; obesity and its dire health consequences; globalization and emerging infectious disease and the need to modernize our nation's public health workforce and infrastructure.

CDC works to provide better services to our customers by coordinating health and information services. Customers include partners, alliances, channels and

# HHS-Centers for Disease Control and Prevention

stakeholders. See operational chart below.

*CDC Operational Chart*



CDC is committed to improving the public health of American Indians/ Alaska Natives (AI/AN) and recognizes the unique relationship it has with AI/AN governments and the cultural diversity of AI/AN communities. AI/AN focused projects exist in virtually all of CDC's organizational components. To some degree, each Center, Institute and Office (CIO) dedicates staff and resources to address public health issues in AI/AN communities. CDC uses a number of approaches to help prevent disease and injury, and promote healthy lifestyles among AI/AN populations; examples include extramural funding (grants, cooperative agreements), direct assistance assignees, technical assistance, training, partnership building and inter-governmental coordination.

Within CDC's Office of the Director (OD), the Office of Minority Health (OMH) is responsible for coordinating the agency's programs and policies that benefit AI/AN communities. To lead these efforts, two full-time professional staff positions have been established within OMH/OD to help plan and coordinate CDC programs for AI/AN communities: the Senior Tribal Liaison for Policy and Evaluation and the Senior Tribal Liaison for Science and Public Health. Located in Atlanta, GA, and Albuquerque, NM, respectively, these senior staff members report directly to the Director for Minority Health and serve as official CDC points-of-contact for issues relating to AI/AN health. In addition, they work closely with CDC's CIOs that have programs and activities involving AI/AN communities and with their sister Agency for Toxic Substances and Disease Registry's (ATSDR) Office of Tribal Affairs. ATSDR has a joint office of the Director with the CDC's National Center for Environmental Health (NCEH) and share CDC Director, Dr. Gerberding as their Chief Administrator.



# HHS-Centers for Disease Control and Prevention



Work was completed on the CDC Tribal Consultation Initiative, an agency-wide effort to respond to HHS directives and Executive Orders to establish official policy on tribal consultation with three key recommendations that are currently under review by the Director of the CDC. These recommendations are to:

- Adopt a newly-revised CDC Tribal Consultation Policy,
- Establish an organizational unit within OD to guide and monitor AI/AN programs across the agency and
- Commit CDC leadership to at least annual visits to Indian country.

The primary components of the revised Consultation Policy are the establishment of a CDC Tribal Consultation Committee composed of tribal leaders and/or their designees and Commitment to ongoing CDC participation in the HHS Annual Regional and National Consultation Sessions. This Policy contains procedural guidance to CDC staff working effectively with AI/AN communities, including guidance on federal consultation procedures, promoting state-tribal consultation and increasing tribal access to CDC programs.

In FY 2004, CDC increased funding awards to tribal governments, tribal health boards or coalitions, tribal organizations, Alaska Native health corporations, and urban Indian health centers - an increase of 45% over FY 2003. These efforts addressed diabetes prevention and other health related projects. These extramural awards were allocated to 14 tribal governments (compared to 9 in FY 2003), 8 tribal health boards (9 in FY 2003), 6 Alaska Native health corporations (5 in FY 2003), 3 Urban Indian Health centers (same as FY 2003), and 11 tribal organizations (7 in FY 2003). Awardees are located in 17 states (15 in FY 2003) across the country.

New funding opportunity announcements released that tribes and tribal organizations were eligible to apply for included: motor vehicle injury prevention, STD control, Steps to a Healthier US (expansion), rapid HIV testing demonstration sites, HIV behavioral surveillance, infant mortality reduction, viral hepatitis integration projects (expansion), public health conference support, emergency medical services linkages and direct assistance field assignees.

The following chart lists funding provided directly to the American Indian/Alaska Native grant-funded projects in FY 2003 and FY 2004.

FY 2003 Cooperative Agreements to AI/ANs Tribes and Organizations						
Project Name	Grantee Name	CIO	Approved Budget	Budget Start Date	Budget End Date	State
FETAL ALCOHOL SYNDROME AWARENESS & EDUCATION PROJ.	NATIONAL INDIAN JUSTICE CENTER	CBDDD	\$125,000	9/30/2003	9/29/2004	CA

# HHS-Centers for Disease Control and Prevention

NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	KAW NATION OF OKLAHOMA	CCDPH	\$248,484	6/30/2003	6/29/2004	OK
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	NAVAJO DIVISION OF HEALTH	CCDPH	\$765,916	6/30/2003	6/29/2004	AZ
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	NW PORTLAND	CCDPH	\$300,001	6/30/2003	6/29/2004	OR
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	SE ALASKA REGION HEALTH CONSORTIUM	CCDPH	\$556,779	6/30/2003	6/29/2004	AK
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	YUKON-KUSKOKWIM HEALTH CORP.	CCDPH	\$305,535	6/30/2003	6/29/2004	AK
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	NATIVE AMERICAN HEALTH RES. CTR.	CCDPH	\$357,290	9/30/2002	9/29/2003	OR
NATIONAL NETWORKS FOR TOBACCO PREVENTION AND CONTROL	NORTHWEST PORTLAND AREA INDIAN HLTH. BRD	CCDPH	\$401,009	9/30/2003	9/29/2004	OR
AI/AN SUPPORT CENTERS FOR TOBACCO PROGRAMS	ALASKA NATIVE HEALTH BOARD	CCDPH	\$305,042	9/30/2003	9/29/2004	AK
AI/AN SUPPORT CENTERS FOR TOBACCO PROGRAMS	NORTHWEST PORTLAND AREA INDIAN HLTH.BRD	CCDPH	\$345,223	9/30/2003	9/29/2004	OR
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	SOUTHCENTRAL FOUNDATION	CCDPH	\$1,260,530	6/30/2003	6/29/2004	AK
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	SOUTH PUGET INTERTRIBAL PLANNING AGENCY	CCDPH	\$665,197	6/30/2003	6/29/2004	WA
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	NARA OF THE NORTHWEST, INC.	CCDPH	\$451,980	6/30/2003	6/29/2004	OR
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	ARCTIC SLOPE NATIVE ASSOCIATION	CCDPH	\$442,139	6/30/2003	6/29/2004	AK
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	MISSISSIPPI BAND OF CHOCTAW INDIANS	CCDPH	\$391,072	6/30/2003	6/29/2004	MS
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	POARCH BAND OF CREEK INDIANS	CCDPH	\$98,135	6/30/2003	6/29/2004	AL
RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH	UNITED SOUTH AND EASTERN TRIBES, INC.	CCDPH	\$299,098	9/30/2003	9/29/2004	TN
RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH	EASTERN BAND OF CHEROKEE INDIANS	CCDPH	\$774,720	9/30/2003	9/29/2004	NC
PHHS BLOCK GRANT	SANTEE SIOUX - EMERGENCY MEDICAL SERVICES	CCDPH	\$40,833	10/1/2003	9/30/2004	NE



# HHS-Centers for Disease Control and Prevention



PHHS BLOCK GRANT	KICKAPOO INDIANS - ADOLESCENT HEALTH PROGRAM	CCDPH	\$40,833	10/1/2003	9/30/2004	KS
AI/AN SUPPORT CENTERS FOR TOBACCO PROGRAMS	INTER-TRIBAL COUNCIL OF MICHIGAN	CCDPH	\$297,946	9/30/2003	9/29/2004	MI
STEPS TO A HEALTHIERUS: A COMMUNITY-FOCUSED ASTHMA, DIABETES, AND OBESITY	INTER-TRIBAL COUNCIL OF MICHIGAN	CCDPH	\$250,000	9/22/2003	9/21/2004	MI
AI/AN SUPPORT CENTERS FOR TOBACCO PROGRAMS	MUSCOGEE (CREEK) NATION	CCDPH	\$227,492	9/30/2003	9/29/2004	OK
NAT'L DIABETES TO PROMOTE DIABETES EDUCATION STRATEGIES IN MINORITY COMMUNITIES	ASSOCIATION OF AMERICAN INDIAN PHYSICIAN	CCDPH	\$440,643	2/27/2003	2/26/2004	OK
RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH	ALBUQUERQUE AREA INDIAN HLTH BOARD, INC.	CCDPH	\$285,806	9/30/2003	9/29/2004	NM
RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH	ASSOCIATION OF AMERICAN INDIAN PHYSICIAN	CCDPH	\$283,725	9/30/2003	9/29/2004	OK
RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH	CHUGACHMUT, INC.	CCDPH	\$300,000	9/30/2003	9/29/2004	AK
RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH	THE CHOCTAW NATION OF OKLAHOMA	CCDPH	\$270,285	9/30/2003	9/29/2004	OK
AI/AN SUPPORT CENTERS FOR TOBACCO PROGRAMS	ABERDEEN AREA TRIBAL CHAIRMEN'S HLTH. BO	CCDPH	\$207,445	9/30/2003	9/29/2004	SD
AI/AN SUPPORT CENTERS FOR TOBACCO PROGRAMS	INTER TRIBAL COUNCIL OF ARIZONA, INC	CCDPH	\$228,571	9/30/2003	9/29/2004	AZ
AI/AN SUPPORT CENTERS FOR TOBACCO PROGRAMS	CALIFORNIA RUAL INDIAN HEALTH BOARD	CCDPH	\$268,314	9/30/2003	9/29/2004	CA
WISEWOMAN - Alaska NATIVE WOMEN'S WELLNESS PROJECT	SOUTHCENTRAL FOUNDATION	CCDPH	\$478,452	6/30/2003	6/29/2004	AK
WISEWOMAN	SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM	CCDPH	\$500,383	6/30/2003	6/29/2004	AK
HIV PREVENTION PROGRAMS FOR CBOS	ALASKA NATIVE HEALTH BOARD	CEHIV	\$209,342	6/1/2003	5/31/2004	AK
HIV PREVENTION PROGRAMS FOR CBOS	INDIGENOUS PEOPLES' TASK FORCE	CEHIV	\$138,000	6/1/2003	5/31/2004	MN
HUMAN IMMUNODEFICIENCY VIRUS (HIV) APPLIED RESEARCH	NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD	CEHIV	\$206,058	9/30/2003	9/29/2004	OR
CAPACITY-BUILDING ASSISTANCE TO IMPROVE THE DELIVERY AND EFFECTIVENESS	INTER TRIBAL COUNCIL OF ARIZONA, INC.	CEHIV	\$227,830	11/1/2002	10/31/2003	AZ
COMMUNITY-BASED HIV PREVENTION PROJECT	NATIVE FAMILY RESOURCE CENTER, INC.	CEHIV	\$225,000	6/1/2003	5/31/2004	IA

# HHS-Centers for Disease Control and Prevention

GAY MEN OF COLOR AT RISK FOR HIV INFECTION	NATIVE AMERICAN COMMUNITY HEALTH CENTER	CFHIV	\$73,333	9/30/2003	5/31/2004	AZ
GAY MEN OF COLOR AT RISK FOR HIV INFECTION	NATIONAL NATIVE AMERICAN AIDS PREV CTR	CFHIV	\$237,500	9/30/2003	9/29/2004	CA
CAPACITY-BUILDING ASSISTANCE TO IMPROVE THE DELIVERY AND EFFECTIVENESS	NATL NATIVE AMERICAN AIDS PREV CENTER	CFHIV	\$777,172	11/1/2002	10/31/2003	CA
CB STRATEGIES TO INC. HIV TESTING OF PERSONS AT HIGH RISK IN COMMUNITIES OF COLOR	NATIVE AMERICAN COMMUNITY HEALTH CENTER	CFHIV	\$88,214	7/1/2003	6/30/2004	AZ
EVALUATE HEP A & B VACCINE AMONG ANs AND STUDY CHRONIC HEP C	ALASKA NATIVE TRIBAL HEALTH CONSORTIUM	NCID	\$299,824	9/30/2003	9/29/2004	AK
	FY 2003 TOTAL FOR CDC		\$14,696,151			
FY 2004 Cooperative Agreements to AI/ANs Tribes and organizations						
Project Title	Grantee Name	CIO	Approved Budget	Budget Start	Budget End	State
NATIONAL NETWORKS FOR TOBACCO PREVENTION AND CONTROL	NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD	CCDPH	\$299,799	9/30/2004	9/29/2005	OR
AI/AN SUPPORT CENTERS FOR TOBACCO PROGRAMS	ALASKA NATIVE HEALTH BOARD	CCDPH	\$228,570	9/30/2004	9/29/2005	AK
AI/AN SUPPORT CENTERS FOR TOBACCO PROGRAMS	NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD	CCDPH	\$228,571	9/30/2004	9/29/2005	OR
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM	CCDPH	\$752,672	6/30/2004	6/29/2005	AK
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	SOUTHCENTRAL FOUNDATION	CCDPH	\$1,888,451	6/30/2004	6/29/2005	AK
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	SOUTHCENTRAL FOUNDATION	CCDPH	\$1,687,621	9/30/2002	6/29/2003	AK
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	SOUTH PUGET INTERTRIBAL PLANNING AGENCY	CCDPH	\$836,941	6/30/2004	6/29/2005	WA
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	NARA OF THE NORTHWEST, INC.	CCDPH	\$657,668	6/30/2004	6/29/2005	OR
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	NORTHWEST PORTLAND AREA IND. HLTH BOARD	CCDPH	\$300,000	6/30/2004	6/29/2005	OR
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	YUKON-KUSKOKWIM HEALTH CORPORATION	CCDPH	\$400,256	6/30/2004	6/29/2005	AK
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	ARTIC SLOPE NATIVE ASSOCIATION	CCDPH	\$706,852	6/30/2004	6/29/2005	AK



