Report to Congress

on the

Social and Economic Conditions of Native Americans

U.S. Department of Health and Human Services

Fiscal Years 2009 - 2012
This U.S. Department of Health and Human Services Report to Congress is in accordance with 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.
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EXECUTIVE SUMMARY

This report contains the descriptions of Staff Divisions and Operating Divisions under the Office of the Secretary who have made a significant impact on Native Americans (Indian tribes, both federally recognized and state recognized, Alaska Natives, Native Hawaiians, and Pacific Islanders located in Guam, American Samoa, and the Northern Mariana Islands). The report provides data specific to awards made to Native Americans and agency highlights of Native American projects that were impacted by the Department of Health and Human Services (HHS) funding. The funding shown in this report represents only funding provided through grants by each reporting office, unless specifically noted otherwise.

Some of the highlights of this report are:

The Office of the Assistant Secretary for Health (OASH) awarded more than $7.9 million to provide training to 80,000 American Indian and Alaska Native (AI/AN) youth at-risk for poor health and social outcomes and behavioral health dysfunction and behavior modification methods for improved health outcomes. To advance the goals of the National HIV/AIDS Strategy, OASH provided prevention education, screening, and treatment best practices to 20,000 AI/AN, Native Hawaiians (NH) and Pacific Islanders (PI).

In fiscal year (FY) 2009, the HHS Office of Minority Health (OMH) participated in the Community Partnerships to Eliminate Health Disparities Demonstration Grant Program. Under this particular grant program two programs were awarded and funded; the Huron Potawatomi, Inc. organization and the Gila River Health Care Corporation. During FY 2009, both programs developed links and/or referrals for access and treatment to racial and ethnic minorities in high-risk, low income communities; integrated community-based education, screening, and outreach services; and addressed sociocultural, linguistic, and other barriers to health care facilities.

In FY 2012, OMH’s AI/AN Health Disparities Program supported projects that enhanced the Tribal Epidemiology Centers (TECs) and Urban Indian Health Programs’ (UIHPs) capacity to carry out disease surveillance including the interpretation and dissemination of surveillance data; address vital statistics needs; conduct epidemiologic analysis; investigate disease outbreaks; develop disease control and prevention strategies and programs; and/or coordinate with other health agencies in the region.

In FY 2009, the Assistant Secretary for Planning and Evaluation (ASPE) conducted a research study entitled Characteristics of American Indians and Alaska Natives (AI/ANs) Participating in Temporary Assistance for Needy Families Programs (TANF). The purpose of this study was to gain a greater understanding of the characteristics and participation of AI/ANs in state and tribal TANF programs over time.

In FY 2011, ASPE staff published the final methodology and disseminated the annual federal funding matching rates for FY 2010, FY 2011, and FY 2012 for Indian tribes that participate in foster care, adoption assistance, and kinship guardianship programs authorized under title IV-E
of the Social Security Act and administered by the Administration for Children and Families.

In FY 2009, the Assistant Secretary for Preparedness and Response coordinated a seminar on the impact of hurricanes on tribes. Participants discussed tribal capabilities and IHS assets in emergency response and shared experiences with deployment during several hurricanes.

In FY 2009 through 2012, the Office for Civil Rights conducted several technical assistance and outreach activities to Native Americans on major civil rights laws such as Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).


The Children’s Bureau within the Administration for Children, Youth and Families which is a part of the Administration for Children and Families awarded over $68 million in grant funds to Native American Communities from FY 2009 through FY 2012.

The American Recovery and Reinvestment Act (ARRA) of 2009 provided $2 billion in supplemental funding for Child Care and Development Fund discretionary funds administered by the Office of Child Care (OCC) within the Administration for Children and Families. This resulted in an additional two percent ($40 million) to tribes.

In FY 2011, OCC awarded a three-year discretionary grant to Keiki O Ka ‘Aina, a Native Hawaiian non-profit organization, to increase the availability, affordability, and quality of child care programs in areas that have been previously underserved and/or have unmet needs for Native Hawaiian youth. The project was awarded $1 million for each year.

The Office of Child Support Enforcement (OCSE) awarded over $31 million to Native American communities in FY 2009. There were 36 tribes operating comprehensive child support programs and nine tribes receiving start-up funding to put a comprehensive child support program into place. In FY 2010, OCSE awarded $36.5 million; in FY 2011, OCSE awarded $35.2 million; and in FY 2012, OCSE awarded $38.2 million.

The Strengthening Communities Fund program administered by the Office of Community Services (OCS) within the Administration for Children and Families focuses on building the

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capacity of nonprofit organizations, both faith-based and secular, to address the broad economic recovery issues present in their communities. Six tribes and tribal organizations in six states received Strengthening Communities Funds in FY 2009. There were no appropriations for SCF after FY 2009.

In consultation with tribal representatives, OCS and LUX (OCS’ technical assistance contractor) collaborated to publish the FY 2012 Tribal Resource Guide which provides technical assistance specifically targeted to tribal anti-poverty and program accountability efforts. The Guide contains technical assistance tools to help tribal grantees meet CSBG program goals and objectives.

Fourteen tribal TANF grantees administer discretionary grants for Coordination of Tribal TANF and Child Welfare Services to Tribal Families at Risk of Child Abuse or Neglect. Total annual funding for the Tribal TANF – Child Welfare Coordination grants was $1.5 million in each of FY 2010 and FY 2011. The project period for these grants was five years, from September 30, 2006, to September 29, 2011. The total FY 2011 annual funding for the Tribal TANF – Child Welfare Coordination grants was $2 million. The project period for these grants was three years, from September 30, 2011 to September 29, 2014.

During 2010, the Office of Head Start (OHS) coordinated with OCS on education, resources, and implementation of the Assets for Financial Independence (AFI) Program in tribal communities. The program assists families with low incomes and limited economic assets improve their financial stability. Many programs have already begun to use asset building strategies, such as financial education, to ensure that parents and staff have the information and skills they need to remain financially secure.

In response to the intent of the Improving Head Start for School Readiness Act of 2007 and the importance repeatedly conveyed by tribal leadership, OHS began in FY 2011 an initiative to learn about the successes, progress, and challenges faced by a number of large and small tribal communities in various stages of preserving, revitalizing, or reclaiming their tribal language. Information was gathered through meetings and discussions with tribes and through the OHS Tribal Language Preservation and Revitalization, resulting in the OFFICE OF HEAD START TRIBAL LANGUAGE REPORT 2012. This report provides illustrative examples of tribal language efforts around the country and discusses the recommendations and implications for OHS.

In FY 2009, the Administration on Community Living held cluster training sessions focused on financial management, program management, reporting requirements, technology, and menu planning. During FY 2010, cluster training sessions were held to provide in-depth information on program management, health and wellness programs, and health education. In FY 2011, cluster training sessions focused on new dietary guidelines, implementing new programs, caregivers, and health promotion.

In FY 2009, the Agency for Healthcare Research and Quality supported a research infrastructure development project run by the Montana-Wyoming Tribal Leaders Council which included six
studies addressing in-depth topics such as seat belt use, eye disease, suicide prevention, emergency medical services, and physical and mental health care access improvement. This project was funded through FY 2011.

In FY 2010, the Centers for Disease Control and Prevention awarded over $52 million in funds through grants and cooperative agreements to Native American Communities including American Indian, Alaska Native tribes and Native American (including Native Hawaiian and Pacific Islander) serving institutions. In FY 2011, over $54 million in funds were allocated through awarded grants and cooperative agreements, nearly a four percent (3.7%) increase. In FY 2012, over $54.5 million in funds were awarded through grants and cooperative agreements to Native American Communities including American Indian, Alaska Native tribes and Native American (including Native Hawaiian and Pacific Islander) serving institutions.

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In November 2009, the Food and Drug Administration participated in the 6th Annual American Indian Symposium held at the University of Missouri at Kansas City (UMKC). The event was sponsored by the American Indian Council of Kansas City. In 2011, FDA’s Office of Minority Health held informal conversations with the Indian Health Service (IHS) and the Native Research Network to share the mission of the new office and seek out opportunities for collaboration.

In March 2012, the Health Resources and Services Administration (HRSA) updated its current Tribal Consultation Policy. The goal of this policy includes, but is not limited to, eliminating health disparities of AI/AN by increasing access to quality health care; increasing the supply of caring and culturally competent primary health care providers in Indian Country and Alaska; engaging in an interagency, continuous, and meaningful consultation; and advancing the social, physical, and economic status of federally-recognized Indian tribes. This policy serves as a guide for tribal participation in HRSA policy development to the greatest extent practicable and permitted by law.

In FY 2009, IHS grant officials provided 25 training sessions to all AI/ANs in the areas of: financial reporting, carryover, and cost principles. In FY 2010, 22 training sessions were provided to over 450 IHS Program Officials (Headquarters and Regional Areas), tribes and non-tribal grantees in the areas of Grants.gov Systems User Training, Funding Opportunity Announcement Process, the Objective Review Process, HHS/IHS Financial Management Requirements, Pre and Post award Requirements, guidance on matters relating to grants operations, and various other HHS/IHS grants policies. In FY 2011 and 2012, IHS held 132 training sessions for over 1,539 IHS Program Officials (Headquarters and Regional Areas), tribes and non-tribal grantees on the following topics: Grants.gov Systems User Training; Funding Opportunity Announcement Process; Application Review Module System; Grant Solutions System; HHS/IHS Financial Management Requirements; Pre and Post award Requirements; guidance on matters relating to grants operations; and other various HHS/IHS grants policies.

In FY 2009, the National Institutes of Health (NIH) provided support for the University of Oklahoma Center for American Indian Diabetes Health Disparities that seeks to improve the health and quality of life of Native Americans with diabetes. The Native American Research
Centers for Health (NARCH) supported partnerships between AI/AN tribes or tribally-based organizations and institutions that conduct intensive academic-level biomedical, behavioral, and health services research. In FY 2011, there were 18 active NARCH Centers with representation from more than 450 AI/tribes.

The National Institute on Drug Abuse (NIDA) has been the second highest funder of the Native American Research Centers for Health (NARCH) Program among NIH Institutes. Through the NARCH, NIDA provided support for four new projects in 2010. These included “Equine-Assisted Substance Use Prevention,” “Development of a Pain Rehabilitation Program for AIs with Chronic Pain,” “CBPR Approach to Preventing Intentional Injury,” and “Improving Health Research Skills for Trainees.”

In FY 2009, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded 74 new and continuation awards to tribes and AI/AN organizations, totaling more than $53 million; in FY 2010, SAMHSA awarded 104 new and continuation awards to tribes and AI/AN organizations, totaling more than $68 million; in FY 2011, SAMHSA awarded 103 new and continuation awards to tribes and AI/AN organizations, totaling more than $71 million; and in FY 2012, SAMHSA awarded 99 new and continuation awards to tribes and tribal organizations, totaling more than $68 million. In FY 2012, SAMHSA awarded to the Pacific jurisdictions grants totaling more than $11 million as well as a contract for $2.9 million, SAMHSA provided focused technical assistance to tribes to address bullying and suicide prevention using the Gathering of Native Americans (GONA) framework.

In FY 2012, HHS held its 14th Annual Tribal Budget Consultation session in accordance with its tribal consultation policy.
The mission of the Department of Health and Human Services (HHS or the Department) is to enhance the health and well-being of Americans by providing effective health and human services and by fostering strong, sustained advances in the sciences, underlying medicine, public health, and social services.

The Department administers more than 300 programs, covering a wide spectrum of services and activities, to protect the health of all Americans and provide essential human services, especially for those who are least able to help themselves. Examples of programs include the following:

- Health and social science research
- Preventing infectious diseases
- Assuring food and drug safety
- Medicare (health insurance for elderly and disabled Americans) and Medicaid (health insurance for low-income people)
- Health Insurance Marketplaces
- Health information technology
- Financial assistance and services for low-income families
- Improving maternal and infant health
- Head Start (pre-school education and services)
- Faith-based initiatives and community initiatives
- Preventing child abuse and domestic violence
- Substance abuse treatment and prevention
- Services for older Americans, including home delivered meals
- Medical preparedness for emergencies, including potential terrorism

Within the Federal Government, HHS is the largest grant-making agency and represents nearly a quarter of all federal outlays. With a budget of $737 billion and 65,630 employees in fiscal year (FY) 2009, $872 billion and 69,919 employees in FY 2010, $902 billion and 72,923 employees in FY 2011, and $901 billion and 73,051 employees in FY 2012, HHS administers more grant dollars than all other federal agencies combined. 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 operating divisions, including eight agencies in the U.S. Public Health Service and three human service agencies, that administer 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.

This report to Congress summarizes the accomplishments of the Department 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.
INTRADEPARTMENTAL COUNCIL ON NATIVE AMERICAN AFFAIRS

The Intradepartmental Council on Native American Affairs (ICNAA), authorized by the Native American Programs Act of 1974, as amended, serves as the focal point within the Department for coordination and consultation on health and human services issues affecting the American Indian, Alaska Native, and Native American (AI/AN/NA) population, which includes more than 560 federally recognized tribes, approximately 60 tribes that are state recognized or seeking federal recognition, Indian organizations, Native Hawaiian communities, and Native American Pacific Islanders including Native Samoans.

It brings together HHS leadership to ensure consistency on policy affecting American Indians, Alaska Natives, and Native Americans, and to maximize limited resources. The major functions of the ICNAA are to:

- Develop and promote HHS policy to provide greater access for Native Americans;
- Assist in the tribal consultation process;
- Develop both short and long term strategic plans;
- Promote self-sufficiency and self-determination;
- Develop legislative, administrative, and regulatory proposals to benefit Native Americans; and
- Promote the government-to-government relationship as reaffirmed by the President.

Membership
The ICNAA membership consists of each of the HHS Operating Divisions heads, Staff Division heads, the Office of Intergovernmental Affairs Director, the Center for Faith-Based and Community Initiatives Director, the Executive Secretary to the Department, and two HHS regional representatives.

Direction and Oversight
The ICNAA is located in the Office of Intergovernmental Affairs and External Affairs (IEA), Immediate Office of the Secretary, and provides executive direction and coordination with the Council Chairperson on all Council activities.

The Commissioner of the Administration for Native Americans (ANA) is ICNAA’s Chairperson and the Director of the Indian Health Service is ICNAA’s Vice-Chairperson. The Chairperson is charged with the overall direction of the Council and shall preside over all Council activities including Council meetings and Executive Committee meetings.

The Executive Committee, comprised of the Chairperson and Vice-Chairperson, the Assistant Secretaries for Children and Families, Aging, Health, and Financial Resources and the IEA Director, is authorized to act on behalf of the Council, and is responsible for overseeing Council functions and recommending subjects and actions for consideration by the full Council.

Management and Administration
IEA’s’ principal advisor on tribal affairs serves as the principal management officer for all Council functions, including management and administration of Council activities, the administration of funds provided for Council activities, and in consultation with the Executive Committee, preparation of agendas for Council meetings and maintaining records of Council business, including minutes from Council meetings. The principal advisor is the primary liaison between Council members and other federal agencies, and reports directly to the Council Chairperson and Vice-Chairperson. The Council meets no less than twice a year. At least one Council tribal liaison has been appointed by each ICNAA member to work with IEA on special projects and on the implementation of Secretarial initiatives and policies affecting AI/AN/NAs.

A key element of the Office of Intergovernmental and External Affairs’ (IEA) mission is to facilitate communication regarding HHS’ initiatives as they relate to state, local, and tribal governments. The Office of Tribal Affairs within IEA coordinates and manages IEA’s tribal and native policy issues, assists tribes in navigating HHS programs and services, and coordinates the Secretary’s’ policy development regarding tribes and national native organizations. The ten regional offices housed in IEA are one of the key components in the ongoing relationship building HHS has with all federally recognized tribes in the United States.

The ten regional offices (Office of the Regional Director or ORD) are the lead organizers of the annual regional tribal consultations. In this responsibility, the ORD in conjunction with the tribal leaders in their respective region plan, coordinate, and conduct consultation meetings. At these meetings the tribal leaders meet with HHS Regional Operating Division staff as well as HHS leadership to discuss policy changes that impact their respective tribal communities. This true government-to-government conversation reaffirms and promotes the sustaining relationships the ORD has with the tribal leaders.

Throughout the year, the ORD continues these exchanges and addresses all the ICNAA priorities. ORD bi-monthly reports document this activity, but the constant and consistent interaction the ORD has with the tribal leaders cannot be overlooked. The priorities of Emergency Preparedness, Health Promotion and Disease Prevention, and Increased Access to HHS Programs and Grants are areas in which the ORD is able to have a positive impact. From the wildfires in California and the flooding in the Plains, to the distribution of educational materials and face-to-face technical assistance from Regional Operating Division personnel to tribal leaders and their councils, these are just a few examples of cooperative work between HHS and tribal nations. These interactions are often held on a weekly basis. The meetings, telephone calls, and emails represent the groundwork of the relationship that the ORD has with the tribes. The ORD and the work of ICNAA go hand in hand. The tribal consultations and the daily connections with tribal leaders allow the ORD to deepen the connections with Indian Country.

**Status and Activities**

- Tribal consultation activities across HHS is an ICNAA priority and is required by Presidential Order 13175. The annual two day HHS Tribal Budget Consultation sessions as well as the regional HHS tribal consultations have proven to be very successful in assuring
that AI/AN communities have an opportunity to communicate their health and human services needs and priorities to HHS leadership. These consultations are partly responsible for a significant increase in the HHS resources that have gone to the AI/AN/NAs community (an increase of over $394 million between FY 2008 and FY 2009).

- ICNAA assists the HHS Office of Minority Health in providing guidance by suggesting research issues that need attention (e.g., training opportunities for young Native researchers, developing appropriate protocols to ensure AI/AN cohorts are considered for national sponsored research studies, etc.) to the HHS AI/AN Health Research Advisory Council (the HHS Office of Minority Health serves as the Executive Secretary of the HHS AI/AN Health Research Advisory Council).

Although, the Indian Health Service serves as the main conduit for the provision of federally supported health care for federally recognized tribal nations, this responsibility is shared with all HHS agencies because of the overarching government-to-government relationship between the federal government and the 562 tribal nations. ICNAA serves to support this relationship across all of HHS which fosters a more meaningful provision of health and human services for AI/AN/NA communities.

Between FY 2009 and 2012, ICNAA established a number of priorities for the Council including:

- Increasing access to HHS Programs and Grants and improving technical assistance for all AI/AN/NAs.
- Increasing awareness and effectiveness of human services
- Holding tribal consultations
- Expansion of Services and Pilot Development (Self-governance Expansion, Tribal/State Relations)
- Expansion of Services (Self Governance Expansion)

Through many workshops and trainings, ICNAA worked to accomplish each of these priorities.
The Office of the Assistant Secretary for Health (OASH) oversees 12 core public health offices — including the Office of the Surgeon General and the U.S. Public Health Service Commissioned Corps — as well as 10 regional health offices across the nation and 10 Presidential and Secretarial advisory committees.

The Office of Assistant Secretary for Health implements an array of interdisciplinary programs relating to disease prevention, health promotion, the reduction of health disparities, women’s and minority health, adolescent health, HIV/AIDS and chronic infectious diseases, vaccine programs, fitness, sports and nutrition, bioethics, population affairs, blood supply, research integrity and human research protections.

OASH promotes the development and utilization of best practices, program and policy development, and increased capacity for direct care services for American Indians, Alaska Natives (AI/AN), Native Hawaiians (NH), and Pacific Islanders (PI) populations.

OASH awarded more than $7.9 million to provide training to 80,000 AI/AN youth at-risk for poor health and social outcomes and behavioral health dysfunction and behavior modification methods for improved health outcomes. To advance the goals of the National HIV/AIDS Strategy, OASH provided prevention education, screening, and treatment best practices to 20,000 AI/AN, NH and PI. OASH also provided 74 multi-disciplinary health professionals for a total of 81 days in-kind at three AI/AN community healthcare facilities to address primary care, behavioral health, immunization, dental, optometry, and public health services during periods of critical community and facility need.

OASH is committed to ensuring the continued social and economic success of the nation’s AI/AN/NH, and PI communities. Dedication of funding, supplying subject matter experts, and technical assistance have proven effective in meeting the public health, health, and capacity building needs of AI/AN/NH/PI communities.

Support Provided to Native American Communities in FY 2009 through FY 2012

The Office of Adolescent Health
The Office of Adolescent Health (OAH) is dedicated to improving the health and well-being of adolescents to enable them to become healthy, productive adults. First funded in 2010, OAH supports and evaluates evidence-based teen pregnancy prevention programs and implements the Pregnancy Assistance Fund; coordinates HHS efforts related to adolescent health promotion and
disease prevention; and communicates adolescent health information to health professionals and
groups, those who serve youth, parents, grantees, and the general public. OAH is the convener
and catalyst for the development of a national adolescent health agenda.

Teen Pregnancy Prevention Program

The Consolidated Appropriations Act, 2010 (P. L. 111-117), provided funding for the Teen
Pregnancy Prevention Program (TPP). TPP supports two types of grant programs: replication of
evidence-based programs (Tier 1) and research and demonstration grants (Tier 2). The five-year
TPP grants were awarded in September 2010 and were funded through August 2015.

In Tier 1, OAH funded two grantees whose efforts focused on serving American Indian Youth:

- Rural America Initiatives of Rapid City, SD, implemented Project AIM with Native
  American Lakota Indian youth ages 12 to 14.
- Capacity Builders, Inc. in Farmington, NM, implemented the Teen Outreach Program
  with 11 to 19 year old Navajo youth at five high schools and three middle schools.

These programs have been proven effective through rigorous evaluation to reduce teen
pregnancy, behavioral risk factors underlying teen pregnancy, or other associated risk factors.
The grantees replicated a range of identified evidence-based program models.

Tier 2 grantees which focused on AI youth included:

- The University of Denver, CO, worked with 13 to 15 year olds enrolled in after-school
  programs at Native Boys and Girls clubs located in rural tribal reservation areas in North
  Dakota and South Dakota. The grantee implemented and evaluated Circle of Life, a
  sexual risk reduction program for Native youth ages 10 to 12 that uses familiar symbols,
  stories, and ways of learning to build knowledge and skills to bring about behavior
  change;
- The National Indian Youth Leadership Project (NIYLP) in Gallup, NM, worked with
  Native American youth ages 12 to 17 in rural McKinley County. The grantee tested Web
  of Life, a development program for middle school Native American youth that included
  26 curriculum sessions, after-school activities, one weekend activity, and a summer
  session;
- The Rural America Initiatives of Rapid City, SD, adapted Project AIM for Lakota
  American Indian youth ages 11 to 14 by adding culturally specific activities, a personal
  Vision Quest, and culturally significant field trips; and
- The State of Alaska, Division of Public Health, Section of Women’s, Children’s &
  Family Health in Anchorage worked with youth ages 11 to 19 in the Matanuska-Susitna
  Valley, the Kenai Peninsula Borough, Kotzebue, and Bethel. The grantee adapted
  Promoting Health Among Teens – Comprehensive Curriculum to train peer educators.

Tier 2 grantees use research and demonstration programs that develop, replicate, refine, and test
models and innovative strategies for preventing teenage pregnancy.

Pregnancy Assistance Fund
The Affordable Care Act (P. L. 111-148) provided funding for Pregnancy Assistance Fund (PAF) a $25 million competitive grant program to support expectant and parenting teens, mothers, fathers, and their families with a seamless network of supportive services to help them complete high school or postsecondary degrees and gain access to health care, child care, family housing, and other critical supports in states and tribes across the country. PAF was awarded in FY 2010 to two tribal organizations: the Inter-Tribal Council of Michigan, Inc. and the Choctaw Nation of Oklahoma. The Inter-Tribal Council of Michigan, Inc. provided support, assessment, education, and referral services to pregnant and parenting American Indian teens at Community Service Centers in 20 counties including two major urban areas in Michigan. The Choctaw Nation of Oklahoma served 600 pregnant and parenting youth through community service centers and public awareness and education efforts.

In addition, the State of Minnesota was awarded $2 million. The state supported these two tribal entities as sub-awardees:

- The Fond du Lac Tribal and Community College; and
- The Leech Lake Tribal College.

**The Office of HIV/AIDS and Infectious Disease Policy**

The Office of HIV/AIDS and Infectious Disease Policy (OHAIDP) plays a leading role in the appropriate and timely implementation and development of policies, programs, and activities related to HIV/AIDS, viral hepatitis, other infectious diseases of public health significance, and blood safety and availability.

**Minority-Serving Institution's HIV/AIDS Prevention Sustainability Demonstration Initiative**

In an effort to advance new strategies to increase HIV prevention activities for minority youth (ages 18 to 25), the OHAIDP contracted with Abt Associates Inc. to administer the Minority-Serving Institution's HIV/AIDS Prevention Sustainability Demonstration Initiative (MSI Demonstration Initiative). The goals of the initiative were to provide technical assistance to MSIs, increase their capacity to address the sexual health needs of minority college and university students, and encourage and promote new partnerships for HIV prevention activities.

In September 2010, seven MSIs were awarded funds to participate in this three-year initiative; these included two tribal colleges and universities. Each participating MSI developed a program with various strategies focusing on: increasing awareness and knowledge of risk factors and prevention methods for HIV/AIDS transmission; reducing high-risk behaviors; and increasing access to counseling, testing, and referral services. Participating MSIs were also required to develop, implement and participate in program components which were designed to assist schools in developing effective and sustainable programs and to advance learning opportunities for and among MSIs. A cross-site evaluation concluded the MSI Demonstration Initiative in September 2013.

The two participating tribal colleges were:

- Stone Child College (Box Elders, Montana)
- Dine College (Shiprock, NM & Tsaile, Arizona)
Funding levels for the two tribal schools under the MSI Demonstration Initiative were as follows:

- Fiscal Year 2011: approximately $100,000 per school
- Fiscal Year 2012: approximately $80,000 per school
- Fiscal Year 2013: approximately $52,000 per school

In addition, Abt Associates subcontracted with the National Native American AIDS Prevention Center to provide technical assistance to the two tribal schools in the areas of program development, staff development, provider training, peer education training, and sustainability plan development.

An initiative under OHAIDP is AIDS.gov whose purpose is to work to increase HIV testing and enhance care among people most at-risk for, or living with, HIV, by using emerging communication strategies to provide access to information on various aspects of HIV/AIDS prevention, treatment and care. As part of its mission, AIDS.gov supports the observance of several annual national HIV/AIDS Awareness Days. National Native HIV/AIDS Awareness Day (NNHAAD) is designated as March 20. NNHAAD is designed to encourage AI, AN, and NH to become educated, tested, involved in prevention, and receive treatment for HIV and AIDS. NNHAAD is a collaboration of several organizations including National Native American AIDS Prevention Center, Asian Pacific Islander Wellness Center, and the Great Plains Tribal Chairmen’s Health Board.

Support for the NNHAAD includes promoting partner activities, developing and implementing a social media strategy, including AIDS.gov- and guest-authored blog posts, and visibility on Twitter, Facebook, the Web, and Pinterest.

As part of its mission to promote federal HIV policies, resources, and programs, AIDS.gov cross-promotes HIV information alerts published by the Indian Health Service through the AIDS.gov website and through its new media channels, including the AIDS.gov blog, Twitter, Facebook, and Pinterest.

**The Office of Disease Prevention and Health Promotion**

The Office of Disease Prevention and Health Promotion (ODPHP) is committed to initiating, coordinating, and supporting disease prevention to build a healthier America. In addition ODPHP involves itself in health promotion activities, programs, and policies. ODPHP is able to collaborate with other HHS agencies in disease prevention and is committed to eliminating health disparities among American Indians and Alaska Natives.

In FY 2009, ODPHP funded Healthfinder®, a user-friendly website designed to ensure access to resources for American Indians and Alaska Natives.

The Community Partnerships to Eliminate Health Disparities Demonstration Grant Program awarded and funded the Huron Potawatomi, Inc. organization and the Gila River Health Care Corporation. During FY 2009, both programs developed links and/or referrals for access and
treatment to racial and ethnic minorities in high-risk, low income communities; integrated community-based education, screening and outreach services; and addressed sociocultural, linguistic, and other barriers to health care facilities.

The HIV/AIDS Health Promotion and Education Cooperative Agreement Program during FY 2009 funded two projects: CHAT’s Indigenous Peoples Task Force and HIRE’s Long Island Association for AIDS Care. The two projects were dedicated to effectively reaching and educating young adult minority populations at risk for affected by and/or infected with HIV/AIDS.

The Indian Health Network (IHN) which was overseen by Health Disparities Existing within the Native American Population Project is a national clearinghouse of information regarding AI/AN health resources and services. This project addressed the health disparities that existed within the AI/AN population, through health research, health education, and health services. During FY 2009, 14,944 visitors joined the site. In FY 2010, there were 26,468 unique visitors to the Indian Health Network website and 191 new self-subscribers.

**The Office of Minority Health**
The Office of Minority Health (OMH) is dedicated to improving the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate health disparities.

**American Indian/Alaska Native Health Disparities Program**
The American Indian/Alaska Native Health Disparities Program is a five-year grant program which supported six projects designed to reduce health-related disparities through a systematic cross-tribal investigation to assess the mediators and barriers that affect translation of quality health data into health service programs and policies. The need for community-level data to set health priorities, programs, and policy is critical to successfully combating health disparities among tribal communities. The American Indian/Alaska Native Health Disparities grant program funded six Tribal Epidemiology Centers (TECs). Each project received awards of $200,000 for FY 2009. Through this funding, the TEC projects were able to assess community-level data in order to set health priorities, programs and policies to successfully combat health disparities existing in tribal communities. The outcomes of the TEC projects funded were well coordinated policies, programs, and strategies that supported sustainability and quality of health care systems in tribal communities.

During the first six months of FY 2010, more than 1,000 individuals received services and/or training from the grantees and their partner organizations. In FY 2011, grants were awarded to TECs for projects to improve the effectiveness of efforts to eliminate health disparities for AI/AN communities. Outcomes of the projects resulted in coordinated policies, programs, and strategies that support sustainable, quality healthcare systems. In FY 2012, the AI/AN Health Disparities Program was recompeted to support projects that enhanced the TECs and Urban Indian Health Programs (UIHPs) capacity to carry out disease surveillance, including the interpretation and dissemination of surveillance data; address vital statistics needs; conduct epidemiologic analysis; investigate disease outbreaks; develop disease control and prevention strategies.
strategies and programs; and/or coordinate with other health agencies in the region. In addition, to building their data capacity, TECs and UIHPs formed collaborative partnerships and alliances to improve access to quality health and human services, and designed programs to increase the number of AI/AN serving as health professionals, paraprofessionals and researchers. In FY 2012, six organizations received awards under this program. Grantees were: (1) Inter Tribal Council of Arizona, Inc.; (2) Seattle Indian Health Board; (3) Northwest Portland Area Indian Health Board; (4) United South and Eastern Tribes, Inc.; (5) Oklahoma City Area Inter-Tribal Health Board; and (6) Alaska Native Tribal Health Consortium. This five-year program ends August 31, 2017.

National Umbrella Cooperative Agreement Program (NUCA)
Through the NUCA, OMH demonstrated the effectiveness of collaborations with federal agencies, tribes, and national organizations by supporting efforts designed to: (1) improve access to care for targeted racial and ethnic minority populations; (2) address social determinants of health to achieve health equity for targeted racial and ethnic minority populations through projects of national significance; (3) increase the diversity of the health-related work force; and (4) increase the knowledge base and enhance availability for health disparities and health equity activities. This was a five-year program that ended August 31, 2015. The following four AI/AN organizations’ projects were supported under this program

The Alaska Native Epidemiology Center (ANEC) project, a five-year project ending in 2017, has four main objectives: to establish a comprehensive overview of existing data on intimate partner violence and sexual violence (IPV/SV) affecting American Indians/Alaska Natives (AI/AN) from all possible data sources in order to paint a detailed picture of this health disparity area; to improve the collection, analysis, interpretation, and dissemination of health data related to IPV/SV among AI/AN; to increase the number of IPV/SV organizations that serve AI/AN with the capacity to effectively evaluate project activities; and to facilitate improved health outcomes by increasing the knowledge-base and awareness related to IPV/SV among AI/AN populations. The outcomes of the project will meet the following OMH expectations for the NUCA Program: improve collection, analysis, interpretation, and dissemination of health data on targeted minority populations; and increase the number of organizations with the capacity to effectively evaluate project activities.

The Great Plains Tribal Chairmen’s Health Board project administered through the Northern Plains Tribal Epidemiology Center (NPTEC); was expected to increase the knowledge-base and enhance data availability for health disparities and health equity activities through the use of Geographic Information Systems (GIS). The NPTEC collaborated with faculty and staff from the University of Nebraska Medical Center College of Public Health to provide epidemiology and GIS training, spatial analysis, and technical assistance to tribal communities in order to enhance the Northern Plains American Indian communities’ capacity to collect, analyze, interpret, and disseminate relevant public health data and information in a culturally appropriate manner. In FY 2011, a total of 45 individuals representing six tribes and four tribal colleges participated in the Mapping Pathways project.
The Minneapolis American Indian Center (MAIC) was the center of operations for the Quality Indian Child Welfare Act (QUICWA) Compliance Collaborative, a national consortium of tribes, urban American Indian organizations, and national advocacy groups from across the country that work together on the issues of child abuse and neglect. QUICWA is an internet-based case management system used to enhance communication and coordination between tribal governments and urban Indian organizations as they work together on Indian Child Welfare Act (ICWA) cases involving Indian children. The goal of the MAIC NUCA project was to organize, train, and provide technological tools to develop the capacities of tribes, urban Indian organizations, and national advocates to gather data on non-compliance of the ICWA and to use that data to advocate for change at the local and national levels.

The Seattle Indian Health Board NUCA Project was administered to increase delivery of quality care specifically for urban AI/AN in cardiovascular disease, depression, and a community-determined disease/health issue. It accomplished this by identifying 4 to 7 best practice interventions or components of interventions shown to reduce, prevent or treat the health issue, increase capacity at a minimum of two urban Indian health organizations to implement these interventions, and increase the number of successful models of care that are recognized at a national level in order to increase awareness and help leverage resources.

National Umbrella Cooperative Agreement II (NUCA II)
In FY 2012, OMH published the National Umbrella Cooperative Agreement (NUCA) II Directed Supplement competitive funding announcement. The expectation of the NUCA II was: increased access to and utilization of health care services; increased level of cultural competency of health care providers serving targeted minority populations; increased interest of minority youth in pursuing careers in the health arena; increased number of minorities recruited and trained for careers in health field; improved collection, analysis, interpretation and dissemination of health data on targeted minority population; increased number of organizations with the capacity to effectively evaluate project activities; reduction in the incidence of youth unintentional/ intentional related injuries; and increased leveraging and efficient use of resource and other assets through strategic partnerships. In September 2012, two Native American organizations received awards under the NUCA II program: Association of American Indian Physicians and National Council of Urban Indian Health.

The Association of American Indian Physicians (AAIP) has conducted the Patty Iron Cloud National Native American Youth Initiative (PIC-NNAYI) for many years. Compared to other racial/ethnic groups, and the overall total, AI/AN are underrepresented in the health professions for a variety of reasons and are the most underrepresented minority in the physician category; only 48 physicians/100,000. The importance of a positive youth development program has become increasingly evident, and as AI/AN communities face issues such as crime and violence, and poor economic circumstances, positive youth development is critical. In FY 2009, 59 students participated in the nine-day NNAYI program in Washington, D.C. The activities conducted during the program period included: pre-college preparation with the Association of American Medical Colleges (AAMC); mentoring activities with AI/AN health professionals and the AAIP physicians; and visits to government, academic, and private organizations that provide...
resources for the pursuit of careers in health professions. In FY 2010, there were 50 student participants and 10 counselors in the program.

The National Council of Urban Indian Health project entitled Access and Resources for Community Health aims to develop, implement, and evaluate best practices in Community Health Representatives (CHR) programs for urban Indian communities that improve health care and wellness, and sustain services for AI/AN people. The goals of the project are to: (1) increase awareness of the significance of health disparities, their impact, and the actions necessary to improve health outcomes for AI/AN populations; (2) improve data availability and coordination, utilization, and diffusion of research and evaluation outcomes; (3) improve health and health care outcomes for AI/AN urban populations; and (4) replicate and sustain an urban Indian CHR program nationally. The CHR Sacramento Native American Health Center (SNAHC) home visitation program works with families with children age five and younger engaging caregivers in activities aimed at improving the children’s health status. SNAHC performed 1,495 visits to families between June and August 2014, with an average of 99.67 visits per month. Forty-three percent of the families report having active health insurance for all members of the family and all but one had enrolled in Medi-Cal. The CHRs document the health insurance status of all people in the home of families being-served. Those not enrolled received education, eligibility assessments, and families were assisted with the enrollment process as applicable.

**HIV/AIDS Programs**

The HIV/AIDS Health Improvement for Re-entering Ex-Offenders Initiative (HIRE) was a three year grant program initiated in FY 2009, which sought to bridge healthcare gaps that existed with the AIDS epidemic to improve the HIV/AIDS health outcomes of ex-offenders re-entering the mainstream population. This demonstration focused on the three states with the highest incidence of inmates known to be infected with HIV or to have confirmed AIDS in state prisons at year end 2006: New York (4,000), Florida (3,412) and Texas (2,693). During the first six months of FY 2010, Long Island Association for AIDS Care (LIAAC) provided services to more than 1,800 formerly incarcerated individuals (including Native Americans in the target population). During FY 2011, LIAAC provided services to more than 1,200 formerly incarcerated individuals (including Native Americans in the target population).

During FY 2010, the Minority Community HIV/AIDS Partnership: Preventing Risky Behaviors Among Minority College Students (MCHP) was established with a purpose to demonstrate the effectiveness of partnerships in improving the health status, relative to HIV/AIDS, of young adults, particularly racial and ethnic minorities by eliminating disparities. In September 2010, the National Indian Women’s Health Resource Center was funded at a level of $257,090 through the MCHP competitive grant process.