# HHS-Centers for Disease Control and Prevention



RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH	CHUGACHMI UT	CCDPH	\$300,000	9/30/2004	9/29/2005	AK
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	ALASKA NATIVE TRIBAL HEALTH CONSORTIUM	CCDPH	\$167,500	6/30/2004	6/29/2005	AK
CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION PROGRAMS	SOUTHCENTRAL FOUNDATION	CCDPH	\$662,129	6/30/2004	6/29/2005	AK
CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION PROGRAMS	SE ALASKA REGIONAL HEALTH CONSORTIUM	CCDPH	\$1,036,332	6/30/2004	6/29/2005	AK
STEPS TO A HEALTHIER US	SEARHC	CCDPH	\$500,000	9/22/2004	9/21/2005	AK
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	MISSISSIPPI BAND OF CHOCTAW INDIANS	CCDPH	\$370,732	6/30/2004	6/29/2005	MS
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	POARCH BAND OF CREEK INDIANS	CCDPH	\$131,907	6/30/2004	6/29/2005	AL
RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH	UNITED SOUTH AND EASTERN TRIBES, INC.	CCDPH	\$299,098	9/30/2004	9/29/2005	TN
RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH	EASTERN BAND OF CHEROKEE INDIANS	CCDPH	\$928,137	9/30/2004	9/29/2005	NC
AI/AN SUPPORT CENTERS FOR TOBACCO PROGRAMS	INTER-TRIBAL COUNCIL OF MICHIGAN	CCDPH	\$228,573	9/30/2004	9/29/2005	MI
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	FOND DU LAC RESERVATION	CCDPH	\$105,740	6/30/2004	6/29/2005	MN
STEPS TO A HEALTHIERUS: A COMMUNITY-FOCUSED ASTHMA, DIABETES, AND OBESITY	INTER-TRIBAL COUNCIL OF MICHIGAN	CCDPH	\$800,000	9/22/2004	9/21/2005	MI
AI/AN SUPPORT CENTERS FOR TOBACCO PROGRAMS	MUSCOGEE (CREEK) NATION	CCDPH	\$228,571	9/30/2004	9/29/2005	OK
NAT'L DIABETES TO PROMOTE DIABETES EDUCATION STRATEGIES IN MINORITY COMMUNITY	ASSOCIATION OF AMERICAN INDIAN PHYSICIAN	CCDPH	\$407,095	2/27/2004	2/26/2005	OK
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	KAW NATION OF OKLAHOMA	CCDPH	\$425,453	6/30/2004	6/29/2005	OK
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	CHEROKEE NATION	CCDPH	\$1,704,991	6/30/2004	6/29/2005	OK
RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH	ALBUQUERQUE AREA INDIAN HLTH BOARD, INC.	CCDPH	\$285,812	9/30/2004	9/29/2005	NM
RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH	ASSOCIATION OF AMERICAN INDIAN PHYSICIAN	CCDPH	\$283,725	9/30/2004	9/29/2005	OK

# HHS-Centers for Disease Control and Prevention

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH	NATIONAL INDIAN COUNCIL ON AGING, INC	CCDPH	\$250,000	9/30/2004	9/29/2005	NM
RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH	THE CHOCTAW NATION OF OKLAHOMA	CCDPH	\$270,285	9/30/2004	9/29/2005	OK
PROGRAMS TO IMPROVE THE HEALTH, EDUCATION, AND WELL-BEING OF YOUNG PEOPLE.	NATIVE AMERICAN INTRNATIONAL CAUCUS	CCDPH	\$175,000	5/15/2004	5/14/2005	OK
ENHANCING CANCER PREVENTION & CTRL FOR AI/AN WOMEN	NATIONAL INDIAN WOMENS HEALTH RESOURCE CENTER	CCDPH	\$350,000	9/30/2004	9/29/2005	OK
STEPS TO A HEALTHIER US	CHEROKEE NATION HEALTH SERVICE GROUP	CCDPH	\$500,000	9/22/2004	9/21/2005	OK
AI/AN SUPPORT CENTERS FOR TOBACCO PROGRAMS	ABERDEEN AREA TRIBAL CHAIRMEN'S HEALTH BOARD	CCDPH	\$228,571	9/30/2004	9/29/2005	SD
PROGRAMS TO IMPROVE THE HEALTH, EDUCATION, AND WELL-BEING OF YOUNG PEOPLE.	NATIONAL INDIAN SCHOOL BOARD ASSOCIATION	CCDPH	\$0	5/15/2004	7/15/2004	MT
AI/AN SUPPORT CENTERS FOR TOBACCO PROGRAMS	INTER TRIBAL COUNCIL OF ARIZONA, INC	CCDPH	\$228,571	9/30/2004	9/29/2005	AZ
AI/AN SUPPORT CENTERS FOR TOBACCO PROGRAMS	CALIFORNIA RUAL INDIAN HEALTH BOARD	CCDPH	\$228,571	9/30/2004	9/29/2005	CA
NATIONAL CANCER PREVENTION AND CONTROL PROGRAM	THE NAVAJO NATION	CCDPH	\$1,046,667	6/30/2004	6/29/2005	AZ
PUBLIC HEALTH CONFERENCE SUPPORT PROPGRAM	NATIVE SOLUTIONS	CCDPH	\$50,000	7/28/2004	7/27/2005	AZ
HUMAN IMMUNODEFICIENCY VIRUS(HIV)PREVENTION PROJECTS FOR CBO	ALASKA NATIVE HEALTH BOARD	CFHIV	\$372,270	7/1/2004	6/30/2005	AK
DEMO PROJ IMPL RAPID HIV TESTING HISTORICALLY BLACK COLLEGES & UNIV	SAULT STE. MARIE TRIBE/CHIPPEWA INDIANS	CFHIV	\$195,094	9/1/2004	8/31/2005	MI
CAPACITY-BUILDING ASSISTANCE TO IMPROVE THE DELIVERY AND EFFECTIVENESS	INTER TRIBAL COUNCIL OF ARIZONA, INC.	CFHIV	\$93,750	11/1/2003	3/31/2004	AZ
PUBLIC HLTH CONFERENCE SUPPORT CORP.AGR.PROG FOR HUMMAN IMM. VIRUS PREVENT	ALBUQUERQUE AREA INDIAN HEALTH BOARD, INC.	CFHIV	\$25,000	4/1/2004	9/30/2004	NM
CAPACITY-BUILDING ASSISTANCE TO IMPROVE THE DELIVERY AND EFFECTIVENESS	NATL NATIVE AMERICAN AIDS PREVENTION CENTER	CFHIV	\$544,238	11/1/2003	9/30/2004	CA
CBA (HIV) PREVENTION SERVICES FOR RACIAL/ETHNIC MINORITY POPULATIONS	THE NAT'L NATIVE AMERICAN AIDS PREVENTION CTR	CFHIV	\$1,350,000	4/1/2004	3/31/2005	CA



# HHS-Centers for Disease Control and Prevention



CBA (HIV) PREVENTION SERVICES FOR RACIAL/ ETHNIC MINORITY POPULATIONS	INTER TRIBAL COUNCIL OF ARIZONA, INC.	CFHIV	\$300,000	4/1/2004	3/31/2005	AZ
HUMAN IMMUNODEFICIENCY VIRUS(HIV)PREVENTION PROJECTS FOR CBO	NATIVE AMERICAN HEALTH CENTER	CFHIV	\$306,885	7/1/2004	6/30/2005	
DEMONSTRATION PROJECTS FOR IMPLEMENTATION OF RAPID HIV TESTING IN HISTORICALLY BLACK COLLEGES AND UNIVERSITIES AND ALTERNATIVE VENUES AND POPULATIONS	NATIVE AMERICAN COMMUNITY HEALTH CENTER	CFHIV	\$157,808	9/1/2004	8/31/2005	AZ
DEMONSTRATION PROJECTS FOR IMPLEMENTATION OF RAPID HIV TESTING IN HISTORICALLY BLACK COLLEGES AND UNIVERSITIES AND ALTERNATIVE VENUES AND POPULATIONS	INTERMOUNTAIN HARM REDUCTION PROJECT	CFHIV	\$164,760	9/1/2004	8/31/2005	UT
AI/AN STD	NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD	CFSTD	\$210,000	9/1/2004	8/31/2005	OR
AI/AN STD	NAVAJO NATION	CFSTD	\$253,836	9/1/2004	8/31/2005	AZ
TRIBAL COLLEGE ASSOCIATE OF SCIENCE IN PUBLIC HEALTH DEGREE PROGRAM	DINE' COLLEGE	CFOHD	\$99,000	9/1/2004	8/31/2005	AZ
EVALUATE THE LONG-TERM PROTECTION FROM HEPATITIS A AND B VACCINE AMONG	ALASKA NATIVE TRIBAL HEALTH CONSORTIUM	CID	\$294,922	9/30/2004	9/29/2005	AK
EFFECTIVE STRATEGIES/ REDUCE MOTOR VEHICLE INJURIES-AI/AN	HO-CHUNK NATION	CIPC	\$71,634	9/1/2004	8/31/2005	WI
EFFECTIVE STRATEGIES/ REDUCE MOTOR VEHICLE INJURIES-AI/AN	WHITE MOUNTAIN APACHE TRIBE	CIPC	\$71,634	9/1/2004	8/31/2005	AZ
EFFECTIVE STRATEGIES/ REDUCE MOTOR VEHICLE INJURIES-AI/AN	TOHONO O'ODHAM NATION	CIPC	\$71,634	9/1/2004	8/31/2005	AZ
EFFECTIVE STRATEGIES/ REDUCE MOTOR VEHICLE INJURIES-AI/AN	SAN CARLOS APACHE TRIBE	CIPC	\$71,634	9/1/2004	8/31/2005	AZ
LINKAGES OF ACUTE CARE & EMS TO STATE & LOCAL INJURY PREVENTION PREPAREDNESS	NTL. NATIVE AMERICAN EMS ASSOC.	CIPC	\$125,000	9/30/2004	9/29/2005	AZ
ENHANCE RESEARCH, INFRASTRUCTURE, & CAPACITY BLDG FOR AI TRIBES	AMERICAN INDIAN HIGHER ED. CONSORTIUM	ODCDC	\$200,000	9/30/2003	9/29/2005	VA
		Grand Total	\$25,510,960			

## *HHS-Centers for Disease Control and Prevention*

In addition to grant-funded projects, CDC was involved with various outreach projects throughout Indian Country.

### **New Mexico Department of Health Assessment Project**

In September 2002, the New Mexico Department of Health (NM DoH) received \$165,000 in the first year of a five year cooperative agreement to enhance the quality and scope of community health assessment practices through a systematic evaluation done in coordination with CDC's Division of Public Health Surveillance and Informatics, Epidemiology Program Office. One of the main activities is providing direct epidemiology support to the 22 tribes within the state. Through this support, it is hoped to improve the knowledge of the community health status among tribes; improve the quality and scope of assessments conducted and increase the number of tribes with community-level evidence to improve public health programs and policies. With this support, the NM DoH has established a tribal epidemiologist position. This new tribal epidemiologist has been instrumental in the development of a methodology to create inter-censal population estimates by tribe. In addition, planning has begun to add a tribal affiliation field to the reportable infectious disease database. It was initiated to provide access to tribal-specific infectious disease data for use in assessment, planning and prevention activities. A tool was developed to evaluate current tribal assessment capacity and completed with five tribes.

### **Diabetes Prevention**

CDC staff from the Division of Diabetes Translation (DDT) provide technical assistance to the Indian Health Service (IHS) Diabetes Program on surveillance of diabetes and diabetes-related complications among American Indian/Alaska Native (AI/AN). CDC works closely with IHS, documenting the large and disproportionate burden of diabetes in this population and the increasing trend in diabetes prevalence, particularly among young AI/AN. For example, CDC used data from the United States Renal Data System (USRDS) to document trends in incidence of treatment for diabetes-related end-stage renal disease. Results of CDC's work have been 1) used to report to Congress on the burden of diabetes among AI/AN, 2) used to allocate IHS diabetes grant funds, 3) disseminated to the IHS coordinators of diabetes prevention and control efforts, 4) posted on the website of the IHS Diabetes Program and 5) included in the CDC National Diabetes Fact Sheet.

To support its community-based prevention research efforts, the NDPC provides funds to the American Indian Higher Education Consortium (AIHEC), a collaboration among tribal colleges and universities (TCUs) representing 34 colleges in the United States and one in Canada. AIHEC provides a unified voice for the tribal college network that gives American- Indian students access to quality higher education programs. Through "Honoring Our Health: Tribal Colleges



# *HHS-Centers for Disease Control and Prevention*



and Communities Working to Prevent Diabetes,” the NDPC supports AIHEC in building capacity for promoting and sustaining innovative diabetes prevention programs within TCUs. The NDPC funding (approximately \$1 million/year) supports program development and technical assistance in the public health approach to diabetes education and program evaluation.

## **National Diabetes Prevention Center**

To address the serious epidemic of diabetes in American Indians, CDC established the National Diabetes Prevention Center (NDPC) in Gallup, NM. The purpose of the NDPC is to prevent diabetes and its complications through culturally appropriate and scientifically sound participatory, community-based prevention research in AI/AN populations. The goals of the NDPC are to 1) identify “what works best” in diabetes prevention by testing and evaluating new and existing models of diabetes prevention and then sharing the outcomes with others; 2) provide training and education activities according to community needs and priorities and 3) provide the latest information and techniques on diabetes and diabetes prevention through conferences, seminars and technical assistance.

## **Steps to a HealthierUS**

In FY 2003 and FY 2004, the Steps to a HealthierUS Cooperative Agreement Program funded community-focused initiatives to reduce the burden of asthma, diabetes, and obesity. Through the Steps to a HealthierUS Cooperative Agreement Program, HHS agencies, including CDC and IHS, are committed to providing and tailoring culturally appropriate technical assistance for the implementation and evaluation of community-based initiatives in funded tribal consortia. Technical assistance will include ensuring collaboration with key partners, facilitating the sharing of resources, results and lessons learned, making available the staff, expertise and evidence-based resources of HHS agencies to assist in areas of surveillance and epidemiology, community assessment and planning, community mobilization, partnership development, monitoring program performance outcomes, data management and program sustainability.

## **HIV/AIDS Prevention**

Also in FY 2003, CDC’s National Center for HIV, STD, and TB Prevention (NCHSTP) supported the National Native American AIDS Prevention Center (NNAAPC) to provide technical assistance to AI/AN and Native Hawaiian entities for enhancing and improving the delivery and effectiveness of HIV prevention interventions; strengthening community capacity for HIV prevention and strengthening HIV prevention community planning.

## *HHS-Centers for Disease Control and Prevention*

In FY 2003, NCHSTP funded the Inter Tribal Council of Arizona (ITCA) to enhance regional community mobilization for AI/AN HIV prevention programs among 19 tribes located in Arizona, Nevada, and Utah. The goal is to improve delivery and effectiveness of HIV prevention services for AI/AN tribes, organizations, and urban health centers in the three states.

In FY 2004, NCHSTP continued support for NNAAPC's and ITCA's technical activities described above and added a third technical assistance provider, Colorado State University's Tri-Ethnic Center (TEC), for Prevention Research. TEC was funded to strengthen the capacity of Community-Based Organizations (CBOs) serving Native people. TEC is developing and implementing specific regional and community strategies to assess service gaps, improve access to HIV/AIDS services and increase use of services through training on use of the Community Readiness Model for assessment, application, strategy development and development of social marketing efforts. TEC is also assisting AI/AN organizations in increasing the proportion of HIV-infected individuals who know they are infected through enhancing early detection/testing. In this endeavor, TEC is collaborating with CBOs to develop community-specific and culturally appropriate social marketing strategies for education, awareness and early testing and to increase the proportion of HIV-infected people who are linked to appropriate prevention, supportive care and treatment.

### **Sexually Transmitted Disease (STD) services**

The National Center for HIV, STD, and TB Prevention Division of HIV/AIDS Prevention supported an intra-agency agreement with the IHS. This agreement provides technical assistance to IHS tribal and urban health facilities, including on-site visits to enhance partnerships among agencies providing STD services to AI/AN persons. The agreement also provided three assignees to IHS to support tribal epidemiology centers, the Infertility Prevention Program, and to manage the IHS STD Program. NCHSTP/DSTDP-funded Prevention Training Centers (PTC) provided on-site training in STD clinical skills, behavioral interventions and partner services for clinicians at IHS and tribal and urban sites. It also provided speakers and information at national IHS Tribal and Urban Indian Health conferences and technical assistance as needed.

### **Health Promotion and Disease Prevention**

CDC, Health Resources and Services Administration (HRSA) and IHS established a collaborative working group to help assess progress toward *Healthy People 2010* Public Health Infrastructure goals in Indian country.

- CDC has worked with tribes, IHS and state/county health departments to apply the National Public Health Performance Standards assessments in several AI communities in the southwest and has drafted a new assessment instrument



# HHS-Centers for Disease Control and Prevention



that will aid tribal communities in conducting their own assessments.

- In partnership with IHS and tribal representatives, CDC/Division of STD Prevention worked with The National Coalition of STD Directors (NCSD) in establishing a NCSD workgroup of state STD directors and external partners to address AI/AN STD issues.
- CDC conducted outreach efforts to direct West Nile Virus educational materials to AI populations potentially at risk during the 2004 outbreak and to learn from 2003 prevention activities conducted by AI health programs.
- CDC Artic Investigation Program collaborated with Yukon-Kuskokwin Native Health Corporation and the Alaska Native Tribal Health Consortium to develop programs to improve adult immunization rates for influenza, pneumococcal and tetanus/diphtheria vaccines.
- CDC National Immunization Program, Office of Workforce and Career Development and Office of Health Equity worked closely with IHS and tribal immunization coordinators to ensure comprehensive and equitable distribution of 2004 influenza vaccine to high risk AI/AN populations across the country.

## Emergency Preparedness

- In FY 2004, \$4 million of states' cooperative agreement funds were disseminated to tribal nations, IHS and tribal organizations in the form of grants, contracts and dedicated staff. Of this amount, \$1.7 million went to benefit tribal nations, associated organizations and other response partners through activities such as the hiring of liaisons, resources to support tribal planning and training and education.
- Since June 2003, the Office of Terrorism Preparedness and Emergency Response (OTPER) Tribal Liaison Officer has conducted over 24 tribal site visits to address bioterrorism in tribal nations. Visits have included presentations, technical assistance and initiating collaboration between tribal entities and state grantees. Sites visited include the Tohono O'odham Nation, Blackfeet Nation, St. Regis Mohawk Nation, Bad River Nation and Red Cliff Nation. Among eight states with federally recognized tribes and international borders, Montana, Minnesota, Michigan, New York and Arizona have involved local tribes in the Early Warning Infectious Disease Surveillance project; Texas, Wisconsin and Washington have similar plans.
- OTPER Progress Reviews provided to CDC by state awardees indicate that a number of tribes in 33 or 36 "reservation states" are involved with states in preparedness efforts; CDC/OTPER will continue to monitor these reports to ensure tribal participation.
- The NW Portland Area Indian Health Board contracted with the CDC-funded

## *HHS-Centers for Disease Control and Prevention*

NW Center for Public Health Practice at the University of Washington to conduct a training needs assessment of Washington tribes. The assessment instrument used for this project is available to others wishing to conduct similar assessments in Indian country; NPAIHB will conduct the same assessment with tribes in Oregon and Idaho.

### **Data and Research**

- CDC staff from multiple centers are working with tribal partners, IHS and state health departments to systematically document and make recommendations to correct AI/AN racial misclassification in health data sets such as cancer registries, death certificates and reportable infectious diseases (STDs, HIV/AIDS).
- CDC's National Center for Health Statistics (NCHS) provides data on the nation's health to support research, health policy and public health. Each NCHS data system collects data on AI/AN and data products (electronic files, reports, Internet releases) including data that detail the health of AI/AN and other populations. *Health, United States*, the HHS Secretary's annual report to the Congress on the nation's health, includes data tables and statistics on American Indians. Some of the statistics include topics on health insurance and infant mortality rates. For instance, the report states Hispanic and American Indian populations are more likely than any other race to be uninsured. Also, the report states that American Indians had the highest infant mortality rates at 8.7 per 1000.
- The Artic Investigation Program continues to study pneumococcal disease prevention in ANs. Results of disease epidemiology, vaccine effectiveness and vaccine coverage studies have been reported to healthcare providers throughout Alaska. New interventions developed include bilingual (English and Yupik) vaccine information brochures, a vaccine video for AN adults and an evaluation of adult vaccination rates in Alaska.
- The findings of a collaborative GIS-based case-control study for plague risk mapping in the southwestern United States, involving CDC, Navajo, Hopi and Zuni Tribes, IHS and the USGS Mid Continent Mapping Center will be used to design improved plague surveillance and prevention.

### **Racial and Ethnic Approaches to Community Health (REACH) 2010**

REACH is a demonstration program to support community coalitions in the design, implementation, and evaluation of unique community-driven strategies to eliminate health disparities. Currently, seven tribes and/or tribal organizations have been funded to develop core capacity projects targeting AI/ANs. These projects are assisting tribes in building infrastructure for scientific capacity and surveillance, developing culturally competent health promotion and disease prevention strategies, providing training and technical assistance and facilitating networking and partnership development through the use of Community Action Plans.



# *HHS-Centers for Disease Control and Prevention*



## **Viral Hepatitis**

Through an inter-agency agreement with the IHS, CDC's National Center for Infectious Disease Division of Viral Hepatitis (DVH) used \$282,877 of FY 2004 funds to fund four continuation projects. The purpose of these Viral Hepatitis Integration Projects (VHIPs) is to provide viral hepatitis risk factor assessment, testing, vaccination, counseling, and referral services at Indian-specific settings in which they were not previously available. These programs operate in Montana, Alaska, Washington and Arizona to determine the feasibility of integrating hepatitis services into existing programs serving high-risk Indian populations; identify the most effective strategies for delivering these services and develop models of care that can be translated to other Indian health settings. The DVH also provided seven in-service presentations to IHS, Tribal and Urban Indian Health staff on viral hepatitis (A, B, and C) epidemiology, prevention and treatment.

## **CDC's National Center for Injury Prevention and Control (NCIPC)**

Since FY 2003, NCIPC maintained an intra-agency agreement with the IHS. This agreement details arrangements for an IHS Epidemiologist to be assigned to the Division of Unintentional Injury Prevention (a division within CDC). The Epidemiologist provides technical assistance and consultation services to IHS and Tribal organizations working in injury prevention and control. Under this agreement, the assignee participated in a project to understand risk and protective factors for self-directed violence and weapon carrying among urban American Indian youth and on projects to distribute smoke alarms for prevention of fire-related injuries among high-risk communities, including residences on Indian reservations. The assignee collaborated with the IHS on an Atlas of Injuries Among Native American Children, which focused on the eight leading causes of injury; assisted the United Tribes Technical College's Associate Degree program in Injury Prevention for Native American students and helped revise and teach the week-long Introduction to Injury Prevention training course used to educate IHS and Tribal staff about community-based injury prevention. This course, conducted since 1985, has trained hundreds of IHS and tribal staff members in basic injury prevention practice. These activities are ongoing and affect many tribal communities.

In FY 2004, CDC awarded four Native American tribes approximately \$72,000 each to design, implement and evaluate effective injury prevention programs to reduce motor vehicle-related injuries and deaths among members of their communities. The San Carlos Apache Tribe in Arizona is developing a community-based intervention to reduce alcohol-impaired driving and lower blood alcohol concentrations among drivers in the community.

The White Mountain Apache Tribe in Arizona is developing an intervention to decrease alcohol-impaired driving and increase seat belt and child safety seat use

## *HHS-Centers for Disease Control and Prevention*

among residents of the Fort Apache Indian Reservation and the Tohono O'odham Nation, also in Arizona, are working to decrease alcohol-impaired driving and increase seat belt and child safety seat use among their members. The Ho-Chunk Nation in Wisconsin is developing an intervention to increase use of seat belts, child safety seats, and booster seats among low-use groups.

In each of these projects, staff will work closely with local law enforcement, community traffic safety coalitions, medical staff, evaluation experts and Indian Health Service injury prevention staff to reduce motor vehicle crashes on the reservations.

### **CDC's National Center for HIV, STD, and TB (NCHSTP)**

NCHSTP at the request of the Sicangu Lakota tribe, conducted an assessment of the STD prevention and control efforts of the Rosebud Comprehensive Health Care Facility and made recommendations for improvement. One of the key recommendations, the development of STD program guidelines and policies, is being implemented. These guidelines and policies will be adapted to distribute nationally to IHS and Tribal healthcare providers.

NCHSTP continued support in FY 2004 to build regional capacity in two IHS Areas (Navajo, and Aberdeen) to prevent and control STDs, including HIV, through contractual arrangements for the services of experienced public health advisors.

NCHSTP worked with the National Alliance of State and Territorial AIDS Directors to develop a report titled "Native Americans and HIV/AIDS: Key Issues and Recommendations for Health Departments."

NCHSTP funded a three-phased assessment, completed in 2004 in collaboration with the Council of State and Territorial Epidemiologists, to assess HIV/AIDS, STD, TB and viral hepatitis surveillance practices among IHS, tribally operated and urban AI/AN healthcare facilities and to identify barriers to participation in surveillance.

In partnership with IHS and tribal representatives, NCHSTP worked with The National Coalition of STD Directors (NCSD) in establishing a NCSD workgroup of state STD directors and external partners to address STD issues as they relate to AI/ANs. This workgroup will

- Define areas for NCSD advocacy as it relates to STDs in AI/ANs;
- Increase awareness of the AI population in each individual project area, and



## *HHS-Centers for Disease Control and Prevention*

---

- Identify resources, national and local, available to address the needs of AI/ANs related to STDs and make available all resources relating to STD prevention.

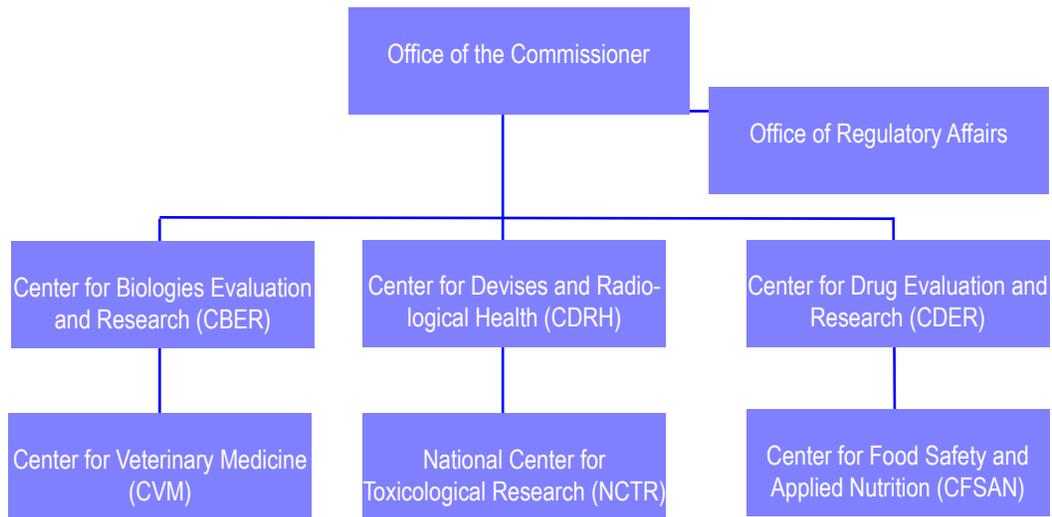


## HHS-Food and Drug Administration

The Food and Drug Administration (FDA) is a division within the U.S. Department of Health and Human Services. The FDA is responsible for protecting the public health by assuring the safety, efficacy and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics and products that emit radiation. The FDA is also responsible for advancing the public health by helping to speed innovations that make medicines and foods more effective, safer, and more affordable and helping the public get the accurate, science-based information they need to use medicine and foods to improve their health.