Curbing HIV/AIDS Transmission Among High Risk Minority Youth and Adolescents by Utilizing a Peer-to-Peer Outreach Model and New Application Technologies (CHAT) was a three year grant program, initiated in FY 2009, through which OMH intended to demonstrate that CHAT was an effective model in addressing the multifaceted factors associated with the prevention and treatment of HIV/AIDS among at-risk youth who were at high-risk for HIV infection. The provision of a multi-faceted approach, including new application technology,
Partnerships Active in Communities to Achieve Health Equity

The Partnerships Active in Communities to Achieve Health Equity (PAC) Program sought to improve health outcomes among racial and ethnic minorities through the establishment of community-based networks that collaboratively employ evidence-based disease management and preventive health activities; build the capacity of communities to address social determinants and environmental barriers to healthcare access; and increase access to and utilization of preventive health care, medical treatment, and supportive services. In September 2010, the Indian Health Care Resource Center of Tulsa received a three-year grant through the PAC competitive grant process.

Youth Empowerment Program

OMH announced the availability of FY 2012 competitive funding for the Youth Empowerment Program (YEP). YEP seeks to address unhealthy behaviors in at-risk minority youth, 10 to 18 years of age, and provide them with opportunities to learn skills and gain experiences that contribute to more positive lifestyles and enhance their capacity to make healthier life choices. The YEP program is intended to test the effectiveness of innovative approaches in promoting healthy behaviors among youth at-risk for poor health/life outcomes. These demonstration grants require a multi-partner approach involving institutions of higher education, primary and secondary schools, community organizations and institutions, and the community at-large. OMH expectations were that the YEP would result in the following outcomes among target youth: reduction in or elimination of high risk behavior; strengthening of protective/resiliency factors; development of sustainable basic life skills needed to deal with the demands of everyday life; and development of skills and behaviors that lead to healthier lifestyles choices. The College of Menominee Nation was funded under this program. The YEP is a five year program that will end August 31, 2017.

Office of Minority Health Resource Center

The Office of Minority Health Resource Center (OMHRC) signed a contract with the Seattle Indian Health Board, Urban Indian Health Institute in 2010 to conduct research and develop and implement a communications campaign to reduce infant mortality in the AI/AN population. Part of OMHRC’s “Healthy Baby Begins with You” campaign, this project spanned a three-year period. The main goals were to raise awareness of infant mortality and Sudden Infant Death Syndrome in the AI/AN population and pilot a campaign to improve the health of urban AI/AN mothers and babies. Four sites were recruited to work on the formative research and pilot campaign activities. These sites were located in Seattle, Salt Lake City, Detroit, and Sacramento. A literature review report, Looking to the Past to Improve the Future: Designing a Campaign to Address Infant Mortality among American Indians and Alaska Natives, was...
submitted by the project. A final video, *Native Generations*, was released in Fall 2012. The video and training guide was distributed to Native American health care clinics and communities throughout the country.

OMHRC worked with Native communities providing capacity building and technical assistance to tribes and Native serving HIV/AIDS organizations and agencies to strengthen programs in Indian Country.

In FY 2011, the OMHRC’s Tribal Initiatives on HIV/AIDS (TIHA) assisted 10 tribes and American Indian organizations throughout the United States. Each tribe and organization received some type of technical assistance or capacity building to assist programming efforts around HIV. In FY 2012, OMHRC, along with IHS and Kat Communications adapted the Circle of Life HIV/AIDS Prevention Curriculum to a multimedia online format, with several internet-based training modules to address the basics of HIV and how to make better decisions for a healthy life. This curriculum for middle school students, ages 10 to 13 engages youth in various skill-building games and activities about making positive choices and the consequences of risky behaviors. The curriculum offers enough flexibility to accommodate a range of school schedules and learning settings, can be led by teachers, group leaders, students or other facilitators, and is flexible enough that it can be tailored to various settings and mixed age/gender groups. This curriculum has been distributed throughout native communities.

A total of five tribal grantees were awarded $20,000 in FY 2010. The tribes were Fort Peck Tribes, Standing Rock Sioux, Pawnee Nation, Choctaw Nation of Oklahoma, and Mississippi Band of Choctaw. Each tribe received capacity building assistance.

In FY 2011, OMHRC and IHS collaborated with the UIHIs to address the need for integrated education and prevention efforts. The Viral Hepatitis and STI Prevention project provided free technical assistance to urban Indian health organizations (UIHO) nationwide to address these health issues, and develop culturally appropriate health promotion materials. The project hosted several webinars throughout the project year.

OMHRC awarded mini-grants for tribes and tribal programs to further develop HIV/AIDS programs or continue HIV/AIDS programs. Mini-grants were awarded to the Red Circle Project, Shoshone-Bannock Tribe, Navajo AIDS Network, Sacred Spirits, Tucson Indian Center, and Native American Interfaith Ministries.

TIHA facilitated a series of webinars for grantees and the public with an average attendance of 90 persons per webinar.

**The Office of Population Affairs**
The Office of Population Affairs (OPA) serves as the focal point to advise the Secretary and the Assistant Secretary for Health on a wide range of reproductive health topics, including adolescent pregnancy, family planning, and sterilization, as well as other population issues.
Activities of OPA included:

- Supported the Navajo Family Health Resource Network in June of 2012 for the implementation of a new data collection system and needed computer upgrades. These funds were also used to provide intensive training to eight family planning staff located within clinics throughout Arizona and New Mexico.

- Supported a two-day Family Planning and Reproductive Health Conference for the Pacific Basin grantees. This conference provided a medical/clinical update track as well as an administrative and fiscal training track. The Commonwealth of the Northern Mariana Islands (CNMI), and representatives from all six jurisdictions attended. This conference provided 10.5 Category 1 Continuing Medical Education (CME) hours and 12.6 Continuing Educational Units hours for medical professionals and had approximately 60 attendees. The program has seen improvements from all family planning projects in meeting the requirements of the grant program as a result of knowledge gained during the training.

- Continued providing technical assistance support to the Hawaii State Department of Health to conduct Domestic Violence/Interpersonal Violence Trainings, facilitated through the Domestic Violence Action Center and open to all family planning clinics throughout the state. The agenda included a brief introduction to the dynamics of domestic violence/intimate partner violence, assessment tools, screening, and developing a safety plan for clients at risk. There were 13 trainings hosted and 313 staff members were in attendance at all of these trainings.

- Supported a two-day Family Planning and Reproductive Health Conference in Hawaii for local clinical staff. There were 99 attendees. The conference offered 15 Category I CME hours.

The Office of Pacific Health

The Office of Pacific Health addresses Native Hawaiian and Pacific Islander (NH/PI) issues in Hawaii and the six U.S. Affiliated Pacific Island Jurisdictions (American Samoa, Guam, Commonwealth of the Northern Mariana Islands, the Marshall Islands, Palau and the Federated States of Micronesia (FSM)—Pohnpei, Chuuk, Kosrae and Yap). Types of technical assistance (TA) and consultation in FY 2012 included:

- TA and consultation as part of a federal team to address the dengue fever epidemics in the Marshall Islands and Yap, including helping to initiate the provision of just-in-time dengue continuing education through the CDC dengue fever branch, and to address Hansen’s disease (leprosy) epidemics in the Marshall Islands and the FSM;

- TA and consultation to Hawaii’s Fair Share Initiative’s Grants Hui to increase knowledge of and success in Federal funding competitions, in particular for NH/PI populations;

- TA to the Pacific Island collegiate nursing program directors resulted in the successful submission of two grants and two contracts to address nursing education in the Pacific, holding four workshops, the initiation of a regional nursing education strategic plan and a Department of Interior-HHS partnership initiative;

- TA and consultation to the Veterans Administration’s Pacific Island Health Care System (VAPIHCS) (Hawaii and the Pacific) to improve access to culturally appropriate care (the VAPIHCS successfully competed for a rural health grant);
• TA to providers serving rural NH and resulted in a federally-designated Rural Health Clinic on the Island of Hawaii;
• Meeting with a representative from New Zealand’s National Institute for Health Initiatives to work on proposals for collaborative activities between New Zealand/HHS and American Samoa/Samoa in the areas of non-communicable disease prevention and tobacco cessation; OMH and Office of Women’s Health regional consultants also participated in the meeting; and
• TA and consultation to the ministers of health in the freely associated states, the secretaries of health in the territories, the Pacific Island Health Officers Association, and the HHS Native Hawaiian and Pacific Islander Stakeholders Group.

Office of the Surgeon General
The Office of the Surgeon General (OSG) provides Americans the best scientific information available on how to improve their health and reduce their risk of illness and injury. The Office also manages the operations of the Commissioned Corps of the U.S. Public Health Service (USPHS).

Public Health Missions
Rosebud Community Health & Services Mission (CHASM) – ‘Operation Fortitude’ More than 60 Commissioned Corps officers deployed on a CHASM to Rosebud, South Dakota in 2012. Eight days of public health work and partnership involved nearly 2,000 patient encounters, 30 percent of which were pediatric patients. USPHS officers provided medical, dental, veterinary, optometry, and pharmacy services estimated at $250,000 and all pediatric patients seen received a full immunization update; completed a policy review and re-write of a Corrective Action Plan to Centers for Medicare and Medicaid Services (CMS) permitting the Rosebud Service Unit to maintain CMS accreditation and to bill Medicaid and Medicare for services; completed six days of Let’s Move in Indian Country initiatives; developed a “Psychological First Aid Kit” approved for dissemination by the Tribe; produced nearly eight hours of recorded public health information to be used by the local radio station; and conducted a HIV survey across entire community.

OSG provided in-kind support to fill an urgent Public Health need at the Crow/Northern Cheyenne Hospital in the Indian Health Service Billings Area. The Crow/Northern Cheyenne Hospital serves two reservation communities with a population of over 13,000 AI residing in this rural/frontier area. Located on the Crow Nation Reservation the hospital was experiencing a Public Health crisis with the recent loss of key medical and nursing staff from extremely hard to fill positions. Eight FTE’s were provided for a 28 day period to augment staff while full time replacements were sought.

OSG provided in-kind support to the United States Coast Guard for Operation Arctic Shield 2012. Arctic Shield was a multi-mission deployment in the Arctic and Northwest region of Alaska between March and November 2012. The initiative was a follow on to a similar deployment called Operation Arctic Crossroads based in Nome, Barrow, and Prudhoe Bay, Alaska in 2009, 2010, and 2011. OSG deployed six full-time employees for a 45 day period to include veterinarians, podiatrists, and optometrists in support of Arctic Shield, each of whom
were instrumental in helping forge stronger relationships with native Alaska communities of Barrow, Kotzebue, Kaktovik, and Nuiqsut.

**The Office on Women's Health**
The Office on Women's Health (OWH) mission is to provide leadership to promote health equity for women and girls through sex/gender-specific approaches. The strategy OWH uses to achieve its mission and vision is through the development of innovative programs, by educating health professionals, and motivating behavior change in consumers through the dissemination of health information.

In October 2010, as part of the OWH Coalition for a Healthier Community Grant Initiative, the Utah Department of Health conducted two hands-on foot exam trainings for American Indian medical professionals (medical assistants, nurses and other medical staff). These trainings involved hands-on learning techniques for conducting proper foot exams for patients with diabetes. Thirty-two participants, representing six tribes, attended one of the two trainings. As part of the OWH Coalition for a Healthier Community Grant Initiative, the Utah Navajo Health System, Inc. (UNHS) collaborated with its Sweet Success Program in partnership with Utah Women’s Health Information Network-UWIN.

**Project Connect**
Project Connect is a national initiative to improve the healthcare response to violence against women by building partnerships between the public health and domestic violence fields. Key components of the program include creating multidisciplinary leadership teams to create policy and system change, training health care providers on implementing a brochure-based clinical intervention to assess for Intimate Partner Violence (IPV) and reproductive coercion, creating and disseminating culturally relevant patient education materials on the connection between health and experiencing violence, and program evaluation of the impact of health-based IPV interventions. Five health sites serving Native communities were selected for Project Connect for funding in FY 2012:

- Little Traverse Bay Bands of Odawa Indians (MI)
- Nooksack Tribal Health Clinic (WA)
- Passamaquoddy Health Center (ME)
- The Queen’s Medical Center (HI)
- Washoe Tribe of Nevada and California (NV)

Native-specific patient education materials and provider training materials were provided. As part of the Project Connect grantee cohort, these teams receive ongoing technical assistance, including monthly technical assistance calls and ongoing email communication with each team, as well as quarterly webinars, email listservs and bi-annual national meetings with all of the sites. Yearly site visits, which include a leadership team meeting and provider training, were also conducted.

K’ima:w Medical Center and Southern Indian Health Council, both in California, created multidisciplinary leadership teams that drafted new clinic protocols for IPV assessment, trained their providers on implementing a brochure-based assessment for IPV and reproductive coercion,
and implemented community events to raise awareness of IPV. K’ima:w Medical Center continued to participate in the initiative, acting as a mentor to the new Native health sites.

**The Health and Wellness Initiative for Women Attending Minority Institutions**

Northeastern State University (Tahlequah, OK) via the National Indian Women’s Health Resource Center and Northwest Indian College (Bellingham, WA) was awarded grant funds to collaborate with student organizations, academic and administrative departments, local health service providers, and community- and faith-based organizations to foster a culture of health, wellness, and safety for the entire campus community. Each institution conducted at least six student-driven women’s health activities in the areas of sexually transmitted infections (STIs), violence against women, overweight/obesity, heart disease, diabetes, reproductive health, substance use and abuse, autoimmune diseases, nutrition, and dental health. The Northwest Indian College hosted a women’s health conference for students and the tribal community. Each school also conducted several student-driven events for National Women and Girls’ HIV/AIDS Awareness Day and National Women’s Health Week. The initiative also engaged men to be partners in the prevention of violence against women.

**In Community Spirit**

First Nations Community HealthSource’s (FNCH) HIV Program provided HIV testing and counseling and HIV prevention education to high risk AI/AN women and men in the Albuquerque and Gallup, New Mexico areas. The Albuquerque urban Indian community is richly diverse with representation of more than 250 tribes. HIV testing and counseling and HIV Prevention education (using adapted DEBI interventions) was provided to AI/AN ages 18 and older. Outcomes were: 45 AI women participated in the Sisters Informing Sisters about Topics on AIDS (SISTA) sessions, 292 AI women, men, and transgender men and women were tested for HIV/STDs, and 51 AI/AN women were referred for support services such as mental health, traditional healing, social services, emergency financial assistance, Medicaid enrollment, case management, and other services.

The Center for Prevention & Wellness (CPW), Salish Kootenai College in Pablo, Montana provided support to Fort Belknap Indian Reservation, youth (Assiniboine and Gros Ventre Peoples). The Native Women HOPE (Honoring an Opportunity to Prevent & Empower) intervention was facilitated on the reservation, with booster sessions in December 2012. Rapid HIV tests were administered to all participants. In FY 2012, Native Women HOPE reached 100 women of 20 different tribes representing both the United States and Canada. In addition, some participants were NH/PI. Due to the Center for Prevention & Wellness location; Salish Kootenai College, the intervention was able to reach a wide range of ethnicities (including NH/PI, Black/African American). Changes the CPW efforts influenced in the community:

- Increased screenings and testing. The CPW has been a mainstay on campus allowing women services for HIV and STD/STI screenings as well as reproductive health. Through partnerships with agencies, there are reproductive health services offered on campus twice a month.
- Increased awareness about HIV/AIDS through Native Women HOPE intervention, Women 4 Wellness, outreach efforts, and capacity building, increased participants’ knowledge and eased many fears about HIV/AIDS.
The Inter Tribal Council of Arizona (ITCA) in partnership with the tribes focused on implementing the completed NA SISTER curriculum and tailored the project to their communities. The project was significant because it addressed the need for culturally appropriate evidence-based intervention models to be implemented in tribal communities. Each tribe tailored the curriculum to their community. For example, the Pascua Yaqui Tribe now calls their Project, “Sewa Hamut” which means Flower Woman. The Hopi Tribe also gave their project a Hopi name to reach more participants. Facilitators taught some parts of the sessions, specifically sessions one and two in their own native language. The curriculum also consisted of AI poems authored by native women. Some of the tribes collaborated with the Language and Culture Department and elders from their communities to assist in the traditional learning techniques. There were a total of 65 women who completed all six sessions of the curriculum and booster sessions. At least another 60 women were provided HIV/AIDS information, by attending at least one session.

The Planned Parenthood Minnesota, North Dakota, and South Dakota Education and Outreach Department worked with a total of 363 AI from the Fond du Lac Band of Lake Superior Chippewa, Red Lake Band of Chippewa Indians, White Earth Nation, and Leech Lake Band of Ojibwe, Bemidji, Cass Lake, and Ball Club to conduct 30 education and intervention programs. Outreach events reached a total of 2,156 AI. Planned Parenthood coordinated with the school districts that serve AI youth to offer a school-based HIV prevention education curriculum (Taking Shape) to sixth through twelfth graders. Planned Parenthood and its collaborating partners provided 137 HIV tests to its AI program and outreach participants. Planned Parenthood offered blocked (specifically set aside time) clinical visits for AI program participations who are residents at collaborating organizational partnerships under OWH funding.

The National Native American AIDS Prevention Center (NNAAPC) provided support to the Native American Interfaith Ministries (NAIM) that serves the Lumbee Nation in North Carolina, to conduct a comprehensive community assessment on predominant attitudes about HIV and AIDS risk creating a locally tailored social marketing campaign. The outcome of this support included an assessment report that was released to the local HIV prevention education sites, member churches, and community partners. NNAAPC used community assessment data collected with NAIM to create targeted messages and materials for a locally tailored, Native-specific own social marketing campaign. The outcome was that approximately 5,000 Native community members would be exposed to Native-specific, and scientifically sound HIV prevention messaging.

NNAAPC provided support to Tewa Women United (TWU) that serves the eight Northern Pueblo nations of northern New Mexico to a comprehensive community assessment on predominant attitudes about HIV and AIDS risk. The outcome of this support included a report that was released to the agency staff, agency Board, and community partners. NNAAPC used the community assessment data from TWU to create targeted messages and materials for a Native (Pueblo)-specific social marketing campaign focused on young Native women and condom utilization. Approximately 1,000 youth were exposed to these HIV prevention
messaging efforts through diffusion at local youth events and community social hubs. In FY 2012, assistance included NNAAPC traveling to TWU's offices in New Mexico and leading a day-long workshop and TA session to adapt and incorporate the Native Women Speaking curriculum into TWU's teen pregnancy prevention program. Outcomes include increased knowledge of HIV prevention and contraception methods to decrease teen pregnancy.

NNAAPC provided support to Sacred Spirits that serves the White Earth Indian Reservation in Minnesota to conduct a comprehensive community assessment on predominant attitudes about HIV and AIDS risk. The data was used to create targeted messages and materials for their own social marketing campaign which were used at their community mobilizing events. Social marketing messages have been disseminated to approximately 22,000 people living on the reservation.

NNAAPC provided support to MAMA Knows, Inc. that serves the Choctaw and Chickasaw Nations of Oklahoma to conduct a comprehensive community assessment on predominant attitudes about HIV and AIDS risk. Additionally, NNAAPC provided support to a Denver-based community coalition that serves the local AI community to conduct a community educational event. Outcomes of this support included the diffusion of social marketing materials and prevention materials and the garnered support of the Denver City Council (by means a city proclamation). Overall, approximately 500 people attended the event and 30 people were tested for HIV.

In FY 2012, NNAAPC provided TA to Alaska Native Tribal Health Consortium (ANTHC) in Anchorage, AK, to provide a session about HIV/STD Women’s Health Training Conference on how Counseling, Treatment, and Referral Services could be designed and tailored to be AN and gender specific. Outcomes included the ANTHC implementing the trainings to better able them to counsel at risk women.

Sage Associate, Inc. facilitates the “BeLieving In Native Girls” (BLING) Program which works in Riverside Indian School, an off-reservation boarding school that serves students from 75 federally recognized tribes. The tribes most represented in the student population are San Carlos and White Mountain Apache, Lakota from Pine Ridge and Rosebud reservations, Zuni and Navajo, Oglala Sioux, Omahas from Nebraska, and Seminoles from Florida. The Riverside Indian School is located in Caddo County, OK, with a population of 25.3 percent AI/AN. The county is also the capital of eight federally recognized tribes: Caddo, Kiowa, Comanche, Apache, Wichita, Delaware, Cheyenne, and Arapaho. The Riverside Indian School has a regular enrollment of about 550 students, and has 11 dorms to accommodate residential programming.

In 2012, “BeLieving in Native Girls” had an enrollment of 93 adolescent girls, with on-going programming to increase protective factors. As part of this programming, SAGE worked with staff to increase knowledge and awareness about sexual behaviors, anger management, and suicide prevention. We dedicated about 200 hours of staff time on site at the school each month, or the equivalent of 2.5 full-time employees. In addition to staff time, BLING developed a sponsorship program for students attending the school from families with severe economic
hardships. Sponsors contributed over $3,600 to assist 47 students financially during the school year.

BLING successfully advocated for students from tribes outside of Oklahoma to be included in the SoonerCare Medicaid program and worked with the State of Oklahoma to extend the National Resource Center for Youth, Independent Living Program to AI/AN students. That program is now part of the school practices for foster care youth. BLING also coordinated a meeting between Anadarko and Riverside staff and representatives from the Museum of Cultural Arts Houston to discuss public space art for the school campus and the City of Anadarko.

Funding Opportunities Available to Native Americans in FY 2009 through FY 2012

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**ASSISTANT SECRETARY FOR PLANNING AND EVALUATION**¹

The Assistant Secretary for Planning and Evaluation (ASPE) advises the Secretary of HHS on policy development in health, disability, aging, long-term care, human services, science and data, 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 does not provide or fund services and it does not have programs that serve American Indians, Alaska Natives, or other Native Americans (AI/AN/NA). A number of ASPE’s research, evaluation, and other activities are beneficial to AI/AN/NA people and to Indian Tribes. However, they are not the types of activities where ASPE is able to quantify the benefits that go directly to the tribes. The following is a brief summary of some of the ASPE activities related to tribes.

Support Provided to Native American Communities in FY 2009 through FY 2012

¹ ASPE did not submit a response to this report for FY 2012.
In FY 2009, ASPE conducted a research study entitled *Characteristics of American Indians and Alaska Natives (AI/ANs) Participating in Temporary Assistance for Needy Families Programs (TANF)*. The purpose of this study was to gain a greater understanding of the characteristics and participation of AI/ANs in state and tribal TANF programs over time. Administrative caseload data submitted to HHS by state and tribal programs were used to obtain a full picture of the caseload sizes and characteristics of these populations. Additionally, trends in AI/AN participation were compared with trends in the non-Indian state TANF populations. A Research Brief has been posted on the ASPE website: [http://aspe.hhs.gov/hsp/09/AI-NA-TANF/rb.shtml](http://aspe.hhs.gov/hsp/09/AI-NA-TANF/rb.shtml).

ASPE staff completed a project examining the feasibility of an AI/AN suicide prevention hotline. The project involved a literature review on AI/AN suicide and discussions with 13 federal and nonfederal experts in the area of AI/AN suicide prevention. The report has been posted on the ASPE web site: [http://aspe.hhs.gov/hsp/09/AIAN-SuicidePreventionHotline/index.pdf](http://aspe.hhs.gov/hsp/09/AIAN-SuicidePreventionHotline/index.pdf).

The HHS Data Council was formed to provide a forum and advisory body to the Secretary on health and human services data policy and to coordinate data collection and analysis activities. The Council consists of senior level officials designated by their Agency and Staff office Heads, The Director of the National Center for Health Statistics, and the HHS Privacy Advocate/Expert. It meets monthly and is co-chaired by the Assistant Secretary for Planning and Evaluation on a permanent basis and the Head of an Operating Division on a rotating basis. The current Co-Chair is the Agency for Healthcare Research and Quality. ASPE provides the Council’s executive secretariat and coordinates the activities of working groups of the Council. ASPE is a member of the Data Council’s Working Group on Race and Ethnicity. This Working Group has implemented a HHS minority data Web site at [http://www.hhs-stat.net/omh/index.htm](http://www.hhs-stat.net/omh/index.htm), which is linked to the HHS Gateway to Statistics Web site.

The National Committee on Vital and Health Statistics (NCVHS) serves as the statutory public advisory body to the Secretary in the area of health data and statistics. ASPE staffs the NCVHS which has a Subcommittee on Populations. One of the main focuses of this Subcommittee is on racial and ethnic health data needs including data needs pertaining to AI/AN/NAs.

In FY 2010 and 2011, ASPE staff developed and published the final methodology and calculated annual federal funding matching rates for fiscal years 2010 through 2012 for Indian tribes that participate in foster care, adoption assistance, and kinship guardianship programs authorized under title IV-E of the Social Security Act and administered by the Administration for Children and Families. These matching rates apply to tribes operating programs directly or through title IV-E agreements or contracts with the states in which they are located. The matching rates are calculated based on a statutory formula that derives from the per capita income of the tribe. Federal matching rates for tribes are typically higher than those for states.

Medical advances and new technologies have provided people in America with the potential for longer, healthier lives more than ever before. However, persistent and well-documented health disparities exist between different racial and ethnic populations and health equity remains elusive. Health disparities — differences in health outcomes that are closely linked with social,
economic, and environmental disadvantage — are often driven by the social conditions in which individuals live, learn, work and play. In FY 2011, ASPE collaborated with the Office of the Assistant Secretary for Health to develop the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*. This Plan outlines goals and actions HHS will take to reduce health disparities among racial and ethnic minorities and reflects the Department’s commitment to continuously assess the impact of all policies and programs on racial and ethnic health disparities. It will promote integrated approaches, evidence-based programs, and best practices to reduce these disparities. The HHS Action Plan builds on the strong foundation of the Affordable Care Act and is aligned with programs and initiatives such as Healthy People 2020, the First Lady's *Let's Move* initiative and the President's National HIV/AIDS Strategy.

**ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE**

The Assistant Secretary for Preparedness and Response (ASPR) serves as the HHS Secretary’s principal advisory staff on matters related to bioterrorism and other public health emergencies. ASPR also coordinates interagency activities between HHS, other federal departments, agencies, and offices, and state and local officials responsible for emergency preparedness and the protection of the civilian population from acts of bioterrorism and other public health emergencies.

Since ASPR is not a service agency, it does not have programs that serve Native Americans specifically. The following is a brief summary of some of the activities and projects supported by ASPR that are pertinent to Native American communities.

**Support Provided to Native American Communities in FY 2009 through FY 2012**

**Regional Public Health Preparedness Project for Special Populations**

The Region 1 (New England) Office of Public Health and Science (OPHS) and the Assistant Secretary for Preparedness and Response (ASPR) initiated a regional public health preparedness project to identify, prioritize, and plan for the needs of at-risk populations. With state and tribal partners, OPHS and ASPR identified and addressed priorities in emergency preparedness for medically fragile, vulnerable, and other populations with functional needs. Recognizing that significant work had been done to address these issues in individual jurisdictions within the region during recent years, the region’s goal was to collaborate with regional partners in the states and tribes to establish priorities for preparedness on a multi-jurisdictional, regional basis. To accomplish this in a meaningful way, states and tribes were asked to participate in an orientation conference and subsequent questionnaire. This situational assessment assisted OPHS

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2 ASPR did not submit a response to this report for FY 2010, 2011 or 2012.
and ASPR in providing Region 1 partners with the support they need from federal agencies, as well as to promote information sharing and planning at the regional level.

**ASPR Region 9 Participation in NAAEP Meetings on Building Surge Capacity**
In June 2009, the Native American Alliance for Emergency Preparedness (NAAEP) held a series of meetings in California on Building Surge Capacity for Emergencies or Disasters for California Indian Health Clinics, tribes, Emergency Responders, and Public Health Departments. An ASPR Regional Emergency Coordinator from Region 9 attended all three meetings and presented on the National Response Framework, types of federal emergency/disaster declarations, federal health and medical capabilities, and the national strategy for pandemic influenza preparedness and response.

**ASPR Participation in FEMA Preparedness Grants Stakeholder Conference**
In 2009, ASPR’s State and Local Initiatives Team attended FEMA’s Preparedness Grants Stakeholder Conference. The purpose of this conference was to solicit state, local, tribal, port personnel, and other stakeholder input and feedback on the overall FY 2009 grant process and to outline suggestions and considerations for FY 2010 and beyond. Seven tribes and one tribal consortium attended the conference. FEMA’s tribal liaison invited ASPR’s State and Local Initiatives Team to coordinate and work with FEMA on integrating tribal preparedness activities into national preparedness.

**Office for Civil Rights**
The Office for Civil Rights (OCR) promotes and ensures that people have equal access to and the opportunity to participate in and receive services from all HHS-funded programs without facing unlawful discrimination, and that the privacy of their health information is protected. Through prevention and elimination of unlawful discrimination and by protecting the privacy of individually identifiable health information, OCR helps HHS carry out its overall mission of improving the health and well-being of all people by its many programs.

**Technical Assistance Provided to Native American Communities in FY 2009 through FY 2012**
In FY 2009 through FY 2012, OCR conducted several technical assistance and outreach activities to Native Americans on major civil rights laws such as Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
Through OCR’s technical assistance and outreach activities, Native American populations become aware of their rights to nondiscrimination under the Federal civil rights laws, as well as their rights under the HIPAA Privacy Rule. The following are examples of OCR’s technical assistance and outreach work activities.
An OCR attended a meeting on the reservation of the Poarch Creek Band of Indians in Atmore, Alabama, in November 2008. Approximately 30 people were in attendance, including four tribal council members. OCR gave a presentation on Title VI of the Civil Rights Act of 1964 and the Hill-Burton Act, and distributed fact sheets.

In April 2009, OCR participated in the 2009 HHS Region VI Tribal Resource Consultation Session held at the Indian Pueblo Cultural Center in Albuquerque, New Mexico. The OCR acting regional manager oriented the audience to HHS programs and introduced the HHS representatives. An OCR Equal Opportunity Specialist served on a consultation panel where she informed the audience about OCR’s mission, jurisdiction, legal authorities, and commitment to ensure equal opportunity for all when accessing the services and programs administered by covered entities, including special needs Navajo populations.

OCR participated in the HHS Joint Regional Consultation in Louisiana, in May 2009. The OCR Region IV manager gave a presentation on the Health Information Technology for Economic and Clinical Health Act.

In June 2009, OCR accompanied other HHS officials on a visit to provide outreach to the Mississippi Band of Choctaw Indians in Philadelphia, Mississippi. The OCR representative gave an overview of federal civil rights laws and the HIPAA Privacy Rule.

OCR exhibited at the Indian Health Summit in Denver, Colorado in July 2009. The Summit is a national gathering of American Indian health professionals and administrative leadership, community health advocates, and tribal leadership. An estimated 1,000 people attended the Summit. OCR answered participants’ questions and distributed information related to OCR’s enforcement of the HIPAA Privacy Rule, Title VI of the Civil Rights Act of 1964, and the rights of persons who are limited English proficient.

OCR in conjunction with a variety of federal, state and other partners, participated in the planning of, and presented at, the Four-Corners Caregivers Conference held at Sky Ute Reservation in Colorado. The event, which had approximately 180 people in attendance, focused on supporting Native American caregivers from the Southern Ute, Mountain Ute, and Navajo Tribes. In August 2009, OCR gave a plenary presentation on HIPAA, conducted a civil rights workshop, and distributed publications.

In August 2009, the OCR Deputy Director for Civil Rights gave a presentation on “The Impact of Civil Rights Laws on Health Care Disparities,” at the Colorado ERACE [“Eradicating Racism and Colorism Everywhere”] conference. The conference was dedicated to reducing health disparities, promoting access and assistance for limited English proficient persons, and eliminating racial and national origin discrimination. The conference’s location was on the Southern Ute Indian Reservation in Ignacio, Colorado; and it attracted tribes from the Four Corners region, including Colorado, Utah, New Mexico, and Arizona. This event was sponsored by the HHS Region VIII Interdepartmental Task Force, a group composed of local, state and federal government agencies, including OCR.
In August 2009, OCR, in conjunction with other HHS OPDIVS, participated in a panel discussion with representatives of the American Indian Community House (AICH) as part of the Department’s outreach efforts to the American Indian community. OCR has an ongoing relationship with AICH, which is a referral agency that provides its constituents with referrals for health issues. As part of the panel discussion, OCR provided information regarding its regulations and compliance and enforcement activities.

OCR staff presented as a panelist at the HUD Office of Native American Programs and the HUD Office of Faith Based and Neighborhood Partnerships in Denver, Colorado in September 2009. This conference, attended by approximately 110 people, was targeted to Native American consumers and faith and community based organizations that provide services to Native Americans. OCR discussed federal civil rights laws, the HIPAA Privacy Rule, and the Security Rule; answered questions from the public; and exhibited at the conference.

In July 2012, OCR provided Privacy and Breach Notification Rule training for Indian Health Services’ (IHS) Aberdeen Area Office (AAO) and the health care facilities IHS oversees. Approximately 200 people participated in the webinar, which IHS recorded and made available nationwide for future reference.

In August 2012, OCR co-hosted the third annual *Pathways to Respecting American Indian Civil Rights Conference* in Denver, Colorado. Twelve plenary and breakout sessions were featured. The sessions focused on education, justice, nutrition, employment, housing, and other topics relevant to urban and on-reservation tribal communities. The conference attracted approximately 300 participants from 10 states and Washington, D.C.

OCR participated in the “Region V Minority Health Interstate and Tribal Data Quality Workgroup.” The Workgroup has a monthly conference call the third Monday of each month. The purpose of the Workgroup is to develop a regional approach to: 1) address gaps in state health data reports with an emphasis on indigenous, racial and ethnic minority populations; 2) exchange information regarding successes and challenges experienced by tribal health and state health departments to resolve minority health data collection, analysis and reporting issues; 3) provide updates on Federal activities/initiatives/policies that are consistent with the goals of the workgroup, state and tribal health entities; 4) standardize racial and ethnic minority health data collection procedures; and 5) share data sources, experiences and expertise to help resolve some of the collection, reporting and dissemination issues of indigenous, racial and ethnic minority populations.
ADMINISTRATION FOR CHILDREN AND FAMILIES

The Administration for Children and Families (ACF), within HHS, had a budget of $50.9 billion in FY 2009, $50.2 billion in FY 2010, and $50.7 billion in FY 2011 and FY 2012. ACF is responsible for federal programs that promote the economic and social well-being of families, children, individuals, and communities. The American Recovery and Reinvestment Act of 2009, P.L. 111-5, appropriated another $10.2 billion to ACF.

ACF works in partnership with American Indian tribes; Alaska Native villages; state and local governments; community organizations; non- and for-profit organizations; the U.S. Territories of Guam, American Samoa, and the Mariana Islands; other Native communities in the United States; and other HHS Agencies.

ADMINISTRATION FOR NATIVE AMERICANS

The Administration for Native Americans (ANA), within ACF, promotes the goal of economic and social self-sufficiency for American Indians, Alaska Natives, Native Hawaiians, and other Native American Pacific Islanders. To achieve ANA’s goal of self-sufficiency and to improve the lives of Native American children and families, community-based project funding is provided through discretionary grants to eligible tribes and non-profit Native American organizations on a competitive basis in the areas of Social and Economic Development Strategies (SEDS), Language Preservation and Maintenance, and Environmental Regulatory Enhancement. In FY 2009, Congress appropriated $47.0 million, for ANA grant projects and training and technical assistance; in FY 2010, $48.8 million, FY 2011, $48.7 million; and in FY 2012, $48.6 million.

Support Provided to Native American Communities in FY 2009 through FY 2012


<table>
<thead>
<tr>
<th>Program Area</th>
<th>FY 2009</th>
<th>FY 2010</th>
<th>FY 2011</th>
<th>FY 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEDS</td>
<td>$28,508,306</td>
<td>$27,049,881</td>
<td>$25,717,993</td>
<td>$24,568,722</td>
</tr>
<tr>
<td>LANG</td>
<td>$9,805,374</td>
<td>$12,260,308</td>
<td>$13,476,956</td>
<td>$14,654,629</td>
</tr>
<tr>
<td>ERE</td>
<td>$2,471,419</td>
<td>$2,350,385</td>
<td>$2,135,245</td>
<td>$1,801,052</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$40,785,099</strong></td>
<td><strong>$41,660,574</strong></td>
<td><strong>$41,330,194</strong></td>
<td><strong>$41,024,403</strong></td>
</tr>
</tbody>
</table>

FY 2009–2012 Report to Congress
As outlined in the Native American Programs Act (NAPA), ANA must evaluate its portfolio at least once every three years. The ANA Division of Policy, Planning, and Evaluation accomplishes this by assessing at least one-third of its closing grant portfolio each year against measures reportable for Government Performance and Results Act (GPRA) compliance. From 2009 to 2011, 71 percent of ANA projects evaluated successfully met or exceeded their objectives, and in 2011 (the first year impact ratings were given in addition to project completion ratings), 73 percent of projects evaluated had a substantial or significantly positive impact in their communities. The following table represents the findings of those impact evaluations for FY 2009 through FY 2012.

<table>
<thead>
<tr>
<th>Impact Data</th>
<th>FY 2009</th>
<th>FY 2010</th>
<th>FY 2011</th>
<th>FY 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projects Evaluated</td>
<td>86 (241)*</td>
<td>70 (232)</td>
<td>73 (222)</td>
<td>64 (187)</td>
</tr>
<tr>
<td>Amount of Funding for Projects Evaluated</td>
<td>$32,601,509</td>
<td>$21,225,344</td>
<td>$33,089,391</td>
<td>$34,506,809</td>
</tr>
<tr>
<td>Jobs Created FTE</td>
<td>402</td>
<td>360</td>
<td>302</td>
<td>273</td>
</tr>
<tr>
<td>Businesses Created</td>
<td>106</td>
<td>36</td>
<td>20</td>
<td>47</td>
</tr>
<tr>
<td>Resources Leveraged</td>
<td>$19,162,326</td>
<td>$6,113,793</td>
<td>$11,395,423</td>
<td>$14,509,127</td>
</tr>
<tr>
<td>Partnerships Formed</td>
<td>1,644</td>
<td>1,114</td>
<td>1,356</td>
<td>1,264</td>
</tr>
<tr>
<td>People Trained</td>
<td>2,762**</td>
<td>2,669</td>
<td>10,272</td>
<td></td>
</tr>
<tr>
<td>Elders Involved</td>
<td>2,610</td>
<td>2,029</td>
<td>5,035</td>
<td>4,211</td>
</tr>
<tr>
<td>Youth Involved</td>
<td>11,757</td>
<td>6,487</td>
<td>21,955</td>
<td>20,917</td>
</tr>
</tbody>
</table>

*(x) = total number of grants in the portfolio for each fiscal year.
** FY 2010 is the first year this data was collected in a standardized format.

Technical Assistance Provided to Native American Communities in FY 2009 through FY 2012

Section 804 of NAPA requires ANA to provide training and technical assistance (T/TA) to communities.

To meet this requirement, ANA contracts T/TA providers in four geographic regions: East, West, Alaska, and Pacific. The T/TA providers are experts in project management, training, and community development, as well as knowledgeable of ANA policies, programs, and the communities served. Additionally, ANA T/TA providers are well-informed of other funding opportunities and partnerships. This information is helpful when shared with ANA grantees for sustainability of the ANA projects.

The T/TA providers conducted three types of training for ANA: Pre-Application, Post Award, and Project Planning and Development (PPD).
TA is provided to communities served by ANA both electronically and through on-site visits. TA is provided during the application stage to review efforts and provide feedback, as well as outreach to unsuccessful applicants to discuss reasons for funding denial and encouraging attendance at ANA trainings for future funding opportunities. Once grantees receive an ANA award, they sometimes meet challenges during the implementation of the project. TA is available to assist grantees in implementing their projects.

In FY 2009, ANA provided 552 instances of T/TA; in FY 2010, 749 instances; in FY 2011, 645 instances; and in FY 2012, 510 instances. Project Development was a new initiative in FY 2009 added to the training conducted by T/TA providers.

ANA has also developed Business Development guides that are free to communities and has posted training manuals for all of the trainings to the ANA website.

### Funding Opportunities Available to Native Americans in FY 2009 through FY 2012

<table>
<thead>
<tr>
<th></th>
<th>FY 2009 Funding</th>
<th>FY 2010 Funding</th>
<th>FY 2011 Funding</th>
<th>FY 2012 Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$40,785,099</td>
<td>$41,543,530</td>
<td>$41,330,195</td>
<td>$41,024,402</td>
</tr>
</tbody>
</table>

### Other Funding Opportunities (Contracts):

ANA contracted with the following Native American organizations:

- **Alaska Summit Enterprises, Alaska (FY 2009 - FY 2010)**
- **ACKCO, Inc., Arizona and Hawaii (FY 2009 - FY 2010)**
- **Oneneka Consulting (FY 2012)**
- **KA‘ANANIʻAU, LLC (FY 2011 - FY 2012)**
- **Native American Management Services, Virginia (FY 2009 – FY 2012)**

Funding levels for these contracts for FY 2009 – FY 2012 were:

<table>
<thead>
<tr>
<th></th>
<th>FY 2009</th>
<th>FY 2010</th>
<th>FY 2011</th>
<th>FY 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$2,632,887</td>
<td>2,404,297</td>
<td>2,445,608</td>
<td>3,044,399</td>
</tr>
</tbody>
</table>

### Administration on Children, Youth and Families

The Administration on Children, Youth and Families (ACYF) is a part of ACF. ACYF administers major Federal programs that support social services promoting:

- positive growth and

**Administration on Children, Youth and Families**

Administration for Children and Families
http://www.acf.hhs.gov/programsACYF
development of children, youth, and their families;
• protective services and shelter for children and youth in at-risk situations;
• child care for working families and families on public assistance;
• adoption for children with special needs; and
• Early childhood education.

ACYF is divided into two bureaus, each of which is responsible for different issues involving children, youth, and families, as well as a cross-cutting unit responsible for research and evaluation. The following discusses the efforts each ACYF Bureau made regarding Native American communities.

CHILDREN’S BUREAU

The Children’s Bureau (CB) seeks to provide for the safety, permanency, and well-being of children through leadership, support for necessary services, and productive partnerships with states, tribes, and communities.

Providing approximately $8 billion in funding every year, CB works with state, local and tribal agencies to develop and implement programs that focus on preventing the abuse and neglect of children in vulnerable families, protecting children and youth from further abuse, and finding permanent placements and connections for those who cannot safely return to their homes.

Support Provided to Native American Communities in FY 2009 through FY 2012

The Stephanie Tubbs Jones Child Welfare Services Program (title IV-B, subpart 1 of the Social Security Act) assists states and tribes to improve their child welfare services with the goal of keeping families together. States and tribes provide services in support of the following purposes: (1) protecting and promoting the welfare of all children; (2) preventing the neglect, abuse, or exploitation of children; (3) supporting at-risk families through services which allow children, where appropriate, to remain safely with their families or return to their families in a timely manner; (4) promoting the safety, permanence, and well-being of children in foster care and adoptive families; and (5) providing training, professional development, and support to ensure a well-qualified child welfare workforce. Services are available to children and their families without regard to income.

The Promoting Safe and Stable Families Program (title IV-B, subpart 2 of the Social Security Act) provides grants to state and eligible tribes to support operation of a coordinated program of family preservation services, community-based family support services, time-limited reunification services, and adoption promotion and support services.

Federally-recognized tribes, tribal organizations, or tribal consortia that are seeking to develop, and within 24 months of grant receipt, submit to the Department a plan to implement a title IV-E foster care, adoption assistance and, at tribal option, guardianship assistance program may apply.
for a one-time Tribal Title IV-E Program Implementation Grant. Funds may be used for the cost of developing a title IV-E plan under section 471 of the Social Security Act to carry out a program under section 470B of the Social Security Act. Examples of areas funds may be used include: data collection systems; cost allocation plan development; financial controls and financial management processes; case planning and case review systems; foster care licensing and standards for tribal foster homes and child care facilities; quality assurance systems, courts, training of child welfare staff, prospective foster and adoptive parents and other stakeholders (e.g. attorneys, Court-Appointed Special Advocates and court staff); coordination with other related tribal or state agencies (e.g. child support enforcement, schools, Medicaid, family assistance).

The Community-Based Child Abuse Prevention Program provides grants to a lead state agency to disburse funds for community child abuse and neglect prevention activities. Funds are used to develop, operate, expand, and enhance community-based efforts to strengthen and support families to prevent child abuse and neglect; foster the development of a continuum of preventive services through state and community-based public and private partnerships; and finance public information activities focusing on the healthy and positive development of families and child abuse and neglect prevention activities. There is a 1 percent set aside that is typically awarded as a grant to tribes or tribal organizations and a migrant program.

In FY 2011, grants up to $138,963 per year for three years were awarded to:
- Confederated Salish and Kootenai Tribes, Pablo, Montana
- Indian Child Welfare Consortium, Temecula, California

The Fostering Connections to Success and Increasing Adoptions Act of 2008 provided for grants of up to $300,000 to be used over a two-year budget period for tribes to develop an approvable Title IV-E Plan. The first round of grantees include:
- Confederated Salish and Kootenai Tribes, Pablo, Montana
- Keweenaw Bay Indian Community, Baraga, Michigan
- Navajo Nation, Window Rock, Arizona
- Sac and Fox Nation, Stroud, Oklahoma
- Tohono O’odham, Sells, Arizona
- Washoe Tribe of Nevada and California, Gardnerville, Nevada
- Confederated Tribe of Siletz Indians, Siletz, Oregon

A second round of grants were awarded September 30, 2010 to:
- The Chickasaw Nation, Ada, Oklahoma
- Lummi Nation, Bellingham, Washington
- The Shoshone-Bannock Tribes, Fort Hall, Idaho
- Yurok Tribe, Klamath, California
The Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351) added a new Section 479B to the Social Security Act allowing Indian tribes the option to apply for federal funding to support the administration of their own foster care, adoption assistance, and guardianship assistance programs under title IV-E of the Social Security Act. Prior to this change in law, tribes could access title IV-E funding only by entering into an agreement with a state.

The first tribal title IV-E program was approved for the Port Gamble S’Klallam Tribe in Kitsap, Washington, effective April 1, 2012.

Funds may be used for the cost of developing a title IV-E plan under section 471 of the Social Security Act to carry out a program under section 479B of the Social Security Act. Examples of areas funds may be used include data collection systems; developing a cost allocation methodology; financial controls and financial management processes; case planning and case review systems; foster care licensing and standards for tribal foster homes and child care facilities; quality assurance systems, courts, training of child welfare staff, prospective foster and adoptive parents and other stakeholders (e.g. attorneys, Court-Appointed Special Advocates and court staff); coordination with other related tribal or state agencies (e.g. child support enforcement, schools, Medicaid, family assistance).

The first seven tribes to receive grants completed the initial two-year grant and submitted drafts of their title IV-E plan preprints for review by CB staff. These grantees requested and were approved for one-year no-cost extensions on their grants to enable them to complete grant activities and to make revisions needed in the plans they have submitted. Tribes in this group include:

- Navajo Nation, Window Rock, Arizona
- Tohono O’odham Nation, Sells, Arizona
- Sac and Fox Nation, Stroud, Oklahoma
- Confederated Salish and Kootenai Tribes, Pablo, Montana
- Keweenaw Bay Indian Community, Baraga Michigan
- Washoe Tribe of Nevada and California, Gardnerville, Nevada
- Confederated Tribes of Siletz Indians, Siletz, Oregon

ACF anticipated being able to approve title IV-E plans for many of the above tribes beginning in the second quarter of FY 2013. Sac and Fox has requested and was approved for an additional no cost extension on the grant to allow them additional time to complete all grant activities. The Tohono O’odham Nation has decided not to pursue title IV-E. The second round of grantees has also requested and were approved for a one-year no-cost extension on their grant. The tribes in this cohort are:

- Lummi Nation, Bellingham, Washington
- Chickasaw Nation, Ada, Oklahoma
- Shoshone-Bannock Tribes, Fort Hall, Idaho
Yurok Tribe, Klamath, California

The first tribal consortium awarded a grant on September 30, 2011 was the South Puget Intertribal Planning Agency, Shelton, Washington.

Grants were awarded on September 30, 2012, to the following five new grantees:

- Winnebago Tribe of Nebraska, Winnebago, Nebraska
- Ute Indian Tribe, Fort Duchesne, Utah
- Smith River Rancheria, Smith River, California
- Muckleshoot Indian Tribe, Auburn, Washington
- Chippewa Cree, Box Elder, Montana

CB’s support to tribal grantees includes regular monthly calls; on-site visits by both regional program and fiscal staff and central office staff; webinars; peer-to-peer calls; specialized technical assistance on information systems and data; and an annual grantee meeting. Three grantee meetings have been held.

The National Resource Center for Tribes (NRC4Tribes) facilitates the bi-monthly peer-to-peer calls that focus on topics identified by the grantees. The National Resource Center for Child Welfare Data and Technology formed the title IV-E Tribal Grantee Group. The group, which includes tribes who have an approved title IV-E plan, have submitted a plan, and those tribes who have a title IV-E development grant, was established to offer guidance, peer-to-peer networking, and a venue for these tribes to learn and discuss considerations for building an information system while ultimately complying with the mandatory data reporting for the Adoption and Foster Care Analysis and Reporting Systems.

CB sponsored two national tribal meetings, “Pathways to Title IV-E,” designed to provide tribes with a deeper level of information about access to direct title IV-E. The Pathways meetings were held in Minneapolis, MN, and Albuquerque, NM, in May 2012. These meetings were designed to focus on tribes that were actively considering direct title IV-E access. All of the 2012 Tribal Title IV-E Plan Development Grantees attended the Pathways meetings.

New Grant Program – Tribal Court Improvement Program

The Child and Family Services Improvement and Innovation Act (P. L. 112-34), which was signed into law on September 30, 2011, created a new Tribal Court Improvement Program (Tribal CIP). The Tribal CIP provides tribal courts and courts for tribal consortia with the opportunity to compete for grants to receive court improvement funds directly. The law allocates $1 million annually for each of fiscal years 2012 through 2016 for competitive grants. Eligible applicants are the highest courts of Indian tribes or tribal consortia that:

1. Are operating an approved title IV–E Foster Care and Adoption Assistance Program;
2. Have been awarded a tribal implementation grant (indicating that they are seeking to implement a title IV–E plan); or
3. Have a court responsible for proceedings related to foster care or adoption.

Tribal CIP funds must be used by tribes and tribal consortia to design and implement projects and/or activities to assess, expand, or enhance the effectiveness of tribal courts and/or legal representation in cases related to child welfare, family preservation, family reunification, guardianship, and adoption. In doing this work, tribal courts are required to engage in and demonstrate meaningful, ongoing collaboration with the tribal social service agencies. Tribal courts can use funds to:

1. Conduct assessments of how tribal courts handle child welfare proceedings and to make improvements to court processes to provide for the safety, permanency, and well-being of children as set forth in the Adoption and Safe Families Act and increase and improve engagement of the entire family in court processes relating to child welfare, family preservation, family reunification, and adoption;
2. Ensure children's safety, permanence, and well-being needs are met in a timely and complete manner (through better collection and analysis of data); and
3. Provide for training of judges, attorneys, and legal personnel in child welfare cases.

Grantees received up to $150,000 for each of the three years beginning in FY 2012. Grantees include:

- Confederated Salish and Kootenai Tribes, Pablo, Montana
- Pokagon Band of Potawatomi Indians, Dowagiac, Michigan
- Navajo Nation Judicial Branch, Window Rock, Arizona
- White Earth Band of Chippewa, White Earth, Minnesota
- Washoe Tribe of Nevada and California, Gardnerville, Nevada
- The Pascua Yaqui Tribe, Tucson, Arizona
- Nooksack Indian Tribe, Deming, Washington

**Technical Assistance Provided to Native American Communities in FY 2009 through FY 2012**

The purpose of the Training and Technical Assistance (T/TA) Network is to build the capacity of state, local, tribal, and other publicly administered or publicly supported child welfare agencies and family and juvenile courts through the provision of training, technical assistance, research, and consultation on the full array of federal requirements administered by the Children’s Bureau. The T/TA Network members provide assistance to states and tribes in improving child welfare systems and conformity with the outcomes and systemic factors defined in the Child and Family Services Reviews and the results of other monitoring reviews conducted by the Children’s Bureau to ensure the safety, permanency, and well-being of children and families. In addition, the T/TA Network is designed to improve child welfare systems and to support states and tribes in achieving sustainable, systemic changes that result in greater safety, permanency, and well-being for children, youth, and families.
The T/TA Network has delivered services to the Native American community through diverse ranges of modalities. Forms of technical assistance that the T/TA Network has provided are: onsite technical assistance, conference presentations, off-site curriculum development, conference calls, webinars, peer to peer, implementation projects, and regional roundtables. Technical assistance that has been provided to the Native American community has ranged from designing and implementing an Indian Child Welfare Act training module for state and tribal welfare workers to tribal child welfare information systems.

Examples of training and technical assistance that have been provided to the Native American community by the T/TA Network are:

- Alabama Coushatta – Tribal Judicial Symposium
- Alaska Child Welfare Disproportionality Reduction Project
- American Samoan Child Welfare and Family Advocacy Branch (CWFAB) – Customized the Reconnect Families database program
- Choctaw – Comprehensive Child Welfare Program Assessment
- Confederated Tribes of Siletz Indians, Inc. – Organizational Assessment and Strategic Plan Development
- North Carolina; Eastern Band of Cherokee – Development and support of collaborative efforts among state and local child welfare and legal communities, tribes and American Indian organizations
- North Carolina; Eastern Band of Cherokee – Coordination of localized "Regional Gatherings"
- Ft. Belknap – Child Welfare Program Assessment
- The Skun-eyah (Garden) Project – to develop and implement a child welfare practice model
- Pueblo of Isleta – Development of policies and procedures
- Little Traverse Bands of Odawa Indians – Michigan Tribal Social Services Coalition Development
- Rhode Island; Narragansett Indian Tribe – ICWA training
- Oglala Sioux (Pine Ridge) – Organizational assessment and strategic plan development
- Rhode Island; Wampanoag of Gay Head – ICWA training
- Spirit Lake – Tribal social services assessment and peer support
- The Shoshone-Bannock Tribes – Case planning roles and responsibilities
- Tlingit-Haida – Foster care and adoption services
- Ute Mountain (Utah Portion) – Ute tribal child welfare systems improvement
- Washoe – Family Group Decision Making
- Ysleta del Sur - Development of policies and procedures for the Ysleta del Sur Pueblo
- Yurok - Tribal Child Welfare Program Development

**Funding Opportunities Available to Native Americans in FY 2009 through FY 2012**
Family and Youth Services Bureau

The mission of the Family and Youth Services Bureau (FYSB) is to promote safety, stability, and well-being for people who have experienced or been exposed to violence, neglect, or trauma. FYSB achieves this through supporting programs that provide shelter, community services, and prevention education for youth, adults, and families. FYSB supports a wide range of comprehensive services and collaborative efforts at the local, tribal, state, and national levels. This report, covering the period between FY 2009 and FY 2012, includes tribal data and information about the following FYSB Programs: Family Violence Prevention and Services (FVPSA); Personal Responsibility Education Program (PREP) and Runaway and Homeless Youth (RHY).

Two programs that no longer exist in FYSB – the Community-Based Abstinence Education Program (CBAE) and the Mentoring Children of Prisoners Program (MCP) – are included for purposes of this report and its requirements.

Our relationship with Native American organizations that are dedicated to increasing the evidence-base for health and wellness has increased. FYSB has also increased linkages with the National Indian Health Board and other regional Indian Health Boards, especially in the area of teen pregnancy prevention.

As part of the Patient Protection and Affordable Care Act of 2010, FYSB received funding for the PREP and a tribal set-aside of 5 percent of total funding, as well as a statutory requirement to consult with tribes and tribal organization prior to developing the program. In summer 2010, FYSB conducted four in-person consultation sessions with tribal leaders, sent out a “Dear Tribal Leader” letter to all of the federally recognized tribes, and conducted a series of calls to obtain input from program directors, staff, and youth who work in the area of adolescent pregnancy prevention. The information gathered from these tribal consultations informed the development of the program parameters for Tribal PREP and influenced the funding opportunity announcement for competitive, discretionary grants that were awarded in FY 2011.
Support Provided to Native American Communities in FY 2009 through FY 2012

Community-Based Abstinence Education Program (CBAE)
Support in FY 2009 included program participation in overall FYSB tribal initiative (initial meeting in July 2009)

Mentoring Children of Prisoners Program (MCP)
In FY 2009, MCP grantees participated in a FYSB-wide tribal strategic planning session

Runaway and Homeless Youth Program (RHY)
In FY 2009 through FY 2012, FYSB served over 4,000 self-identified native youth through its three RHY programs – Basic Center, Transitional Living, and Street Outreach (in both tribal and non-tribal programs).

In FY 2009, FYSB funded a “Support Services for Rural Homeless Youth” demonstration project focused on the coordination of Transitional Living and Independent Living services to young people. Tribes are participating as local community partners in several of the demonstration grants.

Family Violence Prevention and Services Act (FVPSA)
The FVPSA grants to Native American tribes (including Alaska native villages) and tribal organizations are formula grants funded through a 10 percent set aside in the FVPSA appropriation. These grants are primarily for the provision of immediate shelter and supportive services for victims of family violence, domestic violence, or dating violence, and their dependents. In addition, funds may also be used in establishing, maintaining, and expanding programs and projects to prevent domestic violence.

Funding is available to all Native American tribes and tribal organizations that meet the definition of “Indian tribe” or “tribal organization” at 25 U.S.C. 450b, and are able to demonstrate their capacity to carry out domestic violence prevention and services programs. In FY 2010, FVPSA awarded $104,015,008 to 198 tribes and tribal organizations; in FY 2011, $12,979,190 was awarded to 141 tribes and tribal organizations; and in FY 2012 $12,931,071 was awarded to 141 tribes and tribal organizations.

Technical Assistance Provided to Native American Communities in FY 2009 through FY 2012

Community-Based Abstinence Education Program (CBAE)
Technical Assistance to tribal grantees included on-site visits from federal staff and T/TA providers; peer mentoring; webinars and other electronic communication. These types of T/TA were provided in FY 2009

Family Violence Prevention and Services Program (FVPSA)
The National Indigenous Women’s Resource Center (NIWRC) was awarded $1,250,000 in FY 2012 to provide TA, training, and resources to enhance the capacity of Native Americans and Alaska native tribes and tribal organizations. The NIWRC works collaboratively with the FVPSA program and other field experts to develop training tools that are responsive to the needs of tribal domestic violence organizations individually and nationally.

Webinar trainings conducted in Fyn2012 included, but were not limited to:

- Working with Women who are Victims of Domestic Violence and Substance Abuse
- How Domestic Violence Impacts Children
- Legal Barriers to Justice for Native Women
- Evidence Based Practices and working with Children Exposed to Violence;
- What is Trauma Informed Work and Why Should We Care?; and
- Tribal Law and Order Act of 2010

NIWRC’s website www.niwrc.org features policy news, available regional and national trainings, newsletters, and webinars.

Additionally, the FVPSA program utilizes several mechanisms to provide grant management TA, training, and support to its tribal grantees. Support is provided on a daily basis by telephone and email; regional conference calls occur monthly; and the grantee conferences and peer mentoring meetings are held annually. The FVPSA program conducts site visits to a minimum of 10 percent of the grantees annually.

In FY 2010through FY 2012, the FVPSA program’s TA, training, and support primarily focused on domestic violence advocacy training; enhanced statewide collaboration and outreach efforts; program sustainability; and introducing FYSB’s concept of evidence-based practices.

Through the support provided, the FVPSA Program increased the number of tribes and tribal organizations reporting in a more unified, substantive, and timely manner; the number of tribal shelters supported by FVPSA; and maintained the number of federally recognized tribes and tribal organizations that receive FVPSA funding.

Mentoring Children of Prisoners Program (MCP)
In FY 2009, technical assistance to Native American communities and those serving native youth and families included site visits by the MCP Support Center and federal staff; tribal-specific regional workshops; Native American-focused sessions at the MCP National Conference; webinars/e-learning opportunities; and other communication such as emails and phone calls from federal project officers.

Runaway and Homeless Youth Program (RHY)
In FY 2009, FYSB’s RHY T/TA provider, Runaway and Homeless Youth Training and Technical Assistance Center (RHYTTAC), provided culturally competent, proactive technical assistance to Native American grantees as well as to those serving Native youth in their
communities. Federal staff have regular contact with their Native American grantees through site visits, telephone calls, webinars, and participation in tribal meetings and consultations. RHYTTAC increased efforts to assist tribes with making linkages in areas of concern to the RHY population and their families (e.g. the issue of youth suicide). RHYTTAC and RHY grantees participated in the tribal strategic planning initiative sponsored by FYSB in FY 2009.

In FY 2009 through FY 2011, the National Runaway Safeline (then known as the National Runaway Switchboard) or NRS – the toll-free hotline for runaway youth and their families – made efforts to reach out to native communities and organizations to raise awareness of NRS services.

Between FY 2009 and FY 2012, the Support Systems for Runaway and Homeless Youth (SSRHY) Program (a demonstration project across FYSB and CB) grantees continued to work with Indian populations within their states, particularly Minnesota, Iowa and Colorado, to increase linkages for rural youth in the areas of education, training, and other services.

In FY 2012, RHY staff worked with the U.S. Interagency Council on Homelessness (USICH) to create an “Intervention Model for Unaccompanied Youth” and worked with the Department of Housing and Urban Development on a joint information collection and management system to improve the count and assessment of RHY populations.

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<tr>
<th>Name of Tribe or Organization</th>
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*CBAE and MCP Programs no longer funded after FY 2009
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Other Funding Opportunities: Grant/Cooperative Agreement – Cangleska, Inc./Sacred Circle Tribal Resource Center in South Dakota funded at $1,178,812 in FY 2009.

Office of Child Care

The Office of Child Care (OCC) supports low-income working families by providing access to affordable, high-quality early care and after-school programs. OCC administers the Child Care and Development Fund (CCDF) and works with state, territory, and tribal governments to provide support for children and families juggling work schedules and struggling to find child care programs that will fit their needs and prepare children to succeed in school.

The Child Care and Development Fund (CCDF), authorized by the Child Care and Development Block Grant Act (CCDBG) and Section 418 of the Social Security Act, makes block grants available to states, territories, and tribes to assist low-income families, families receiving temporary public assistance, and those transitioning from public assistance in obtaining child care so they can work or attending training/education.

CCDF grantees can also use funds to improve the quality of care to support children’s healthy development and learning by supporting child care licensing, quality improvements systems to help programs meet higher standards and support for child care workers to attain more training and education.

Support Provided to Native American (Tribes, Native Hawaiians and Pacific Island Territories) Communities in FY 2009 through FY 2012

3 The first year for awards for Tribal PREP was FY 2011.
4 Effective FY 2011, the Child Care Bureau separated from the Office of Family Assistance to become the Office of Child Care. Through-out this report we use the Office of Child Care (OCC) for consistency purposes.
The CCDBG Act reserves “not less than 1 percent and no more than 2 percent” of the aggregate CCDF funds for Indian tribes. The Secretary has elected to reserve a two percent set-aside. Annually, the Office of Child Care serves approximately 520 federally-recognized tribes by awarding 260 tribal grants directly to tribes and tribal consortia.

OCC also may reserve up to $2 million from tribal funds for two competitive grants for a Native Hawaiian and an American Indian non-profit organization for the purpose of serving youth who are Indians or Native Hawaiians.

In FY 2011, OCC awarded a three-year discretionary grant to Keiki O Ka ʻAina, a Native Hawaiian non-profit organization, to increase the availability, affordability, and quality of child care programs in areas that have been previously underserved and/or have unmet needs for Native Hawaiian youth.

The CCDBG Act reserves an amount up to one-half of one percent of the appropriated funds for the U.S. Territories of Guam, America Samoa, Puerto Rico, the Virgin Islands, and the Commonwealth of the Northern Mariana Islands. For the purpose of this report, only the Pacific island territories data and activities are reported. The Pacific island territories include: America Samoa, Guam and the Northern Mariana Islands.

The American Recovery and Reinvestment Act (ARRA) of 2009 provided $2 billion in supplemental CCDF Discretionary funds. These funds were in addition to the FY 2009 CCDF Discretionary fund appropriation amount provided through the regular appropriations process. Tribal grantees received two percent ($40 million) from the ARRA CCDF allocation, and territories received one percent ($20 million).

In addition, OCC, in partnership with the Health Resources and Services Administration (HRSA), administers the Affordable Care Act (ACA) Tribal Maternal, Infant, and Early Childhood Home Visiting Grant Program (Tribal MIECHV). This program supports and strengthens cooperation and coordination and promotes linkages among various programs that serve pregnant women, expectant fathers, young children, and families in tribal communities. It results in high-quality, comprehensive early childhood systems in communities, assuring that all individuals can reach their full potential for health and well-being throughout the course of their lives, regardless of their societal context.

Technical Assistance Provided to Native American (Tribes, Native Hawaiians, and Pacific Island Territories) Communities by FY 2009 through FY 2012

Through the Office of Child Care's Child Care Technical Assistance Network (CCTAN) and federal leadership, OCC provided training and technical assistance to states, territories, tribes, and local communities. This involved assessing CCDF grantees' needs, identifying innovations in child care administration, and promoting the dissemination and replication of solutions to the challenges that grantees and local child care programs face. OCC technical assistance helped
states, territories, tribes, and local communities build integrated child care systems that enabled parents to work and promoted the health and development of children.

Federal regulations [45 CFR Section 98.60(b)(1)] provide a set-aside of one-fourth of 1 percent (.25 percent) of the Child Care and Development Fund (CCDF) for the purpose of providing technical assistance (TA) to CCDF grantees. In fiscal year 2009, approximately $12 million was provided to meet the TA needs of state, territorial, and tribal CCDF grantees. Also in FY 2009, an additional $5 million in one-time ARRA funding was made available for TA activities that will be conducted over a multi-year period. In FY 2012, approximately $13 million was provided to meet the TA needs of state, territorial, and tribal CCDF grantees.

OCC provides a variety of technical assistance and professional development services targeted to support CCDF administrators and their staff in identifying and implementing effective policies and practices that build integrated child care systems to help parents work and to promote the healthy development of young children.

OCC used multiple methods to deliver technical assistance to support tribal grantees in child care capacity-building efforts:

- The Child Care Technical Assistance Network (https://childcare.gov/);
- A toll-free information and referral line;
- On-site technical assistance to grantees;
- Materials development including OCC TA Guides and training documents;
- Support for regional TA activities;
- An annual Administrators Training (basics);
- An annual Tribal Child Care Conference.

In March 2009, OCC developed and conducted intensive CCDF Plan Preprint trainings in each of the ACF regions that included CCDF tribal grantees. This intensive training approach provided participating Tribal CCDF administrators with comprehensive, step-by-step plan completion instruction; on-site writing time with hands-on assistance from the trainers and regional office staff; and training materials and resources to support their continued work on the plan following the training. Nine regional training events were conducted between March and May 2009; a total of 309 tribal representatives participated. As a result of the CCDF Plan training, tribes submitted more substantive and complete tribal plans that required less follow-up by OCC staff than prior years.

In September 2009, the Tribal CCDF Management Institute (TMI), “Accountability in Tribal CCDF Programs: Effective Fiscal and Program Management” was conducted to provide training to Tribal CCDF administrators and fiscal staff on CCDF financial and program management issues including timely and accurate federal reporting requirements. There were also special sessions on the reporting and use of one-time ARRA funding. There were 402 conference participants.
At the TMI, a new publication, *Tribal CCDF Guide to Financial Management, Grants Administration, and Program Accountability* was provided to participants. The focus is fiscal administration and accountability issues related to the tribal CCDF program, including basic financial management and grants management principles.

In May 2010, the Tribal CCDF new administrators training was held. This training provided 59 CCDF administrators, fiscal officers, tribal leaders, and key program staff, an opportunity to gain knowledge and skills related to the administration of their CCDF grants. Training sessions focused on eligibility, fiscal and program accountability, reporting, payment rates, sliding fee scales, and quality activities. Immediately following this training was the annual National American Indian/Alaska Native Child Care Conference with 514 tribal registrants attending. Session topics included health and safety, culturally relevant curriculum, emergency preparedness, data systems, classroom management, family/friend and neighbor care, monitoring, program integrity, and supporting the care of infants and toddlers.

In July 2010, technical assistance (TA) was provided through multi-regional efforts to address the unique issues facing tribal child care centers. The training design was developed in partnership with OCC regional managers and the Tribal Child Care Technical Assistance Center, to support Tribal CCDF administrators who manage tribally operated centers to build administrative skills related to Tribal CCDF program operation. Administrators had an opportunity to share best practices and to increase competencies to successfully meet the challenges of managing a center. The outcomes for the training were to increase administrators’ knowledge and expertise in preparing a CCDF budget, monitoring staff professional development, implementing health and safety standards, and to develop ideas for sustaining a quality program.

In July 2010, OCC conducted two pre-conference calls on the proposed changes to the Child Care and Development Fund (CCDF) Tribal Plan Preprint with over 120 tribes. The purpose of the calls was to obtain input and recommendations from the tribes. The proposed plan preprint marked the first revision since 1997 when the Tribal CCDF preprint was submitted as a separate document from the states. The goal of the revision was to enable grantees to provide information on their plans and activities to use CCDF funds to provide quality child care that meets the needs of children and families in tribal communities.

In FY 2010, OCC convened a number of regional technical assistance meetings, including the following:

- A training on “Policies and Procedures for Health, Safety and Quality” conducted in August 2010. The three-day workshop focused on assisting CCDF administrators in developing and revising health and safety policies and improving the quality of tribal child care. Tribal administrators toured and observed three local early childhood programs that participated in a Quality Rating Improvement System.

- Training to seven tribes, in FY 2010, on program development. The TA topics included tracking and reporting of grant funds, health and safety issues, and ideas for building
quality early childhood programs. The training was designed so that these tribes could both enhance their CCDF programs and share best practices with other tribal programs.

In FY 2010 and FY 2011, the Tribal CCDF new administrators training provided 116 tribal representatives an opportunity to gain knowledge and skills related to the administration of their CCDF grants. Training focused on program eligibility, fiscal and program accountability, reporting, payment rates/sliding fee scales, and quality activities.

In April and May 2011, OCC conducted regional and multi-regional training sessions on the revised CCDF tribal plan. The content was comprehensive, allowing the 246 participants to review each section of the new plan. Group discussions took place on key topics including market rate surveys, sliding fee scales, and health and safety standards.

In April 2011, the National American Indian & Alaska Native Child Care Conference “Pathways to Excellence: Planning the Future of Tribal Child Care”, supported the OCC Pathways and Partnerships for Child Care Excellence. Over 322 tribal representatives attended this event. The workshops were designed to help attendees strengthen program administration, encourage collaboration, enhance program quality, and ensure healthy and safe child care environments.

In June 2011, OCC convened the first National P.L. 102-477 Child Care Conference to address the unique needs of CCDF programs administered under 102-477. The meeting focused on strengthening the integrity of CCDF activities while building a child care subsidy system that is child-focused, family-friendly, and works in partnership with child care providers. The two and a half day event consisted of plenary sessions, training workshops, and open dialogue that focused on supporting the early childhood workforce through improved professional development opportunities.

In August 2011, OCC sponsored a Let’s Move! Child Care in Indian Country at the National Indian Child Care Association (NICCA) Bi-Annual Conference. The track included sessions on: (1) I Am Moving, I Am Learning; an obesity prevention strategy developed by the Office of Head Start to promote children’s healthy development and physical activity through movement, music, and nutrition; (2) Physical Activity Kit (PAK); training conducted by representatives from Indian Health Service that provides an effective and efficient method to package, implement, evaluate, and disseminate culturally appropriate physical activity for American Indian/Alaska Native communities. Seventy-three tribal representatives from participating CCDF tribes completed the training sessions and received certificates of completion. Participants also received information on how to join the Let’s Move! in Indian Country 25,000 Presidential Activity Lifestyle Award (PALA) Challenge.

During FY 2012, OCC developed, through consultation with the tribes, a framework for the Tribal CCDF Peer Learning and Leadership Network (PLLN). This Network provided intensive training and support to 14 emerging tribal child care leaders who are current CCDF administrators or key staff.
In January 2012, OCC conducted training with five new Tribal CCDF grantees on the administration of the CCDF program. Topics included a CCDF overview, the CCDF Plan, and Plan Amendment requirements, and fiscal administration.

In February 2012, representatives from the OCC’s Technical Assistance Network including the Child Care State Systems Specialist Network and National Center on Tribal Child Care Implementation and Innovation (NTC) conducted a site visit with the Jemez Pueblo child care administrator. During the visit, the state systems specialist and NTC facilitated a meeting between the Jemez Pueblo Child Care program and New Mexico’s CCDF Lead Agency and the Children Youth and Families Division (CYFD). The meeting resulted in a partnership between the State of New Mexico and Jemez to assist the Jemez Child Care Center in meeting new State licensing regulations. The Jemez Pueblo Child Care Center is now a two-star licensed facility for New Mexico.

In March 2012, OCC hosted the first Parent Engagement in Indian Country Webinar Series, with child care providers from over 25 tribes. In the first webinar, tribal grantees learned how to use social media to engage parents in the early care and education of their children. During the second webinar, participants learned strategies to manage messages on the Internet about their tribal child care programs. The final webinar featured a step-by-step guide to making sure parents can find the grantees’ tribal child care programs on the Internet. Participants learned how to rank their tribal child care programs in the top 20 search engine results. Materials from the webinar series can be found at: http://taevents.occ-cmc.org/region5/parentengagementwebinars.

In June 2012, OCC worked with OCC’s National Center for Data and Technology (NCDT) to hold two webinars for new tribal administrators. The two-part activity provided an overview of the data reporting requirements for the ACF-700 report and a demonstration of the Tribal Data Tracker.

In July 2012, OCC sponsored the biennial National American Indian/Alaska Native Child Care Institute with 227 participants in attendance. The Institute consisted of five tracks, which included Let's Move! Child Care, Program Administration, Advanced CCDF Program Administration, Professional Development and Program Quality, and Health and Safety. Through collaborative efforts with United Tribes Technical College (UTTC), participants of the Institute earned CEUs for the training sessions. OCC and UTTC worked out an agreement for tribal participants to earn CEUs for future OCC CCDF approved training activities.

In September 2012, OCC conducted an “I Am Moving, I Am Learning (IMIL)” train-the-trainer session for 13 tribes throughout Region VIII. Cherokee Nation of Oklahoma IMIL trainers conducted the three-day IMIL training. Twenty-one individuals completed the training and received a certificate and CEUs from the United Tribes Technical College. Following the training, the regional office provided IMIL CDs for each participating tribal program to support the tribes’ ability to implement IMIL in their individual programs.
In September 2012, ACF’s Office of the Deputy Assistant Secretary for Early Childhood Development in collaboration with the Office of Child Care, Office of Head Start, and the Children’s Bureau launched the Tribal Early Learning Initiative (TELI). The purpose of TELI is to support tribes to fully and effectively coordinate tribal early learning programs to meet the needs of individual tribal communities and to create and support seamless quality early childhood systems across the various programs. Four tribes are participating in TELI: Choctaw Nation of Oklahoma, White Earth Band of Chippewa in Minnesota, Pueblo of San Felipe in New Mexico, and Confederated Salish and Kootenai Tribes in Montana. Each tribe received FY 2012 single-source program expansion supplements to their Head Start/Early Head Start and Tribal MIECHV grants in order to facilitate their participation.