The FDA consists of eight offices/centers: Center for Biologics Evaluation and Research (CBER); Center for Devices and Radiological Health (CDRH); Center for Drug Evaluation and Research (CDER); Center for Food Safety and Applied Nutrition (CFSAN); Center for Veterinary Medicine (CVM); National Center for Toxicological Research (NCTR); Office of the Commissioner and Office of Regulatory Affairs.

*FDA Operational Chart*



The FDA provides funding for innovative food safety and research projects and conducts numerous outreach briefings and seminars. The following is a listing of the FDA collaborative projects with Tribes in FY 2003 and FY 2004.

### **Food Safety Projects**

- FDA continued partnership agreements on seafood safety with various Tribes in fiscal 2003 and FY 2004. Through these partnership agreements, the Tribes and FDA exercise concurrent jurisdiction over inspecting fish and fishery products harvested, processed and sold by tribal members. FDA's Hazard Analysis and Critical Control Point (HACCP) on seafood rules direct all fish processors to



## *HHS-Food and Drug Administration*



complete an HACCP training program, to develop an HACCP plan, to keep records to confirm their HACCP plans and to reassess their HACCP plan yearly. FDA's Office of Federal State Relations provided in-kind support to the Keweenaw Bay Indian Community, the Bad River Band of the Lake Superior Tribe of Chippewa and the Red Cliff Band of Chippewa. The in-kind support included HACCP certifications, inspection, good manufacturing training and equipment. The three Tribes' annual harvest is at least one million pounds of fish. The Tribes sell most of the fish off reservation to local restaurants and grocery stores.

- FDA's Pacific Region Retail Food Specialists continue to work with the Crow Reservation, Montana, in the Voluntary National Retail Program. The Specialists provided several food safety management courses for Indian Health Service (IHS) Food Specialists in Portland, OR, and Phoenix, AZ. The Specialists also provided information on the Food Code to IHS Sanitarians. The Regional Shellfish Specialists provided training and technical support to Tribes in western Washington on shellfish harvesting and handling practices.

The Pacific Region is helping the Tribe with a self-assessment program. The self-assessment is an internal Tribal review by the program management to determine whether their existing program meets the National Voluntary Retail Food Program Standards. The Voluntary Retail Food Program Standards serve as a guide for regulatory or tribal retail food programs to design and manage a retail food program. The Standards also provide a means of recognition for those programs that meet the standards. The focus of the Program is the reduction of risk factors known to cause or contribute to food borne illness and to promote active managerial control of these risk factors. The following link will take you to the Retail Food Program Standards. The Tribal Agencies that are enrolled in the Program Standards are: Viejas Tribe and Government, California; Mashantucket Pequot Tribe, Connecticut; Mohegan Tribe, Connecticut; Crow Reservation, Montana; Squaxin Island Gaming Commission-Little Creek Casino-Hotel, Washington. Other registrations are located at: <http://www.cfsan.fda.gov/~dms/ret-jur.html>.

### **Research Projects**

#### **Tribal College Initiative**

- FDA worked with the U.S. Environmental Protection Agency (EPA), Bureau of Indian Affairs, U.S. Department of the Interior and the Department of Justice to teach a pilot environmental health workshop at four tribal colleges. The colleges include: Southwestern Indian Polytechnic Institute (SIPI), Little Big Horn College, United Tribes Technical College and Cankdeska Cikana Community College.

## *HHS-Food and Drug Administration*

### **Environmental**

- FDA collaborated with the Global Village Engineers, SIPI and EPA to provide environmental health training for the people of the Taos Pueblo. The primary unresolved issue of environmental concern for this community is elevated radon in an estimated 67 percent of the homes. The participants developed a work plan to address the radon problem during the training. The participants also developed the knowledge and tools to resolve the problem.
- FDA collaborated with Harvard University's School of Public Health and the Global Village Engineers to provide environmental health training for the Winnebago Reservation in Nebraska. The Tribe's unresolved environmental health issue is lead. FDA worked with collaborators at the Harvard School of Public Health and Global Village Engineers to successfully provide ICEHAP training for the people of the Winnebago Reservation during the week of September 20-24, 2004. With only a population of 2,000 people, this tribe's most pressing unresolved environmental health issue of concern is lead. During the course of the training, it was revealed that 20 Head Start children had elevated blood lead levels. A work plan to address the lead problem was developed by the end of the training and participants had developed knowledge and tools to accomplish the following work plan:
  - Determine the extent of the lead problem;
  - Identify potential areas of contamination;
  - Develop a Scope of Work (SOW) for a contractor to come and teach stakeholders the following three classes in order: 40 hour hazardous waste operation training course, lead sampling and analyses, and lead abatement and mitigation;
  - Obtain funding to carry out SOW and implement the lead training program;
  - Educate the community about the lead problems;
  - Establish a tribal lead program.

### **Collaborative Projects with Tribes**

- FDA introduced the Hoopa Valley Tribe to the Agency's Model Food Code in FY 2003. The Tribe reported its adoption of the Food Code as part of their business laws. FDA and the Tribe are negotiating to confirm a partnership agreement in FY 2005.
- FDA's New England District Office took steps to increase collaborations and outreach to tribal governments. The New England District developed a "working outline" to promote and define outreach visits to Tribes in the New England states. The New England District incorporated programs in its "outline" to improve tribal government access to FDA information on



## *HHS-Food and Drug Administration*



health risks and policy issues. The New England District plans to schedule multiple state tribal visits to promote health and policy awareness between tribal governments in the New England States and FDA.

- FDA worked with the Department of Veterans Affairs (DVA), the Shinnecock Reservation and elders from other New York State Tribes to set up the Native American Indian Health Council. The purpose of the council is to resolve issues and to encourage Native Americans to learn about available opportunities and resources from the Federal government. FDA and the DVA meet monthly with elders from various Nations in New York State. The Council developed a logo, mission statement and a strategic plan. FDA sponsored health fairs and developed cultural and plain language materials on Diabetes, food safety, cardiovascular health and tobacco.
- FDA's New England District Office initiated outreach activities with ten Federally recognized New England Tribes. FDA conducted telephonic and e-mail communications with the tribal chiefs, health directors and the education directors; introduced and promoted FDA's outreach briefings; researched tribal history; prepared briefing scripts and selected, packed and distributed informational materials.

### **Outreach Briefings and Seminars**

- FDA conducted an outreach briefing on April 16, 2004, for 16 members of the Eastern Pequot Tribe at their reservation-meeting lodge in Groton, Connecticut.
- FDA conducted an outreach briefing on August 11, 2004, for eight members of the Aroostook Band of MicMacs at their reservation health clinic in Presque Isle, Maine.
- FDA conducted an outreach briefing on August 11, 2004, for five members of the Houlton Band of Maliseets and their tribal center and health clinic in Littleton, Maine.
- FDA conducted an outreach briefing on January 29, 2004, for three members of the Narragansett Tribe at their tribal administrative center located in Charlestown, Rhode Island.
- FDA set up a relation with the clinic at the Prairie Island Indian Community. The clinic hires full-time nurses and physical therapists that specialize in diabetes education and promoting physical activity. The clinic receives the "Take Time to Care About Diabetes" publication.
- FDA took part in the first Diabetes Expo at the Prairie Island Indian Community nearby Redwing, MN. Minneapolis District staffed a booth with FDA diabetes resources that included the "Take Time to Care About Diabetes"

## *HHS-Food and Drug Administration*

materials and information specific to Native Americans. The program also features presentations from exhibitors and a diabetic holiday meal.

- FDA's Florida District Office provided general FDA publications for distribution during a casino employee health fair and food safety materials to a preschool food handler's class for the Seminole Tribe of Florida
- FDA took part in the HHS Region I, II and IV Indian Health Service Tribal Consultation Session in Nashville, TN. The meeting organized by the United South and Eastern Tribes, Inc. (USET) included tribes east of the Mississippi River. Nearly 100 people representing the various HHS operating divisions in the three regions were in attendance.
- FDA partnered with the U.S. Department of Agriculture (USDA) Food and Nutrition Service to participate in 73rd Annual American Indian Exposition that was held in Anadarko, OK. Four food safety messages of the Fight BAC! campaign were highlighted: clean, separate, cook and chill. Several thousand Native Americans attended the yearly event, with hundreds of families camping on-site at the Caddo County fairgrounds. Several FDA and USDA-trained food safety volunteers from the Comanche, Cheyenne and Arapaho, Kiowa, Wichita, and Chickasaw Nations Food Distribution Programs, with Oklahoma, Caddo, and Comanche County Oklahoma State University Extension Service volunteers aided in the demonstrations. Demonstrations were on going throughout the Expo, and practical food safety consumer incentives were given to each household attending a demonstration.
- FDA took part in the HHS Region VI Tribal Consultation Session that took place in Oklahoma City. FDA provided an overview of its responsibilities and offered speakers, training, and FDA publications to the Tribes. FDA also staffed the Center for Food Safety and Applied Nutrition's exhibit, "Working Globally to Protect the Nation's Food Supply," both days of the session. Nearly 100 people attended.
- FDA coordinated a mail campaign during March, 2004 that promoted the Office of Women's Health, "Take Time to Care (TTTC) ... About Diabetes" program with the Title VI Senior Program Directors of the Native American Indian tribes in California and Hawaii. Diabetes is a growing health crisis and this disease disproportionately affects Native Americans. FDA offered samples of diabetes materials including the TTTC brochure and recipe card, the low-literacy publication and the National Institutions of Health's Fact Sheet for American Indians to more than 40 directors. FDA mailed nearly 500 brochures and recipe cards to the Tribes.



# *HHS-Health Resources and Services Administration*



The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, directs grant programs that improve the nation's health by expanding access to comprehensive, quality health care for low-income and uninsured people, mothers and their children, people with HIV/AIDS and residents of rural areas.

HRSA programs seek to improve the diversity of the U.S. health care workforce and encourage placement of health professionals in communities where health care is scarce. The agency also oversees a national organ and tissue transplantation system and administers programs that improve America's ability to respond to large-scale emergencies and disasters.

HRSA envisions optimal health for all, supported by a health care system that assures access to comprehensive, culturally competent, quality care.

The Mission of HRSA is to provide national leadership, program resources and services needed to improve access to culturally competent, quality health care. As the Nation's Access Agency, HRSA focuses on uninsured, underserved and special needs populations in its goals and program activities:

- GOAL 1: Improve Access to Health Care.
- GOAL 2: Improve Health Outcomes.
- GOAL 3: Improve the Quality of Health Care.
- GOAL 4: Eliminate Health Disparities.
- GOAL 5: Improve the Public Health and Health Care Systems.
- GOAL 6: Enhance the Ability of the Health Care System to Respond to Public Health Emergencies.
- GOAL 7: Achieve Excellence in Management Practices

HRSA's operating components include six divisions: Bureau of Health Professions; Bureau of Primary Health Care; Healthcare Systems Bureau; HIV/AIDS Bureau; Maternal and Child Health Bureau and the Office of Rural Health Policy. The following is a brief description of each.

**The Bureau of Health Professions (BHP<sub>r</sub>)** provides national leadership in coordinating, evaluating and supporting the development and utilization of the Nation's health personnel. The Bureau also manages the National Health Service Corps and the National Practitioner Data Bank.

**The Bureau of Primary Health Care (BPHC)** provides national leadership in assessing the Nation's health care needs of underserved populations and in assisting communities to provide primary health care services to the underserved in moving toward eliminating health disparities. The major program component is the Consolidated Health Center Program. The Bureau also

## *HHS-Health Resources and Services Administration*

administers the Black Lung Clinics program, the Native Hawaiian Health Care Program, the Healthy Communities Access Program, the Radiation Exposure Screening and Education Program and the National Hansen's Disease Program. A significant number of Native Americans are served by Health Centers.

**Healthcare Systems Bureau (HSB)** provides national leadership and direction in several key functional areas: 1) the procurement, allocation and transplantation of human organs and blood stem cells; 2) the facilitation of the development of State, territorial and municipal preparedness programs to enhance the capacity of the Nation's hospitals and other healthcare entities to respond to mass casualty incidents caused by terrorism and other public health emergencies; 3) the provision of programmatic, financial and architectural/engineering support for healthcare facilities construction/renovation programs; 4) the reduction in numbers of uninsured persons through the State Planning Grants Program and 5) the management and operation of the national programs for childhood vaccine and smallpox vaccine injury compensation.

**The HIV/AIDS Bureau (HAB)** provides leadership in the delivery of high quality clinical care and supporting services for uninsured and underinsured individuals living with and families affected by HIV/AIDS. It includes the Office for Advancement of Telehealth, the HRSA-wide developer of telehealth, including the use of electronic information and telecommunications technologies for all types of health-related activities. It also includes HRSA's Center for Quality, which strengthens and improves the quality of health care, especially related to Agency programs and service populations.

**The Maternal and Child Health Bureau (MCHB)** provides national leadership, in partnership with key stakeholders, to improve the physical and mental health, safety and well-being of the maternal and child health (MCH) population. The MCH population includes all of the Nation's women, infants, children, adolescents and their families (including fathers) and children with special health care needs. The Bureau also manages the HRSA Office of Women's Health.