Also in September 2012, under the Tribal Maternal, Infant, and Early Childhood Home Visiting (Tribal MIECHV) program, 25 grants totaling $10.5 million were provided to tribes (including consortia of tribes), tribal organizations, and urban Indian organizations in FY 2012. This includes $1.5 million for six new grants competitively awarded under the Tribal MIECHV program in FY 2012. Tribal MIECHV grantees are awarded five-year grants (cooperative agreements) to conduct community needs assessments; plan for and implement high-quality, culturally-relevant, evidence-based home visiting programs in at-risk tribal communities; and conduct tribally-driven research and evaluation activities. The larger MIECHV program, which provides grants to states, also provided support to many Native American communities in FY 2012. Of the 48 states currently participating in the MIECHV program, there are currently 10 working directly with 20 Native American communities to develop and implement home visiting programs. A number of additional states, while not funding specific tribal sites, are using their MIECHV funds to support programs in communities with significant tribal populations.

Finally, in September 2012, the region I office worked with the OCC’s National Tribal Center to hold a webinar for the tribal grantees from the State of Maine on the market rate survey, sliding fee scales, and payments rates. The newly appointed state administrator participated in the webinar, which provided an opportunity for cross collaboration among the tribes and state. Currently, several of the tribal grantees use the State of Maine information when setting their fee scales and rates.

*Territories*5

Similar to Tribal CCDF grantees, the territories receive TA through the OCC’s Child Care Technical Assistance Network (CCTAN), which is comprised of nine projects that provide information, training, and technical assistance to help CCDF grantees and their partners administer CCDF funds and programs. In addition, many CCTAN partners provide information and outreach to parents, child care providers, institutions of higher education, federal agencies, and national organizations. CCTAN partners also provide direct consultation and TA to CCDF administrators and child care stakeholders in states, territories, and tribes.

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5 For purpose of this report Territories include the Pacific Island Territories: America Samoa, Guam, and the Commonwealth of Northern Mariana Islands.
Technical assistance provided for the territories remains consistent over the years. Here are examples of TA provided:

- Commonwealth of Northern Mariana Islands (NMI) received on-site technical assistance that included consultation and presentations in the following areas: plan preparation; guidance regarding market rate survey, licensing regulations, and early learning guidelines.
- Guam received on-site technical assistance that included consultation and presentations on multiple issues including: documentation requirements that can be imposed on license-exempt providers; discussion of what constitutes “quality” care; trends regarding infant and toddler care; and the use of ARRA funds. OCC provided TA to develop written policies to address Guam’s internal communication around the CCDF program budgeting processes between partnering agencies to facilitate understanding of federal fiscal requirements and how they relate to accurate planning, budgeting, development, and implementation of activities leading to an effective early care and education system.
- American Samoa received TA on CCDF program regulatory flexibility relative to eligibility requirements to meet family and community needs in times of disaster. Due to earthquakes, tsunamis, and the resulting impacts on American Samoa, interim policies were put in place that enabled families to maintain child care program eligibility while disaster relief was obtained. This assisted the American Samoa CCDF program to provide stability to families during both the disaster and recovery process.

Funding Opportunities Available to Native Americans in FY 2009 through FY 2012

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<tr>
<th>Tribal Grantee</th>
<th>FY 2009 Total</th>
<th>FY 2010 Total</th>
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<td>$102,792,537</td>
<td>$113,108,907</td>
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</table>

OFFICE OF CHILD SUPPORT ENFORCEMENT

The mission of the Child Support Enforcement Program 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 paternity, establishing support obligations, and monitoring and enforcing those obligations. Child Support programs are moving towards more holistic service delivery, linking clients with employment and fatherhood services. In addition, tribal child support programs recognize cultural and customary values as evidenced by the ability to accept in-kind rather than cash payments, where allowable by tribal law.

Federally recognized tribes may apply for, and upon approval, receive funding to operate Child Support Enforcement programs meeting the requirements of 45 CFR part 309. The Tribal IV–D program is an entitlement program. Tribes submit an annual budget and must contribute a non-
federal share of the costs of the program. The amount of non-federal share is dependent upon how long the program has been in operation. Tribes operating for three years or less must contribute 10 percent of the cost of the program and those in operation for more than three years must contribute 20 percent of the cost of the program.

Realizing the importance of automated systems to the effective delivery of child support services OCSE worked with tribal partners in the child support community to plan, conceptualize, and design a generic model computer system for use in Tribal Child Support Enforcement programs nationwide. Known as the model tribal system or MTS, it was designed to be highly customizable, ensuring that every tribe is able to adapt a copy of the system to its own individual program and cultural requirements. The initial development of the MTS was completed in May 2010. The final rule: “Computerized Tribal IV-D systems and Office Automation” was published in the Federal Register on February 25, 2010 [75 FR 8508.] Two tribes, the Forest County Potawatomi Community in Wisconsin and the Modoc Tribe in Oklahoma, volunteered to perform user acceptance testing and pilot test the MTS. OCSE provided technical assistance to both tribes in developing funding requests and contract preparations for the pilot testing. The MTS pilot phase was completed in 2012.

Support Provided to Native American Communities in FY 2009 through FY 2012

In FY 2010, there were 39 tribes receiving funding to operate comprehensive Tribal Child Support Enforcement Programs. There were eight tribes receiving start-up funding, for a total of 47 tribes receiving IV-D funding. This amounted to $36 million in grant awards for tribal programs.

In FY 2011, there were 42 tribes receiving funding to operate comprehensive Tribal Child Support Enforcement Programs. There were 10 tribes receiving start-up funding, for a total of 52 tribes receiving IV-D funding. This amounted to $35 million in grant awards for tribal programs.

In FY 2012, there were 47 tribes receiving funding to operate comprehensive Tribal Child Support Enforcement Programs. There were 11 tribes receiving start-up funding, for a total of 58 tribes receiving IV-D funding. This amounted to $38.5 million in grant awards for tribal programs.

Model Tribal System Technical Assistance Provided to Native American Communities in FY 2010 through FY 2012

- OCSE issued an MTS National Sandbox Dear Colleague Letter, an invitation to all tribes to join, use, and allow tribal staffs to experiment with an online copy of the MTS.
- The MTS National Sandbox, an online, internet-accessible copy of the MTS, began operation in July 2010 through November 2010. Twenty tribes and one territory registered to use the Sandbox – 75 unique users total.
- OCSE conducted two “Introduction to the MTS Sandbox” webinars, followed by three “MTS Usage and Operations” training webinars.
• OCSE provided on-site, hands-on technical assistance to both Forest County Potawatomi Community and the Modoc Tribe in their testing, use, and operation of the MTS. Weekly status teleconferences were held.
• OCSE provided week-long training sessions for information technology and caseworker staff piloting the MTS.
• OCSE presented MTS and tribal systems regulations training sessions at the National Tribal Child Support Association Training Conference in Mescalero, New Mexico and the Region X Tribal Director’s meeting in Seattle, Washington.
• OCSE presented MTS and tribal systems regulations training sessions at the National Child Support Enforcement Association Training Conference in Chicago, Illinois.
• OCSE conducted four webinars to provide interested Tribal IV-D programs with the status of the MTS project and on the process to secure Federal funding for systems.
• OCSE reopened the MTS Sandbox for three months to all interested Tribal IV-D programs, supported by weekly “MTS Operation and Use” webinars.
• Testing completed and Forest County Potawatomi Community and the Modoc Tribe entered live cases into their copies of the MTS and began operational use of the system.
• OCSE sent a Dear Tribal Leader Letter to gather information on tribes’ plans for potential use of the system to determine a plan for the MTS nationwide launch. To further understanding of the options for use of the MTS, we also held a webinar to elaborate on the information contained in the Dear Tribal Leader Letter.

Technical Assistance Provided to Native American Communities FY 2009 through FY 2012

• OCSE provided ongoing technical assistance to several tribal grantees on the tribal child support financial and statistical reporting matters, as well as general child support policy guidance. Other purposes included discussions on processes, issues, and best practices affecting case processing when parties reside in different jurisdictions; procedures of federal reporting issues; interpretation of federal regulations and compliance; assisting tribes on Letters of Inquiry.
• OCSE met in Boston with four members of Mashpee Wampanoag Tribe (a federally recognized Massachusetts tribe), including a member of the tribal council and two tribal social services program directors, to discuss possible tribal participation in several ACF programs, including the Tribal Title IV-D program. The Tribal IV-D program was explained and promoted, and the Tribe was invited to seek further information and technical assistance if they were interested in applying for Tribal Title IV-D program funding.
• Start-Up Grant Approval and Award Letter formally presented to St. Regis Mohawk Tribe, welcome meeting and photo opportunity attended by the regional administrator, tribal fiscal specialist, child care regional program manager and Centers for Medicare and Medicaid Services staff. St. Regis is the regional office’s first tribal IV-D partner.
• OCSE joined the child welfare regional program manager and specialist for the regional office’s first official site visit to St. Regis Mohawk Tribe. A meeting was held to discuss OCSE and child welfare issues and federal staff leaned about the Tribe’s environment, infrastructure, and concerns.
• The St. Regis Mohawk Tribe’s chief judge and interim director participated in the regional office’s annual IV-D directors meeting. The Tribe was introduced to policy, procedural, and processing concerns common to fully operational IV-D programs.

• The regional office arranged for and participated in St. Regis Mohawk’s visit to two tribes (Forest County Potawatomi and Oneida Nation) to learn about the pros and cons of automated system options (Model Tribal stand-alone system versus integration into existing state automated system). The visit allowed the Tribe to make an informed decision to adopt a stand-alone system and to contract with the Forest County Potawatomi Tribe for respective technical assistance.

• At the invitation of Sac and Fox Tribe of Mississippi in Iowa, region VII regional program manager made a presentation to the Tribal Council and other Tribal government and court officials about the IV-D program in September 2011. In November 2011, the Tribal Council passed a resolution to apply for IV-D start-up funding.

• OCSE regional staff delivered program and financial training to the Kickapoo Tribe of Oklahoma located in Texas. The Tribe is in the first year of comprehensive funding and brought all new employees to the training.

• Region VII staff hosted an intergovernmental meeting with representatives from all tribal programs with IV-D funding. Representatives from seven tribes attended and participated in discussions and training presentations on processing child support cases across tribal and state jurisdictions. Topics included case transfers, tribal FIPS codes, accurate reporting of collections on shared cases, and a demonstration of the MTS.

• At the request of the Prairie Band Potawatomi Nation, Region VII OCSE staff attended a meeting at the tribal government center between the tribe, the State of Kansas, and the Kickapoo Tribe in Kansas, to provide input into their deliberations about the establishment of shared case protocols and case transfer processes.

### Funding Opportunities Available to Native Americans in FY 2009 through FY 2012

<table>
<thead>
<tr>
<th>Office of Child Support Enforcement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tribes and Tribal Organizations</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

### Other Funding Opportunities (Contracts)

The “Shoalwater Bay-Washington State Outreach, Education and Support Enforcement Program” (2009) grant responded to OCSE’s Priority Area 2: Improving Child Support by Encouraging Parents and Child Support Enforcement Agencies to Work Together for Better Case Management and Results. This program was intended to establish an integrated case management process with the Washington State Division of Child Support; install a support enforcement-specific database; provide community outreach; and offer education services/referrals to encourage tribal parental responsibility and healthy marriage. The goal was to assist noncustodial parents (NCPs) in obtaining the education and skills needed to allow them to meet their support obligations. The total amount awarded for FY 2009 was $24,991. This project began September 1, 2007 and ended on August 31, 2010.

*FY 2009-2012 Congressional Report*
The grantee entered into an agreement with the State of Washington and established a “trust relationship” with its state support-enforcement counterparts. This allowed the tribe to have Full Faith and Credit for child support orders issued through the tribal Court. Conversely, the State assisted the tribe with cases outside the reach of the tribal court. Additionally, the tribe enforced state-ordered obligations from those who were employed by tribal enterprises through wage withholding.

This project provided a “one-stop” approach to support enforcement. On-site assistance was available for those who resided on or near the reservation and for employees who work on the reservation. Through community partnerships and service referrals, participating parents were offered educational assistance, job placement, and other support services, as appropriate.

Program reports, data gathered, court records, participant counts, etc., were reviewed to determine what extent project goals and objectives have been achieved.

OCSE awarded a grant to the Oklahoma Child Support Services (OCSS) in FY 2011. While this grant was not directly awarded to a Tribal IV-D program, the Chickasaw Nation will benefit from this grant award. OCSS plans to increase child support collections and manage arrears by collaborating with the Texas and Chickasaw Nation IV-D programs to automate the collection process for their Automated/Administrative Enforcement in Interstate (AEI) tax refund offset referrals. It is anticipated that child support collections will increase and arrears management will improve for the Texas and Chickasaw Nation IV-D programs. This will benefit children and families by providing a reliable source of support from noncustodial parents.

In FY 2012, OCSE posted a grant forecast for Tribal Child Support Innovation Grants. The forecast was advance notice about our planned grants and noted that eligibility for this grant program was open to tribal child support agencies operating comprehensive programs. Applicants had the opportunity to compete for funds to develop and administer innovative, family-centered child support services that help parents provide reliable support for their children as they grow up. In addition, OCSE held two listening sessions to gather background information and tribal input in planning for the Tribal Innovation Grants. These grants were awarded in September 2013.

**OFFICE OF COMMUNITY SERVICES**

The Office of Community Services’ (OCS) mission is to increase the capacity of individuals and families to become more self-sufficient and assist them to build, revitalize, and strengthen their communities. Its vision is to provide leadership to address the causes and effects of poverty and 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, non-profit 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.

Technical Assistance Provided to Native American Communities in FY 2009 through FY 2012

OCS and its training and technical assistance providers supply technical assistance to tribes in conferences and meetings, on site, by telephone and correspondence, and in printed material.

• Printed material included the Low Income Home Energy Assistance Program (LIHEAP) Tribal manual, which provided in-depth information for tribes to apply for LIHEAP funds and operate a LIHEAP program.
• OCS also supplied technical assistance on the Community Services Block Grant (CSBG) to tribes through quarterly conference calls, Dear Colleague emails, Information Memoranda, webinar training and workshops at national and regional training events hosted by organizations serving significant tribal populations.
• Since 2012, LUX Consulting Group, Inc. has served under contract with OCS as the Tribal Technical Assistance provider for tribes and tribal organizations receiving direct CSBG funding. In consultation with tribal representatives, OCS and LUX collaborated to publish the FY 2012 Tribal Resource Guide which provided technical assistance specifically targeted to tribal anti-poverty and program accountability efforts. The Guide contained technical assistance tools to help tribal grantees meet CSBG program goals and objectives. In addition, LUX contributed to the CSBG Tribal Training and Technical Assistance website to support information sharing; developed “Funding News” to announce Tribal funding opportunities; hosted conference calls on “Conducting a Needs Assessment” and “Maximizing Resources;” and produced a webinar on “How to Apply for CSBG Direct Tribal Funding.”

Native Asset Building Initiative for FY 2011 and FY 2012

Launched in 2011, the Native Asset Building Initiative (NABI) is a partnership between ANA and the Assets for Independence (AFI) program in OCS. The goal of NABI is to build capacity for Native communities to offer financial literacy, asset building, and related services to more families. Under NABI there is a joint funding opportunity through which organizations can apply for both the AFI program and ANA's Social and Economic Development Strategies (SEDS) program. If successful, organizations are awarded both an AFI and a SEDS grant, which are used together to provide individual development accounts (IDAs), financial education, and other supportive services, as allowable under each program. AFI grants provide funds to community-based nonprofits and government entities to provide matched savings accounts (i.e.
IDAs) for low-income individuals to enable these individuals to combine their earned income with federal and non-federal matching funds to purchase a first home, finance post-secondary education or training, or start or expand a small business. Through the SEDS program area, ANA promotes the goal of economic and social self-sufficiency for American Indians, Alaska Natives, Native Hawaiians, and Native American Pacific Islanders. Projects funded under NABI provide IDAs: training on financial issues such as family budgeting and credit; and other related services that help Native American individuals and families achieve greater financial stability. In 2011, five projects were funded under NABI, and in 2012 there were four additional projects funded.

Funding Opportunities Available to Native Americans in FY 2009 through FY 2012

OCS funded grants to tribes and tribal organizations totaled more than $120 million between FY 2009 through FY 2012. Grant programs in OCS are a combination of formula block grants and competitive discretionary grants.

FY 2009 through FY 2012 Total OCS Funding to Tribes/Tribal Organizations

<table>
<thead>
<tr>
<th>OCS Programs</th>
<th>Total Funding to Tribes and Tribal Organizations FY 2009</th>
<th>Total Funding to Tribes and Tribal Organizations FY 2010</th>
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**Compassion Capital Fund in FY 2009**

The Compassion Capital Fund (CCF) grant program helped grassroots organizations increase their effectiveness and enhance their ability to provide social services to low-income individuals. Their goal was to strengthen the role of organizations in their ability to provide social services to low-income communities. Three tribal organizations in two states received Compassion Capital Funds in FY 2009. There were no appropriations for CCF after FY 2009.

**Strengthening Communities Fund in FY 2009**

The Strengthening Communities Fund (SCF) enabled nonprofit organizations to contribute to the economic recovery and help federal, state, local, and Indian/Native American tribal governments ensure that the information and services described in the American Recovery and Reinvestment Act of 2009 (ARRA) reach disadvantaged and hard-to-serve populations. Capacity building activities were designed to increase project partners' sustainability and effectiveness, enhance their ability to provide social services, create collaborations to better serve those in need, and to increase the partners’ ability to address the broad economic recovery issues present in their communities. Each grant award was for a performance period of 24-month period. SCF supported two capacity building grant programs:

- **Nonprofit Capacity Building program** made one-time awards up to $1 million to 35 experienced lead organizations to provide nonprofit organizations -- or project partners -- with capacity building training, technical assistance, and competitive financial assistance.
- **SCF State, Local, and Tribal Government Capacity Building program** made one-time awards up to $250,000 to 49 state, city, county, and Indian/Native American tribal government offices (e.g., offices responsible for outreach to faith-based and community organizations or those interested in initiating such an effort), or their designees, to build the capacity of nonprofit faith-based and community organizations to better serve those in need and to increase nonprofit organizations' involvement in the economic recovery.

Six tribes and tribal organizations in six states received SCF funding in FY 2009. There were no appropriations for SCF after FY 2009.
LIHEAP assistance and services are provided through the LIHEAP block grant, the leveraging incentive program for LIHEAP grantees, and the Residential Energy Assistance Challenge Program (REACH) for LIHEAP grantees. The LIHEAP block grant helps low-income households meet the costs of home energy. State and tribal grantees use LIHEAP 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 non-federal 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 their home energy costs and achieve energy self-sufficiency.

State LIHEAP programs serve American Indian households that are not in the service population of direct tribal grantees. More specific data on the number of American Indian households served by state LIHEAP programs efforts are not available.

In FY 2009, LIHEAP was funded at $5.1 billion, including $590 million in contingency funds for unforeseen energy crises. In that year, 146 tribal grantees received funding totaling $58,596,285 in direct LIHEAP funding, including regular LIHEAP block grants, emergency contingency releases, and leveraging incentive fund awards.

In FY 2010, LIHEAP was funded at $5.1 billion, including $591 million in contingency funds for unforeseen energy crises. In that year, 153 tribal grantees received funding totaling $59,956,026 in direct LIHEAP funding, including regular LIHEAP block grants, emergency contingency releases, leveraging incentive fund awards, and Residential Energy Assistance Challenge (REACH) fund awards.

In FY 2011, LIHEAP was funded at $4.7 billion, including $200 million in contingency funds for unforeseen energy crises. In that year, 152 tribal grantees received funding totaling $51,251,990 in direct LIHEAP funding, consisting entirely of regular LIHEAP block grants.

In FY 2012, LIHEAP was funded at $3.5 billion. There were no contingency funds. In that year, 151 tribal grantees received funding totaling $43,357,323 in direct LIHEAP funding, including regular LIHEAP block grants, leveraging incentive fund awards, and REACH fund awards.

Community Services Block Grant

CSBG provides federal and state-recognized Indian tribes and tribal organizations with funds to alleviate the causes and conditions of poverty in communities. Indian tribes and tribal organizations receiving direct CSBG funds from the federal level provide services and activities that address the need for employment, education, better use of available income, housing,
nutrition, emergency services and health care. The target population for CSBG services is low-income Native American elders, adults, families, adolescents, and young children.

In FY 2009, OCS awarded 50 Community Service Block Grants to tribes and tribal organizations for a total of $4,815,024, which served 218,074 low-income American Indians and Alaska Natives.

That same year, in response to the severe economic recession, under the American Recovery and Reinvestment Act (ARRA) of FY 2009, OCS made an additional 50 tribal CSBG-ARRA awards totaling $6,696,123. Overall, the CSBG-ARRA funds enabled some tribes to provide new services while others expanded existing emergency services programs to serve more individuals and, in some cases, new population groups. Some tribal departments formed new partnerships with other tribal departments or external organizations and used CSBG ARRA funds to hire and support new staff.

In FY 2010, OCS awarded 55 Community Services Block grants to tribal organizations for a total of $4,942,408. In FY 2011, OCS awarded 58 Community Services Block grants to tribes for a total of $4,853,137.

In FY 2012, 51 tribes and eight tribal organizations, living across 21 states, received direct CSBG funding for a total of $5,057,945. Core CSBG tribal services funded in 2012 include: employment programs (47 tribal grantees), education programs (31 tribal grantees), income management, including tax preparation (13 tribal grantees), housing programs (35 tribal grantees), emergency services (39 tribal grantees), nutrition programs (42 tribal grantees), support for improved service linkages (52 tribal grantees), self-sufficiency programs (51 tribal grantees), and health programs (36 tribal grantees).

The structure of the Community Services Block Grant allows tribes and tribal organizations that receive funding to participate in a broad range of activities to meet the unique needs of their communities. Each tribe captures outcome data specific to its individual goals and priorities. In 2012, Indian tribes and tribal organizations reported on the results of their use of CSBG funds.

| Community Services Block Grant FY 2012 Tribes and Tribal Organizations Goals and Outcomes |
|-----------------------------------------------|------------------------------------------------------------------------------------------------|
| **Goal 1: Low income people become more self-sufficient** | • 88% (52) tribal grantees invested CSBG funds in specific programs that result in greater self-sufficiency for low-income people, including employment services, education and training, financial management and reducing barriers to work. |

FY 2009-2012 Congressional Report
| **Community Services Block Grant**  
**FY 2012 Tribes and Tribal Organizations Goals and Outcomes** |
|---|
| **Goal 2:** The conditions in which low-income people live are improved.  
- 83% (49) tribal grantees invested CSBG funds in community improvement and revitalization, increased community Quality of Life assets, and community engagement and volunteerism. |
| **Goal 3:** Low-income people own a stake in their community.  
- 66% (39) tribal grantees invested CSBG funds in programs to increase community engagement, including community decision-making activities, community outreach and communication and support for home and business ownership. |
| **Goal 4:** Partnerships among supporters and providers of services to low-income people are achieved.  
- 84% (50) tribal grantees invested CSBG funds in programs that facilitate interagency, tribal/state, and public/private partnerships. |
| **Goal 5:** Agencies increase their capacity to achieve results.  
- 84% (50) tribal grantees invested CSBG funds to increase their capacity to serve their most needy families and achieve results. |
| **Goal 6:** Low-income people, especially vulnerable populations, achieve their potential, strengthening family and other supportive environments.  
- 56% (33) tribal grantees invested CSBG funds in strengthening family and other supportive environments to help vulnerable populations achieve their potential. |

**Community Economic Development Program in FY 2009 through FY 2012**

Community Economic Development (CED) discretionary grants are awarded to nonprofit community development corporations (CDC) in disinvested communities for purposes of creating new jobs for low-income individuals, including Temporary Assistance for Needy Families (TANF) recipients.

There were no tribal projects funded in FY 2009 and 2011.

**Rural Community Development Program in FY 2009 through FY 2012**
Arizona
Inter-Tribal Council of Arizona, Inc.
FY 2009 funding: $800,000
FY 2010 funding $529,046
FY 2011 funding $400,000
FY 2012 funding $400,000

Tennessee
United South and Eastern Tribes, Inc.
FY 2009 funding $0
FY 2010 funding $230,403
FY 2011 funding $115,201
FY 2012 funding $163,505

Rural Community Development (RCD) program addresses the infrastructure need by aiding access to safe water systems in low-income rural communities. RCD 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 waste water treatment facilities. Most people impacted by the program are very low-income individuals living in sparsely populated rural areas.

In FY 2009, RCD awarded one grant to a tribal organization, Inter-Tribal Council of Arizona, Inc. (Inter-Tribal). Inter-Tribal program increased tribal capacity for sustainable safe drinking water and for a sanitation through the tribal water operator certification program and provided site-specific technical assistance services. Inter-Tribal received RCD grant awards for this project in FY 2010, 2011, and 2012.

In FY 2010, RCD awarded a grant to a second tribal organization United South and Eastern Tribes, Inc. (USET) to create a water and wastewater certification, training, and technical assistance program to assist member tribes in developing, operating and sustaining efficient and safe water and wastewater facilities. This program helped member tribes achieve and maintain compliance with the Safe Drinking Water Act, Clean Water Act, and other applicable state and tribal regulations. In addition, USET utilized its staff expertise to assist member tribes build technical, managerial, and financial capabilities through training, technical assistance, and tribe-to-tribe peer assistance activities.

Assets for Independence

The Assets for Independence (AFI) program awards grants to community-based nonprofits; state, local, and tribal government entities; and certain financial institutions to implement and demonstrate an assets-based approach for supporting low-income individuals and their families. AFI grantees enroll participants to save earned income in special-purpose, matched savings accounts called Individual Development Accounts (IDAs).

Congress appropriated approximately $24 million for the program in FY 2009, 2010, and 2011. In FY 2012, the appropriation was reduced, at just under $20 million. There are more than 250 active AFI projects throughout the nation.

OFFICE OF FAMILY ASSISTANCE
TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

The Division of Tribal TANF Management in the Office of Family Assistance (OFA) is responsible for providing program guidance and technical assistance to: (1) federally recognized
American Indian tribes and certain statutorily identified Alaska Native entities in development, implementation, and administration of tribal Temporary Assistance for Needy Families (TANF) programs; (2) federally recognized tribes and tribal organizations in implementation and administration of Native Employment Works (NEW) programs; (3) tribes and tribal organizations administering TANF programs in implementation and administration of Tribal TANF – Child Welfare Coordination projects; (4) tribal entities in implementation and administration of Health Profession Opportunity Grants; and (5) where appropriate, providing general and specific information, guidance, and technical assistance to tribes, tribal organizations, and state and federal agencies on issues relating to these programs, related legislation, and other initiatives affecting these programs.

Technical Assistance Provided to Native American Communities in FY 2009 through FY 2012

Technical assistance is provided to current grantees and applicants by ACF Regional TANF Program staff and OFA central office (TANF Bureau) staff on a continuing basis via telephone conversations, e-mails, fax, direct meetings, site visits, regional TANF grantee training and technical assistance, conferences, and regularly scheduled grantee meetings. Technical assistance also is provided by peers, and through TA contract.

Funding Opportunities Available to Native Americans in FY 2009 through FY 2012

TANF provides assistance and work opportunities to needy families by providing states and tribal grantees the federal funds and 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. Four tribes began TANF programs in FY 2009; one tribe began a TANF program in FY 2010; and one tribe began a TANF program in FY 2011.

Fourteen tribal TANF grantees administer discretionary grants for Coordination of Tribal TANF and Child Welfare Services to Tribal Families at Risk of Child Abuse or Neglect. These grantees are: Association of Village Council Presidents, Central Council of the Tlingit and Haida Indian Tribes, Chippewa Cree Tribe of the Rocky Boy’s Reservation, Coeur d’Alene Tribe, Confederated Salish and Kootenai Tribes, Confederated Tribes of Siletz Indians, Cook Inlet Tribal Council, Forest County Potawatomi Community, Hoopa Valley Tribe, Nooksack Tribe, Port Gamble S’Klallam Tribe, Quileute Tribe, South Puget Intertribal Planning Agency, and Tanana Chiefs Conference. Total annual funding for the Tribal TANF – Child Welfare Coordination grants in FY 2009 was $1,489,296 and $1,489,296 for FY 2010. The project period for these grants was five years, from September 30, 2006, to September 29, 2011. The total FY 2011 annual funding for the Tribal TANF – Child Welfare Coordination grants was $2,000,000. The project period for these grants was three years, from September 30, 2011, to September 29, 2014.
Five tribal grantees administer discretionary Health Profession Opportunity Grants (HPOG) that provide education and training to TANF recipients and other low-income individuals for occupations in the health care field that pay well and are expected to experience labor shortages or be in high demand. These grantees – four tribal colleges and one tribal organization – are: Blackfeet Community College in Montana, Cankdeska Cikana Community College in North Dakota, College of Menominee Nation in Wisconsin, Cook Inlet Tribal Council in Alaska, and Turtle Mountain Community College in North Dakota. Total annual funding for these tribal HPOG cooperative agreements in FY 2010 was $9,562,350, $9,012,753 in FY 2011 and $9,602,086 for FY 2012. The project period for these grants is five years, from September 30, 2010, to September 29, 2015.

### TANF Tribal – Family Assistance Grants

<table>
<thead>
<tr>
<th>Tribe or Tribal Organization</th>
<th>FY 2009</th>
<th>FY 2010</th>
<th>FY 2011</th>
<th>FY 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totals</td>
<td>$181,464,856</td>
<td>$181,715,461</td>
<td>$181,679,019</td>
<td>$181,673,227</td>
</tr>
</tbody>
</table>

The Native Employment Works (NEW) program began July 1, 1997; it replaced the Tribal JOBS program. In FY 2009, there were 78 NEW grantees. This included all of the entities eligible by law for NEW program funding. In FY 2010, FY 2011, and FY 2012 there were 79 NEW grantees. By law, only federally recognized Indian tribes and Alaska Native organizations that operated a Tribal JOBS program in FY 1995 are eligible for NEW program funding. In FY’s 2009, 2010, and 2011, the total annual federal funding awarded for NEW programs was $7,558,020 for each year. By law, NEW grant awards are set at FY 1994 Tribal JOBS funding levels. The purpose of the NEW program is to make work activities available to grantees’ designated service populations and service areas. Allowable work activities include educational activities, training and job readiness activities, and employment activities. NEW funds also may be used for supportive and job retention services that enable participants to prepare for, obtain, and retain employment. Allowable activities also include job creation.

### NATIVE EMPLOYMENT WORKS (NEW) GRANTEES AND FUNDING PROGRAM YEAR (JULY 1 - JUNE 30)

<table>
<thead>
<tr>
<th>NEW Program Grantees</th>
<th>FY 2009</th>
<th>FY 2010</th>
<th>FY 2011</th>
<th>FY 2012</th>
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<tbody>
<tr>
<td>Totals</td>
<td>$7,558,020</td>
<td>$7,558,020</td>
<td>$7,558,020</td>
<td>$7,558,020</td>
</tr>
</tbody>
</table>

### OFFICE OF HEAD START

The Office of Head Start (OHS) provides leadership and coordination for the activities of the Head Start program.

Early Head Start promotes healthy prenatal outcomes, enhances the development of infants and toddlers, and promotes healthy family functioning. Head Start agencies are to improve
school readiness outcomes and promote long-term success by enhancing the social and cognitive development of primarily low-income children. This is accomplished through the provision of early childhood development and educational services including health, nutritional, social, and other services to enrolled children and their families.

The Office of Head Start has increased its focus on building partnerships with states and local Head Start Programs, including those Tribal Head Start Programs on reservations, in Alaska Native Villages and in the Native Hawaiian and Pacific Islander communities to ensure all children are prepared to successfully transition to local schools. One of the cornerstones of Head Start is family engagement. Foundational to this is supporting the leadership role of parents in guiding their child’s learning to accomplish educational and literacy goals. In addition, parents and other community members have significant roles in governance of their community’s Head Start Program.

Head Start has often been, on or near reservations, the only avenue for infants and toddlers to attend an early childhood development program. Head Start programs serve approximately 42,500 children of AI/AN heritage. More than 23,000 of those children are served in the 152 AI/AN Head Start programs. The rest are served by non-tribal programs. Over the last decade, there has been a steady decline in the number of Head Start children who speak a tribal language at home. According to 2009 Head Start Program Information Report (PIR) data, less than four percent of Head Start children speak Native North America/Alaska Native Languages. This is a 10 percent decrease from 2001.

Support Provided to Native American Communities in FY 2009 through FY 2012

Tribal Consultation
The Office of Head Start convenes tribal consultation sessions as required by Section 640(1)(4) of the Head Start Act and in conformity with the Department of Health and Human Services Tribal Consultation Policy and the ACF Tribal Consultation Policy established in August 2011. They provide a forum for discussing how to better meet the needs of American Indian and Alaska Native children and families. Tribal consultation reports reflect comments and recommendations raised by tribal leaders and their representatives, comments and responses from OHS, and areas identified at the tribal consultations as requiring follow-up by Head Start.

Technical Assistance Provided to Native American Communities in FY 2009 through FY 2012

Technical assistance was provided to each grantee through a contract funded to ICF, International in FY 2009. The American Indian Technical Assistance network had twelve specialists located across the nation to serve the tribal grantees as well as six content experts to provide additional training and technical assistance to grantees.

During FY 2010, the national Office of Head Start Training and Technical Assistance (T/TA) System was redesigned to more effectively and efficiently support each grantee to build capacity and sustain quality early childhood programming in their local communities. The National
T/TA System expands the expertise available to all Head Start and Early Head Start grantees and includes:

- Six national centers including:
  - National Center for Cultural and Linguistic Responsiveness (NCCLR)
  - Early Head Start National Resource Center (EHSNRC)
  - National Center on Health and Mental Health (NCH)
  - National Center on Parent, Family and Community Engagement (NCPFCE)
  - National Center on Program Management and Fiscal Operations (NCPMFO)
  - National Center of Quality Teaching and Learning (NCQTL)

- American Indian/Alaskan Native and Migrant and Seasonal (MSHS) Contractor is FHI 360 Incorporated.

- National American Indian State Collaboration Office

- State T/TA Centers

- Direct funding to grantees to address their identified TA/T priorities. Over 50 percent of all funding appropriated for technical assistance is awarded directly to grantees to address their identified needs.

To address the expanded educational requirements for teaching staff and the limited access to higher education resources in tribal communities, Head Start partnered with the National Center for Quality Teaching and Learning and held four Child Development Associate (CDA) Academies for AI/AN grantees.

During FY 2010, the Office of Head Start coordinated with the Office of Community Services on education, resources, and implementation of the Assets for Financial Independence (AFI) Program in tribal communities assist families with low incomes and limited economic assets improve their financial stability. Many programs have already begun to use asset building strategies, such as financial education, to ensure that parents and staff have the information and skills they need to remain financially secure.

In response to the intent of the Improving Head Start for School Readiness Act of 2007 and the importance conveyed by tribal leadership, OHS began, in FY 2011, an initiative to learn about the successes, progress, and challenges faced by a number of large and small tribal communities in various stages of preserving, revitalizing, or reclaiming their tribal language. Information was gathered through meetings and discussions with tribes and through the OHS Tribal Language Preservation and Revitalization, resulting in the OFFICE OF HEAD START TRIBAL LANGUAGE REPORT 2012, which is available at http://eclkc.ohs.acf.hhs.gov/hslc/states/aiian/pdf/ohs-tribal-language-report-jan-2012.pdf. This report provides illustrative examples of tribal language efforts around the country and discusses the recommendations and implications for OHS.

The Centers of Excellence Program was established by the Improving Head Start for School Readiness Act of 2007 to recognize grantees, nominated by their governor, or the regional program manager for Tribal Head Start Programs, for quality services in Head Start and Early Head Start. During FY 2010 the first ten Centers of Excellence were designated and during FY 2011, the second ten were designated. The Tribal Head Start Program, Pueblo Laguna of New
Mexico, was selected as a Center of Excellence for their family engagement programming including promotion of culture and home language.

The Early Learning Mentor Coach Study (ELMC) was a descriptive study of professional development grants awarded competitively to Head Start programs. The Head Start Early Learning Mentor and Coach grants were funded in September of 2010 to 131 grantees in 43 states, each with a project period of 17 months. According to the grant announcement the ELMC funds were to pay mentor coaches to provide on-the-job guidance, technical assistance and training to classroom teaching staff, home visitors and family child care providers who work in Head Start and Early Head Start programs. The overall goal of the coaches was to improve staff qualifications and training; assist grantees to promote positive, sustained outcomes for children; and promote career development in Head Start grantees. The model of mentor coaching was not prescribed, and grantees proposed approaches to fit their particular circumstances. As part of this pilot, those selected grantees share their approaches and mentoring strategies with other tribal Head Start grantees. Tribal grantees awarded ELMC grants included Sault Ste. Marie Tribe of Chippewa Indians, Mille Lacs Band of Ojibwe, Cheyenne and Arapaho Tribes and the Rosebud Sioux Tribe.

Monitoring
All Head Start & Early Head Start Agencies have a full on-site monitoring review conducted by the Office of Head Start, at least once every three years (the Triennial Review).
- In FY 2009, 59 tribes were monitored and three tribes met all requirements: Kickapoo Tribe of Oklahoma, Upper Skagit Indian Tribe, and the White Earth Band of Chippewa Indians.
- Of the 37 tribal grantees reviewed in FY 2010, three percent (1 grantee) was determined to be in full compliance and 68 percent (25 grantees) had no deficiencies.
- Of the 51 tribal grantees reviewed in FY 2011, 20 percent (10 grantees) were determined to be in full compliance and 65 percent (33 grantees) had no deficiencies.
- Of the 57 tribal grantees reviewed in FY 2012, nine percent (5 grantees) were determined to be in full compliance and 84 percent (48 grantees) had no deficiencies.