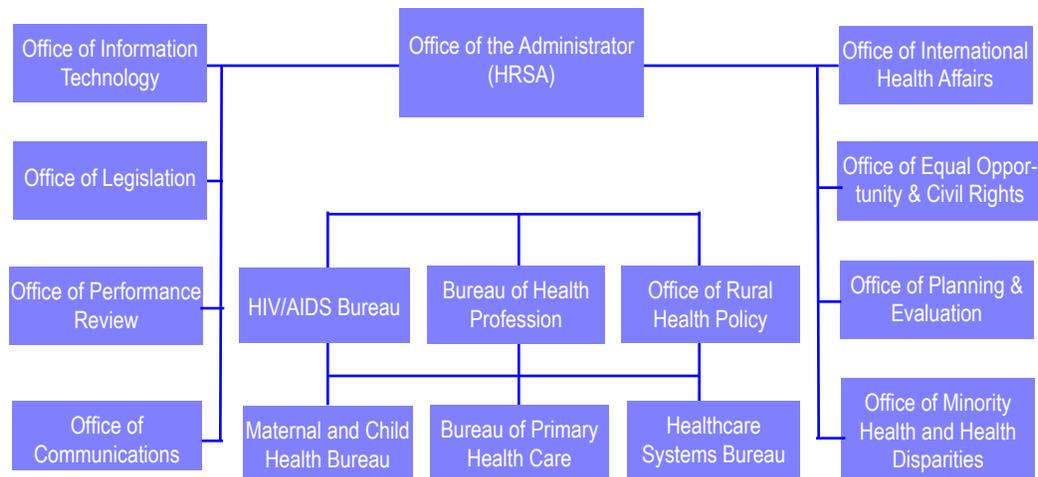
**The Office of Rural Health Policy (ORHP)** serves as a focal point within the Department and as a principle source of advice to the Administrator and Secretary for coordinating efforts to strengthen and improve the delivery of health services to populations in the Nation's rural areas and border areas. The HRSA operational chart is displayed on the next page.



# HHS-Health Resources and Services Administration



*HRSA Operational Chart*



There are numerous programs available to tribes, tribal organizations and tribal communities through HRSA as well as various collaborative accomplishments.

## **HRSA Programs**

**The University of New Mexico LEND Program (MCHB/HRSA Training Program)** The partnership between the University of New Mexico and Native American populations yielded the following success stories.

- UNM graduated a Native American student who is completing her clinical requirements for her Occupational Therapy license this semester. Due to her experiences with our program, she worked two summers in Washington, DC as a counselor for a young Native American's leadership program. She has stated that she would never have had the confidence to even apply had it not been for her LEND experience.
- UNM graduated a Native American student who is currently a Social Worker for a local school district working with the Child Find Program. This past fall she received the Ann Rudigier award from AUCD as outstanding student of the year.

## **Arizona Primary Care Association (PCA)**

In April 2000, the HRSA Region IX Field Office; Navajo, Phoenix and Tucson Area IHS Offices; Arizona Department of Health Services (ADHS) and the Arizona Primary Care Association (PCA) signed a Memorandum of Understanding (MOU) creating the Native American Program within the PCA.

## *HHS-Health Resources and Services Administration*

- Currently, the Native American Program coordinates efforts between HRSA, IHS and Arizona Department of Health Services (ADHS) to improve the health status of Native Americans in Arizona through accessible, coordinated and high quality primary care. The program assesses and implements solutions to address the primary care needs of urban/tribal Indian communities throughout Arizona. The program developed an implementation plan entitled ACES: Advocacy, Coalition Building, Education and Support.
- The Native American Program has greatly influenced the way that the local, state and federal agencies that are not intimately involved with Indian people work with tribes and urban programs to improve and/or enhance primary care resources. The program has provided direct assistance to several tribes and urban programs that have resulted in positive outcomes. They have now begun to lay a foundation for long term solutions that address health disparities.

### **Oklahoma PCA (OPCA)**

- OPCA hosted a Community Health Center (CHC)/Tribal affiliation conference in March 2004 to discuss how Section 638 compacted tribal or urban-Indian organizations might implement an effective affiliation. Ten tribes were represented. OPCA has several dues-paying tribal and urban Indian members which include: Indian Health Care Resource Center, Tulsa (whose CEO is also Vice-President of OPCA); Cherokee Nation Health Service, Tahlequah; Choctaw Nation Health Service, Tahlequah; and the Iowa Tribe.
- Most tribes mentioned have participated in OPCA's grant writing intensive course, *"Mastering the Grants Process: Section 330 Core Competencies,"* a two-day workshop that began before National Association of Community Health Centers (NACHC) launched their version.

### **Montana PCA (MPCA)**

MPCA has undertaken a number of activities in their work with Tribal and Urban Indian Populations:

- Hired a consultant, with an American Indian background, to facilitate communication with Indian Health Service (IHS) facilities regarding Tribal and Urban Indian CHC application development (August 2003). MPCA is working with current tribal and Urban Indian services to be developed as CHCs. The addition, a Native American Community Development Manager, has been a great success. Their staff member's rapport and liaison with Indian Tribal and Urban Indian leaders has been exceptional.



## *HHS-Health Resources and Services Administration*



- Coordinated a Montana Tribal Conference in Great Falls, Montana, on November 17-18, 2003, for Tribal leaders interested in CHC application. Tribes represented included: Conferderated Salish and Kootenai Tribe of the Flathead Reservation, Fort Peck Assiniboine and Sioux Tribes, Chippewa Cree Tribe, Crow Tribe, Northern Cheyenne Tribe. Several tribal leaders expressed interest in CHC application. Plans are underway to organize a second Tribal Conference to target additional Tribes and provide follow-up from the November Conference. Additionally, MPCA's Native American consultant has been speaking with people in Alaska to learn from their experiences in working with Tribal Populations.

### **Community Health Care Association of the Dakotas (CHAD)**

CHAD received supplemental dollars in September 2003 to work with communities to increase the number of approvable applications. CHAD works with tribal groups at a statewide level as well as one-on-one with interested tribes. They have been working with several tribal communities primarily in North Dakota.

- CHAD works through the Indian Health Service and its Aberdeen Area Indian Health Service (AAIHS) Office. They participated in several workshops hosted by the AAIHS in February and July in 2003. In February, there was a three day work shop that was presented to the tribes in North and South Dakota. In July, they helped AAIHS coordinate a presentation to the Aberdeen Area Tribal Health Chairman's Board by an Indian operated Community Health Center.
- CHAD's work with American Indian communities has focused both on establishing new access points, in areas such as Porcupine, SD, as well as transitioning existing Indian Health Service sites to community health centers. CHAD works with Tribes and Urban Indian populations in multiple capacities beginning with the basic needs assessment through application completion. CHAD assists American Indian/Reservation communities in developing systems to increase access to primary health care services.

### **Alaska Primary Care Association (APCA)**

The Alaska PCA provides support to implement the CHC program. They take HRSA and other officials to the field and accompany BPHC consultants on New Start visits. They provide an orientation for National Association for Community Health Centers (NACHC), HRSA and others unfamiliar with tribal culture. In addition, they facilitate a Tribal 330 Workgroup, support peer-to-peer networking and research and disseminate information on implementation issues.

## *HHS-Health Resources and Services Administration*

- The strategies for this program are as follows:
  - Identify needs, assets and outside resources
  - Promote community development
  - Unify two separate systems (tribal and non-tribal)
  - Highlight successful tribal Community Health Centers (CHC)
  - Provide grant writing support to potential health center applicants

Successes of the APCA include:

- The APCA sponsored Tribal 330 workgroup was founded in March 2003. Issue-specific committees and a community listserv were formed, to discuss tribal 330 implementation challenges and solutions. APCA staff is encouraged to attend the Alaska Native Heritage Center's 2-day training on Alaska Native Heritage and Culture as part of their orientation (to increase cultural competency).

- The Executive Directors of the APCA and the Alaska Native Health Board meet regularly to discuss organizational missions and purpose and to cross-reference agendas for future joint work. The Alaska Spring Primary Care Conference provided an excellent opportunity to network with Native leaders from around the state.

- The Native American Program Director of Arizona Association of CHCs and the Community Development Specialist of the APCA share information regularly. They are working to build a network of PCA personnel who work with Alaska Natives and American Indians.

- Alaska Tribal 330 employees, APCA staff and BPHC PO attended a meeting in Denver in October of the Office of Rural Health Policy to discuss the Integration of Native/Non-Native Health Care.



- A workgroup has been organized by the APCA for organizations that receive both tribal funds and Section 330 funds (Tribal 330s) to discuss special issues of implementation and operation. This kicked off in March 2003 in Anchorage and was followed by another meeting in April 2003. The group will converse via a



# HHS Health Resources and Services Administration



listserv and come together on an as-needed basis.

- The ANTHC CEO was a plenary speaker at the Alaska 2003 Spring Conference. He addressed commitments and strategies that bring people and systems closer together for assuring access to care. His talk promoted the values of building bridges, closing gaps and moving toward coordination of resources in order to have more responsive and seamless health care in Alaska.
- ACPC Community Development Specialist, Carolyn Gove, assisted Conocer, a contractor, to plan sessions with NWRPCA in Spokane in May 2004. These sessions sought to improve the ability of PCAs and PCOs to work with tribal entities.



## HRSA Success Stories

### The Holistic Native Network

In 2002, HRSA's HIV/AIDS Bureau funded the *Holistic Native Network*, a 5-year project through the Special Projects of National Significance (SPNS) initiative. The *Holistic Native Network* is coordinated by the HIV Services Department within the Native American Health Center primary medical clinic in San Francisco, CA.

The goal of the Holistic Native Network is to develop a holistic, integrated and culturally relevant HIV/AIDS treatment system for Natives living with HIV. Traditional Native American culture is at the center of this practice model, where services include nurse case management, peer advocacy, mental health, primary medical, dental and substance use support. The three main activities are outreach, assessment and service coordination. A coordinated, integrated and culturally relevant health care system for HIV+ Native Americans is the best practices model that the Holistic Native Network attempts to create. The model includes theoretical approaches that emphasize integrated services and cultural context, making this model replicable in other communities. This model links treatment with prevention, medical care and mental health with substance abuse and HIV services.

This SPNS project impacts the community by directly addressing the community needs. Outreach strategies are based on the creative use of community cultural events and in-house support groups like talking circles and weekly beading classes. In this beading class, individuals are offered an opportunity to socialize with other community members while partaking in a ritualized artisan practice. Another alternative therapy that acts as an outreach tool is monthly sweat lodges. Assessment

## *HHS Health Resources and Services Administration*

and coordination strategies are based on client-centered and culturally appropriate services, including harm reduction substance use support, traditional and western medicine, art therapy, cultural activities and Ryan White standards of care for people living with HIV. The impact on the community has been positive; there has been an increase in quality of life measures, where individuals, for example, feel happier and experience less physical and emotional problems through their participation in the Holistic Native Network. What makes this project unique is the embeddedness of culture, in implicit and explicit ways, throughout the work that is done on a daily basis.

After three years, the *Holistic Native Network* has continued to make a difference in the lives of HIV+ Natives. *Holistic Native Network* has placed value on the cultural experiences and expertise of its clients as well as on the cultural, professional and experiential expertise of the staff. The *Holistic Native Network* has been guided by more than programmatic objectives; it is guided by Native belief systems such as respect, love, truth and a sense of community.

### **Malama A Ho'opili Pono Project**

Many of the Pacific Islanders who are not U.S. citizens are covered by the compact of Freely Associated States, and can take advantage of provisions permitting unrestricted travel into the United States to work and establish residence there. Hawaii is the preferred destination for people from the Marshall Islands, Micronesia and other Pacific Islands due to perceived economic viability and ease of acculturation. Immigration continues to rise. No medical visa or INS processing is necessary, and individuals are often malnourished and suffering from chronic and/or infectious disease processes. English is not spoken or understood, and psychological stress and high anxiety is common. Communicating the importance of maintaining their cultural practices and rituals is crucial, and they often find this very difficult to do.

#### **• Development of Best Practice Models**

One group served by the Malama A Ho'opili Pono Project are the Marshallese people. The Project used the best practice model of "Malama Concept" (NIH research/demonstration RO1, 1994-1997 Congressional Language) to develop a framework linking specific assessments with interventions pertaining to socio-cultural barriers in the delivery of care to eliminate racial and ethnic disparities. The Malama Project is a culturally-based perinatal program serving women from the Marshall Islands, Micronesia, and other Pacific Islands.

It was explained to us that Marshallese women often return to the Marshall Islands before the birth of their baby to perform a special "cleansing bath" ritual that they believe will keep the woman healthy in the long-term, maintaining strong



## *HHS Health Resources and Services Administration*

---

mental health, physical and emotional well being. This ritual is vital to women's health, good parenting and quality. As it was financially impossible to return to the Islands, the project staff developed a partnership with the Marshallese pastor's wives and wise Marshallese elders. These folks were asked to coordinate an effort to locate these special herbs in Hawaii's mountains and ocean area and even air express the dried herbs from their contacts in the Marshall Islands. A "ritual bath" was created within the confines of the pregnant woman's community in Hawaii, and the postpartum woman was able to soak in this herbal "cleansing bath." This clearly helped eliminate one risk factor toward what could have lead to post partum anxiety and possibly depression. Now, each and every Marshallese woman is assured of this very important custom. Using the cultural group as the experts in teaching the Project staff the important ritual was the best approach. The Project honored and validated the importance of cultural practices in health promotion and healing.

The "Malama Concept" is replicable in other communities. It is critical to learn what is important to the clients being served. Communities should incorporate what is important to each and every specific cultural group as best possible in order to achieve the best outcome in the women's pregnancy as well as in her post partum family life.