Designation Renewal System
Under new regulations announced in November 2011, Head Start and Early Head Start agencies determined not to have met quality thresholds will compete, for the first time ever, with other potential providers for designation as a Head Start or Early Head Start agency and continued Head Start funding.

The new rule builds upon requirements of the Improving Head Start Act of 2007, as well as on recommendations from a National Advisory Committee of child development experts and early education leaders. The Committee’s report called on the Administration to implement a system to assess Head Start grantees that was “transparent, valid, and reliable.” The Designation Renewal System uses an evidence-based, rigorous classroom evaluation tool to measure classroom quality along with clear standards of financial integrity and compliance with Head Start rules to determine which programs are – and are not - meeting key indicators of program quality and integrity.
The new regulation, which went into effect Dec. 9, 2011 specifies seven conditions that HHS will consider to evaluate an agency’s quality as well as to determine whether an agency will be required to compete for designation as a Head Start or Early Head Start agency and continued funding for a five-year period. This regulation helps ensure accountability direct taxpayer dollars to programs that offer high-quality Head Start services and works to ensure that Head Start programs provide the best available early education services to children in every community.

Funding announcements for Head Start and Early Head Start service areas subject to competition were posted in early 2012. HHS will only award funds to organizations able to demonstrate they are the most qualified entity to deliver a high-quality and comprehensive Head Start program. Over the next three years, all 1,600 Head Start grantees will be evaluated against these seven quality benchmarks that are transparent, research-based, and include standards for health and safety and fiscal integrity. Based on analysis of current program performance data, it is estimated that one-third of all grantees will be required to re-compete for continued funding within the three-year transition period established by the 2007 Head Start Act.

While non-tribal programs that meet one of the conditions in the final rule will be required to compete for Head Start/Early Head Start agency designation and a five-year project period, American Indian and Alaska Native agencies meeting one or more of the conditions triggering the designation renewal process will enter a two-part program improvement process. The yearlong process will include government to government consultation and training and technical assistance. After the consultation and technical assistance is completed, each tribal grantee will be re-evaluated to determine whether or not they continue to meet one of the conditions requiring competition for renewed funding.

Funding Opportunities Available to Native Americans in FY 2009 through FY 2012

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Total HS Funds</th>
<th>Total EHS Funds</th>
<th>Total Funds (HS/EHS)</th>
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</thead>
<tbody>
<tr>
<td>FY 2009</td>
<td>$175,847,310</td>
<td>$29,368,576</td>
<td>$205,243,536</td>
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<tr>
<td>FY 2010</td>
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<td>$47,192,651</td>
<td>$241,447,434</td>
</tr>
<tr>
<td>FY 2011</td>
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<tr>
<td>FY 2012</td>
<td>$176,355,154</td>
<td>$46,647,066</td>
<td>$223,002,220</td>
</tr>
</tbody>
</table>

TRIBAL COLLEGES FUNDING AWARDS: FY 2009 through FY 2012

The Office of Head Start awarded five-year grants to those institutions that offer degrees in Early Childhood Education to help local tribal head start programs meet expanded educational requirements. Some of the major outcomes from the support of this funding included:

- Northwest Indian College: Ten Head Start staff completed their CDAs during FY 2010
Oglala Lakota College hired a full-time staff person to work with Head Start on an Early Literacy Advocacy Program for parents and children as part of a service learning project.

Oglala Lakota College developed a partnership with a local elementary school for one of the students to complete their practicum/student teaching. This led to an acceptance from the Rapid City School District at Rapid City, South Dakota for teachers training during the 2011 fall semester. This student was the first to become certified with the new state teacher certificate for a bachelor of arts in early childhood education.

College of Menominee Nation hired faculty to teach courses in language arts and reading as well as other courses. The college provides tuition assistance and has recognition and incentive programs for faculty and staff.

### HEAD START AWARDS TO TRIBAL COLLEGES

<table>
<thead>
<tr>
<th>PROJECT PERIOD</th>
<th>Tribal College</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
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<tr>
<td>Montana</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009-2013</td>
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<td>$261,480</td>
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<tr>
<td>2009-2010</td>
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<tr>
<td>South Dakota</td>
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<td>2006-2010</td>
<td>Northwest Indian College</td>
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<tr>
<td>Wisconsin</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>2009-2013</td>
<td>College of Menominee Nation</td>
<td>$500,000</td>
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<tr>
<td>Grand Total</td>
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### HEAD STARTS AWARDS TO NATIVE HAWAIIANS & PACIFIC ISLANDERS

<table>
<thead>
<tr>
<th>Grantee Name</th>
<th>FY 2010</th>
<th>FY 2011</th>
<th>FY 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HS Enroll</td>
<td>EHS Enroll</td>
<td>Total Funding</td>
</tr>
<tr>
<td>Grand Total</td>
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</table>

*FY 2009-2012 Report to Congress*
ADMINISTRATION FOR COMMUNITY LIVING

The Administration for Community Living (ACL) brings together the efforts of the Administration on Aging, the Administration on Intellectual and Developmental Disabilities, and the HHS Office on Disability to serve as the Federal agency responsible for increasing access to community supports, while focusing attention and resources on the unique needs of older Americans and people with disabilities across the lifespan. All Americans, including people with disabilities and older adults, should be able to live at home with the supports they need and participate in communities that value their contributions. To help meet these needs, the Department of Health and Human Services created the Administration for Community Living.

Administration on Aging

The mission of the Administration on Aging (AoA) is to help elderly individuals maintain their dignity and independence in their homes and communities through comprehensive, coordinated, and cost effective systems of long-term care, and livable communities. The agency does this by serving as the federal agency responsible for advancing the concerns and interests of older people and their caregivers, and by working with and through the national aging services network to promote the development of a comprehensive and coordinated system of care that is responsive to the needs and preferences of older people and their family caregivers.

Administration on Intellectual and Developmental Disabilities

The Administration on Intellectual and Developmental Disabilities (AIDD) supports approaches that shape attitudes, raise expectations, change outdated or broken systems and empower individuals with developmental disabilities to pursue the lives they imagine for themselves. AIDD provides financial and leadership support to specific types of organizations in every state and territory. These bodies assist individuals with developmental disabilities of all ages and their families obtain the support they need to achieve all aspects of a life envisioned and defined by the Developmental Disabilities Assistance and Bill of Rights Act of 2000.

ACL Support Provided to Native American Communities in FY 2009 through FY 2012

The Office of American Indian, Alaska Natives, and Native Hawaiian Programs (OAIANNHP), has statutory responsibility to provide training and technical assistance to tribal organizations receiving funds under Title VI of the Older Americans Act. The purpose of Title VI is to promote the delivery of supportive and nutrition services to American Indian, Alaska Native and

6 In FY 2012, ADD became the Administration on Intellectual and Developmental Disabilities and moved to a new Operating Division, Administration on Community Living, formerly the Administration on Aging.
Native Hawaiian elders. ACL carries out this responsibility by conducting regional, cluster, on-site, and national training, and technical assistance forums.

In FY 2009, cluster training sessions focused on financial management, program management, reporting requirements, technology, and menu planning. During FY 2010, cluster training sessions provided in-depth information on program management, health and wellness programs, and health education. In FY 2011, cluster training sessions focused on the new dietary guidelines, implementing new programs, caregivers, and health promotion.

In FY 2010 and 2011, ACL held its National Training and Technical Assistance Forum. Nearly 200 tribal program staff and elders participated in each Forum. The 2010 and 2011 National Title VI Training and Technical Assistance Forums provided participants with practical information and tools necessary to develop and strengthen Title VI programs and help their communities respond to the needs of older Indians.

In FY 2012, ACL held its National Title VI Training and Technical Assistance Forum. Nearly 250 tribal program staff and elders participated in the Forum. The 2012 National Title VI Training and Technical Assistance Forums provided participants with practical information and tools necessary to develop and strengthen Title VI programs and help their communities respond to the needs of older Indians. The 2012 Forum also offered several workshops and discussions around issues of long term care in Indian country, moving Title VI programs from thinking of them as “just” a meals program to realizing that they play an integral role in providing long term services and supports that help maintain tribal elders in their own homes and communities.

AoA also provided support to Title VI grantees through a web site where technical assistance is provided via training manuals, presentations from training sessions, and resource links. Timely information is posted on the web site, including availability of grants, and monthly web chats are hosted.

**AIDD Support Provided to Native American Communities FY 2009 through FY 2012**

State Councils on Developmental Disabilities. The Developmental Disability Network works through State Councils. They do not work directly with tribes unless tribes have developed a collaborative agreement with a particular state around disabilities issues and have tribal goals and tasks included in that state plan.

There are 56 State Councils in the United States and its territories. Councils are independent, self-governing organizations that work at the state level to advance the interests of individuals with developmental disabilities and promote policies and practices that fully meet the needs of all Americans.

State Councils are committed to the advancement of public policy that helps individuals with developmental disabilities gain more control over their lives. They are composed of individuals with developmental disabilities, family members, advocates, and state agency representatives. In part because of their diverse membership, State Councils analyze and improve systems, services
and trends within a state, and ensure that the voices of people with developmental disabilities and their families are heard.

**Protection and Advocacy (P&A) Systems**
Each P&A works to empower, protect and advocate on behalf of individuals with developmental disabilities and their families. There are 57 P&As in the United States and its territories, and each is independent of service-providing agencies.

Protecting individuals with developmental disabilities from abuse and neglect is at the core of the P&A mission. Along with the other AIDD grantees, P&As are dedicated to the ongoing fight for the personal and civil rights of individuals with developmental disabilities. P&As provide legal support to traditionally unserved or underserved populations, such as individuals with developmental disabilities, to help them navigate the legal system to achieve resolution. P&As ensure that individuals with disabilities have the ability to exercise their rights to make choices, contribute to society and live independently.

**Projects of National Significance**

In 2008, AIDD awarded grants to four entities, to plan implement one-stop centers to assist military families with children with disabilities navigate needed supports/services between the military and civilian systems. Each of the grants was funded for a period of five years. These one-stop centers were slated to enhance the capabilities of families in assisting children with developmental disabilities to achieve their maximum potential; support the increasing ability of children with developmental disabilities to exercise greater choice and self-determination and to engage in leadership activities in their communities; and ensure the protection of children with developmental disabilities’ legal and human rights.

The University of Guam was one of the four entities awarded a FS 360 Military grant. It was funded for a period of five years. Guam’s *The Navigator’s Compass* goal is to enhance the capabilities of families to assist their children with developmental disabilities to achieve their maximum potential, support the increasing ability of children with disabilities to exercise greater choice and self-determination and to engage in leadership activities in their communities.

In FY 2009, AIDD awarded 12 grants to plan multiagency partnerships to design emergency preparedness planning projects to assist unserved and underserved families with a member who has a disability. The applicants were asked to pool resources, coordinate services, and share expenses in order to effectively train individuals with developmental disabilities and family members to prepare for emergency situations. The University of Hawaii at Manoa was one of the five entities awarded an Emergency Preparedness Special Initiatives grants. The goal/objectives of the project are to address the following:

- Methods for evacuation to a safe location and rapid reunification with families
- Provision of medications or durable medical devices and continuous access to medical and mental health care and other necessary services and supplies
• Provision of transportation services accessible to individuals with developmental disabilities
• Methods by which students can be transitioned back into educational settings
• Provisions for transitioning into safe and effective housing
• Provisions of a variety of personal assistance and supports to include caregivers, home health aides, and service animals
• Provisions to assist individuals with developmental disabilities and their families with developing personal disaster kits
• Information and referrals for at least 60 families
• Training and information provided to at least 5 local agencies or partners responsible for emergency response activities

AIDD funds one P&A (Native American Disability Law Center, Inc., Farmington, NM) which covers the Four Corners region of Arizona, New Mexico, Utah, and Colorado, and services individuals of the Navajo Nation and the Hopi reservation. The issues the Native American Disability Law Center addresses include civil rights, special education, health care, and rights to public and private services. NADLC staff investigates abuse and neglect in care facilities, and provides rights-based training for people with disabilities, their families, educators and service providers.

It currently focuses on the following areas:

1. Community Based Services:
   a. Advocate for increased access to public buildings and services.
   b. Advocate for appropriate services & accommodations to increase access for people with disabilities.

2. Abuse and Neglect:
   a. Monitor the investigation by the appropriate agency of all reported incidents of abuse and neglect.
   b. Represent children in abuse & neglect cases as appointed by relevant courts.
   c. Provide information regarding rights and services to individuals living in group homes & institutions on the reservation by visiting them on a quarterly basis.

3. Employment:
   a. Increase awareness of vocational rehabilitation services by: distributing informational brochures and providing training on employment opportunities and supports for 30 people receiving Social Security benefits.
   b. Research Navajo and Hopi tribal policies regarding employment of people with disabilities and advocate for preferential hiring.
   c. Provide direct assistance to individuals with disabilities, who are currently receiving Social Security benefits, in their efforts to obtain appropriate vocational rehabilitation services.

4. Special Education:
a. Provide two trainings on education rights to parent support groups or parents of children with disabilities reaching 100 individuals.
b. Provide technical assistance to the parents or guardians of 20 children with disabilities to empower them to advocate for their children to obtain and receive appropriate education services in their community and in the least restrictive environment.
c. Provide direct representation in meetings and other informal settings for 15 children with disabilities who are not receiving a free appropriate public education in the least restrictive environment.
d. Provide direct representation in administrative proceedings for 10 children with disabilities who are not receiving a free appropriate public education in the least restrictive environment.

5. Community Awareness:
   a. Work with other disability advocacy organizations to address systemic discrimination toward individuals with disabilities and to increase the awareness of their needs and services.
   b. Develop a stakeholders group & work with group to draft & pass a Navajo Guardianship Act that protects the due process rights of adults with disabilities facing guardianships.

6. Government Benefits:
   a. Assist individuals with disabilities with understanding and completing the application process for benefits provided by the Social Security Administration.
   b. Provide direct representation for 30 individuals with disabilities in their efforts to obtain benefits provided by the Social Security Administration.

7. Housing:
   a. Advocate for simplified Navajo and Hopi housing application procedures and policies that accommodate the needs of people with disabilities.
   b. Assist five individuals with disabilities in their efforts to obtain public housing, when they have been denied housing or reasonable accommodations because of their disability.

In FY 2012, NADLC had 32 individual clients with developmental disabilities. AIDD funds four more P&As that serve Native American communities.

**University Centers for Excellence in Developmental Disabilities (UCEDD)**

In FY 2011, AIDD’s provided funding to American Samoa Community College, University of Guam, and the University of Hawaii at Manoa to carry out their University Center of Excellence in Developmental Disabilities core functions. This discretionary grant is awarded to public service units of universities or public or not-for-profit entities associated with universities. The grant is used to support the operation and administration of the center and additional funds are
leveraged to implement the core activities of: interdisciplinary training community service (e.g., training, technical assistance, exemplary services) and research information dissemination.

The University Center supports activities that address various issues such as early intervention, competitive integrated employment, community living, and health.

In FY 2012, AIDD provided funding through discretionary grants awarded to public service units of universities or public or not-for-profit entities associated with universities. The grants are used to support the operation and administration of the center and additional funds are leveraged to implement the core activities of:

- interdisciplinary training
- community service (e.g., training, technical assistance, exemplary services)
- research
- information dissemination.

The University Center supports activities that address various issues such as early intervention, competitive integrated employment, community living, and health.

Several UCEDDs work directly with the Native American community, including the UCEDDs in Arizona, New Mexico, Oklahoma, Alaska, Oregon, Montana, Washington, and South Dakota.

**Technical Assistance Provided to Native American Communities FY 2009 through FY 2012**

ACL employs training and technical assistance to help meet and advance ACL’s mission as mandated by both the Older Americans Act and the Developmental Disabilities Act. Training and technical assistance can be used when a grantee needs to address an issue it cannot handle independently. It may wish to tackle a problem that crosses state lines, or may need assistance to carry out its work in a manner that is both responsive to the needs of its clients and efficient in its use of taxpayer dollars.

Training and technical assistance can take many forms. TA providers can help build capacity for greater service, provide training to personnel, improve inter-grantee communication, facilitate cross-grantee collaboration, streamline administrative processes, collect information, implement technology advances and provide expert advice in a wide range of areas. Technical assistance provides a greater ability for ACL and its grantees to meet ongoing needs and sustain progress toward more successful, fulfilling lives for individuals with developmental disabilities.

ACL provided training and technical assistance to each of its grantee programs through contracts with a number of organizations including:

- AoA funded the Native American Resource Centers on Aging at the Universities of Alaska, Hawaii, and North Dakota.
- AoA funded the National Indigenous Elder Justice Initiative (NIEJI) at the University of North Dakota.
- On-going training and technical assistance provided by both regional and central office staff.

FY 2009–2012 Report to Congress
• Monthly Title VI webinars.
• Postings on www.olderindians.aoa.gov.
• The National Title VI Training and Technical Assistance Forums.
• UCEDD Resource Center, implemented by the Association of University Centers on Disabilities (AUCD), which provides technical assistance to UCEDDs.

AIDD employs training and technical assistance to help meet and advance AIDD’s mission as mandated by the DD Act. ADD provided training and technical assistance to each of its grantee programs through contracts with a number of organizations including:

• UCEDD Resource Center, implemented under contract by the Association of University Centers on Disabilities (AUCD), which provides technical assistance to UCEDDs.
• Training and Advocacy Support Center (TASC), implemented under contract by the National Disability Rights Network (NDRN), which provides technical assistance to state P&As.
• Information and Technical Assistance for Councils on Developmental Disabilities by the National Association of Councils on Developmental Disabilities (NACDD), which provides technical assistance to state Councils through the Information and Technical Assistance Center for Councils (iTACC) contract.
• BETAH Associates, which provides technical assistance to the PNS family support grantees.

Funding Opportunities Available to Native Americans in FY 2009 through FY 2012

The Native American (Title VI) Grants are a combination of discretionary and formula grants. Title VI grants to Native American tribes and Hawaiian Americans require that, like discretionary grants, grantees must submit an application that meets the requirements if they wish to be considered for funding. A population-based formula is used to distribute the funds available to grantees under this title. Title VI Part A Grants are awarded to Indian tribes and Title VI Part B Grants are awarded to Native Hawaiians. The purpose of these grants is to promote the delivery of supportive and nutrition services to American Indian, Alaska Native and Native Hawaiian elders in order for them to be able to remain healthy, active and independent in their homes and communities as long as possible. Title VI Part C Grants are for the Native American Caregiver Support Program. This program provides support for unpaid family members caring for their elders.

The Nutrition Services Incentive Program (NSIP) is another grant program funded under Title III of the OAA, and is also available to Native Americans, Alaska Native, and Native Hawaiian tribal entities. NISP is an incentive program to encourage and reward effective performance in the efficient delivery of nutritious meals to older individuals. Tribes can chose to receive NSIP in the form of all cash, all agricultural commodities from the Department of Agriculture, or a combination of cash and agricultural commodities.

In FY 2012, the Older American Act (OAA) awarded more than $31,000,000 in Title VI grants to 256 organizations serving American Indians, Alaska Natives, and Native Hawaiians in over 400 tribal communities.
Due to the Title VI funding cycles and fiscal years, data collection is actually gathered two years behind. The following chart lists the collected program data that is available from FY2011 reports that shows services provided using Title VI funds:

<table>
<thead>
<tr>
<th>Total Clients Served</th>
<th>69,467</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Congregate Clients</td>
<td>46,621</td>
</tr>
<tr>
<td>Total Home-delivered Clients</td>
<td>22,846</td>
</tr>
<tr>
<td>Total Number of Meals Served</td>
<td>5,118,974</td>
</tr>
<tr>
<td>Total Number of Congregate Meals Served</td>
<td>2,344,017</td>
</tr>
<tr>
<td>Total Number of Home-delivered Meals Served</td>
<td>2,774,957</td>
</tr>
<tr>
<td>Total Units of Respite Care Provided</td>
<td>123,993</td>
</tr>
<tr>
<td>Total Caregiver Clients Receiving Respite Care</td>
<td>9,525</td>
</tr>
<tr>
<td>Total Units of Transportation Provided</td>
<td>804,807</td>
</tr>
</tbody>
</table>

Title VI Part A, B, C, NSIP and ARRA grantees are listed on the following tables.

<table>
<thead>
<tr>
<th>FY Totals</th>
<th>AoA Title VI Part A, B, C and NSIP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>TITLE6 A/B</td>
</tr>
<tr>
<td>FY 2009</td>
<td>$26,830,170</td>
</tr>
<tr>
<td>FY 2010</td>
<td>$26,936,716</td>
</tr>
<tr>
<td>FY 2011</td>
<td>$27,479,621</td>
</tr>
<tr>
<td>FY 2012</td>
<td>$27,031,734</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AIDD Funding Amount</th>
<th>AIDD Funding Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2010</td>
<td>FY 2011</td>
</tr>
<tr>
<td>$4,068,754</td>
<td>$4,052,299</td>
</tr>
</tbody>
</table>

No awards were made to Native American organizations in FY 2009 or 2012.

**Other Funding Opportunities or Contracts Awarded**

In FY’s 2009, 2010, and 2011, the Older American Act Title IV Discretionary grants were awarded to the following organizations serving American Indians, Alaska Natives, and Native Hawaiians:

- National Resource Center for American Indians, Alaska Natives and Native Hawaiians, North Dakota, University of North Dakota.
- National Resource Center on Native American Aging, University of Hawaii.
In FY 2012, the Older American Act Title IV Discretionary grants were awarded to the following organizations serving American Indians, Alaska Natives, and Native Hawaiians:

Three tribes were funded under the Elder Abuse Prevention/Intervention Program Option Two: Native American Elder Abuse Prevention Grants to test interventions designed to prevent elder abuse, neglect, and exploitation. Funding originated from the Prevention and Public Health Fund (PPHF). This initiative helps to implement the Elder Justice Act, which was enacted as part of the Patient Protection and Affordable Care Act. These prevention projects will draw on existing research and promising practices, while building a stronger evidence base and improving data collection systems that are needed to more effectively address this troubling issue in tribal communities.

<table>
<thead>
<tr>
<th>TRIBE</th>
<th>FUNDING LEVEL</th>
<th>PROJECT PERIOD</th>
<th>STATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poarch Creek Band of Indians</td>
<td>$250,000</td>
<td>9/30/2012 - 9/29/2015</td>
<td>Alabama</td>
</tr>
<tr>
<td>Winnebago Tribe of Nebraska</td>
<td>205,249</td>
<td>9/30/2012 - 9/29/2015</td>
<td>Nebraska</td>
</tr>
<tr>
<td>Tohono O’odham Nation</td>
<td>246,711</td>
<td>9/30/2012 – 9/29/2015</td>
<td>Arizona</td>
</tr>
<tr>
<td><strong>TOTAL:</strong></td>
<td><strong>$701,960</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

National Resource Centers on Native American Elders

ACL/AoA currently funds three Resource Centers for Older Indians, Alaska Natives, and Native Hawaiians. These centers provide culturally competent health care, community-based long-term care, and related services. They serve as the focal points for developing and sharing technical information and expertise for Native American organizations, Native American communities, educational institutions, and professionals working with elders.

1. **National Resource Center for American Indian, Alaska Native and Native Hawaiian Elders**
   - **Grantee:** University of Alaska, Anchorage
   - **Audience:** Alaska Native elders organizations working with this population, tribal councils and Title VI programs in the State of Alaska
   - **Goal:** The goals of this project are to assess the current status of Native elders in Alaska; develop an understanding of the cultural values that drive expectations and perceived needs for care; document “best, promising and emerging practices” that are in current use; solicit recommendations for community responses to elder abuse, exploitation and violence that are appropriate to Alaska Native cultures; and provide education to medical providers.

2. **National Resource Center for Native Hawaiian Elders (Hā Kūpuna)**
   - **Grantee:** University of Hawaii
   - **Audience:** Native Hawaiian elders and family caregivers
   - **Goal:** The center’s goal is to develop and disseminate knowledge on health and long-term care to increase and improve the delivery of services to Native Hawaiian elders and their family caregivers.
3. National Resource Center on Native American Aging  
**Grantee:** University of North Dakota  
**Audience:** Tribes, community-based and other organizations who deal directly with American Indians, Alaska Natives and Native Hawaiians in their communities.  
**Goal:** The goal of the program is to improve the quality of life for Native elders through research, training, and technical assistance. UND seeks to identify and increase awareness of evolving Native elder health and social issues and to empower Native people to develop community based solutions to meet their most pressing needs.

<table>
<thead>
<tr>
<th>UNIVERSITY</th>
<th>FY 2012 FUNDING LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>U of Alaska</td>
<td>$215,841</td>
</tr>
<tr>
<td>U of Hawaii</td>
<td>$129,852</td>
</tr>
<tr>
<td>U of North Dakota</td>
<td>$336,020</td>
</tr>
<tr>
<td><strong>TOTAL:</strong></td>
<td><strong>$681,713</strong></td>
</tr>
</tbody>
</table>

4. National Center on Elder Abuse in Indian Country  
**Grantee:** University of North Dakota School of Medicine and Health Sciences  
**Audience:** Tribes, care providers, stakeholders, law enforcement  
**Goal:** The National Indigenous Elder Justice Initiative (NIEJI) was created to address the lack of culturally appropriate information and community education materials on elder abuse, neglect and exploitation in Indian Country. Some of the undertakings of the initiative include:

- Establishment of a resource center on elder abuse to assist tribes in addressing indigenous elder abuse, neglect, and exploitation;
- Identification and making available existing literature, resources and tribal codes that address indigenous elder abuse; and
- Developing and disseminating culturally appropriate and responsive resources for use by tribes, care providers, law enforcement and other stakeholders.

<table>
<thead>
<tr>
<th>UNIVERSITY</th>
<th>2012 FUNDING LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>U of North Dakota</td>
<td>$259,446</td>
</tr>
<tr>
<td><strong>TOTAL:</strong></td>
<td><strong>$259,446</strong></td>
</tr>
</tbody>
</table>

**Identifying the Needs of American Indian, Alaska Native, and Native Hawaiian Elders**

Under the cooperative agreement from the Administration on Aging, the National Resource Center on Native American Aging at the University of North Dakota assists tribes in creating a record of the health and social needs of elders. A survey instrument was constructed using questions from nationally administered questionnaires so comparisons could be made with data from the nation. Data is collected on: general health status, activities of daily living, vision, hearing and dental care, screening, health care access, tobacco and alcohol usage, weight and nutrition, social support/housing, demographics, and social functioning. Data have now been collected for five cycles: Cycle 1 - 2001; Cycle 2 - 2004; Cycle 3 - 2007; Cycle 4 - 2011, and Cycle 5 - 2014. During this time changes in demographics have been documented, for example:
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>55-59</td>
<td>38%</td>
<td>19%</td>
<td>14%</td>
<td>15%</td>
<td>16%</td>
</tr>
<tr>
<td>60-69</td>
<td>36%</td>
<td>40%</td>
<td>40%</td>
<td>44%</td>
<td>43%</td>
</tr>
<tr>
<td>70-79</td>
<td>17%</td>
<td>25%</td>
<td>27%</td>
<td>28%</td>
<td>28%</td>
</tr>
<tr>
<td>80+</td>
<td>5%</td>
<td>11%</td>
<td>12%</td>
<td>13%</td>
<td>13%</td>
</tr>
<tr>
<td><strong>Living Arrangements</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>28%</td>
<td>24%</td>
<td>27%</td>
<td>28%</td>
<td>28%</td>
</tr>
<tr>
<td>With Family</td>
<td>68%</td>
<td>72%</td>
<td>68%</td>
<td>66%</td>
<td>66%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
<td>4%</td>
<td>5%</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married w/partner</td>
<td>41%</td>
<td>50%</td>
<td>43%</td>
<td>42%</td>
<td>42%</td>
</tr>
<tr>
<td>Single</td>
<td>31%</td>
<td>28%</td>
<td>29%</td>
<td>11%</td>
<td>13%</td>
</tr>
<tr>
<td>Divorced/Separated</td>
<td>20%</td>
<td>17%</td>
<td>18%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Widowed</td>
<td>7%</td>
<td>5%</td>
<td>10%</td>
<td>27%</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Annual Household Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under $15,000</td>
<td>74%</td>
<td>58%</td>
<td>63%</td>
<td>57%</td>
<td>54%</td>
</tr>
<tr>
<td>$15,000-$24,999</td>
<td>15%</td>
<td>24%</td>
<td>18%</td>
<td>21%</td>
<td>21%</td>
</tr>
<tr>
<td>$25,000-$49,999</td>
<td>15%</td>
<td>28%</td>
<td>22%</td>
<td>17%</td>
<td>17%</td>
</tr>
<tr>
<td>$50,000 +</td>
<td>2%</td>
<td>3%</td>
<td>4%</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than High School</td>
<td>23%</td>
<td>22%</td>
<td>20%</td>
<td>13%</td>
<td>10%</td>
</tr>
<tr>
<td>High School</td>
<td>22%</td>
<td>44%</td>
<td>16%</td>
<td>52%</td>
<td>52%</td>
</tr>
<tr>
<td>College</td>
<td>19%</td>
<td>16%</td>
<td>24%</td>
<td>35%</td>
<td>39%</td>
</tr>
<tr>
<td><strong>Functional Status:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty Walking</td>
<td>28%</td>
<td>24%</td>
<td>31%</td>
<td>31%</td>
<td>30%</td>
</tr>
<tr>
<td>Difficulty Bathing</td>
<td>17%</td>
<td>15%</td>
<td>16%</td>
<td>16%</td>
<td>15%</td>
</tr>
<tr>
<td>Difficulty Dressing</td>
<td>12%</td>
<td>10%</td>
<td>11%</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>Difficulty getting out of Bed</td>
<td>13%</td>
<td>12%</td>
<td>13%</td>
<td>13%</td>
<td>14%</td>
</tr>
<tr>
<td>Difficulty Toileting</td>
<td>9%</td>
<td>8%</td>
<td>8%</td>
<td>9%</td>
<td>8%</td>
</tr>
<tr>
<td>Difficulty Eating</td>
<td>8%</td>
<td>5%</td>
<td>6%</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td><strong>Long-term Care Services Received</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>59%</td>
<td>65%</td>
<td>50%</td>
<td>58%</td>
<td>58%</td>
</tr>
<tr>
<td>Home &amp; Community Services</td>
<td>15%</td>
<td>13%</td>
<td>16%</td>
<td>22%</td>
<td>22%</td>
</tr>
<tr>
<td>Assisted Living</td>
<td>13%</td>
<td>11%</td>
<td>14%</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>Skilled Nursing Home</td>
<td>13%</td>
<td>11%</td>
<td>12%</td>
<td>13%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Data from Cycle 5 indicates:
Health Conditions:
Native elders were 1% less likely to experience arthritis than the general U.S. population.
Native elders were 2% more likely to experience congestive heart failure than the general U.S. population.
Native elders were 2% more likely to experience a stroke than the general U.S. population.
Native elders were 2% more likely to experience asthma than the general U.S. population.
Native elders were 19% less likely to experience cataracts than the general U.S. population.
Native elder women were 2% more likely to experience cervical cancer and .4% less likely to experience breast cancer than the general U.S. population of women.
Native elder men were 2% less likely to experience prostate cancer than the general U.S. population of men.
Native elders were 1% less likely to experience colon/rectal cancer than the general U.S. population.
Native elders were 22% more likely to experience diabetes than the general U.S. population.
65% of Native elders have never drink alcohol or have not had a drink for at least a year and 76% do not smoke.
22% of Native elders are normal weight, 33% are overweight and 46% are obese, as measured by BMI.
29% of Native elders are at high nutritional risk.
71% of Native elders have never drink alcohol or have not had a drink for at least a year and 76% do not smoke.
22% of Native elders are normal weight, 33% are overweight and 46% are obese, as measured by BMI.
29% of Native elders are at high nutritional risk.

These programs, technical assistance and supports, although limited, work together with tribes to improve the quality of life for American Indians. We are working collaboratively with the Centers for Medicare and Medicaid Services and the Indian Health Service to broaden our impact and to positively influence the overall health and well-being of our elders and persons with disabilities.
The mission of the Agency for Healthcare Research and Quality (AHRQ) is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. The Agency works to fulfill this mission through health services research. Health services research examines how people get access to health care, how much care costs, and what happens to patients as a result of the care they receive. The principal goals of health services research are to identify the most effective ways to organize, manage, finance, and deliver high quality care, reduce medical errors, and improve patient safety. AHRQ conducts and supports health services research, both within AHRQ as well as in leading academic institutions, hospitals, physicians’ offices, health care systems, and many other settings across the country.

Support Provided to Native American Communities in FY 2009 through FY 2012

The Montana-Wyoming Tribal Leaders Council (TLC) was awarded a Minority Research Infrastructure Support Program (M-RISP) grant at the end of 2003 which was completed in 2012. At the time of the initial award, TLC had very limited research infrastructure and capacity, with four staff and two research partners. Tribes in the region were skeptical of research and had little experience. A structured approach to infrastructure development was implemented, focusing on engaging tribes, expanding financial and administrative capacity, and building staff and partnerships. Several research studies were designed and implemented to increase both TLC and Tribal research experience.

Over the eight years of the M-RISP, the TLC: (1) engaged tribes in research activities and created both the Rocky Mountain Tribal Epidemiology Center and the Rocky Mountain Tribal Institutional Review Board (IRB) to serve the tribes in its region; (2) increased its professional research staff to sustain and expand capacity; (3) developed partnerships with academic institutions to augment substantive and technical research capacity; (4) obtained numerous grants from a diverse set of federal agencies and foundations, many of which are multi-year and provide a solid foundation for sustainability of TLC research; and (5) engaged in dissemination activities to contribute to knowledge of AI/AN health research and methods for engaging tribes in research.

In FY 2009, AHRQ supported a research network of 54 primary care providers, 21 of whom are American Indian and all of whom serve a largely American Indian population in Robeson County, North Carolina, to study disease- and tribal-specific data on such issues as diabetes prevalence and processes of care. Robeson County, North Carolina, is a rural county that is home to most of the over 50,000 members of the Lumbee Tribe who live in the State. In addition to creating the network of primary care practices where disease and tribe specific data was collected, researchers estimated diabetes prevalence in adults and children as well as collected pilot data on processes of care for diabetes. The creation of the network, measurement
of prevalence, and results of the pilot study resulted in assessment of the needs for further work to improve the identification and care for diabetes in the community.

In FY 2009, the Holomua Project brought together the Hawaii Primary Care Association, the Kalihi-Palama Health Center, Kokua Kalii Valley Health Center, Hawaii Pacific Health, and the Queens Medical Center in an approach to information sharing during transitional care. The implementation plan assisted the Holomua partners in achieving the ultimate project goal to increase patient safety, quality and continuity of care during transitional care for vulnerable populations in Hawaii through improving the flow of information between patients/families, community health centers and hospitals using health information technology (HIT). The project consisted of both technological and non-technological solutions to the problem of transitional care.

In FY 2010 and 2011, The Hawaii State Center for Nursing project provided support for a series of annual research dissemination and translation conferences titled "Pacific Institute of Nursing: Advancing Practice, Education, and Research." The Hawaii State Center for Nursing, in collaboration with 23 health care organizations throughout the state, organized and hosted the workshops. The focus was on evidence-based practice, and participants included nursing administrators, clinicians, educators, and researchers from Hawaii and the Western Pacific region. The goal was to foster the delivery of safe, quality patient care; enhance the translation of research findings into practice and policy; provide a venue for capacity-building partnerships across the practice, education, and research domains; and disseminate best practices in an informal environment.

In FY 2009, AHRQ continued its efforts to work with the Indian Health Service (IHS) on several fronts including:

AHRQ supported the IHS’ Planned Care Collaborative initiative which focused on improving delivery systems and self-management with resources and technical assistance. An AHRQ staff member was on the national faculty supporting the current 35 plus clinics. AHRQ’s efforts targeted: skill building training to do self-management and preparing a DVD specifically for Indian country on self-management.

The Family Health History was an effort by IHS to develop, test, and deploy a system to capture information on family health history in electronic health records. The system produced a standards-based, machine-readable file that could be used by organizations across the government and private industry.

The pilot test of the IHS Electronic Health Records System was an effort to pilot test the AHRQ “Common Format” data set which is used nationally to report patient adverse events to Patient Safety Organizations. IHS worked with AHRQ on nursing home and long term care common formats.

In FY 2009 through 2012, AHRQ supported the Tribal Health Research Advisory Council (HRAC), which is a group of tribal leaders who advise the Department on health research.
matters and provided support for the annual American Indian/Alaska Native Health Research Conference.

AHRQ also supported a project to identify quality improvement opportunities and the progress of quality improvement efforts “Yale CAHPS.” The purpose of this project was to demonstrate the potential usefulness of the CAHPS® as a tool for identifying opportunities for the Indian Health Service quality improvement and monitoring improvements (see https://cahps.ahrq.gov/about.htm for information on the AHRQ CAHPS program). The Wind River Reservation Indian Health Service in Wyoming, worked collaboratively with the Eastern Shoshone and Northern Arapaho Tribal Health Departments and Sundance Research Institute, and developed a modified CAHPS survey instrument reflecting the unique characteristics and priorities of IHS and tribes. The Baseline American Indian CAHPS survey identified areas needing improvement. Based on this survey work, the joint IHS-Tribal Working Group developed a specific quality improvement initiative that was evaluated at its completion and found to have been effective at improving customer service. In FY 2010, Wind River, the Tribal Health Directors, and the IHS leadership team collected baseline Health Plan CAHPS® Survey data to identify patients’ perceptions of the care they received. Results were reported to the Tribal-IHS Working Group. At the Fort Peck Indian Reservation and the Yale team worked with the Tribal Health Directors to collect baseline patient experience data in the Tribally-operated dialysis unit with the CAHPS® In-Center Hemodialysis Survey. After review of the data, quality improvement interventions were developed. During FY 2011, they conducted and analyzed the tailored American Indian CAHPS survey at each reservation, and presented the findings to the Tribal-Indian Health Service Working Group at each site. The Wind River Tribal-IHS Working Group identified Customer Service as the specific QI area that they would pursue and developed and implemented a QI work plan. Results for the first three months were positive with both clinics producing higher scores on the short survey each month through August. During the final year of the project (FY 2012), monitoring and documentation of the QI interventions continued, another round of site visits were conducted, and the follow-up CAHPS surveys were conducted at each site. Results of the project were presented to each Tribal-IHS Working Group during the final month of the study.

AHRQ supported a project to study the implementation of a Patient-Centered Medical Home in Alaska. The grantee assessed the process and outcomes related to implementing several components of a patient-centered medical home (PCMH) model at Southcentral Foundation (SCF), a tribally owned and managed primary care system in Alaska. This study focused on process and outcomes related to three components of the PCMH model: patient-provider match (empanelment); integrated primary care teams (team-based care); and increased access (often same day). This study included a cost assessment and a time series analysis of primary care sensitive patient outcomes and patient service utilization from medical record data. The SCF PCMH was viewed as a success within quality improvement circles but the impact of the PCMH transformation had not undergone rigorous scientific investigation. In this effort, University of Alaska Anchorage and SCF partnered to address the following specific aims: (1) to determine the impact of the PCMH transformation on the characteristics and quality of patient care delivery and (2) to assess changes in healthcare delivery, such as quality and safety efforts, efforts to bring evidence to the point of care, use of information systems, and costs. There had been no
studies which examined the impact of a health system redesign among the AI/AN population. As the PCMH model lent itself to implementation in other primary care settings, this effort could have national implications for improving the health status of AI/AN people. In FY 2011, the project was in its final stages.

In FY 2011, AHRQ entered into an intra-agency agreement (IAA) between AHRQ and the Indian Health Service for the purposes of improving the delivery of self-management support services to AI/AN people. This agreement transferred funds from AHRQ to IHS for the purpose of supporting the improvement of the delivery of prevention and care management services through the IHS Improving Patient Care Program (IPC). This project was designed to help understand, develop and test Electronic Health Record (EHR) elements that improve the delivery, documentation, and tracking of self-management support services.

In an effort to improve patient care learning networks, AHRQ provided (directly or through funding) subject matter experts for 16 presentations to the IHS learning network teams. The project built on a previous IAA that provided clinical staff training and skill-building in self-management support for 38 clinical sites and teams participating in the IPC learning collaborative. Self-management support is a key component of patient-centered health care and the Chronic Care Model.

AHRQ continued its efforts to work with IHS on several fronts including two large American Recovery and Reinvestment Act (ARRA) programs. Over the past decade, the IHS developed a national information technology infrastructure that allowed for the routine, reproducible measurement of ambulatory quality of care across a spectrum of conditions for AI/AN communities. This infrastructure represented a model for evaluating the use of a nationally integrated health information system to conduct comparative effectiveness research (CER) and ultimately identify the most capable quality improvement activities. This project used electronic clinical data from the IHS national health information systems to create a longitudinal database linking quality of care measures for diabetes, cardiovascular disease, and cancer screening over a nine year period. A second objective was to conduct two comparative analyses to determine the effectiveness of delivery system interventions, such as the use of an advanced electronic health record and a chronic care model (Improving Patient Care) to assess health care quality and outcomes for diabetes, cardiovascular care, and cancer screening.

Drawing on the same longitudinal database being developed for the first OS ARRA project, above, this project (Project studies comparative effectiveness of disease management by IHS advanced practice pharmacists) linked service data, pharmacy cost data, and health status measures and assess utilization and spending for a population subset in 12 IHS regions. The contractor then conducted a targeted CER project focusing on health delivery system strategies, such as advanced pharmacy practice, to reduce cardiovascular disease (CVD) risk among AI/AN adults.

Properly evaluating the health status of AI/ANs and other minority populations is difficult because public health data sources are frequently unsuccessful in securing accurate race/ethnic information. The Improving Data and Enhancing Access project, awarded to the NW Portland
Area Indian Health Board, used the most complete roster of Northwest AI/ANs to conduct record linkages with an array of health-related data systems in the three-state region of Oregon, Washington, and Idaho. These activities benefitted both state governments and tribes by: (1) improving the validity and reliability of race data in state data systems, and (2) providing more accurate and complete health status data to northwest tribal communities. Moreover, results from this project informed ongoing efforts to eliminate health disparities experienced by AI/ANs in the Northwest and served as a model to further address health disparities of AI/ANs at the national level.

The New Mexico Race and Ethnicity Data project involved the improvement in the quality of race and ethnicity data in hospital discharge and emergency department databases by the New Mexico Department of Health. In particular, this project collected tribal identifier data and established methods and procedures for tribal identifiers that could be used as a model by other states.

In order to identify, understand, and eliminate healthcare disparities, it is critically important to make headway in the way that hospitals and other providers and payers successfully collect consistent and accurate data regarding race, ethnicity, and language from their patients. The Improving Reporting of Race, Ethnicity, and Language in California project integrated and improved upon methods for collection, auditing, and post-collection data imputing of race, ethnicity, and language data. The size of California, its diverse population, and large number of hospitals made it an important testing location for the development and dissemination of approaches that could work across a large spectrum of states.

The goal of the Enhancing Hawaii Hospital Information Content proposal is to develop the capacity to perform comparative effectiveness research (CER) by enhancing the breadth and scope of data contained within a statewide, all-payer hospital discharge and emergency department data set in Hawaii, which had the nation's most racially diverse population, the longest life expectancy, the longest experience with employer-mandated health care benefits (over 35 years), and one of the lowest Medicare costs per beneficiary.

The overall purpose of the Comparative Effectiveness of Disease Management by Advanced Practice Pharmacists for American Indians and Alaska Natives project created and enhanced the data infrastructure for the IHS in such a way that comparative effectiveness research (CER) could be facilitated. The second phase of the project aimed to use the database created to carry out a CER study that would look at the outcomes of education and case management services provided by various health care providers, including pharmacists.

Existing data from four different sources were analyzed and linked by the contractor in a variety of ways as SAS datasets to provide information regarding health status, utilization, and treatment costs. The resulting dataset covers four fiscal years (2007 through 2010), 14 project sites, and included data on approximately 440,000 AI/ANs.

At the end of the two-year project, certain challenges in acquiring data and identifying and addressing the variability among encoded data resulted in an exploratory analysis. This modified
analysis resulted in findings that created the basis for a longitudinal CER study in the future and targeted quality improvement efforts. For the exploratory analyses, the contractor examined the association between the use of education and case management services (provided by a variety of healthcare providers), and the use of hospital emergency department and inpatient services, based on a cross-sectional analysis of one year’s worth of data (Fiscal Year 2010).

The overall purpose of the Comparative Effectiveness of Quality Improvement Efforts project was to support the IHS development of a longitudinal data infrastructure (LDI) capable of building the capacity for CER or patient centered outcomes research (PCOR). The second phase of the project aimed to use the CER database to enhance the capacity to electronically measure quality of care and to conduct a CER study to identify certain care delivery models that resulted in improved health outcomes.

The contractor developed a LDI after conducting a thorough evaluation of the technical functionality of the IHS database systems and their data dictionaries. The LDI was used to conduct a physician survey regarding use and functionality of the electronic health record (EHR). Extracts from the LDI were then used to conduct analyses on how to best identify a medical home within the IHS with regards to quality of care, and on understanding the impact of meaningful use of the IHS EHR.

**Funding Opportunities Available to Native Americans in FY 2009 through FY 2012**

<table>
<thead>
<tr>
<th>Tribe/Organization</th>
<th>State</th>
<th>FY 2009</th>
</tr>
</thead>
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<tr>
<td>MT/WY Tribal Leaders Council</td>
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<td>$175,000</td>
</tr>
<tr>
<td>Pacific Institute of Nursing Research conference</td>
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**Other Funding**

<table>
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<td>Native Research Network</td>
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<table>
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<tr>
<td>Transforming Primary Care Practice/Medical Home Model for Alaska Natives</td>
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<tr>
<td>California</td>
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<td>Improving Reporting of Race, Ethnicity, and Language in CA</td>
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_FY 2009–2012 Report to Congress_
<table>
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<th>Tribe/Organization</th>
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<th>FY 2011</th>
<th>FY 2012</th>
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<td>AI/ANs Perceptions of Care</td>
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The Centers for Disease Control and Prevention (CDC) serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and health education activities designed to improve the health of the people of the United States. To accomplish its mission, CDC identifies and defines preventable health problems and maintains active surveillance of diseases through epidemiologic and laboratory investigations and data collection, analysis, and distribution; serves as the Public Health Service (PHS) lead agency in developing and implementing operational programs relating to environmental health problems, and conducts operational research aimed at developing and testing effective disease prevention, control, and health promotion programs; administers a national program to develop recommended occupational safety and health standards and to conduct research, training, and technical assistance to assure safe and healthful working conditions for every working person; develops and implements a program to sustain a strong national workforce in disease prevention and control; and conducts a national program for improving the performance of clinical laboratories.

CDC is responsible for controlling the introduction and spread of infectious diseases, and provides consultation and assistance to other nations and international agencies to assist in improving their disease prevention and control, environmental health, and health promotion activities. CDC administers the Preventive Health and Health Services Block Grant and specific preventive health categorical grant programs while providing program expertise and assistance in responding to Federal, State, local, and private organizations.

CDC provides extensive technical assistance to the public to fulfill its mission, including Native Americans. Highlights of such activities may be found in the next section that also includes select descriptions of contracts, grants, in-kind contributions and cooperative agreements.

Support Provided to Native American Communities in FY 2009 through FY 2012

Cancer Prevention and Control

National Breast and Cervical Cancer Early Detection Program (2009): The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) was established as part of the Breast and Cervical Cancer Mortality Prevention Act of 1990 to provide free or low-cost breast and cervical cancer screening and diagnosis to low-income, uninsured, and under-insured women. In FY 2009, the NBCCEDP received funding for the Breast and Cervical Cancer Early Detection Programs in all 50 states, the District of Columbia, five U.S. territories, and 12 AI/AN tribes and tribal organizations. The NBCCEDP targets low-income women with little or no health
insurance. Racial and ethnic minority women comprise priority populations in the program, which has helped to reduce disparities in cancer screening and health outcomes.

Through the NBCCEDP, AI/AN organizations detected a total of 241 breast cancers, 13 invasive cervical cancers, and 468 high-grade pre-cancerous cervical lesions. The NBCCEDP will continue to promote screening for underserved women through states and tribal organizations. In 2010 through 2012, the NBCCEDP began reimbursement for full field digital mammography, the community screening standard, which has the potential to increase provider participation in the program, thereby increasing underserved women’s access to screening. The program funded the following organizations: Arctic Slope Native Association, Cherokee Nation Health Service Group Funding, Cheyenne River Sioux Tribe, Hopi Tribe, Kaw Nation of Oklahoma, Native American Rehabilitation Association, Navajo Nation, Poarch Band of Creek Indians, South Puget Intertribal Planning Agency, Southcentral Foundation, Funding, Southeast Alaska Regional Health Consortium and Yukon-Kusokokwim Health Corporation.

Early Act AI/AN Project - "Walking Together: Making A Path Toward Healing (2009-2012): Between FY 2009 and FY 2012, CDC and IHS provided funding through an Intra-Agency Agreement (IAA) to support the Phoenix Indian Medical Center Oncology Program to identify and describe the impediments to care physically, psychologically, and spiritually faced by young AI/AN women diagnosed with breast cancer under the age of 45 from their own viewpoint. Through focus groups, the patients came to understand the barriers they faced in getting care for their breast cancer. Their viewpoints regarding services available or unavailable to them were studied. The information gathered was used to develop recommendations for targeted interventions that address common concerns in these patients breast cancer journey.

National Colorectal Cancer Control Program (2009-2012): In 2005, AI/ANs had the second highest incidence rate of colorectal cancer. Routine colorectal cancer screening can find precancerous polyps before they become cancerous, as well as find colorectal cancer at an early, treatable stage. CDC launched the National Colorectal Cancer Control Program (NCRCCP), with approximately $22 million awarded to fund 22 states and four tribal organizations as CRCCP sites. The NCRCCP supported these sites to conduct population-based screening efforts and provided colorectal cancer screening services to low-income men and women aged 50 to 64 years who were underinsured or uninsured for screening when no other insurance was available. Funding supported diagnostic follow-up, patient navigation, data collection and tracking, public education and outreach, provider education, and CRCCP evaluation.

In FY 2010 through FY 2012, the Northwest Portland Area Indian Health Board (NPAIHB) entered into an agreement with the Indian Health Service for the purpose supporting the Tribal BRFSS Project at NPAIHB. The objective of this project was to provide tribal grantees of the National Comprehensive Cancer Control Program with accurate health behavior data that was not readily available through the state BRFSS for tribal communities so that programs could use these data to assess cancer risk factors for their population and monitor progress toward reaching cancer plan objectives. Northwest Portland Area Indian Health Board subcontracted with the Intertribal Council of Arizona to support a Tribal BRFSS Project with the Tohono O’odham Nation.
National Program of Cancer Registries (NPCR) (2009): To properly estimate the cancer burden in AI/ANs, researchers must have correct identification of race of the cancer patient available in their data. Some central cancer registries and geographic areas have reported misclassification of AI/ANs as non-AI/ANs, decreasing the accuracy and reliability of cancer incidence data for AI/ANs. In 2008, CDC staff addressed this issue by implementing data linkages between the IHS patient registration database and central cancer registry data. CDC continued this activity in FY 2009 to improve data on race and reduce AI/AN misclassification. Prior to the NPCR—Cancer Surveillance System data submission, CDC staff worked with 30 central cancer registries to link incidence data with the IHS patient registration database.

The IHS database continues to make necessary modifications to improve data accuracy and is constantly adding new data. This improvement required some central cancer registries to conduct data linkage activities annually, which has improved incidence cancer data for the AI/AN population. Linking cancer incidence records to the IHS datasets from Contract Health Service Delivery Areas countries continued to improve the classification of race for AI/AN cases in cancer registries. This activity will continue to improve cancer surveillance data for AI/AN communities and should aid in the planning, implementation, and evaluation of more effective cancer control and reduced health disparities in this population.

Tribal Cancer Plans (2009): Comprehensive Cancer Control (CCC) is an integrated and coordinated approach to reducing cancer incidence, morbidity, and mortality through the range of the disease—prevention, early detection, treatment, rehabilitation, and palliation. CCC efforts emphasize the benefits of healthy lifestyles and recommended cancer screening and tests, and works to increase access to quality care and improve quality of life for cancer survivors. In FY 2009, CDC funded CCC programs in seven tribes and tribal organizations to develop Tribal Cancer Plans. These plans included strategies outlining systematic approaches to address the needs of at-risk populations, including AI/ANs. These plans focused on building infrastructure to increase access to cancer screening and treatment. CDC’s CCC Program worked with tribes and tribal organizations to implement their Tribal Cancer Plans and foster collaborations with external partners.

Follow-Up of Elevated PSA Tests among AI/AN Men in Urban Health Clinics (2009): Since November 2008, CDC has worked with the Fred Hutchinson Cancer Research Center and the Urban Indian Health Institute to develop a data abstraction form and questionnaire. The research project obtained National IHS IRB approval in 2009 to survey men with elevated PSA. CDC abstracted urban health-clinic data to identify eligible men with elevated PSA. CDC then contacted these men to see if prostate cancer was diagnosed and determine their course of treatment. After analyzing the data, CDC disseminated research findings to help increase our understanding of AI/AN men’s experience with prostate cancer diagnosis and treatment.

Cross-Cutting Chronic Disease Programs

Racial and Ethnic Approaches to Community Health (REACH) U.S. Program (2009-2012): In FY 2009, REACH continued to build on the successes, strong outcomes, and body of knowledge
to eliminate racial and ethnic health disparities. Forty REACH U.S. communities—18 Centers of Excellence in the Elimination of Health Disparities (CEED) and 22 Action Communities (AC)—were engaged in eliminating disparities by supporting community coalitions. Effective strategies were applied through innovative and nontraditional partnerships at the community level. Under the REACH U.S. program, CDC awarded six entities targeting the elimination of health disparities in AI communities; all six were fully engaged in intervention activities. Two of these entities (Oklahoma State Department of Public Health; University of Colorado at Denver and Health Sciences Center) functioned as CEEDs and served as resource centers on effective interventions in addition to working in their communities. Four entities (the Choctaw Nation of Oklahoma; the Eastern Band of Cherokee Indians; the Inter-Tribal Council of Michigan; the Northern Arapaho Tribe) were funded as ACs. They implemented and evaluated successful approaches with specific communities to impact AI/AN populations. All of the REACH US communities implemented activities. Below is a brief description of the individual projects:

CEED: Oklahoma State Department of Health “Southern Plains REACH US (SPRUS) chose to work with tribal communities in Oklahoma, Texas, and Kansas to reduce their risk of diabetes and CVD through activities related to nutrition, physical activity (PA), and tobacco control and prevention. There were two Legacy Project recipients, comprising two different tribal organizations (who focused on PA and nutrition from their own particular cultural context) with the goal of increasing the community’s knowledge and practice of healthy eating and active living through community assessment and partnership, program planning, education, and hands-on activities. This CEED provided TA for these projects and held them up as an example from which other tribal communities could model, with expectations of expanding the Legacy Project reach into the rest of the SPRUS service area States of Texas and Kansas.

For grant year two, SPRUS had efforts that spanned the entire socio-ecological model, with tribes introducing curriculum and tobacco control policy at various levels within the community or schools, and initiating the development of the SPRUS as a regional and national resource for tribal organizations interested in using the REACH US approach. The main attributes of SPRUS and the Southern Plains AI CEED for grant year three were school-based wellness programs for children and tobacco-free, healthy nutrition, and PA policy support and promotion in tribal entities, including businesses and health centers. They were provided through direct services and TA. SPRUS partnership included the Oklahoma Department of Health, Southern Plains Intertribal Epidemiology Center (SPIEC), Oklahoma State Bureau of Investigation, Oklahoma Turning Point, and CDC.

CEED: University of Colorado at Denver CVD Risk Reduction among Denver American Indians/CVD Risk Reduction among Albuquerque American Indians implemented an evidence-based organizational change process with approximately 240 members of the Special Diabetes Program for Indians (SDPI) who were not involved in the competitively awarded demonstration projects; delivered intensive train-the-trainer workshops about organizational culture and effectiveness and the importance of improving performance of health organizations to reduce disparities; and disseminated lessons learned about organizational change to private sector, tribal, and government agencies concerned with diabetes prevention.
AC: Choctaw Nation of Oklahoma (CNO) “Lifetime Legacy Program” received a Core Capacity Building Grant under the REACH 2010 program. After successfully building their capacity and infrastructure, they implemented their Lifetime Legacy Project with REACH US as an Action Community. The project focused on the health priority area of cardiovascular disease (CVD) as well as the intervening variables of childhood obesity, tobacco, and substance abuse, specifically methamphetamine use. The target population was AI/ANs living within the 10.5-county service area of the CNO. They developed a presentation that shows the correlation between substance abuse and CVD, “The Effects of Substances on the Heart,” and have delivered the presentation to 10 different organizations across the CNO and the United States. Additional staff was hired and trained to present the program by September 2009. Staff and coalition members were trained in the “Honoring the Gift of Heart Health,” a cardiovascular disease prevention curriculum, with the goal of introducing and implementing this curriculum into the areas of the CNO chosen for the intervention.

AC: Eastern Band of Cherokee Indians “Cherokee REACH –US Coalition” (EBCI) reduced the risk for Type 2 diabetes in the EBCI communities by promoting physical, emotional, and cultural well-being. Viewing poverty, racism, and inactive physical lifestyles as major contributors to the health disparities related to diabetes, this program worked to change social norms, utilized formal and informal leaders, and engaged communities across the lifespan to create change among individuals, organizations, systems, and policies. Importantly, the EBCI attempted to facilitate key opinion leaders—both formal and informal—and youth and elders to model healthy lifestyle behaviors and active living so that these leaders served as change agents for the rest of the EBCI community. The project also implemented culturally specific school-based mentoring programs and health and physical activity experiential curriculum and activities. In addition, the EBCI REACH Coalition initiated a School Health Council, which looked at school health policy support and development. Finally, activities to support a healthy built environment included developing a walkable community initiative.

AC: Northern Arapahoe WIC Program “Wind River Reservation Infant Mortality Prevention Project” (2009-2010) (WRIR) planned to reduce the rate of infant mortality among AIs through community-based approaches. These approaches included increasing community awareness and commitment to eliminating infant mortality disparities through coordinated and multi-organizational action; increasing the number of Northern Arapaho and Eastern Shoshone women initiating early and sustaining prenatal care; ultimately achieving measurable improvements in infant mortality rates. This work was done through community organization, education, inter-agency coordination and partnerships, systems development, and higher levels of access to health services. The WRIR project conducted focus groups to obtain information on barriers to prenatal care and maintaining healthy pregnancies; conducted key informant interviews with representatives of tribes and others who served pregnant women, infants, parents about barriers to care and strategies for reducing infant mortality; and held community meetings for comments and discussion. For grant year five, an important aspect of the Community Action Plan (CAP) was to convene and organize all partners to consider how to sustain the momentum the IMPP had created around the healthy priority while expanding the breadth and the depth of their programmatic efforts.

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The second annual Wind River Indian Reservation Healthy Babies Conference was held with speakers who were AI experts in their area of specialization or who had specific experience in working in tribal communities. During this second grant year, the program focused on programs aimed at improving men’s wellness. Culturally specific components of training focused on tribal-specific culture and traditions around pregnancy and health care-seeking and increasing health providers’ knowledge and understanding of tribal cultural issues that affect early prenatal care seeking. Both tribes on the Reservation prepared a tribal-specific cultural guide for health providers.

Healthy Communities Program/ Building a Healthy Nation—Strategic Alliance for Health (2009-2012): The Sault Sainte Marie Tribe of Chippewa Indians (SSMT) and the Cherokee Nation (CN) entered into the second year of a five year cooperative agreement to develop and implement policy, systems, and environmental changes addressing chronic disease risk factors of physical inactivity, poor eating and nutrition, and tobacco use and exposure to reduce the burden of chronic diseases such as obesity, diabetes, and cardiovascular disease. Four communities from the SSMT participated in this initiative: Sault Sainte Marie, St. Ignace, Manistique, and Munising. Four counties across the CN participated in this initiative: Cherokee county, Mayes County, Sequoyah County and Adair County. Comprehensive community coalitions of key local community leaders were formed to assess the gaps in policy, systems, and environmental changes and prioritize what each community needed to focus on in addressing these risk factors in building healthy community initiatives. By implementing the Community Health Assessment and Group Evaluation (CHANGE) tool, communities assessed their gaps and needs across five community sectors, including schools, work sites, and communities as a CAP from the information analyzed in conducting the CHANGE tool assessment. Then they implemented policy, systems, and environmental changes from that plan. From these community experiences, each community developed an implementation guide around one policy, systems, or environmental change they initiated and mentored other non-funded communities regarding the processes and lessons learned in developing these initiatives for healthier communities.

Prevention Research Centers (PRC) Program (2009): Through the Tribal Vision Impairment Prevention Project, approximately 450 residents, located in Oregon Health and Science University, Center for Healthy Native Communities and residents from three Tribes (Umatilla in Oregon, Shoshone-Bannock in Idaho, and Lummi in Washington, received basic eye exams performed onsite by a vision technician, and participants who needed them were given free prescription eyeglasses. Participants with abnormal results or risks related to diabetes received testing and treatment using telemedicine to examine patients. Results from the study were presented at the Association for Research in Vision and Ophthalmology Conference in April 2009. The center was funded for the 2010 through 2014 program cycle.

Healthy Kids Project was implemented by the University of Oklahoma, the PRC, and Anadarko, Oklahoma, public schools, where 60 percent of students are AI. More than 8,000 students were screened to determine risk for obesity-related diseases. Information was shared with parents and school officials, and the findings served as the basis for developing new physical activity
interventions and promoting changes in nutrition. Data from the project were published in April 2009 in the *American Journal of Hypertension*.

**Teen Health Resiliency Intervention for Violence Exposure (THRIVE) (2009):** University of New Mexico, Center for Health Promotion and Disease Prevention, and Tohajilee Community THRIVE program tested the effectiveness of school- and community- based interventions for identifying and reducing psychological distress among AI youth (6th through 12th grade students) who witness or experience violence. Through the in-school intervention, participants met individually with a health counselor and in small groups to share experiences, express feelings, receive group support, and build coping skills. Their parents and teachers were trained to support them at home and in the classroom. The community intervention trained parents, teachers, and community members to recognize the signs of trauma among youth and get them help. Data are being evaluated to determine on the successfulness of increasing participants’ coping skills, reducing the symptoms of trauma, and maintaining positive effects over time. The center was funded for the 2010 through 2014 program cycle.

**Communities Putting Prevention to Work (2012):** The Pueblo of Jemez Health and Human Services Department (New Mexico) received funds to promote increased physical activity, encourage healthy food choices, and support the local growers market. Successes included district-wide wellness physical activity policy that requires children in the after-school programs be offered 45 minutes of physical activity on a daily basis and a snack that consisted of fresh, unprocessed, organic food, such as fruits and vegetables, whole grains and legumes, raw nuts and seeds, or fresh sprouts. Since August 2010, approximately 27 students benefitted daily from this policy.

The Cherokee Nation Health Service Group of Oklahoma received funds to fight obesity and tobacco use with farm-to-school programs, physical education, and tobacco cessation programs. Successes included launching the new community-based campaign, the Cherokee Challenge, to encourage individuals and families to eat healthy and exercise throughout the year. The campaign impacted 109,843 members of the Cherokee Nation. A supplement was awarded for a mentorship component, enabling the Cherokee Nation Health Service Group to build capacity and mentor tribes and communities in schools, communities, worksites and health care settings to implement high-impact, population-wide strategies for obesity and tobacco.

**Adolescent and School Health**

**Improving Health and Educational Outcomes of Young People (2008–2013):** The Cherokee Nation (CN) Health Services Group and the CN Education Services Group collaborated with multiple community partners to improve the health of young people in the 14-county CN Tribal Jurisdictional Service Area in northeastern Oklahoma. The CN received funding to provide HIV prevention education and to conduct the Youth Risk Behavior Survey (YRBS). CN Behavioral Health Services successfully recruited a number of schools in northeastern Oklahoma to take part in the CDC’s School Health Profiles Survey (Profiles). Conducted biennially, Profiles is a system of surveys assessing school health policies and programs related to health education, physical education and activity, healthy and safe school environment, health services, school...
health coordination, and family and community involvement. A sufficiently large number of public schools (237, 70 percent) participated in the 14-county area of the CN, allowing for generalized results and improved planning for all schools in the area. This improvement was accomplished through collaboration with the CN’s Health Promotion/Disease Prevention program and the Oklahoma Department of Education. The CN used these results to develop model health-prevention programs focusing on HIV prevention and reproductive health.

The Nez Perce (NP) Tribal Government received funding to plan and implement coordinated school health programs in local schools. The NP Students for Success Program was a collaborative effort between the NP Education Department, Nimiipuu Health, and four local school districts to support the development of coordinated school health programs in four K through 12 schools on the Nez Perce reservation. The Students for Success Program worked to improve the health of children through planning and coordination of programs across and within agencies. During FY 2009, the NP government provided professional development to seven partner schools on the reservation and further promoted a coordinated school-health approach for physical activity/nutrition/tobacco control efforts to neighboring tribes. Representatives from the Colville, Shoshone-Bannock, and Suquamish tribes participated in the professional development workshop on physical education.

Multiple states also funded under this program further illustrated activities conducted that support coordinated school health and included a youth component for affecting or supporting AI/ANs:

Alaska—The Alaska Department of Education and Early Development provided HIV prevention education and conducted the YRBS. These programs were developed and delivered in collaboration with the Alaska Department of Health and Social Services. Alaska has a robust e-learning system, which provides training modules and other resources on HIV prevention education to educators in remote rural areas where many Alaska Natives live. Alaska provided the “Making Proud Choices” HIV prevention curriculum that was used for adolescents in Department of Juvenile Justice facilities across the state. The program reached many Alaska Native adolescents, as they made up a large percentage of the incarcerated youth in the state.

Colorado—Colorado initiated efforts to address HIV/AIDS prevention education for AI/AN populations through partnerships with the Indian Education Program and the Denver Indian Center. The partners identified ways to work together to meet the health needs of the Indian community, a rapidly growing population in Denver.

Nebraska—The Nebraska Department of Education collaborated with the Santee Tribe to conduct a Health Education Week during June 2009 that focused on specific topics affecting the health of tribal members, including alcohol and methamphetamine use, cancer, child abuse, blood-borne diseases (including HIV and Hepatitis C), STDs, and diabetes. About 40 percent of the tribe—more than 350 AIs, including almost 50 youth—participated in sponsored workshops during the week.

North Dakota—Selected activities of the North Dakota Department of Education HIV/AIDS Prevention Program included the following: an ongoing collaborative project with the Mental
Health Association in North Dakota–Tribal Rural Mentoring Partnership to help increase education and healthy life choices for approximately 123 AI youth on the Standing Rock, Fort Berthold, Turtle Mountain, and Fort Totten reservations; and a collaborative youth-focused project for HIV prevention education, Sources of Strength, on North Dakota reservations. The reservation programs reflected a core belief system, or a tribal worldview, that “health is spread through relationships.” The Sources of Strength curriculum focuses on strategies that help youth develop family support, positive friendships, caring adult relationships, and healthy activities. Tribes involved in this collaboration were the Affiliated Tribes, or the Mandan-Hidatsa-Arikara Nation. North Dakota used the Circle of Life HIV science-based curriculum (developed by CDC) in addition to the Sources of Strength model.

Oregon—The goal of Oregon’s work with Native American youth was to address, through state agency and community partnerships, the HIV prevention needs for youth of color and youth in high-risk situations. Oregon contracted with the Native Wellness Institute for conducting Healthy Relationship curriculum training of trainers held in early 2010 in partnership with the Confederated Tribes of Grande Ronde and the Oregon Department of Education.

Diabetes

Using Traditional Foods and Sustainable Ecological Approaches for Health Promotion and Diabetes Prevention in AI/AN Communities (2009-2012): In FY 2008, CDC released a Funding Opportunity Announcement for tribes/tribal organizations for five year cooperative agreements to: (1) support community use of traditional foods and sustainable ecological approaches for diabetes prevention and health promotion in AI/AN communities; and (2) engage communities in identifying and sharing the stories of healthy traditional ways of eating, being active, and communicating health information and support for diabetes prevention and wellness. Eleven cooperative agreements were awarded for the first year to two tribal corporations in Alaska, one urban Indian health program, one tribal college, and seven rural reservation communities. The total award made to the 11 grantees was $1 million.

Aleut Diet Program (2010 - 2012): The Aleut Diet Program includes sustainable hands on activities focusing on the healthy preparation and utilization of local traditional foods. The purpose of these activities was to promote health and prevent type 2 diabetes in the Aleutian and Pribilof Islands Region of Alaska. The program focus was to improve the nutritional health of people in the region through increased awareness of the benefits of traditional foods and the important role these foods play in reducing rates of dietary-related diseases such as diabetes, obesity, cancer, heart disease, hypertension, and dental caries. The program sought to encourage increased consumption of traditional foods from the land and sea by all members of the community as part of a healthy diet. The activities of the program were centered on culturally relevant information dissemination and the development of written resources that speak to the nutritional benefits of traditional foods.

Catawba Lifestyle and Gardening Project (2010-2012): The Catawba Cultural Preservation Project (CCPP) in South Carolina increased awareness and the use of traditional foods and food practices by supporting individual and community gardens, and increasing fruits, vegetables,
beans, and herbs in tribal members’ diets by providing access to local gardens and a tribal farmer’s market. The tribe adopted policies that included preferred ecological methods for gardens using traditional growing methods to encourage a new generation of environmental stewards to care for the reservation ecosystem. The tribe increased physical activity with gardening, fishing, and traditional dancing and drumming. Innovative partnerships between the tribal senior center, CCPP, the Catawba tribal offices, and a master gardener yielded a successful community garden project that is increasing local access to fresh, locally grown, and in some cases traditional foods.

Cherokee Nation - Health Nation (2010-2012): The “Cherokee Nation – Health Nation” project incorporated a variety of activities including community and school gardens, traditional foods gathering trips, traditional Cherokee foods cultivation, gathering, preparation, and preservation, traditional Cherokee foods education, and incorporation of the traditional Cherokee games Stickball and marbles into community and school activities. Over 55,000 members of the Cherokee Nation and their families benefited from the initiative’s focus on nutrition, fitness, personal responsibility and a renewed awareness of their shared heritage. Youth activities focused on summer camp activities, organized sports and traditional games. Adult fitness activities were year round and centered on recreation center classes, league sports walking clubs and community races. Traditional games such as stickball and marble saw an exponential increase from the year before. Nutrition classes, healthy cooking classes, community garden classes and recipe exchanges (all with a focus on traditional Cherokee foods) were offered in all fourteen of the counties within the Cherokee Nation jurisdiction.

Healthy Roots for Healthy Futures (2010-2012): Healthy Roots for Healthy Futures works to increase the availability and accessibility to healthy, local, traditional foods and traditional forms of physical activity. The availability and access to local, traditional, healthy foods have been increased through the creation of entrepreneurial training and gardening programs, revision of the School Wellness policies, and development of a Farm to School system. Physical activity is promoted through gardening and trail use. Revitalization of trails reconnected communities to the traditional paths of their ancestors, while increasing options for physical activity.

Indian Health Care Resource Center of Tulsa: Strengthening Traditional Ties (2010-2012): The program encouraged American Indian families to eat nutritious diets and adopt healthy active lifestyles. Families participated in school-based health, nutrition, and physical education programs, including summertime wellness camps and a theatrical production. The program also engaged in educational programs that emphasize healthy lifestyle choices within the context of traditional cultural practices, such as expanding existing and creating new neighborhood and school-based gardening projects. "Building Community" established gardening partnerships with two local elementary schools, summer camp programs featuring the Coordinated Approach to Child Health curriculum, and worked with state-level leaders on healthy food initiatives to address the problem of food deserts.

Listen to the Elders Project (2010-2012): Nooksack Indian Tribe, Listen to the Elder’s Project involved gardening and planting activities, distributing garden related materials, increasing
community knowledge, awareness and use of traditional foods, and increasing physical activities, such canoeing and hunting.

Return to a Healthy Past (2010-2012): Return to a Healthy Past” (RTHP) has reintroduced traditional foods and physical activities in the Prairie Band of Potawatomi Nation (PBP) to promote health and prevent diabetes among other chronic conditions. Serving as a model for rural and urban communities, RTHP has established gardens, increasing production and access to traditional produce. Through partnerships with the Land Department, Tribal Council, local hunters and the Diabetes Prevention Program, a wider variety of indigenous produce and meats were offered in diabetes education courses, Elders’ Center and Language Department gatherings and the Fall Harvest Feast. Traditional forms of physical activity have been broadened through nature hikes, camping trips, and gardening activities. RTHP continues to engage tribal members of all ages, at risk for or living with diabetes. Community members have increased access to traditional and other physical activities due to their exposure to this project’s activities such as hiking to identify wild plants and traditional foods such as wild onions, milk weeds and individual/family gardens.

Uniting to Create Traditional and Healthy Environments (2010-2012): Sault Ste. Marie (SSM) Tribe of Chippewa Indians, “Uniting to Create Traditional and Healthy Environments.” The project served seven county service units. Partnership and collaborations with other tribal programs and surrounding health services helped the Project organize, support, and serve SSM tribal members. The project created a Healthy Traditions Advisory Council (HTAC), which has helped the Project to carry out Traditional Foods, Social Support and Physical Activities and/or events, such as berry picking camp, workshops, training master preservers, implementing garden projects, building a Hoop House, implementing the harvest feast celebration, involvement in the local farmer’s market, implement fitness promotion, healthier food fundraising event, and digital storytelling.

The Native Gardens Project: An Indigenous Permaculture Approach to the Prevention and Treatment of Diabetes (2010-2012): By reclaiming cultural knowledge and traditions of companion gardening through their Native Gardens Project, the Standing Rock Sioux Tribe prevented diabetes and contributed to a better quality of life for individuals and families living with diabetes. The Nutrition for the Elderly Program Advisory Council, the Standing Rock Special Diabetes Program, the state and county extension service, Sitting Bull College, and other partners supported the Native Gardens’ efforts to make local foods from farms and family gardens available and accessible. In collaboration with the United States Department of Agriculture Nutrition for the Elderly program, the program documented that 60 percent of 3,000 vouchers distributed to elders generated $9,000 in 2010, encouraging local, certified farmers to keep growing.

Tobacco Programs
American Indian Adult Tobacco Survey—Cherokee Nation (2009): The Cherokee Nation Tribal Support Center (CNTSC) has completed a fielding of a tribal-specific Cherokee Nation AI Adult Tobacco Survey, and data are currently being analyzed. This survey was developed in collaboration with the tribal support centers and OSH. Findings will provide CNTSC with relevant information on prevalence, quit attempts, commercial tobacco abuse behaviors, beliefs, and attitudes. These findings will inform and improve strategies and interventions to reduce commercial tobacco abuse among its members.

Nicotine Exposure and Metabolism in Alaska Native Adults Research Study (2010-2012): The Division of Laboratory Sciences (DLS) Emergency Response and Air Toxicants Branch provided in-kind laboratory analysis via agreement with the Alaska Native Medical Center (ANMC) /Indian Health Service (IHS) on a cross-sectional study of 400 Alaska Native (AN) adult tobacco users, 50 male and female smokers, commercial chew users, iq’mik users and non-tobacco users who received medical services in Dillingham, Alaska. The objective of the study was to generate information on nicotine & carcinogen exposure in underserved Alaska Natives. DLS completed chemical analysis of Alaskan iq’mik, a native smokeless tobacco mixture that combines tobacco and fungus/plant ash, and performed measurements in urine for cotinine (a nicotine byproduct). Select findings were published in FY 2012.