## *HHS-National Institutes of Health*

The National Institutes of Health (NIH) is an agency of the Department of Health and Human Services. The mission of NIH is science in pursuit of fundamental knowledge to improve human health. This means pursuing science to expand fundamental knowledge about the nature and behavior of living systems; to apply that knowledge to extend the health of human lives and to reduce the burdens resulting from disease and disability. NIH accomplishes its mission by:

- Fostering fundamental discoveries, innovative research and their application in order to advance the Nation's capacity to protect and improve health;
- Developing, maintaining, and renewing the human and physical resources that are vital to ensure the Nation's capability to prevent disease, improve health and enhance quality of life;
- Expanding the knowledge base in biomedical, behavioral and associated sciences in order to enhance America's economic well-being and ensure a continued high return on the public investment in research and
- Exemplifying and promoting the highest level of scientific integrity, public accountability and social responsibility in the conduct of science.

The National Institutes of Health (NIH) is the principal health research agency of the Federal Government; it is a component of the Department of Health and Human Services. With headquarters in Bethesda, Maryland, the NIH is a large, complex organization composed of 27 distinct institutes and centers, hereafter called "institutes" or "ICs."

The 27 ICs include: Office of the Director; National Cancer Institute; National Eye Institute; National Heart, Lung and Blood Institute; National Human Genome Institute; National Institute on Aging, National Institute on Alcohol Abuse and Alcoholism; National Institute of Allergy and Infectious Diseases; National Institute on Arthritis and Musculoskeletal and Skin Diseases; National Institute of Biomedical Imaging and Bioengineering; National Institute of Child Health and Human Development; National Institute of Dental and Craniofacial Research; National Institute of Diabetes and Digestive and Kidney Diseases; National Institute on Drug Abuse; National Institute of Environmental Health Sciences; National Institute of General Medical Sciences; National Institute of Mental Health; National Institute of Nursing Research; National Institute of Neurological Disorders and Stroke; National Library of Medicine; John F. Fogarty International Center for Advanced Study in the Health Sciences; National Centers for Complimentary and Alternative Medicine; National Center on Minority Health and Health Disparities; Nation Center for Research Resources; Clinical Center; Center for Technology; and Center for Scientific Review.

In FY 2003, NIH provided competitive grant funding of \$108 million dollars



## *HHS-National Institutes of Health*

to support Native Americans and Alaska Natives, and in FY 2004 NIH increased this competitive grants funding to \$134 million. With as many as 526 active funding opportunities at any given time, NIH supports Medical research through grants, cooperative agreements, and contracts. All NIH grant programs are available to qualified recipients without regard to race or ethnicity.

Three examples of projects affecting Native Americans, Alaska Natives or Native Hawaiians follow.

**1. Led by the National Cancer Institute's (NCI) Center to Reduce Cancer Health Disparities (CRCHD) and the NIH National Center on Minority Health and Health Disparities (NCMHD),** a team of health care experts from the Pacific Basin community, supported through the NCI's Special Populations Network Papa Ola Lokahi, in Hawaii, worked to develop a needs assessment tool and administer this tool to community leaders and health professionals in six jurisdictions throughout the Pacific Basin in FY 2003: the Republic of the Marshall Islands, Republic of Palau, Federated States of Micronesia, Commonwealth of the Northern Marianas, Guam, and American Samoa. The team examined a number of issues including health infrastructure needs, socio-economic factors, current sources of health services, quality of care and adequacy of health care providers, as well as the knowledge, attitudes and behaviors of the Pacific Basin Islanders to cancer care. This effort continued in 2004, and is expected to yield opportunities to engage other HHS agencies in supporting efforts in leveraging resources to address the myriad of health issues affecting Pacific Basin communities.

**2. The National Institute of General Medical Sciences (NIGMS)** funds research activities at institutions serving minority students through its Minority Opportunities in Research (MORE) Division. The mission of the MORE Division is to increase the number of American and Alaska Native researchers and other underrepresented minorities, including Pacific Islanders, engaged in biomedical research. The Minority Biomedical Research Support Branch addresses the inadequate representation of minorities in biomedical research by the MORE Division bolstering research activities at eligible institutions, including those serving Native Americans and Pacific Islanders. These awards serve to foster faculty and student participation in biomedical research, thereby helping to create a growing cadre of minority scientists who are making important contributions in the health sciences. In particular, the Research Initiative for Scientific Enhancement program targets institutions that wish to develop the research potential of faculty and students. The MORE Division also administers two Bridges programs; one program that encourages connections between institutions that offer only associate-degree programs and colleges and universities that award baccalaureate degrees (the 2-year to 4-year bridge), and another that supports interactions between institutions that offer the Master's as a terminal degree and institutions that grant doctoral degrees (the M.S. to Ph.D. bridge). The balance of NIGMS support to institutions serving



## *HHS-National Institutes of Health*

Native Americans, Asian Americans and Pacific Islanders provides fellowships and traineeships in both the traditional areas noted above as well as those supported by the Minority Access to Research Career (MARC) Branch. MARC, a component of the MORE Division, has five mechanisms: MARC Undergraduate Student Training in Academic Research, predoctoral fellowships, the MARC Faculty Fellowship and the MARC Visiting Scientist fellowship, and the Post-Baccalaureate Research Education Program.

**3. The Native American Research Centers for Health (NARCH)** initiative was developed to empower tribes to decide the kinds of research that would take place among their members and to increase the number of American Indian and Alaska Native researchers. It is a collaborative effort between NIGMS and the Indian Health Service (IHS) that relies on funding from several of NIH's Institutes and Centers. Awards are made by IHS using its authority to support research and to make grants directly to tribes or tribally sanctioned health boards. Eleven awards support collaborations that involve more than thirty tribes and villages. The projects are predominantly in clinical research or in public health, which reflects the most pressing interests of the tribes.

Other NIH accomplishments include:

### **Type 2 Diabetes Research and Education Efforts**

American Indians and Alaska Natives are at high risk for developing type 2 diabetes and its devastating complications. The National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) conducts basic and clinical research on diabetes in Native American populations at its intramural Phoenix Epidemiology and Clinical Research Branch in Arizona, and additionally supports other efforts to improve the health of American Indians and Alaska Natives. For example, in 2004, the National Diabetes Education Program, supported by the NIDDK and CDC, launched a research-based awareness campaign designed for American Indians and Alaska Natives, "We Have the Power to Prevent Diabetes," to promote the message that type 2 diabetes can be reduced by losing a modest amount of weight through dietary change and moderate exercise. This awareness campaign was based upon the results of the Diabetes Prevention Program clinical trial, supported by the NIDDK, other NIH components, the CDC, and the IHS. The NIDDK also funded a Southwest American Indian clinical center at its Phoenix Branch as part of a multi-center clinical trial of the health effects of long-term weight loss in obese adults with type 2 diabetes, the Look AHEAD trial. This trial is ongoing. In another effort, the NIDDK supported the Diabetes Education for Tribal Schools (DETS) program, in collaboration with the IHS and CDC. Through this program, funding was provided to eight Tribal Colleges to develop and implement a K-12 school-based diabetes curriculum to integrate American Indian and Alaska Native culture and community with diabetes-related knowledge. Still ongoing, this program aims to increase



## *HHS-National Institutes of Health*

understanding of health and healthy lifestyle for prevention and management of diabetes and to promote interest among American Indian and Alaska Native children in entering biomedical professions.

### **Research Endowment Program**

An award from the Research Endowment Program of the National Center on Minority Health and Health Disparities (NCMHD) to the University of Montana is being used to: (1) create new tenure track faculty lines for Native Americans and other underrepresented minorities; (2) enhance opportunities for minority students to earn PharmD degrees or Doctor of Physical Therapy degrees and obtain postdoctoral fellowship training in clinically-relevant areas, especially those involving health disparity research; (3) enhance incentives and opportunities for minority students leading to Ph.D. degrees; (4) run university academies on Saturdays and during the summer to encourage American Indian high school students to enter the pharmacy, social work, and physical therapy fields and (5) continue using endowment income to leverage private support.

### **Patient Navigator Program**

The National Center Institute (NCI) has created a Patient Navigator Program to eliminate access barriers and facilitate timely access to quality cancer care in a culturally sensitive and appropriate manner. A partnership among the NCI's Center to Reduce Cancer Health Disparities, the Minority-Based Community Clinical Oncology Program oncology group and the Indian Health Service created six pilot projects for Native Americans in the Pacific Northwest and South Dakota and Hispanics in Texas. These efforts are expected to have a positive impact on improving early screening, diagnosis, and treatment to improve cancer outcomes.



## *HHS-Office of Public Health Emergency Preparedness\**

On behalf of the Secretary, the Office of Public Health Emergency Preparedness (OPHEP) directs and coordinates HHS-wide efforts with respect to preparedness for and response to bio-terrorism and other public health and medical emergencies. These efforts coordinate not only with relevant Federal, State, and local health officials, but also with Tribal health officials to ensure integration of preparedness and response activities, and to promote emergency medical services with respect to public health emergencies. OPHEP works closely with all entities to promote communication between Federal, State, local, and Tribal public health officials. OPHEP is an office of the Public Health Service (PHS) and is responsible for ensuring a “One-Department” approach to developing such preparedness and response capabilities and directing and coordinating the relevant activities of the HHS Operation Divisions (OPDIV). The principal areas of program emphasis are:

- Enhancement of State, local and Tribal preparedness – primarily health departments and hospitals;
- Development and use of National and Departmental policies and plans relating to the response to public health and medical threats and emergencies (e.g., Emergency Support Function (ESF) 8 of the National Response Plan (NRP), Homeland Security Presidential Directives (HSPD) 5, 8, and 10, HHS's Concept of Operations Plan for Public Health and Medical Emergencies (CONOPS) and the Secretary's Emergency Response Team (SERT) System Description);
- Coordination with relevant entities inside and outside HHS such as State, local and Tribal public health and medical officials, the Departments of Homeland Security (DHS), Defense (DOD), Veterans Affairs (VA), Justice (DOJ), the Homeland Security Council (HSC), other ESF 8 partner organizations and others within the National security community and
- Rapid public health and medical support to Federal, State, local and Tribal governments who may be responding to incidents of national significance or public health emergencies.

OPHEP is headed by the Assistant Secretary for Public Health Emergency Preparedness (ASPHEP), who reports directly to the Secretary, and includes Office of Research and Development Coordination (ORDC); Office of Mass Casualty Care Planning (OMCCP); Office of Emergency Operations and Security Programs; and Office of Medicine, Science and Public Health.\*\*

\* The Office of Public Health Emergency Preparedness has been renamed as the Office of the Assistant Secretary for Preparedness and Response (ASPR)

\*\* The new name of offices headed by ASPR include: Biomedical and Advance Research Development Authority (BARDA); Office of Preparedness and Emergency Operations (OPEO); Office of Policy and Strategic Planning (OPSP); and the Office of Medicine, Science, and Public Health (OMSPH).



# *HHS-Agency for Toxic Substances and Disease Registry*



The mission of the Agency for Toxic Substances and Disease Registry (ATSDR), as an agency of the Health and Human Services Department is to serve the public by using the best science, taking responsive public health actions and providing trusted health information to prevent harmful exposures and disease related to toxic substances.

ATSDR is directed by congressional mandate to perform specific functions concerning the effect on public health of hazardous substances in the environment. These functions include public health assessments of waste sites, health consultations concerning specific hazardous substances, health surveillance and registries, response to emergency releases of hazardous substances, applied research in support of public health assessments, information development and dissemination and education and training concerning hazardous substances.

ATSDR is a service agency created to protect America's health from toxic exposures. Accordingly, the agency, agency staff members and the agency's partners commit to the following values:

- **Accountability**-The agency is responsible for providing quality products and services to stakeholders.
- **Trust**-The agency is committed to being honest and ethical in all communications and actions.
- **Service**-The agency pledges to understand and meet the needs of stakeholders.
- **Diversity**-The agency will foster a diverse workforce committed to improving the health of all people.
- **Respect**-The agency will treat all people with dignity and respect and value them as individuals.

The following goals have been established for ATSDR:

- Prevent ongoing and future exposures and resultant health effects from hazardous waste sites and releases.
- Determine human health effects associated with exposure to Superfund-related priority hazardous substances.
- Mitigate the risks of human health effects at toxic waste sites with documented exposures.
- Build and enhance effective partnerships.

## HHS-Agency for Toxic Substances and Disease Registry

- Promote effective and efficient agency management.

In order for ATSDR to carry out its statutory responsibilities, ATSDR has a joint office of the Director with the National Center for Environmental Health (NCEH). The Office of the Director contains seven functional units. In addition, there are three offices and five program-specific divisions to support and implement program areas: Office of the Director; Office of Financial and Administrative Services; Office of Policy, Planning, and Evaluation; Office of Communication; Division of Health Assessment and Consultation; Division of Health Education and Promotion; Division of Health Studies; Division of Toxicology and Division of Regional Operations.

The following chart lists the division programs and budget activities that were available to tribes or tribal organizations in FY 2003 and FY 2004.