Tribal Tobacco Control Program to Reduce Tobacco Use among American Indians and Alaska Natives (2012): The Nez Pierce Tribal Commercial Tobacco Abuse Prevention Program implemented evidence-based strategies to reduce tobacco abuse among tribal members. Program staff members partner with the Idaho Tobacco Control Program, Project Filter for training activities, developing culturally appropriate messaging, and strategies for encouraging tribal members to use the Quit Line and other cessation services. The Nez Perce Program has met several milestones, including establishing a tobacco control coalition with representation from the Tribal Community Health Center, Diabetes Program, tribal police, Tribal Housing Authority and the Nez Perce Tribal Executive Committee. In addition the program educated several tribal agencies on the health benefits of strengthening and enforcing their existing smoke-free workplace policy. The program partnered with the school district to enforce their closed campus policy at the high school to discourage students from leaving campus to purchase and smoke cigarettes. Also, the program has implemented the American Indian Adult Tobacco Survey successfully.

Great Plains Tribal Chairmen's Health Board (2012): The Great Plains Tribal Chairmen's Health Board collaborated with 18 tribes located in four states to implement culturally appropriate interventions to reduce commercial tobacco use. The project conducted several public health surveys and established a broad-based community coalition to facilitate communications, information sharing, and action plan development in tribal communities, among other public health activities.

Inter-Tribal Council of Michigan (ITCM) (2012): The ITCM partnered with seven Michigan tribes to reduce commercial tobacco use by building the capacity of the tribes to maintain a surveillance system, educate tribal members about the health impact of tobacco use, incorporate
a physician reminder system in the existing medical assessments, implement the American Indian Adult Tobacco Survey, and strengthen and enforce existing smoke-free policies. The program, in collaboration with the Michigan Public Health Institute Evaluation team and the seven funded Michigan tribes, developed a tobacco control surveillance and monitoring system, among other public health activities.

**Muscogee Creek Tobacco Program (2012):** The Muscogee Creek Tobacco Program focused on reducing commercial tobacco abuse among tribal members, engaging tribal elders, leaders, and communities in activities that encouraged tribal members who use tobacco products to quit, and collaborated with partners to eliminate youth access to tobacco products through various strategies. They partnered with multiple state and local partners on their multi-dimensional activities.

**National Network for Commercial Tobacco Use (2012):** The National Network for Commercial Tobacco Abuse Prevention (National Native Network) Program was designed to build the capacity of tribal tobacco control programs. This goal was achieved by recruiting individuals and organizations to facilitate learning and information sharing across and within Indian Country.

**SouthEast Alaska Regional Health Consortium (SEARHC) (2012):** SEARHC is a non-profit, Native-administered health consortium that represents the health care needs of Tlingit, Haida, Tsimshian, and other Native and rural-dwelling people of Southeast Alaska. In collaboration with the State of Alaska Tobacco Prevention and Control Program, SEARHC brought forward a resolution in support of a statewide smoke-free workplace law at the 2011 Alaska Federation of Natives (AFN) Convention to support healthy lifestyle. The resolution was passed by delegates of the convention and solidifies tribal leader support for smoke-free workplaces.

**Tanana Chiefs (2012):** The grantee described sustained efforts to promote smoke-free facilities for the Tanana Chiefs Conference (TCC) in the spring of 2012. The patient and sustained work, as well as the strong example of statewide Alaska Federation of Natives tribal leaders who passed a resolution of support for statewide smoke-free workplaces, resulted in the TCC Full Board of Directors supporting the TCC tobacco-free policy. This provides a foundation for working with tribal leaders in the villages to promote health effects of smoke-free air.

**Disease and Stroke Prevention**

**National Heart Disease and Stroke Prevention Program (2009):** The Montana Department of Public Health and Human Services Cardiovascular Health Program completed a heart attack campaign on the Crow Reservation and a stroke campaign on the Flathead Indian Reservation. The latter was Montana’s first stroke campaign customized for American Indians. Montana’s heart attack and stroke media campaigns received national recognition with three American Advertising Federation ADDY Awards, a Telly Award, and a Silver Aster Award. The Montana CVH Program worked with three Urban Indian Clinics to improve the blood pressure and cholesterol of patients. The project assessed lipid and hypertension control in patients and provided feedback on the quality of care to providers and staff. Interventions for the project...
included patient education and self-management tools via the distribution of blood pressure (BP) and cholesterol kits given to participating patients, provider feedback (after completion of a baseline chart review), and provider education on hypertension management and how to effectively work with patients on smoking cessation.

**Birth Defects and Developmental Disabilities**

A Prospective Birth Cohort Study Involving Environmental Uranium Exposure in the Navajo Nation, Health Investigations Branch (2010-2012): Extensive uranium mining and milling operations have occurred on the Navajo Nation during the last half century. Due to these anthropogenic activities, there remains a level of potential uranium exposure to the Navajo people from various sources including abandoned uranium mills/mines, contaminated drinking water, soil, and homes built with mining waste. While there have been many studies of occupational exposure to uranium and renal effects, there have been very limited studies on other adverse health effects. There is also limited toxicological and epidemiological data that indicates that uranium may pose a risk to the developing fetus. The purpose of this study was to quantify fetal risk from uranium by recruiting Navajo mothers, assess their uranium exposure at key developmental milestones, and then follow the children post-birth to evaluate any associations with birth defects in developmental delays. The study also applied public health goals to provide educational outreach to increase prenatal care utilization, earlier assessment and referral for developmental delays, and mitigation of uranium exposure among Navajo mothers.

**Physical Disabilities**

Limb Loss Public Health Practice and Information Resource Center (2012): The focus of this program was the development of culturally appropriate peer support programs for the Plains Indians tribal community focused on limb loss, enhancing quality of life for amputees and their families, improving patient care, and preventing limb loss.

**HIV/AIDS and Other Sexually Transmitted Diseases**

Native Students Together Against Negative Decisions (NativeSTAND)—a peer education curriculum for healthy decision-making for Native youth (2009): This project was a coordinated effort between the National Coalition of STD Directors (NCSD), the IHS National STD Program, CDC’s Division of STD Prevention, Project Red Talon (PRT), and Mercer University School of Medicine (MUSM). A multidisciplinary workgroup was formed (including Native youth and a Native elders) to identify existing native curricula to address healthy decision making for Native youth. Finding none, the workgroup identified an existing non-native curriculum—Students Together Against Negative Decisions (STAND)—developed by MUSM. The workgroup proceeded to adapt the curriculum and (pilot) test select sections with Native youth groups. CDC analyzed evaluation data, made prescribed modifications, and widely disseminated information throughout Indian Country.

Ongoing Sexually Transmitted Disease Projects for AI/AN (2009): The Division of Sexually Transmitted Diseases Prevention (DSTDP) funded ANTHC to assess the acceptability,
feasibility, and impact of self-collected specimens on reducing barriers to health-care-seeking behaviors and increasing STD screening opportunities among Alaska Natives in both rural and urban settings. ANTHC strives to promote internet-based educational messages targeting Alaska youth and adults that will link users to self-collected STD testing through a confidential online testing resource. They are using MySpace and Facebook to deliver educational messages and link to the online STD testing program that provides self-collected specimen kits. DSTDP plans to maintain their IAA with IHS to support and enhance STD prevention and control efforts in AI/AN populations.

This IAA assists DSTDP to raise awareness of STDs among AI/AN as a priority health issue, support partnerships and collaborations with multiple public health partners (state STD programs, IHS, tribal, and urban Indian health programs (I/T/U), and support improvement of STD programs for AI/ANs. Both CDC and IHS have felt that this IAA helps them to collaboratively increase access to up-to-date STD training for clinicians and public health practitioners—and support and strengthen surveillance systems to monitor STD trends by promoting STD research and identifying effective interventions for reducing STD. The IAA has also supported STD outbreak response efforts and integration of STD, HIV/AIDS, TB, and hepatitis prevention and control activities.

HIV Prevention Projects: HIV Prevention by State and Selected City Health Departments with HIVP Community Planning (2012): This project assisted public health departments in their efforts to decrease transmission of HIV by conducting HIV prevention services for high risk persons, refocusing some activities to reduce the number of new HIV infections in the United States. It emphasized counseling, testing, and referral for the estimated 180,000 to 280,000 persons who are unaware of their HIV infection; partner notification, including partner counseling and referral services; and prevention services for persons living with HIV to help prevent further transmission once they are diagnosed with HIV. In addition, since perinatal HIV transmission can be prevented, CDC strengthened efforts to promote routine, universal HIV screening as a part of prenatal care. All of this was accomplished through four strategies: (1) Making HIV screening a routine part of medical care; (2) creating new models for diagnosing HIV infection, including the use of rapid testing; (3) improving and expanding prevention services for people living with HIV; and, (4) further decreasing perinatal HIV transmission.

Human Immunodeficiency Virus (HIV) Prevention Projects for HIV Prevention by Community-Based Organizations (2012): This project was funded to provide HIV prevention services for members of racial/ethnic minority communities in which there may be a high risk for HIV infection. Prevention services included behavioral interventions [i.e., Evidence-based Behavioral Interventions (EBIs), Comprehensive Risk Counseling and Services (CRCS)], HIV Counseling, Testing, and Referral (CTR) Services. Funding for the first year also supported outcome monitoring of selected behavioral interventions (CBO Monitoring and Evaluation Project).

Clinical Characteristics and Survival of HIV-Positive American Indians (2012): This project examined the medical records of 460 HIV-positive American Indians receiving care at an urban IHS facility that incorporates an HIV center of excellence to conduct a survival analysis.
and examine clinical outcomes amongst this cohort. Persons from a multitude of tribes were included in this study because patients from a very wide geographic area, encompassing many states, access care at the HIV center of excellence. American Indians living with HIV are seldom included in HIV/AIDS studies or clinical trials and little reported data is available on the clinical characteristics and course of illness in this population. Collaborators included: IHS, CDC, and the Arizona Department of Health Services.

Infectious Diseases in Alaska Natives (2009): The Arctic Investigations Program (AIP) is a CDC infectious disease field research station located on the campus of the Alaska Native Medical Center in Anchorage, Alaska. The program’s mission is the prevention of infectious disease in people of the Arctic and subarctic, with particular emphasis on indigenous people’s health. AIP coordinates disease surveillance in Alaska for selected bacterial and viral infections and conducts public health research to determine risk factors for disease, to evaluate prevention strategies, and to improve laboratory diagnosis. AIP operates one of only two Laboratory Response Network laboratories in Alaska and is involved in preparedness and response to public health threats in Alaska. The program provides leadership and expertise in public health concerns of peoples of the circumpolar north through international collaborations and surveillance. The AIP works closely with ANTHC and other tribal health organizations in Alaska to improve infectious disease prevention activities by providing health data, laboratory expertise, focused investigations, and interventions.

Response to the Emergence of Replacement Pneumococcal Disease in Alaska Native Infants (2009-2010): Historically, rates of pneumococcal infections (meningitis, pneumonia, bloodstream infections) among AN children were among the highest in the world. A pneumococcal conjugate vaccine introduced in 2001 in AK, PCV7, reduced preventable disease by 95 percent in Alaska. However, since 2004, investigations by AIP have shown that disease rates due to strains not included in PCV7 among AN children have increased and overall disease rates approach the levels seen before use of PCV7. This emergence of bacterial types not covered by PCV7 limits the utility of the current vaccine among this population. A new pneumococcal conjugate vaccine containing six additional serotypes, including those causing most of the non-PCV7 disease, has been introduced among AN children in certain areas with highest rates of disease and is expected to be licensed for use in the general population in 2009 and 2010.

During FY 2009, the YKHC and Wyeth Vaccines, with support from AIP and ANTHC, introduced a new pneumococcal vaccine called PCV13 in southwest Alaska where disease rates are highest. This vaccine was offered before licensure under a compassionate use agreement with the manufacturer and the Food and Drug Administration. The vaccine included the most common replacement types and could prevent 75 percent of cases. This plan included careful safety monitoring, evaluations of disease transmission and serious infection rates, and ongoing recruitment of infants and children to receive the vaccine while monitoring use, safety, and effectiveness. Results were reported to local health authorities and leadership as well as interested public health authorities.

Dental caries among AN children represents a substantial and long-standing health disparity. For example, an assessment from 2004 showed that 87 percent of AN third graders had evidence of caries compared with 55 percent of Caucasian Alaskans of the same age. In August 2008, AIP was asked by the YKHC in western Alaska to conduct a public health investigation to determine the prevalence of pediatric dental caries, risk factors for caries and to identify feasible plans to address the problem. The investigation included oral health exams on children in five communities, a behavioral health evaluation, and an evaluation of available data sources. The investigation concluded that pediatric dental caries are approximately five times more common in the region than for the general U.S. childhood population. The principal risks include lack of water fluoridation and soda consumption. A complete report, including recommendations, was presented to the YKHC in July 2009, and discussions began to develop a workable long-term strategy for improving pediatric oral health. The published article (CDC MMWR, Sept 23, 2011) was used to support village council decisions to fluoridate water supplies in three rural Alaska communities in October 2011. CDC’s Division of Preparedness and Emerging Infections (DPEI), along with two Alaska Native tribal health organizations, conducted a cost-effectiveness study of caries prevention strategies. AIP also worked to establish a caries surveillance system using electronic health records in collaboration with a tribal health organization in southwest Alaska.

**Management of the Alaska Area Specimen Bank (2009):** The specimen bank, located in the AIP building, houses nearly 500,000 specimens that are residual from health research done in the past half century in Alaska. AIP joined with tribal health leadership throughout Alaska to create policies and procedures related to the bank to ensure that this valuable collection is used to maximize health benefit for AN people while protecting individual privacy, respecting tribal health priorities, and informing the ANs of this resource.

The new policy and procedure provided a model for shared management and governance of this unique and valuable specimen repository. AIP co-chaired quarterly meetings with a committee of representatives from ANTHC, Aleutian Pribilof Islands Association, Norton Sound Health Corporation, Bristol Bay Health Corp, Manilaaq Health Corporation, SouthCentral Foundation, Arctic Slope Native Association, Yukon Kuskokwim Health Corporation, and Southeast Alaska Regional Health Corporation. The revised policy is now under review by the nine tribal health organizations whose people have contributed to the specimen bank. AIP is collaborating with SouthCentral Foundation to assess attitudes and desired uses for the specimen bank among Alaska Natives, as well as a catalog of specimen bank activities since its inception. These data will guide future uses of specimen bank materials and public education about the repository.

Communication efforts have included a briefing with the CDC director on the status of the pandemic in AI/AN populations, addition of a tribal page on the CDC website to disseminate specific guidance and information, and development of specific brochures and posters to promote influenza vaccinations among AI/AN. Next steps will include supporting adverse event monitoring after influenza vaccinations; promoting the use of influenza illness data to appropriately allocate resources to AI/AN populations at increased risk; and supporting ongoing vaccination, mitigation and communications efforts in tribal communities. The study data have been collected and are undergoing analysis.
Arctic Investigations Program (AIP) (2009-2012): AIP’s program mission is the prevention of infectious disease in people of the Arctic and subarctic, with particular emphasis on indigenous people’s health. AIP coordinates disease surveillance and operates one of only two Laboratory Response Network labs in Alaska.

Skin and soft tissue infections in rural Alaska: In 2012, The Yukon Kuskokwim Health Corporation, a tribal health organization in southwest Alaska, requested CDC assistance through an Epi-Aid mechanism to improve prevention and control of skin and soft tissue infections caused by methicillin-resistant Staphylococcus aureus. AIP responded with a three-week field investigation in the villages with the highest rates of infection.

Alaska Native Tribal Health Consortium (2012): These funds are used to improve efforts to prevent hepatitis A and B through vaccination in Alaska Natives and to study interventions to reduce mortality and morbidity from chronic hepatitis B and C in this population.

Other Infectious Diseases

Overall and Specific Infectious Diseases among the AI/AN Population (2009): Activities include various ongoing epidemiologic collaborative projects between CDC and the IHS, ANTHC, the AIP, other divisions, government agencies, and universities to describe and address disease burden, risk factors, and health disparities for overall infectious disease and specific infectious diseases among the AI/AN population. The findings from the studies and investigations provide information to assist in developing prevention strategies and reducing health disparities for specific infectious diseases among the AI/ANs. The findings increased awareness of specific infectious diseases in the population, and initiated diseases and geographic target areas to further investigate and addressed the identified health disparities. These findings were used by IHS and CDC to improve the health of AI/ANs. Further, the studies along with their findings were also disseminated through presentations at international and national conferences and meetings, and in reports and publications in peer-review journals. Ongoing collaborations on studies and investigations to address infectious disease burden and disparities continue.

Rickettsial Disease among American Indians (2009): Ongoing investigation and education efforts of rickettsial disease take place through collaboration with the IHS, particularly within areas in the Southwest region. Focus groups were conducted to identify community barriers to prevention and control and acceptability of different educational tools. A new educational program was implemented to increase awareness of Rocky Mountain spotted fever (RMSF) among the AI population in the Southwest. The program addressed and initiated prevention efforts to reduce the occurrence of rickettsial disease, including provision of staff and supplies for tick reduction activities. In addition, the annual incidence and case-fatality rates for RMSF were found to be increasing among the AI population, substantially more than other races. This finding was published in the *American Journal of Tropical Medicine and Hygiene*. 2009; 80:72-77.
In many areas of the world, only 30 to 50 percent of dogs are vaccinated against rabies. On some U.S. Indian Reservations, vaccination rates may be as low as 5 to 20 percent. In 2003 and 2004, researchers studied the effectiveness of commercially available baits to deliver oral rabies vaccine to feral and free-ranging dogs on the Navajo and Hopi Nations. Dogs were offered one of the following baits containing a plastic packet filled with placebo vaccine: vegetable shortening-based Ontario slim baits (Artemis Technologies, Inc.), fish meal crumble-coated sachets (Merial, Ltd.), dog food polymer baits (Bait-Tek, Inc.), or fish meal polymer baits (Bait-Tek, Inc.). One bait was offered to each animal and its behavior toward the bait was recorded. Behaviors included the following: bait ignored, bait swallowed whole, bait chewed and discarded, bait chewed and discarded (sachet punctured), or bait chewed and consumed (sachet punctured). Bait acceptance ranged from 30.7 percent to 77.8 percent with the fish meal crumble. Analysis of AI/AN hospitalizations and outpatient visits for dog bite injuries with focus on affect related to tick-borne diseases and rabies. Dog bites were found to be a significant public health threat among AI/AN children living in the Alaska, Southwest and Northern Plains West regions, which indicate that enhanced animal control and education efforts should reduce dog bite injuries and emerging infectious diseases. Paper was accepted for publication.

Infectious Diseases (2010): Published a description of the occurrence of overall and specific infectious disease hospitalizations among the AIAN population. This analysis provides recent rates and identifies high-risk diseases and areas to focus further study and prevention measures for the reduction of infectious diseases in AI/AN communities. In FY 2012, CDC conducted an analysis of overall and specific infectious disease hospitalizations among the AI/AN population using IHS data to provide recent infectious disease hospitalization rates, high-risk diseases and high-risks areas to focus further study and prevention measures for the reduction of infectious diseases in the AI/AN population. The findings were presented at the World Society of Pediatric Infectious Diseases Conference. Also in FY 2012, CDC analyzed the occurrence of overall and specific infectious disease hospitalizations among the Alaska Native (AN) population using IHS data. This analysis provided recent infectious disease hospitalization rates, high-risk diseases and high-risks areas to focus further study and prevention measures for the reduction of infectious diseases in AN communities. The findings were presented at the International Congress on Circumpolar Health.

Gastroenteritis (2010-2012): Completed analysis of the occurrence of gastroenteritis hospitalizations among AI/ANs prior to and after the introduction of the rotavirus vaccine to describe the effect of the vaccine on hospitalizations. In 2012, published analysis of the occurrence of gastroenteritis hospitalizations among AI/ANs prior to and after the introduction of the rotavirus vaccine to describe the effect of the vaccine on hospitalizations. The findings underscored the importance of rotavirus vaccine among this population.

Molluscum Contagiosum (2010): Case control study was conducted to describe the epidemiology and risk factors that contribute to the high incidence of molluscum contagious in certain AI/AN communities. This work will help target outreach and education activities with the long term goal of reducing disease incidence in these communities. In FY 2012, the case/control study was analyzed to describe the epidemiology and risk factors that contribute to
the high incidence of molluscum contagiosum among children in two specific AI/AN communities. Presentation of a description of molluscum contagiosum cases in the communities was given at the Native Health Research Conference.

Prevention and Control of Rocky Mountain Spotted Fever (RMSF) on tribal lands in Arizona (2009-2012): Since 2003, Rocky Mountain spotted fever (RMSF) has emerged as a significant public health threat in American Indian communities in Arizona, on the White Mountain Apache, San Carlos Apache, and Gila River Indian Community reservations. Human infection is associated with transmission from Rhipicephalus sanguineus, the brown dog tick, and is supported by large numbers of free-roaming community dogs that provide a food source for the ticks. Through 2011, over 200 human cases of RMSF were reported. The region’s reported incidence (527 cases per million persons) is 70 times the national incidence of RMSF. Over 50 percent of deaths occur in children. CDC, working together with the Arizona Department of Health Services and the Indian Health Service, are assisting tribes with developing and implementing prevention efforts to control the RMSF problem. CDC offers consultation, clinical evaluations of patients, educational materials, and guidance for environmental control. In addition, CDC provides field staff each year to support San Carlos and White Mountain’s summer prevention campaigns, consisting of treating tick-infested homes with pesticide and placing tick collars on dogs. Funding not awarded directly to the tribes. In 2011, CDC provided design input and printing of 5,000 coloring book calendars that were distributed to children of the San Carlos and White Mountain Apache tribes, with a goal of educating children about RMSF. Following the distribution of these calendars, CDC assisted the tribes with an evaluation of the efficacy of the coloring book calendar campaign, by conducting a door to door survey in August 2011. CDC assisted tribes with the first-ever census of dogs on the reservations. The census identified that 70 percent of dogs on the reservation were free-roaming, which contributes greatly to the problem of tick distribution. CDC developed a pilot program for a remote dog treatment baiting system, using food as an attractant and treating dogs for ticks. CDC provided eight staff members who assisted with summer prevention efforts for both tribes, working in the field in Arizona for two weeks at the end of June, 2011. CDC worked with both tribes to conduct a systematic chart review of severe and fatal RMSF cases to identify risk factors for poor outcome; chart reviews were conducted throughout the year, with CDC IRB exemption and tribal approval from both the San Carlos and White Mountain Apache tribes. On Gila River Indian Community, CDC provided four staff members during April 2011. These staff conducted a canine serosurvey to assess possible spread of RMSF from an affected housing district, and to assess efficacy of prior year’s prevention efforts on the reservation.

During FY 2012, the Rickettsial Zoonoses Branch responded to requests for assistance from several tribes (Tohono O’odham Nation, Gila River Indian Community, Hopi Tribe, Navajo Nation, San Carlos Apache Tribe) related to RMSF assessment and prevention activities, as follows: (1) In November 2011, in response to the first human case of RMSF identified in a resident of the Tohono O’odham Nation, the tribe requested a CDC Epi-Aid #2012-011m to conduct a canine seroprevalence survey to identify RMSF risk throughout the reservation. The Epi-Aid identified widespread exposure among dogs on the reservation (overall rate 28.6%), and recommended broad prevention measures to control RMSF throughout the reservation. (2) In March 2012, in follow-up to a prior year’s Epi-Aid, Gila River Indian community requested
assistance from the Rickettsial Zoonoses Branch to assess ongoing rates of canine seroprevalence on their reservation. This was not conducted as an Epi-Aid. Overall seropositivity was low (<5%), but evidence of recent RMSF transmission was noted, suggesting that additional prevention measures were needed to reduce human risk. (3) In June 2012, following the identification of a fatal RMSF in a Hopi tribal member who lived off-reservation, the Rickettsial Zoonoses Branch was invited to participate in Epi-Aid # 2012-047. This investigation identified the presence of RMSF exposure among reservation dogs (12.5%), but was not able to conclusively identify a source for the patient’s infection. (4) In July 2012, in response to concerns about RMSF on nearby tribal lands, the Navajo Nation requested assistance to evaluate its risk status through a systematic canine serosurvey spanning the reservation (Epi-Aid 2012-058); 16 percent of dogs were found to be positive.

**Strategic Partnerships and Capacity Building**

**CDC/IHS American Indian and Alaska Native Health Analyses Collaborations (2009-2012):** CDC has ongoing epidemiologic collaborative projects with the Indian Health Service (IHS), Alaska Native Tribal Health Consortium (ANTHC), CDC Arctic Investigations Program (AIP), other agencies, divisions, and universities to detect and describe disease burden and health disparities for overall and specific infectious diseases among American Indian and Alaska Native (AI/AN) communities. Studies provide information for developing prevention strategies, vaccination policies, and reducing health disparities related to infectious diseases. Findings increase awareness of specific infectious diseases, and highlight disease, person and geographic target areas to further investigate health disparities. For example, the identification of lower respiratory tract infections disparities among Alaska Native children led to more in-depth respiratory studies and educational efforts for children in Alaska.

**Cooperative Agreement with the National Indian Health Board (2009):** CDC has continued to support the National Indian Health Board (NIHB) to improve the health of underserved AI/ANs by strengthening efforts to build public health capacity throughout Indian Country and to foster culturally appropriate public health care services that focus on partnership building, health advocacy, promotion, education, and prevention. At the center of these public health initiatives is the strong, collaborative relationship between NIHB, Area Tribal Health Boards, and CDC, which is vital to successfully achieving critical health outcomes for AI/ANs. NIHB increased its collaboration with the Tribal Epidemiology Centers’ and Area Tribal Health Boards’ public health surveillance, epidemiologic research, and prevention activities by highlighting their successes via NIHB outreach and communication. NIHB is posting successful tribal research and program activities and achievements on its website and in the *NIHB Health Reporter*, and has disseminated some 15,000 tribal public Health brochures to tribal stakeholders.

**Tribal Epidemiology Center Consortium (“the Consortium” or TECC) (2009):** The TECC is made up of the Northwest Tribal Epidemiology Center (NTEC), the Southern Plains Inter-Tribal Epidemiology Center (SPIEC), and the California Tribal Epidemiology Center (CTEC). This interregional network has collaborated to strengthen tribal epidemiologic and public health capacity to promote the standardization and culturally competent use of health data to eliminate
health disparities facing AI/AN communities. The TECC’s lead agency is the NTEC and collaboratively serves the tribes of Idaho, Oregon, Washington, Kansas, Oklahoma, Texas, and California. Together, the TECC serves tribes in four Department of Health and Human Services’ (HHS) regions (Regions VI, VII, IX, and X). The consortium model has established a number of mechanisms for ongoing consultation with constituent tribes and a list of joint projects, allowing each epicenter to benefit from the experience and expertise of the others. The TECC has shared tools, data collection projects, and successful interventions being used in Indian Country that have increased the cultural competence, effectiveness, and data quality in all three areas. TECC continues to plan health initiatives based on joint or individual epicenter findings. The TECC is collaborating with the IHS National Epidemiology Program and Program Statistics Office to begin establishing standard protocols addressing how data can be accessed by tribal epicenters to allow an analysis and comparison to be done between areas. The TECC has held Injury Prevention Leadership Summits to share specifics about successful community-based interventions in the area of injury prevention and best practices.

In FY 2010, over $52 million in total funds were awarded through grants and cooperative agreements to Native American Communities including American Indian, Alaska Native Tribes and Native American (including Native Hawaiian and Pacific Islander) serving institutions.

Petition for Health Assessment Regarding Potential Contamination from Shellfish Consumption on the Port Gamble S’Klallam R (2010): The Port Gamble S’Klallam tribe requested ATSDR Region 10’s involvement as they investigate their concerns regarding potential chemical exposures through shellfish consumption. After a formal consultation discussion with the Port Gamble S’Klallam tribe, it was agreed by all parties that a Public Health Consultation be conducted through ATSDR’s Cooperative Agreement Program with the Washington State Department of Health (WDOH).

Colorado State University’s (CSU) Center for Applied Studies in American Ethnicities and Inter Tribal Council of Arizona, Inc. (ITCA) (2009): Colorado State University (CSU) has provided CBA to Native communities, Tribal Health Departments, state health departments, CDC-funded CBOs, and other organizations serving AI/ANs and Native Hawaiians. It has worked to strengthen the capacity of CBOs serving Natives to develop and implement regionally specific and community-specific strategies to assess service gaps, improve access to HIV/AIDS services, and increase utilization of services. CSU implements, improves, evaluates, and sustains the delivery of effective human immunodeficiency virus (HIV) prevention services for high-risk racial/ethnic minority populations of unknown or negative serostatus.

The Inter Tribal Council of Arizona, Inc. (ITCA) has provided CBA to AI/AN health organizations, CDC- directly and indirectly funded CBOs, health departments, and local Community Planning Groups (CPGs) to increase parity, inclusion, and representation (PIR) of AI/AN in the community planning process. ITCA provided the member tribes with the means for action on matters that affect them collectively and individually, to promote tribal sovereignty, and to strengthen tribal governments. ITCA’s National STD/HIV/AIDS Prevention Program (NSHAPP) began as the Regional STD/HIV/AIDS Prevention Program (RSHAPP) and was formed in 1989 by ITCA to respond to the increasing HIV/AIDS and STD disparity among AI
tribes in Arizona, Utah, and Nevada. ITCA delivers CBA through a process that begins with four broad components: (1) cultural competencies; (2) problem identification; (3) strategy development and implementation; and (4) monitoring and evaluation.

Capacity Building Assistance (CBA) to Improve the Delivery and Effectiveness of Human Immunodeficiency Virus (HIV) Prevention Services for High-risk and/or Racial/Ethnic Minority Populations (2009): CDC, under PS 09-906, has funded two organizations: CBA for CBOs—strengthening organizational infrastructure, interventions, strategies, monitoring and evaluation for HIV prevention, to deliver CBA to community-based organizations serving all high-risk and racial/ethnic minority populations, including Native communities. In addition, CDC has funded two organizations: CBA for Communities—Strengthening community access to and utilization of HIV prevention services, to specifically focus on Native communities. The organizations funded in Category B are AATCHB and Colorado State University. The FY 2010 CBA was designed to assist in implementing and sustaining science-based and culturally proficient HIV prevention behavioral interventions and HIV prevention strategies. This project was funded under Category B (Strengthening community access to and utilization of HIV prevention services) to provide CBA to Community Planning Groups (CPGs), community-based organizations (CBOs), health departments (HDs) and other HIV prevention stakeholders. It focused on the following goals: (1) Improve the capacity of CBOs to strengthen and sustain organizational infrastructures that support the delivery of effective HIV prevention services; (2) Improve the capacity of CBOs and HDs to implement, improve, and evaluate HIV prevention interventions; (3) Improve the capacity of CBOs and other stakeholders to implement strategies that will increase access to HIV prevention services for racial/ethnic minorities at high risk; and (4) Improve the capacity of CPGs and HDs to include HIV-infected and affected racial/ethnic minority populations and subpopulations in the community planning process, and increase parity, inclusion, and representation (PIR) on CPGs. In FY 2012, funding was provided to the following: Colorado State University – Fort Collins, the National Native American AIDS Prevention Center (NNAAPC), and the Great Plains Tribal Chairmen's Health Board (Aberdeen Area Tribal Chairmen's Health Board).

Capacity Building Assistance to Improve Health in Tribal Populations (2012): Reducing Rates of Childhood Obesity in Alaska Native/American Indian Populations: The Tribal Support Unit awarded funds to the Southcentral Foundation (SCF) to assist in reducing childhood obesity among Alaska Native and American Indian youth in Alaska. SCF’s capacity building assistance will support a breastfeeding education class for pregnant women; a support group for women after childbirth; lactation education courses and certification for three health educators; revisions to the InJoy curriculum so that it is culturally relevant and teaches breastfeeding basics; the Snuggle Time weekly support group, through which participants share their struggles and joys with one another, a behavioral health consultant, and a certified lactation educator; and the Physical Activity Club for Kids, an after-school program for overweight and obese children, led by two Alaska Native clinical exercise specialists.

Accreditation Support Initiative (2012): Accreditation support to prepare for national accreditation through the Public Health Accreditation Board (PHAB) Partners: The Association of State and Territorial Health Officials (ASTHO), the National Network of Public Health
Institutes (NNPHI), and the National Association of County and City Health Officials (NACCHO). Tribal grantees:

- **Yellowhawk Tribal Health Center (Oregon)** – Yellowhawk Tribal Health Center completed a departmental strategic plan and integrated it into the Tribal Health Improvement Plan. They also evaluated public health laws and developed a guide to assist staff and providers in understanding their roles and responsibilities in enforcement.

- **InterTribal Council of Arizona, Inc.** – InterTribal Council of Arizona, Inc. increased awareness about public health accreditation and the application process among tribes in Arizona, Utah, and Nevada; developed a tribal-specific accreditation readiness tool for conducting a community health assessment; and increased opportunities for tribal public health systems in Arizona to communicate and coordinate public health accreditation.

**Public Health Foundation (PHF) – Core Capacity Building (2012):** PHF explored how it can better develop, deliver, and disseminate existing program management (PM) and quality improvement (QI) products and services for use by tribal health departments. PHF adapted PM and QI resources to enhance their applicability within tribal health departments.

**Public Health Foundation (PHF) – Minority Student Outreach Pilot Project (2012):** PHF’s project was to help increase the number of minority public health professionals working in STLT health departments. They have conducted research and learned about tribal health leadership and the unique challenges that must be addressed in order to best serve tribal communities.

**Epidemiologic Intelligence Officer (EIS) Officer Assignments:** There was an EIS officer assigned to the Alaska Division of Public Health from July 2010 to July 2012. An Epi-Aid was in progress to assist with an investigation of what appears to be ongoing tuberculosis transmission in a long-term care facility in Anchorage, Alaska. The team reviewed the medical records of residents residing in the neighborhood in April 2011, reviewed records of residents in the neighborhood since January 2010 who were deceased/transferred out; made recommendations on further clinical work-up of residents still in the neighborhood; and tested staff that had primary assignments in the neighborhood. The team also did a symptom screen and chest x-ray on all staff of interest and cross-checked all known people who spent time in the unit with the state's TB database.

**Support for Maternal and Child Health Epidemiologist (2012):** The Epidemiologic Intelligence Service (EIS) had an EIS officer assigned to the Indian Health Service, Division of Epidemiology and Disease Prevention located in Albuquerque, New Mexico during August 2010—December 2010. The EIS officer’s most notable project during this time was an investigation of an outbreak of severe respiratory illness among American Indian children in Arizona.

Two staff epidemiologists deployed with Public Health Service (PHS) Applied Public Health Team-4 (APHT-4) to the Pine Ridge Reservation in South Dakota during the week of August 21–27, 2011. This was in conjunction with a clinical and public health training mission funded by the PHS Office of Force Readiness and Deployment. The epidemiologists worked with the Oglala Sioux Tribe and other CDC, APHT-4, and Indian Health Service epidemiologists to plan
for an upcoming Community Health Profile and to conduct training on epidemiologic tools for accomplishing this activity.

Public Health Prevention Service Fellow Assignments: (2012): A Public Health Prevention Service (PHPS) fellow assigned to the Minneapolis Department of Health & Family Support (MDHFS), is coordinating a project called VOICE—Valuing Our Individual Communities through Engagement. The goal of this project is to build upon and sustain engagement of cultural communities in efforts to prevent obesity and related chronic disease. American Indian/Native American community members have participated in one of the multi-cultural health story-telling sessions (similar to a focus group).

A Public Health Prevention Service (PHPS) fellow assigned to CDC’s Office of Public Health Preparedness and Response, Division of Strategic National Stockpile (DSNS), worked collaboratively with CDC colleagues and partners at NACCHO and ASTHO to develop and implement a special focus tribal track of the SNS summit. The goal of the special focus track was to share best practices in working with the tribes and tribal SNS planning. NACCHO provided travel scholarships for both the presenters and up to 50 tribal participants to attend the conference. After the Summit, the PHPS fellow continued to work with the tribes to follow up on action items; collaborated with ASTHO and NACCHO to begin developing a more formal SNS tribal workgroup; and reached out to other centers within CDC who are working with tribes in public health preparedness and emergency response to share lessons learned and determine any potential collaborations that might provide better leveraging of resources to meet the needs of tribes, local coordinators, and state coordinators responsible for SNS planning.

The Public Health Prevention Service (PHPS) had a fellow assigned to the New Mexico Department of Health, Public Health Division, Health Systems Bureau, Office of School and Adolescent Health from Oct. 2008 - Oct. 2010. In this role, the fellow worked with Native American populations. The fellow’s assignment focused on adolescent health and school health. Specifically, the fellow led an effort to identify and understand why many school-based health centers (SBHC) are under-utilized, particularly by Hispanic, Native American and African American youth, despite the high need for services; findings are being used to create and disseminate youth-informed marketing materials to promote SBHC services to all youth.

Public Health Associate Program (PHAP) (2012): PHAP is a competitive, two-year, paid Centers for Disease Control and Prevention (CDC) fellowship. A PHAP associate is assigned to a state, tribal, local or territorial public health agency and works alongside local public health professionals. After completing the program, PHAP graduates will be qualified for future jobs with federal, state, tribal, local and territorial public health agencies, and will be uniquely prepared to pursue an advanced degree in public health. Three students are currently working in Indian Country: Shoalwater Bay Tribal Health Department and Wellness Center in Tokeland, Rocky Mountain Tribal Epidemiology Center, California Tribal Epidemiology Center.

Preventive Health and Health Services Block Grant (2011): The funds are used to complement existing funds to support the tribal EMS system. Data development and training are two areas of
need. Funds were also provided to a Boys/Girls Club Youth Leadership Initiative which entails attendance at a National Youth Leadership Conference and local activities.