FY 2003 Name of Program/Budget Activity	Amount \$
<b>Extramural</b>	
Tribal Colleges and Universities	\$200,000
Health Education and Promotion Activities	\$175,000
Upper Peninsula Michigan Fish Advisory Project	\$150,000
State Cooperative Agreement Program	\$39,334
Tribal Cultural Sensitivity Awareness	\$38,592
Tribal Colleges and Universities, NCHSTP	\$99,000
<b>Intramural</b>	
Intramural Support	\$266,745
ANA	\$307,925
Tribal Assessment of Emergency Response Capabilities, EPA	\$80,000
Bureau of Indian Affairs Activities	\$168,690
<b>TOTAL</b>	<b>\$1,217,361</b>



# HHS-Agency for Toxic Substances and Disease Registry



FY 2004 Name of Program/Budget Activity	Amount \$
<b>Extramural</b>	
Capacity Bldg through Tribal Colleges and Universities	\$100,000
Increasing AI/AN/NH Careers in Public Health	\$5,000
Upper Peninsula Michigan Fish Advisory Project	\$100,000
State Cooperative Agreement Program	\$46,873
Build Capacity among American Indian Tribes Impacted by Releases from Hanford Nuclear Reservation	\$250,000
<b>Intramural</b>	
Intramural Support	\$199,326
Tribal Cultural Sensitivity Awareness	\$769
Tribal Assessment of Emergency Response Capabilities, EPA	\$29,378
Bureau of Indian Affairs Activities	\$140,557
<b>TOTAL</b>	<b>\$871,900</b>

Overall, ATSDR worked on 20+ sites where Tribal Governments and organizations are consulted when a public health assessment or a public health consultation is developed. The following describes a few of these outreach projects conducted.

## **Tar Creek Superfund**

- On May 6, 2004 ATSDR met with 8 of the 10 tribes potentially affected by the Tar Creek Superfund site (Ottawa County, Oklahoma) at the Miami, Oklahoma Civic Center to discuss issues related to the sharing of tribal sensitive data with ATSDR and future tribal public health assessment activities at the site. The Tribes in attendance for this Tar Creek Meeting were the Peoria Tribe of Indians of Oklahoma, Quapaw Tribe, Ottawa Tribe, Shawnee Nation, Seneca-Cayuga Tribes of Oklahoma, Eastern Shawnee Tribe of Oklahoma and Wyandotte Nation. Not in attendance were the Modoc Tribe and the Miami Tribe. Cherokee Nation was consulted and agreed to have ATSDR involvement shortly after the meeting.

As a result of these sessions, a closer partnership between ATSDR and the Tribes was established as ATSDR moved through the development of public health assessment and related research and education activities. Tribal concerns about ATSDR were addressed and ATSDR reaffirmed its commitment to the enhancement of the Tribal Environmental Health Education Program. (TEHEP). Also discussed were issues related to the sharing of tribal sensitive

# *HHS-Agency for Toxic Substances and Disease Registry*

---

data with ATSDR and future tribal public health assessment activities at the site.

## **Tribal Budget Consultation Meeting**

- In May, 2004, the Centers for Disease Control and Prevention (CDC) and Agency for Toxic Substances and Disease Registry (ATSDR) participated in the Department of Health and Human Services (HHS) Sixth Annual Tribal Budget Consultation Meeting with American Indian/Alaska Natives (AI/AN) which was held in Washington, D.C.

## **Training**

- ATSDR provided “Working Effectively with Tribal Governments” training to Federal, State, Local, and tribal staff in Region 4, which consists of Kentucky, Tennessee, North Carolina, South Carolina, Georgia, Alabama, Mississippi, and Florida.

## **Emergency Preparedness**

- ATSDR and the Environmental Protection Agency (EPA) are partnering to assess the emergency response capabilities of tribes to terrorist attacks.
- ATSDR is proactively attempting to develop methodologies to improve tribal emergency preparedness and response capabilities, as well as develop culturally relevant training programs that could be used for the development of a comprehensive emergency response plan with implementation activities.

## **Conferences**

- In July of 2004 ATSDR partnered with CDC to develop the 1<sup>st</sup> Conference on Increasing the Number of American Indian/Alaska Native/Native Hawaiians in Public Health Careers.



## *HHS-Office of the Assistant Secretary for Planning and Evaluation*



The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is located in the Department of Health and Human Services Office of the Secretary. The ASPE advises the Secretary of HHS on policy development in health, disability, human services and science and provides advice and analysis on economic policy. ASPE leads special initiatives, coordinates the Department's evaluation, research and demonstration activities and manages cross-Department planning activities, such as strategic planning, legislative planning and review of regulations.

ASPE is organized into four principal offices each of which is headed by a Deputy Assistant Secretary: Office of Disability, Aging and Long-Term Care Policy; Office of Health Policy; The Office of Human Services Policy and Office of Science and Data Policy.

Since ASPE is not a service agency, it does not have programs that serve Native Americans specifically. In regard to ASPE's research, ASPE is not able to quantify the benefits that go directly to the Tribes. The following is a brief summary of some of the research projects funded by ASPE that are pertinent to Native American communities.

### **South Dakota Family Support Program—State Innovation Grant**

Awarded in FY 2001, this project was implemented over several years including FY 2003 and 2004. The South Dakota Department of Human Services, Division of Developmental Disabilities was awarded a grant to expand and enhance their current system of family support with a focus on providing a wide array of culturally competent services to families who have developmentally disabled children over the age of 21 living in the rural areas and on Tribal lands. Nine federally recognized Sioux Tribal lands are involved in this project as well as rural communities with a population under 15,000. As these families and their children transition from the school to the adult community, this program allows for choices other than the child moving out of their home community to the location of services or the family unit moving.

### **Cash and Counseling: Next Steps**

The Robert Wood Johnson Foundation (RWJ) has funded 11 states to replicate "cash and counseling" models for their Medicaid populations with long-term functional disabilities living at home. These models focus on alternative ways of delivering Medicaid-funded home and community-based care to the elderly and disabled. Several of the grantee states—New Mexico and Minnesota—are focusing on the use of culturally competent outreach strategies to recruit and enroll elderly and disabled residing in isolated Tribal communities. FY 2004 funding from ASPE, AoA and RWJ supports the technical assistance costs of overseeing planning and

## *HHS-Office of the Assistant Secretary for Planning and Evaluation*

implementation by the grantee states and providing specialized expertise to them.

### **The Tribal Self-Governance Evaluation Feasibility Study**

This study examined ways in which HHS and Tribes could evaluate Tribal management of health and social service programs under Self-Governance. The study was completed in March 2004. Findings indicate that an evaluation of the IHS and any potential demonstration of non-IHS programs is feasible. Study results are posted on the web at <http://aspe.hhs.gov/SelfGovernance>.

### **Evaluation of the Tribal Welfare-to-Work Programs (WtW)**

The Department of Labor's Welfare-to-Work (WtW) grants program supplements other program resources in addressing employment needs of American Indian Tribes and Alaska Native villages. Congress mandated that the WtW program, including the Tribal component, be evaluated by HHS, and ASPE had the lead in conducting this study. The last of four reports pertaining to the Tribal WtW program, entitled *Overcoming Challenges to Business and Economic Development in Indian Country*, was released in August 2004. This report describes examples of business and economic development (BD/ED) activities and the federal programs and initiatives used by a sample of eight Tribes and two Alaska Native corporations; the legal, historical and cultural context of Tribal BD/ED; and the challenges Tribes/ Native Corporations face in pursuing BD/ED as well as promising approaches they are developing. This report is available at <http://aspe.hhs.gov/hsp/wtw-grants-eval98/tribal-dev04/>

### **The Adequacy of HHS Collection of Racial and Ethnic Data**

A consortium of HHS agencies including ASPE supported a study by the National Academy of Sciences. This study to review HHS' data collection systems and practices. The panel focused on: 1) reviewing data needs for evaluating the effects of socioeconomic status, race and ethnicity (including Native Americans) on access to health care and on disparity in health and other social outcomes, and the data needed to enforce existing protections for equal access to health care; 2) evaluating the effectiveness of the data systems and collection practices of HHS and 3) identifying critical gaps in the data and suggesting ways in which they could be filled. The final report, entitled *Eliminating Health Disparities – Measurement and Data Needs*, was released in 2004 and can be found on <http://www.nap.edu/books/0309092310/html>

### **Barriers to AI/AN/NA Access to HHS Programs**

The Assistant Secretary for Budget, Technology and Finance (ASRT), ASPE, ANA and the ICNAA are funding a research project to increase understanding of



## *HHS-Office of the Assistant Secretary for Planning and Evaluation*

---

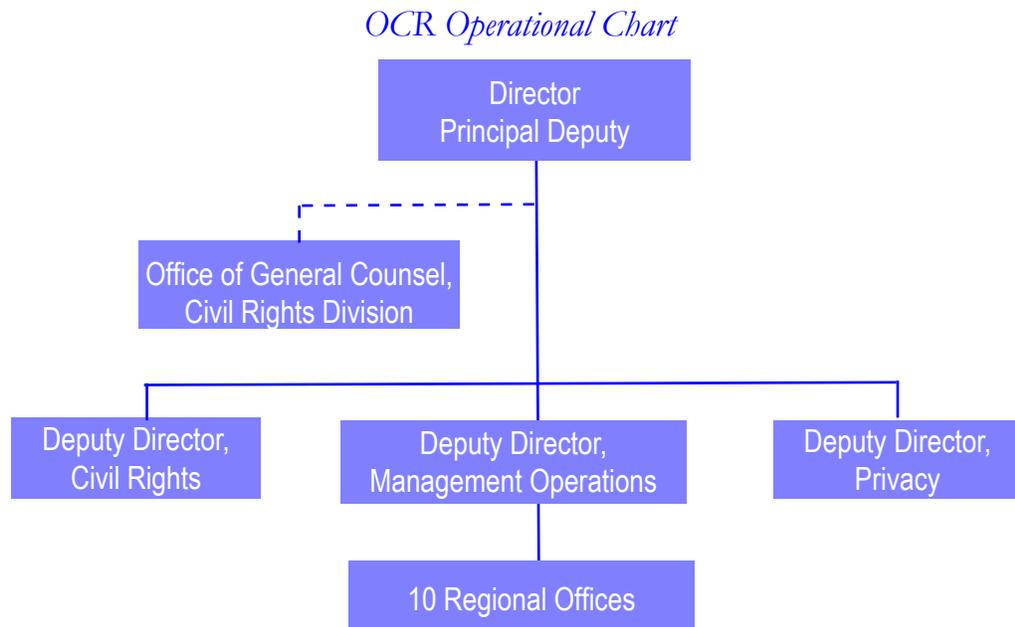
the programmatic and administrative barriers preventing AI/AN/NA communities from more fully participating in those HHS grants programs for which they are eligible. Using a survey of HHS officials and discussions with a subset of these officials and Tribal representatives, this study will gather information on funding barriers and related issues and consider strategies for improving access. A workgroup of HHS and Tribal representatives meets at major junctures during the project. Expected completion date is December 2005.



## HHS-Office for Civil Rights

The Office for Civil Rights (OCR) is responsible for enforcing civil rights statutes and regulations that prohibit discrimination on the basis of race, color, national origin, age, disability, and in some instances, gender and religion, and for protecting the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. To carry out its mission, OCR conducts public education, outreach, complaint investigation and resolution, and other compliance activities to prevent and eliminate discriminatory barriers to health and human services and to ensure the privacy of protected health information.

The OCR operational chart is displayed below.



### OCR Accomplishments

OCR does not have any specific funded programs that serve solely Native Americans. OCR engages in outreach activities to Tribes and Native American people to educate them about their health information privacy and civil rights and to listen to concerns and issues surrounding non-discriminatory and meaningful access to services. OCR attends tribal listening sessions and conducts workshops on civil rights and the Privacy Rule. As a result, Tribes and tribal organizations are more aware of their rights; potential discriminatory barriers to access to critical health and human services are removed; and OCR is more aware of the civil rights concerns in Indian country. The outreach, public education, training, and technical assistance sessions for FY 2003 and FY 2004 are summarized next.



## *HHS-Office for Civil Rights*

### **Presentations**

· In support of the HHS Secretary's initiative to strengthen the Department's relationship with Native Americans, OCR Region I (Boston) presented on the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and addressed specific issues relating to Tribes and urban Indian organizations, including: Section 1808/Multiethnic Placement Act as it relates to the Indian Child Welfare Act; language access; health disparities and national origin discrimination. Representatives from nine federally-recognized Tribes of New England and urban Indian organizations, as well as representatives from several Federal agencies, were in attendance at this HHS Regional Tribal Consultation in South Portland, Maine. (August 2003)

· At the CMS (Centers for Medicare and Medicaid Services)-sponsored listening and training conference in Nashville, Tennessee, with the United South and Eastern Tribes, OCR Region IV (Atlanta) presented on the HIPAA Privacy Rule and participated on a panel of Federal agencies. OCR addressed tribal concerns and questions. (July 2003)

· OCR Region V (Chicago) conducted two workshops on civil rights in Indian Country at the HHS Secretary's Tribal Consultation in Prior Lake, Minnesota. (July 2003)

· At the HHS Region VIII Tribal Consultation Session in Denver, OCR Region VIII participated as a presenter and exhibitor. Region VIII Tribal Chairs and representatives, various HHS component agencies, the Social Security Administration, and others were in the audience. (July 2003)

· OCR Region VIII (Denver), through a partnership with the Equal Employment Opportunity Commission, presented at the Eighth Annual Dakota Coalition Conference in Rapid City, SD. The conference brought together the directors and board members of the North and South Dakota Tribal Employment Rights Offices and the event addressed an array of employment discrimination issues. OCR staff presented on Title VI of the Civil Rights Act of 1964, other HHS civil rights laws and OCR's jurisdictional relationship with the Indian Health Service. (December 2002)

· OCR Region VIII (Denver) presented on the Office's Olmstead initiative at a focus group conference sponsored by the University of North Dakota (at Fargo) National Resource Center on Native American Aging. Participants represented a cross-section of tribal leaders and state agents involved with tribal health and aging issues, tribal college staff and Native American advocates. (November 2002)

· At the Equal Employment Opportunity Commission's 2003 Tribe Employment



## *HHS-Office for Civil Rights*

---

Rights Officer Training Conference in Billings, Montana, OCR Region VIII (Denver) gave a three-hour presentation on OCR's civil rights jurisdiction. Representatives from Indian tribes located in Montana, Colorado, and North and South Dakota were in attendance. (December 2002)

- At the California Indian Rural Health Board's 4th annual Billing and Compliance Workshop in Reno, Nevada, OCR Region IX (San Francisco) presented on the HIPAA Privacy Rule and OCR's complaint and investigation procedures. (May 2003)

- OCR Region X, at its Seattle office, provided technical assistance on the HIPAA Privacy Rule and compliance issues to representatives of the Tulalip Tribe. (April 2003)

- In October 2003, OCR Region IV (Atlanta) staff collaborated with CMS and the HHS Tribal Technical Advisory Group to address cultural competence and Medicaid reimbursement issues in Indian Health Services facilities.

- In December 2003, OCR Region I (Boston) staff accompanied the HHS Deputy Secretary on his listening tour of three Tribes in Maine (Passamaquoddy at Indian Township, Passamaquoddy at Pleasant Point and Penobscot Nation). OCR provided general information regarding the applicability of civil rights laws to Tribes.

- In December 2003, OCR Region VI (Dallas) staff developed databases containing contact information (i.e., current director, address and telephone number) for Navajo, Nashville, Oklahoma and Albuquerque Indian Health Service locations and recognized Tribal entities within Region VI's jurisdiction (22 in New Mexico, 37 in Oklahoma, 1 in Arkansas, 4 in Louisiana, and 3 in Texas). A letter, with fact sheets describing Federal laws prohibiting discrimination on the basis of disability and national origin (including limited English proficiency) and providing general information on OCR, was sent to the Tribes to inform each entity about OCR's civil rights responsibilities in the health and social services arenas.

- At the Region I Tribal Issues team meeting in March 2004 in Boston, OCR staff discussed civil rights issues as they relate to access to health care and social services for tribal members in New England.

- OCR Region X (Seattle), in conjunction with staff from CMS, discussed section 1115 waivers with Tribes at the HHS Tribal Consultation meeting in Portland, Oregon, in March 2004.

- In March 2004, OCR Region V (Chicago) staff participated on the HHS Response Panel for "New, Emerging Tribal Issues/Priorities." The Budget Consultation Session, held in Bloomington, Minnesota, was jointly organized by HHS and the Midwest Alliance of Sovereign Tribes. Tribal representatives from



## *HHS-Office for Civil Rights*

throughout the Midwest were in attendance.

- In April 2004, OCR Region IV (Atlanta) staff participated in a Nashville Tribal Conference and OCR Region VII (Kansas City) staff participated in the Tribal Consultation Session at Haskell Indian Nations University in Lawrence, Kansas, by discussing OCR's various civil rights and HIPAA Privacy Rule responsibilities.

- In July 2004, OCR Region IX (San Francisco) staff participated in the Regional Tribal Listening Session in Las Vegas, Nevada, by discussing civil rights issues and the HIPAA Privacy Rule.

- OCR staff in Region VI (Dallas) gave a presentation and answered questions regarding Section 504 and Title II of the Americans with Disabilities Act (ADA) to approximately 150 participants at the National Council on Disability Tribal Affairs National Forum in Santa Ana Pueblo, New Mexico, during April 2004.

- In April 2004, OCR Region VI (Dallas) staff made a presentation on Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the HIPAA Privacy Rule to about 50 participants at the 6th Annual Circle of Harmony Conference in Albuquerque, New Mexico. OCR discussed how these laws affect HIV/AIDS issues and how the Native American population can use OCR and Federal civil rights laws to ensure they have an equal opportunity to access health and human service programs.

- A member of OCR Region V's (Chicago) staff participated as a federal panelist at the first conference held by the American Indian Health Service of Chicago. The conference, held in June 2004, focused on Native American health care issues in the State of Illinois. The OCR representative addressed concerns regarding civil rights raised by the audience.

- In June 2004, OCR Region VI (Dallas) staff conducted four workshops at the 26th Annual Navajo Area Federal Women's Conference held in Farmington, New Mexico. Approximately 80 people attended the workshops on Limited English Proficiency and Racial and Ethnic Health Disparities. About 200 people visited OCR's exhibit booth for information.

- OCR Region VIII (Denver) staff gave a civil rights presentation at the June 2004 meeting of the Colorado Commission on Indian Affairs (CCIA). CCIA acts as liaison between the Southern Ute and Ute Mountain, Colorado-based tribes, Indians living in urban areas and the State of Colorado. CCIA reviews all proposed or pending legislation and amendments to existing legislation affecting Indian residents and makes legislative recommendations.

- In July 2004, OCR HIPAA staff in Region IV (Atlanta) exhibited at the



## *HHS-Office for Civil Rights*

“Conference on Increasing the Number of American Indian, Alaska Native and Native Hawaiian Professionals in Public Health” at Emory Conference Center in Atlanta, Georgia. Over 150 participants from the National Institutes of Health, Centers for Disease Control and Prevention, various public health schools and undergraduate students, Emory University, and local Tribal health departments, were in attendance. OCR staff disseminated materials on the Office’s authorities, compliance activities and initiatives. OCR staff also attended workshops; networked with interested parties and stakeholders; educated providers, consumers and advocates; responded to questions and provided on-site technical assistance regarding specific issues identified by a local tribal health department.

- At the HHS Tribal Consultation in Syracuse, New York, in August 2004, OCR Region II staff participated in a joint effort with other HHS components in discussing issues affecting Native Americans. OCR’s role at the Consultation was to provide a forum for listening to concerns related to health disparities for the Tribal Nations and to provide information regarding OCR, its regulatory provisions and complaint processing. Information material was provided to the representatives on health issues and civil rights. The 12 representatives from Tribal Nations within the New York State area included the Saint Regis Mohawks, the Seneca Nation, the Onondagas, the Oneidas and the Shinecock Nation.

- In August 2004, OCR Region VIII (Denver) staff gave an overview of civil rights laws under OCR’s jurisdiction and the Privacy Rule at the Tribal Program Director’s meeting at the Sisseton-Wahpeton Tribal College.

- At the second annual Region VIII HHS Tribal Consultation Session held in Billings, Montana, in August 2004, OCR Region VIII (Denver) staff presented on civil rights authorities and disseminated fact sheets. OCR staff helped to plan the event.

- In September 2004, OCR Region I (Boston) staff participated in a meeting of the Northeast Consortium for Native Americans in Mashantucket, Connecticut. The purpose of the Northeast Consortium is the identification and coordination of resources to improve the health and education of Native Americans living in New England.



## *HHS-Office on Disability*



The Office on Disability (OD) oversees the implementation and coordination of disability programs, policies and special initiatives for 54 million persons with disabilities. The Director of the Office on Disability reports to the Secretary of Health and Human Services and serves as an advisor on HHS activities relating to disabilities. The OD was created in October 2002 in response to President Bush's New Freedom Initiative (NFI)—a national effort to develop integrated and appropriate services for people with disabilities and eliminate the barriers to community living. The New Freedom Initiative established seven distinct domains in the area of disability: community integration, education, employment, health, housing, technology, and transportation. The Office on Disability focuses its efforts on these seven domains.

The charge to the Office is:

- Serve as the focal point within HHS for the implementation and coordination of policies, programs, and special initiatives related to disabilities with the Department and with other Federal agencies;
- Oversee the implementation and coordination of disability programs, policies, and special initiatives;
- Heighten the interaction of programs within HHS and with Federal, State, community and valuable private sector partners;
- Support plans and initiatives designed to tear down barriers facing people with disabilities, which prevent them from fully participating and contributing in an inclusive community life;
- Centralize the solutions outlined in the New Freedom Initiative report to President Bush; and
- Increase focus and awareness to help Americans living with disabilities. The following is a brief summary of a specific OD program that had a relevant and significant impact on Native American communities.  
Information on the Office on Disability Program: Improving Outcomes for Young Adults with Disabilities

The Young Adult Program was a joint effort by the Office on Disability and the National Governors Association Center (NGA Center), in direct response to the OD's actions to fulfill the President's New Freedom Initiative (NFI). It was planned in 2004 and implemented in 2005 to address the challenges of young adults with disabilities as they transition from youth to adult health and human services. The program helped improve services for young adults ages 14-30 including Tribal youth to facilitate transitions to independent living, and reduce institutionalization, incarceration, and homelessness through changes in the demonstration states' administrative infrastructures. In coordination with the NGA Center, 17 states submitted applications and project proposals; six states—Colorado, Connecticut, Washington, Florida, Kansas, and Montana — were selected to participate in the program with five (not Florida) that included Tribal

## *HHS-Office on Disability*

participation. In 2006 each state received a \$35,000 grant to help design and implement their strategic plan. At the conclusion of the program in September 2007 the participating states indicated they planned to continue implementing those programs and develop additional projects based on new knowledge. The program's ongoing evaluation (began at the program onset) includes a 6-month follow up scheduled to occur on or before June 2008 which will document these states' progress.

A key focus of the program was on the development of comprehensive policies that addressed the needs of youth with disabilities and facilitated the transition to adult life. A central measure of a program's comprehensiveness was the level in which each state's strategic plan considered and addressed the needs of underrepresented populations, particularly young Native American's with disabilities. Partnerships between state and Tribal governments, in conjunction with various Tribal organizations, were instrumental and invaluable when addressing the particular challenges of program development and implementation. Programs included designing culturally appropriate programs, building trust and providing access to resources on Native American reservations, facilitating the transition between Tribal and public services, and developing programs that focus on those disabilities with a higher rate of incidence.

Of the six state participants, Washington's strategic plan presented a comprehensive and nuanced program for addressing the needs of young Native Americans with disabilities. The Yakama Nation Vocational Rehabilitation Program and the Toppenish School District—in coordination with ten other public school districts—conducted a series of community forums that aimed to improve communication and understanding between various sectors of society, including Native American youth, parents, teachers, and Tribal leaders. This conversation provided information regarding special education programs, vocational training, and employment opportunities for Native American youth with disabilities. Additionally, informational and educational media was produced and distributed by Tribal representatives that focused on culturally relevant information. Finally, the 2007 Cultural Awareness Forum brought together Tribal elders, teachers, and community leaders and focused on methods of aiding Native American students with special needs, both in school and in the future workplace. The program's follow-up evaluation will assess how this input was utilized in improving health, human and education services for Tribal youth.

A comprehensive report and analysis of this program's procedures, projects, and results will be available for the Office on Disability by later February 2008.



## *HHS-Center for Faith-Based and Community Initiatives*



The mission of the Center for Faith-Based and Community Initiatives (CFBCI) is to create an environment within the Department (HHS) that welcomes the participation of faith-based and community organizations as valued and essential partners assisting Americans in need. The CFBCI's mission is part of the Department's focus on improving human services for our Country's neediest citizens. This Center leads the Department's efforts to better use faith-based and community organizations in providing effective human services.

HHS has made great strides in improving current faith-based and community partnerships, providing opportunities for new partnerships with faith-based and community organizations and removing existing barriers to the inclusion of these groups in HHS programs. Technical assistance has been provided throughout the country to increase the capacity of faith-based and community organizations working with vulnerable and needy populations. HHS has reached out and collaborated with religious and neighborhood organizations that for decades have been bringing solutions to bear on some of our country's most intractable problems.

The Administration for Children and Families (ACF) and the Substance Abuse and Mental Health Services Administration (SAMSHA) currently administer pilot programs that are features of the President's Faith Based and Community Initiative. Through the Compassion Capital Fund, Mentoring Children of Prisoners program, and the Access to Recovery voucher program; the Federal government is partnering with faith-based and community organizations to serve those in need—including grants to organizations serving Native American communities.

The CFBCI supplies information and training, but it does not administer grant programs and does not make the decisions about which groups will receive funding. Those decisions are made through procedures established by each grant program, generally involving a competitive process. No grant funding is set-aside for faith-based organizations. Instead, the Faith-Based and Community Initiative creates a level playing field for faith-based and other community organizations so that they can work with the government to meet the needs of America's communities.

Additional information about the Faith-Based and Community Initiative, including information on grant opportunities and technical assistance, can be found on the CFBCI website at [www.hhs.gov/fbci](http://www.hhs.gov/fbci).



*FY 2003 & FY 2004  
Report to Congress*

## Conclusion

This Report provides Congress, and the public, first-hand information about HHS programs that can help build self-sufficient and sustainable Native American communities in the United States, American Samoa, Guam and the Northern Mariana Islands. The information is an important tool for Native American community leaders to use in their strategic planning, project development, and immersion into the resources offered at HHS.

Our strong commitment to this ideal was solidified with the reactivation and elevation of the Intradepartmental Council on Native American Affairs (ICNAA) to the immediate Office of the Secretary. Through the “Grants Access Validation Study” to inventory HHS programs and the accessibility to programs by Tribes, ICNAA took the next steps to determine what is preventing Tribes from accessing and/or applying for grant programs. It was the Council’s recommendation to assess the regulatory and policy barriers that exist and to document “Best Practices” that work for Tribes. Based on the results, ICNAA will make recommendations.

ANA was appropriated \$45,457,000 in FY 2003 and \$45,157,000 in FY 2004 to fund grant programs that help build self-sufficient tribal communities. ANA developed a reporting system which requires grantees to identify performance indicators. This type of data will allow ANA to inform Congress through outcome data on the effectiveness of the ANA programs.

The Indian Health Service was allocated approximately \$3.5 billion for FY 2003 and \$3.7 billion in FY 2004 to provide services to Native American communities. Other partnerships between IHS and other HHS agencies created in FY 2003 and FY 2004 addressed health promotion and disease prevention in Native American communities.

Our work is exciting. Our work is challenging. Our work improves the health, safety, security and the quality of life of Native American children, youth and families. This report is indicative of our successes and provides us with a blueprint for closing the gap on the health and safety challenges that we have not yet conquered. We will continue our efforts to improve access to health and social services by working at every level of HHS to promote Native American community based projects.