Public Health Emergency Preparedness

Epi-Aid in Arizona: San Carlos Apache Reservation (Epi-Aid 2012-066): The San Carlos Apache Tribe in eastern Arizona reported their first human cases of Rocky Mountain Spotted Fever (RMSF) in 2006, and cases have been reported every year since. RMSF has reached epidemic status on the reservation, and two fatal cases were reported in March 2012. In August 2012, the EIS conducted an Epi-Aid at the San Carlos Apache Reservation in Arizona to evaluate an RMSF prevention program.

Epi-Aid in Arizona, New Mexico, Colorado, and Utah: Navajo Nation (Epi-Aid 2012-058): In June 2012, the EIS conducted an Epi-Aid in Arizona, New Mexico, Colorado, and Utah to assess the risk for RMSF among the Navajo Nation. Although human cases have not been previously reported from the Navajo reservation, a published report in 2010 described seroprevalence rates to spotted fever rickettsiae among dogs as greater than 50 percent on the nearby Hopi reservation, suggesting possible human risk on the reservation.

Epi-Aid in South Dakota: Oglala Sioux and Cheyenne River Sioux Tribes (Epi-Aid 2012-051): The rates of gonorrhea and chlamydia among American Indians in South Dakota are disproportionately high and steadily increasing. In June 2012, the EIS conducted an Epi-Aid with the Oglala Sioux and Cheyenne River Sioux Tribes in South Dakota to: (1) characterize the increases in chlamydia and gonorrhea among American Indians with respect to demographics and geography; (2) determine if increases in cases could be attributed to increased screening, changes in test technology, or other factors; and (3) identify opportunities for prevention and control.

Epi-Aid in Arizona: Hopi Reservation (Epi-Aid 2012-047): In May 2012, the EIS conducted an Epi-Aid to assess the risk for RMSF on an Arizona Hopi reservation after a fatal case occurred in a Hopi tribal member.

Technical Assistance Provided to Native Americans FY 2009 through FY 2012

Alaska Native Colorectal Cancer Projects: Through an interagency agreement between CDC and IHS and collaboration with the Alaska Native Epidemiology Center (ANEC), CDC provided ongoing services and technical assistance for colorectal cancer projects in Alaska. These projects included promoting colorectal cancer screening through itinerant endoscopy services provided to rural tribal health facilities and providing a case manager/case navigator position at a regional hub healthcare facility to coordinate patient outreach, recruiting, scheduling, tracking, and follow-up. This patient outreach prioritized screening individuals with a family history of colorectal cancer or who were aged 50 and older and had never been screened. The patient outreach efforts also involved maintaining and using a colorectal cancer First Degree Relative database and installing colorectal cancer-screening report software on the electronic medical records system of regional health care facilities to identify those at high risk and those in need of.
screening. CDC used this work in Alaska to complete a research project evaluating the performance of immunochemical fecal occult blood tests (iFOBT) as a potential alternative to Guaiac-based fecal occult blood testing (gFOBT), which was not used for ANs based on the high prevalence of *H. pylori* infection. The iFOBT was believed to perform well even in the presence of *H. pylori* infection and could have been an important addition to possible screening options for this population. CDC also planned to produce a report summarizing various colorectal cancer screening reminder systems and results-tracking systems currently in use at IHS, tribal, and urban facilities. The ANEC would continue to receive funding through the CDC/IHS interagency agreement (IAA) to carry out these and other projects in the future.

**National Death Index (NDI) Linkage Project:** CDC collaborated with the National Center for Health Statistics (NCHS) and IHS to minimize the effects of racial misclassification and improve estimates of cancer mortality among AI/ANs. This project secured funding in 2009 to link IHS and NDI data to produce an analysis file with all records from the NCHS Mortality Statistics file and flag records that linked to the IHS patient registration file. In FY 2010, the IHS Division of Epidemiology and Disease Prevention (DEDP) provided NCHS/NDI with the IHS patient registration file containing approximately 3.5 million records of AI/AN persons who have received services in the IHS since 1985. NCHS/NDI linked data between NDI and IHS for deaths occurring from 1985 to 2007, and CDC processed and adjudicated the linkage results. CDC sent NCHS/NDI a file of all “true” matches, and NCHS returned a file to IHS DEDP that contained all deaths occurring in the United States during that time period with flags for records that matched to the IHS file. CDC then created an analysis file of all deaths. Using appropriate cause of death records, CDC generated tables of cancer and other deaths and used these tables as the basis for a series of reports and manuscripts characterizing major causes of mortality for AI/ANs.

**Diabetes Education in Tribal Schools Curriculum:** Since 2001, the National Institutes of Health, NIDDK, in partnership with the Tribal Leaders Diabetes Committee, CDC Native Diabetes Wellness Program, the IHS, and eight tribal colleges and universities, have developed the K-12 science and culturally based *Health is Life in Balance* Diabetes Education in Tribal Schools curriculum. All partners worked with school sites throughout the United States to test the curriculum in three evaluation phases. CDC assisted with evaluation format and scientific oversight for the project. The Eagle Books are included as part of the K-4 lessons plans. The curriculum was rolled out in November 2008 at the Smithsonian National Museum of the American Indian in Washington, D.C. The roll out coincided with the Eagle Book art exhibit at the same locale. From FY 2009 through FY 2010, all partners were providing education outreach and teacher development training in all states with AI/AN populations. NDWP lead a DETS impact evaluation case study in four communities each year through 2012 to provide community-specific information on DETS curriculum use and acceptance.

**Native Diabetes Wellness Program Tribal/State Relationship Building Initiative:** From 2008–2009, NDWP launched an initiative to encourage and support working relationships between state Diabetes Prevention and Control Programs (DPCPs) and the respective tribal nations in each state. The initiative had support from CDC’s Tribal Council Advisory Committee (TCAC) and the TLDC. Partnerships included all state DPCPs with an initial emphasis on “model”
DPCPs demonstrating innovation in their relationships with tribal partners and tribal nations.
State-based programs received guidance to seek opportunities for tribal consultation with tribes in their states. NDWP printed 15,000 AI/AN Culture Cards, initially developed by SAMHSA, for distribution to state DPCPs and tribal nations. NDWP worked with the New Mexico Diabetes Advisory Council (DAC) and the New Mexico Native American/DPCP alliance to facilitate outreach to tribal entities within the state. All 17 traditional foods grantees received congratulatory letters from NDWP with copies to the respective state DPCP to encourage relationship building between the two entities. These efforts were one of many steps in place to build and maintain tribal and state DPCP relationships. In October 2009, CDC released the new NDWP website that describes NDWP’s many programs and activities. The website can be accessed at www.cdc.gov/diabetes/projects/diabetes-wellness.htm.

American Indian Adult Tobacco Survey Training and Media Training for Tribes: Office on Smoking and Health (OSH), Epidemiology Branch (EPI) and the National Native Commercial Tobacco Abuse Prevention Network (PN) collaborated on a series of trainings tailored for tribes who wish to implement their own AI Adult Tobacco Survey (AI ATS). The trainings stressed the importance of tribal-specific surveillance in informing and improving comprehensive, commercial tobacco prevention and control at the tribal health-system level and provided the knowledge and tools that allowed tribes to implement this surveillance system. Tribes served by the Inter-Tribal Council of Michigan, the Aberdeen Area Tribal Chairmen’s Health Board (AATCHB), Muscogee (Creek) Nation and the Tribal Support Centers for Tobacco Programs committed to working collaboratively on these trainings that were held at least twice per year. Ongoing technical assistance for tribes in the area of surveillance implementation and data analysis was provided.

Trainings were held in Minneapolis, Minnesota, and Rapid City, South Dakota in 2009. OSH and the network collaborated on a series of trainings tailored for tribes in the area of using the media for targeted health campaigns. The trainings were co-presented with Gerald Wofford, Media Department Head at the Muscogee (Creek) Nation, and provided a culturally appropriate training module. Topics included budgeting for media campaigns, developing news releases, working with reporters, and developing targeted media campaigns. The training was held April 2010, in collaboration with the CDC-funded Oklahoma AI CEEDS.

Tribal Health Behavior/Maternal Child Health Surveys: DRH provided technical assistance in the design, implementation, and analysis of Behavioral Risk Factor Surveys, Maternal, and Child Health Surveys, and related population-based surveys for more than 30 AI populations throughout the United States. The topics addressed in these surveys included tobacco use, alcohol use, diet/weight, physical activity, diabetes, cardiovascular health, injury issues, maternal/child health, and use of health services, among others. Data was collected in face-to-face interviews conducted by local community members. DRH worked with tribes and other AI organizations to develop questionnaires, design the sampling field approach for the surveys, train interviewers, develop data entry programs, analyze the information collected in the surveys, and produce reports on the survey results. DRH worked with the tribal organizational staff to determine how to utilize the results. Results were used to provide input into health programs and interventions and to document the current health situation to obtain resources to address health.
problems. In FY 2009, DRH staff was a member of the planning group for a behavioral risk factor survey on the Navajo. DRH was involved in discussions of survey design, sampling, and budgeting for the survey planned in FY 2010. DRH continued to provide assistance to tribes as requested to design and implement population-based health surveys. DRH moved toward building capacity within tribal organizations so that they were better able to carry out their own surveys.

Support for Breastfeeding in the Workplace: In 2007, the Division of Nutrition, Physical Activity, and Obesity’s (DNPAO) Breastfeeding Work Group partnered with the Navajo Nation, providing technical assistance for the purpose of addressing low breastfeeding duration rates. Also in 2007, the Navajo Nation Breastfeeding Coalition (NNBC) was formed to address the common goal to increase breastfeeding duration rates on the Navajo Reservation. A major action undertaken by the coalition was to build partnerships to work on passing a worksite breastfeeding support law to accommodate the need for breastfeeding mothers to breastfeed on express milk at work. The NNBC made a deliberate decision to focus on a grassroots effort to influence tribal leaders to pass a worksite breastfeeding support law. Multiple partners worked with the local communities to pass worksite breastfeeding support resolutions in 90 percent of the 110 chapters.

As a result of this success, the Navajo Nation Council passed the Healthy Start Act in October 2008. The law requires employers to provide a private room and a flexible work schedule for breastfeeding or milk expression. In December 2008, the NNBC was awarded a small grant by HRSA to help the Tribal Government enforce the Healthy Start Act by developing an implementation plan. This plan addressed increasing awareness and education among employers about how to make changes in the worksite policies and environment to comply with the law.

Integrating HIV Prevention into Reproductive Health Services for AI/AN: For two successive years, DRH successfully competed for Minority AIDS Initiative funds from HHS Office of HIV/AIDS Policy. In year one, JSI Regional Research and Training Center for Family Planning (RTC) was funded to adapt training and technical assistance tools developed for providers of AI/ANs. In year two of the project, the Center for Health Training (CHT) in Oakland, California, also an RTC, piloted the adapted training and technical assistance package with an urban Indian health care facility in Oakland, California, and at ANTHC through the CHTs in Seattle, Washington. They finalized the HIV integration toolkit and presented the package at the HHS Office of Population Affair’s annual HIV grantee meeting, and they conducted a national teleconference on the package for health care providers of AI/ANs. CHT received a no-cost extension for 2010. The remaining funds will be directed to training and technical assistance for HIV integration with CHTs Alaska partner.

Support for Alaska Native Health Research: AIP promoted research activities by tribal health organizations and supported AI/AN health researchers. Ongoing efforts included joint CDC/tribal health research projects and technical support to tribal health research activities such as the ANTHC Hepatitis Program, the Alaska Native Tribal Epicenter, and the SouthCentral Foundation research program. This support included medical and epidemiologic consultation, laboratory and specimen handling, database and statistical support, grant submission, access to
other CDC resources, membership on the Alaska Area IRB (ethics board), and training students and researchers through seminars, internships and conferences. AIP was a co-sponsor of the AN Health Research Conference held March 19–20, 2009, and sponsored an AI Emerging Leaders Fellow in FY 2009 to develop a policy document and research agenda for assessing and responding to climate change in rural Alaska communities, and we mentored an Alaska Native Pharmacy Resident to research trends in antibiotic prescribing in Alaska. In FY 2009, AIP supported tribal research activities related to tobacco control, stroke management, diabetes care, cancer screening, STDs, pharmacy services, and environmental health. CDC anticipates continuing this support and seeking additional student mentorship opportunities.

Rocky Mountain Spotted Fever (RMSF) Rodeo: A Demonstration Prevention Project on the San Carlos Apache Reservation, 2012: The RMSF Rodeo was developed as a pilot demonstration project and carried out in a single community. The RMSF Rodeo was a collaborative project involving CDC, IHS, USDA, the San Carlos Apache Tribe, the State of Arizona, and private donors (Bayer, Petsmart Charities). The project received San Carlos Apache tribal approval in February 2012. The tribe selected Peridot Heights to receive the intervention, largely due to the high number of RMSF cases that had been reported from this community in recent years. Utilizing field teams composed of federal, state, and tribal staff members, the project delivered appropriately timed and integrated pet care and tick control techniques to every participating home in Peridot Heights, including the following key activities: (1) placing a new eight-month tick collar (the first such collar available in the U.S. and donated pre-marketing for the project by Bayer) on every dog; (2) treating every house in the project area once a month for four months with a tick-killing pesticide product; (3) creating a dog licensing and traditional collaring program to track dogs in the neighborhood; (4) providing free stakes and tethers to encourage owners to reduce pet dog roaming; (5) providing free spay-neuter services to promote dog population control. The project commenced in April 2012 and ran through August 2012, concluding with an evaluation of tick counts and knowledge in the RMSF Rodeo community, compared to parts of the reservation that received usual tribal RMSF prevention efforts. The project was highly successful, with 99 percent of eligible homes participating. Tick infestation counts dropped dramatically in the RMSF Rodeo neighborhood; at registration, only 66 percent of dogs were tick-free, but by August 2012, 99 percent of dogs were tick-free. In contrast, only 63 percent of dogs outside the RMSF Rodeo area had ticks during the August evaluation.

National Colorectal Cancer Control Program: In FY 2009-2012, four tribal organizations—the Alaska Native Tribal Health Consortium, the Arctic Slope Native Association, South Puget Intertribal Planning Agency, and the SouthCentral Foundation—were funded as NCRCCP sites after a competitive review process. During November 2009, CDC hosted a NCRCCP reverse site visit for CRCCP grantees to discuss the population-based approach, communication strategies to promote screening, and NCRCCP evaluation plans. The new five-year project period began June 2009, and CDC planned to continue to provide technical assistance to funded sites for screening program and population-based screening activities. In FY 2010 - 2012, the Colorectal Cancer Control Program's goal was to increase colorectal (colon) cancer screening rates among men and women aged 50 years and older from about 64 percent to 80 percent in the funded organizations by 2014.
Enhancing Cancer Prevention and Control Programs for American Indian/Alaskan Native Women (2010-2012): As part of Native American Cancer Research Corporation's (NACR) ongoing CDC grant for FY 2010 and 2012, NACR coordinated two regional meetings. NACR implemented and evaluated 10 regional planning conferences/working meetings in collaboration with local public health professionals and organizations that actively work with American Indian or Alaska Native (AI/AN) organizations and communities. They addressed gaps in AIAN cultural awareness materials (including designing, developing, and distributing AI/AN cultural appropriate public education and awareness materials. This included one Native Wellness booklet and one case study annually. NACR provided technical assistance related to cultural appropriateness and awareness, as approved by the CDC, to states' Indian Health Service, tribal and urban programs and others, on an as needed basis. Lastly, NACR implemented and evaluated cultural awareness trainings.

Racial and Ethnic Approaches to Community Health (REACH) U.S. Program (2009-2012): AC: Inter-tribal Council of Michigan “Reaching Toward Healthier Anishinaabe REACH ” (ITCM) continued to implement community-based intervention activities to reduce cardiovascular and diabetes related disparities that were culturally tailored to each of three tribal communities, while providing overall technical assistance to the tribes and disseminating results of the culturally tailored interventions among consortium partners. This was accomplished through refining Community Action Plans (CAP) and hosting technical assistance and information-sharing meetings with partner programs, agencies, and tribal leadership. For grant year two, diabetes education groups and Talking Circles began. The Hannahville Indian community planned and hosted the Native Health Summit in April 2009. The summit featured Native spiritual leaders, health care providers, and traditional medicinal people sharing wisdom about Native health and wellness, with an emphasis on heart health and diabetes, and included information on traditional use of tobacco for natives and speakers discussing the mind-body-spirit connection.

Employee and worksite wellness was a focus for year two, with programs that incorporate CVD screenings into all activities, including an employee health fair, lunch and learns, one-on-one nutrition counseling and referrals, smoking cessation support groups, and other available services led by health professionals such as dietitians. Personal Action Toward Health and Weight Watchers at Work were examples of programs that the ITCM project focused on that fit inside the interpersonal or group level of the socio-ecological model. Environmental and systems change emphasized through convenience store nutrition labeling, community walk-ability assessments, and local trails planning. Community capacity building through mapping assets, established partnerships, and developed simple activities such as cooking classes that incorporated traditional food recipes were important aspects of this REACH program.

Communities Putting Prevention to Work (2012): The annual meeting was a training to strengthen and expand agency capacity to achieve program goals to reduce obesity and tobacco use, network with peers, and accelerate successes by building peer-to-peer consultation. Participants included: Cherokee Nation representatives, CDC, contractors, and technical assistance providers. The Healthy Communities meeting increased knowledge of strategies and resources to assist in development and implementation that increase access to
healthy food and physical activity, and reduce secondhand smoke exposure. The meeting was
designed and facilitated by Cherokee Nation and participants included tribal leaders, tribal health
administrators and program managers, allied health professionals, and health educators.

three tribal schools were selected in a competitive process to participate as priority schools in the
state’s coordinated school-health program. Beginning in October 2009, the programs received 3
years of professional development tailored to their needs, mini-grants ($10,000/school/year), and
ongoing technical assistance. Training for, and completion of, the CDC’s School Health Index
was the first expectation for the participating tribal schools. The Department of Education (DE)
Coordinated School Health Program Director secured funding for this initiative above and
beyond their program’s established budget. Maine’s DE conducted “Be Proud! Be
Responsible!” training for tribal school educators reaching 30 participants of the Passamaquoddy
Nation. Maine’s AI youth cultural camp, which included a modified “Be Proud Be Responsible”
training, reached 25 middle school youth and 40 college students.

Wisconsin—Wisconsin provided technical assistance and educational resources to the
HIV/AIDS Coordinator at the Great Lakes Intertribal Council to support ongoing HIV
prevention initiatives for Native youth in 11 tribes in the state.

Students for Success (2010): Promoted coordinated school health policies, programs, and
practices with an emphasis on physical activity, nutrition, and tobacco-use prevention. They
provided technical assistance to four partner schools to support the planning and implementation
of school health council meetings. They provided professional development and technical
assistance to school personnel on curriculum, policy, social marketing, and other activities to
support building a healthy nutrition environment. They used CDC’s Health Education
Curriculum Assessment Tool to identify health education curricula that meets national standards
and best practices. They offered professional development and follow-up technical assistance
opportunities to teachers and curriculum directors on Health Education Standards. The program
encouraged site coordinators to attend national training to improve their capacity and skills in
providing technical assistance to local school districts and buildings. They conducted CDC’s
Youth Risk Behavior Survey without being funded to do so.

Coordinated School Health (2010 and 2012): The Maine Department of Education was funded
for HIV Prevention, Coordinated School Health (CSH)/Physical Activity, Nutrition, and
Tobacco, and the YRBS. Maine’s three tribal schools were selected in a competitive process to
participate as priority schools in the state’s coordinated school health program. All tribal schools
participated in professional development tailored to their needs, and were awarded mini-grants of
$5,000 per school per year, and on-going technical assistance. All tribal schools completed
CDC’s School Health Index (SHI) and used the results to revise and improve their wellness
policies. Every tribal school implemented new healthy eating and/or physical activity promotion
initiatives. Highlights included: new physical activity breaks during the academic day policies,
recess before lunch policies, and inclusion of students in school menu choice, before school
walking clubs and establishing school gardens and healthy cooking clubs. In addition, the Maine
Indian Unified School Committee augmented their tobacco policy passed last year with
implementation of an alternative to suspension tobacco cessation program. The tribal schools represented a small portion of students served with Maine's CSH program.

**Using Traditional Foods and Sustainable Ecological Approaches for Health Promotion and Diabetes Prevention in AI/AN Communities:** In FY 2009, CDC funded six additional grantees from the 60 original applicants, for a total of 17 grantees. Each grantee is funded at about $100,000 per year through FY 2013, making the total expenditure at $1.7 million each year for the next four years. Evaluation and planning technical assistance was provided by NDWP to grantees on a regular basis. In addition to the use of locally developed evaluation tools and data gathering, aggregate data was compiled and analyzed every six months by NDWP to share with grantees, CDC, and others.

**Empowering Ramah Navajos to Eat Healthy (ERNEH) (2010-2012):** This Project provided materials, training, and technical assistance to families to help them grow fresh vegetables in their own yards by using conventional in-ground gardens, developing raised bed gardens, or planting in commercially-viable garden boxes. The Project also encouraged physical activity and worked to improve access to a greater variety of physical activities through community support. The Project also provided technical assistance and training regarding food use, preservation, and assistance in selling excess produce. Finally, the book, "Traditional Navajo Foods & Cooking", will be updated, first published by the Ramah Navajo School Board in 1983. Forty-five community members participating in the gardening project increased access to healthy traditional food fully as a result of the efforts of the ERNEH Project; another fifty-nine increased access partially as a result of project efforts. Sixty-seven Honor Walk participants increased access to information about traditional food fully as a result of the ERNEH Project.

**Cherokee Nation Tobacco Program (2012):** Partners with schools, communities, worksites, and health care settings within the Cherokee Nation tribal jurisdictional area implemented policy, systems, and environment change. The program goal was to make Cherokee Nation citizens healthier by making the healthy choice the easy choice for all tribal citizens. The program partnered with the Oklahoma State Health Department to administer the Youth Tobacco Survey in schools located inside of Cherokee Nation jurisdiction and provided technical assistance to 112 elementary, middle and high schools implementing 24/7 school tobacco-free policies in the 14-county Tribal Jurisdictional Service Area. It also collaborated with the tribal health care system to implement the clinical practice guidelines for tobacco dependency and document interventions on the electronic medical records, among other public health activities.

**South Dakota Tribal Pregnancy Risk Assessment Monitoring System (PRAMS) Project (2010):** The Yankton Sioux Tribe (YST) and the AATCHB identified maternal and child health as the highest health priority in response to persistently high rates of infant mortality. In South Dakota during 2002–2004, AIs made up 18.1 percent of births, but accounted for 34 percent of infant deaths. The South Dakota Tribal PRAMS (SDTP) initiative was a unique PRAMS project collecting information exclusively from AI women (and mothers of AI infants) who gave birth to a live infant in South Dakota and Sioux County, North Dakota. PRAMS is an ongoing, population-based risk factor surveillance system initiated and designed to identify and monitor selected maternal experiences and behaviors that occur before and during pregnancy and in the
child’s early infancy among women who deliver live, born infants. In this project, CDC provided technical assistance including development of a model protocol for data collection, assistance with question design, survey instrument development, and training on human subjects’ protections and telephone interviewing.

CDC also provided and installed data entry software and survey tracking software, conducted onsite training of staff on the software, and gave ongoing technical assistance on the systems. In October 2008, CDC provided SDTP with the cleaned and weighted final dataset. Currently, CDC provides ongoing consultation regarding data analysis and data dissemination activities. Data collection was completed in June 2008. Project response rates met the PRAMS threshold of 70 percent, and the SDT PRAMS staff convened community meetings in spring 2008 to discuss tribal priorities for data analysis. This input was combined with that of the Steering Committee and the Tribal Oversight Committee (which has representatives from all nine South Dakota tribes) in the development of an analysis plan. The plan was approved by the Tribal Oversight Committee. A surveillance report combining data from all tribes is scheduled to be published by the end of 2009. Tribal-specific reports are being developed for release only to the tribes. The SDT PRAMS staff evaluated the alternate surveillance methodologies used to reach tribal women and presented this evaluation along with a description of their procedures at the International Meeting in Indigenous Child Health, the PRAMS National Meeting, and the Maternal and Child Health Epidemiology Conference at the end of 2008. The SDT PRAMS data manager, a Native who recently graduated with an M.P.H. degree, was hired as a Council of State and Territorial Epidemiologist (CSTE) fellow working at the Northern Plains Tribal Epicenter and will continue with some PRAM activities.

Health Marketing of an Efficacious Intervention to Prevent Alcohol-Exposed Pregnancies (2009): With FY 2009 funds, TKC Integration Services focused on collaborating with IHS to identify settings and populations of AI/AN women at risk for an AEP; identified and made needed adaptations or modifications to the intervention and training curricula and materials; and developed, implemented, and evaluated a plan for disseminating the training and provided technical assistance. To begin this process, CDC and TKC Integration Services provided a generic pilot CHOICES training to 12 MCH staff working in the Bemidji IHS area in May 2009 and gathered preliminary feedback from trainees on possible changes in the curricula and materials that may be needed. CDC and TKC Integration Services focused on strengthening collaborations with IHS through meetings with stakeholders, additional needs assessment activities, adaptation of the training curricula and intervention materials as needed based on feedback from potential users, and development and evaluation of dissemination and technical assistance activities.

STD, HIV, Sexual Violence Among AI/AN Women Living in the Great Lakes Region (2009): AI/AN women have the highest rates of sexual violence in the United States. AI/ANs have the second highest rates of STDs and high rates of HIV. There is a relationship between (1) risky sexual behavior following sexual assault; and (2) STDs that result from sexual assault. An initial conference call was conducted with representatives from diverse groups working on this issue (e.g., tribal, community-based organizations [CBO] state, regional, federal) to identify the most pressing challenges and to identify strategies to work together to address them. From that
experience, CDC/IHS National STD Program provided funding to the IHS Bemidji Area Office (BAO) who partnered with the Great Lakes Inter-Tribal Epi Center (GLITEC) to provide mini-grants to one tribe or tribal organization in each of the three States of Michigan, Minnesota, and Wisconsin served by BAO and GLITEC. GLITEC funded three tribal organizations to work on this project. Each organization developed its project based on local need, ranging from campaigns to make this issue more visible at the community level to establishing a Sexual Assault Nurse Examiner program. Collaborations and technical assistance were provided to BAO and GLITEC as they worked with tribes and tribal organizations to complete their projects.

Ongoing HIV Projects for American Indian/Alaska Natives (2009): Since 1989, CDC has partnered with the National Native American AIDS Prevention Center (NNAAPC) to provide capacity building assistance (CBA) to organizations providing services to AI/ANs nationwide. With funds from CDC, NNAAPC has developed training manuals and resource guides for HIV providers serving Native peoples, produced multi-day regional trainings for Native-specific programs, conducted grant-writing workshops, organized national focus groups and workgroups, facilitated national strategic planning for high-school aged youth with federal and tribal education stakeholders, and championed the visibility and viability of Native communities. NNAAPC used a national approach with regional strategies to facilitate cross-site communication, partnership development, and resource sharing. Their CBA activities were guided by a regional coalition made up of five member organizations. These coalition partners are Inter Tribal Council of Arizona (ITCA), American Indian Community House, Papa Ola Lokahi, AATCHB, and ANTHC. NNAAPC provided one-on-one technical assistance and tailored training to community-based organizations (CBOs) and health departments on effective organizational management techniques, policies and protocols needed for HIV prevention programs (confidentiality, universal precautions, safety for off-site outreach activities, and counseling and testing protocols), effective fund development, standards for reporting, executive coaching, and cultural competency. NNAAPC provided CBA to CBOs and health departments serving Native populations, emphasizing the integration of Native principles, beliefs, and communication styles into HIV prevention activities.

Capacity Building Assistance (CBA) to Improve the Delivery and Effectiveness of Human Immunodeficiency Virus (HIV) Prevention Services for High-risk and/or Racial/Ethnic Minority Populations (2009): AATCHB successfully competed for funding for five years to provide culturally appropriate CBA to tribal HIV and STD prevention personnel on reservations and urban centers in Colorado, Iowa, Illinois, Indiana, Kansas, Minnesota, Michigan, Missouri, Montana, North Dakota, Nebraska, Ohio, South Dakota, Utah, Wisconsin, and Wyoming to reduce health disparities currently existing for AI populations; through an expanded advisory committee, conducted a needs assessment of all regional reservations to identify current HIV/STD prevention methods, training, and technical assistance needs, and attitudes and barriers to adopting and using new techniques; and marketed and delivered culturally appropriate CBA resources (e.g., DEBI trainings, technical assistance, and information) to tribal communities based on results from the needs assessment. Colorado State University (CSU) successfully competed for 5-year funding to continue to strengthen the capacity of CBOs serving Native people to develop and implement regionally specific and community-specific strategies to assess service gaps, improve access to HIV/AIDS services, and increase use of services; train CBOs in...
the use of the Community Readiness Model for assessment, application, strategy development, and social marketing; ensure the CBO has broad involvement of community stakeholders and policy makers; integrate each community’s unique culture, values, traditions, history, and beliefs into the strategies; and use assessment, training, and workshops built into a solid theory-based structure and logic model.

**Strengthening the Capacity of Tribal Health Departments to Implement HIV Prevention (2009):** The Tribal Support Unit awarded a cooperative agreement to the National Native American AIDS Prevention Center (NNAAPC) for capacity building and technical assistance to five tribal health departments. Funding supported strengthening organizational infrastructure and programmatic skills, providing culturally responsive HIV counseling, testing, and referral services, and applying a link-to-care protocol based upon the Antiretroviral Treatment Access Studies model. Funded tribes included the Confederated Tribes of the Colville Reservation (Washington), Fort Peck Assiniboine and Sioux Tribes (Montana), Shoshone Bannock Tribes (Idaho), Standing Rock Sioux Tribe (North and South Dakota), and White Earth Reservation (Minnesota). NNAAPC also received a supplement from NCHHSTP for STD prevention in urban Indian populations in Denver, CO, and Billings, MT.

**Responding to Pandemic H1N1 2009 Influenza among AI/AN Populations (2009-2012):** CDC committed to ensuring that all of Indian country was included in the 2009 H1N1 influenza preparedness and response efforts, and activities to do so include both partnerships with IHS and direct engagement with tribal governments and organizations. To coordinate these activities and enhance governmental responses to H1N1 in Indian country, CDC established an AI/AN Populations Team in the CDC Emergency Operations Center (EOC) in September 2009. Priority activities for this team included enhancing efforts to understand the impact of the pandemic on tribal communities, providing technical assistance to IHS, facilitating communications across public health agencies serving AI/AN communities, and assisting in the development and distribution of H1N1 educational materials, PSAs, etc. for tribal governments and communities. Surveillance activities so far have included an evaluation of influenza illness surveillance in AI/populations, evaluations to determine rates of hospitalizations and deaths for AI/AN compared with other racial groups, and a workgroup with the CSTE and Tribal Epicenters to improve hospitalization and mortality surveillance.

**Tribal Epidemiology Center Consortium (“the Consortium” or TECC) (2009):** The TECC distributed the Injury Prevention Toolkit developed in Years 2 and 3 during site visits where they provided training and technical assistance to promote injury prevention interventions. The Consortium is positioned to become a national network involving all the Tribal Epidemiology Centers across the United States with additional funding and support to further build tribal epidemiologic capacity with community-based participatory methods that maximizes resources and experience. The TECC is committed to maintaining the personnel infrastructure at each epicenter to support a steady funding stream and to ensure that the services offered to tribes remain consistently available.

In FY 2010, over $32.5 million total funds were awarded through contracts to Native American Communities including American Indian, Alaska Native Tribes and Native American (including
Native Hawaiian and Pacific Islander) corporations or firms. The CDC provided extensive technical assistance to the public to fulfill its mission, including Native Americans.

Support for Maternal and Child Health Epidemiologist (2012): DRH provided support for a lead maternal and child health epidemiologist assigned to the Northwest Tribal Epidemiology Center. Epidemiologist provided consultation, technical assistance, surveillance, and analysis of epidemiologic information.

Cherokee Nation Technical Assistance (2012): The Cherokee Nation is a sovereign people, but they do not live on a reservation or sovereign land protected by treaty. The Cherokee Nation public health staff co-exists in a working relationship with county and state public health partners. Originally the Cherokee Nation requested public health law technical assistance in their NPHII proposal to develop a public health code. However, the lack of sovereign land and the requirement to engage in a working relationship with county and state public health partners created very complex jurisdictional issues that do not permit the Cherokee Nation to independently create a new public health code as described in the original request for technical assistance. Partnering with the American Public Health Association (APHA) the OSTLTS, Public Health Law Program (PHLP) engaged in a series of conference calls that included the CDC Associate Director for Tribal Affairs, APHA, the NPHII Senior Public Health Advisor and J.T. Pethrick from the Cherokee Nation. Legal research conducted by PHLP and discussions with tribal officials determined that the Cherokee Nation does not have the exclusive authority to create a public health code that supersedes the authority of local and state officials. While the Cherokee Nation is a sovereign nation, the land they occupy is purchased, privately owned land located within the state and county jurisdictions. J.T. Pethrick determined that he needed additional time to better develop an understanding of potential strategies to work with local and state officials and determine whether all parties involved may be receptive to developing a memorandum of understanding to better identify resources and the management of public health issues. The current status of the issue is on hold until J.T. Pethrick can better formulate a formal request for technical assistance with deliverables. Currently, Cherokee Nation is working with local and state partners, in-house counsel and leadership to identify whether a specific TA request is appropriate or whether CDC can assist in the development of a memorandum of agreement.

Navajo Nation Technical Assistance (2012): The Navajo Nation sought technical assistance to seek PHLP input on proposed legislation to update the Navajo Nation Statutes relating to public health services. Specifically, the Navajo Nation Division of Public Health sought to pass an enabling statute to expand its current powers and authority to incorporate the ten essential services of public health, improve public health authority to oversee programs that promote chronic disease prevention and oversee hospital and clinical care. As part of several conference calls and opportunities to edit proposed legislation, the PHLP provided input to Navajo Nation Public Health official Anita Muneta that provided authority for a newly created Department of Public Health to operate under the scope of the recognized ten essential services of public health and further provides for the development of programs that emphasize prevention of non-communicable diseases. If the Council passes the final Bill, PHLP will provide additional technical assistance to research state statutes that enable health departments that provide
oversight to hospitals and medical clinics including authority to manage staff licensure requirements. These statutory examples will provide Navajo Nation, Department of Public Health with direction related to this aspect of the legislation.

Legal Foundations for Traditional Hunting and Fishing Rights (2012): PHLO provided direct technical assistance to Toiyabe Indian Health Project, Inc. (California) in the form of a memorandum on the legal theories behind Native American tribes and nations exercising their traditional hunting and fishing rights in off-reservation locations.

Public Health Law and Science – A Seminar for Tribal Judges (2012): PHLO conducted a seminar about infectious diseases and the law for tribal judges in Arizona. This seminar was part of a series of judicial training sessions funded by CDC’s Office of Public Health Preparedness and Response (OPHPR) and implemented by the University of Pittsburgh.

National Network of Public Health – Leadership to Provide Technical assistance for the Tribal Public Health Institute Feasibility Study (2012): NNPHI provided ongoing technical assistance to Red Star Innovations as it conducted the feasibility study to support the development of a Tribal Public Health Institute (TPHI). Red Star Innovations initiated the feasibility study in May 2012.

Association of State and Territorial Health Officials (ASTHO) – Development and Implementation of Native Diabetes Wellness Program Traditional Foods Project Technical assistance Protocol (2012): This project addressed the following priorities: Increasing diabetes prevention behaviors through sustained community member access to local traditional healthy foods and physical activity; enhancing and improving community and environmental strategies to prevent diabetes through sustained access to opportunities for physical activity in culturally relevant ways and in safe areas; and integrating physical activity with accessing local traditional healthy foods. This work is integrated with all of the Native Diabetes Wellness Program’s efforts to address diabetes-related health disparities in Indian Country.

Funding Opportunities Available to Native Americans in FY 2009 through FY 2012

<table>
<thead>
<tr>
<th>CDC Awards To AI/AN Tribes And Organizations</th>
<th>FY 2009 Funding Amount</th>
<th>FY 2010 Funding Amount</th>
<th>FY 2011 Funding Amount</th>
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**FOOD AND DRUG ADMINISTRATION**

The Food and Drug Administration (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 by helping the public get accurate, science-based information they need to use medicines and foods to improve their health.

**Support Provided to Native American Communities in FY 2009 through FY 2012**

**Health Promotion, Disease Prevention, and Outreach**

In July 2009, the Food and Drug Administration (FDA) (Region VII Denver) conducted a food defense and safety exhibit at the Indian Health Summit. The summit was organized and produced by the Indian Health Service and had approximately 800 participants. FDA’s public affairs specialist provided FDA materials and contact information.

In August 2009, FDA conducted a large electronic outreach to promote National Food Safety Education Month. FDA reached out to hundreds of California and Nevada health professionals and health educators. A short article on the theme “Food Safety Thrives When You Focus on Five” was distributed. A list of available publications and educational materials were also provided. Approximately 50 organizations responded; more than 10,000 publications were distributed by the participating health organizations. Tribal organizations that received information included the Washoe Tribe of Nevada and California, UIHS Howonquet Elder Nutrition and the Tonapah Senior Center.

In October 2009, FDA participated in the National Native Alaskan American Indian Nurses Association Conference. The meeting attracted some 100 nursing professionals from federal, state, and tribal government organizations and academic institutions serving American Indian and Alaska Native people. Participants from Alaska, Florida, Oklahoma, North Dakota, and South Dakota talked with FDA staff to learn about FDA’s Office of Women’s Health partnership program and career opportunities.

FDA established relationships with nurse representatives from the Standing Rock Indian Reservation (Sioux Tribe Reservation in North Dakota and South Dakota) and shared outreach materials on childhood obesity.

**Health Professional Recruitment and Outreach**

In June 2009, FDA hosted approximately 80 Native American high school students supported by the Association of American Indian Physicians Youth Initiatives Program (AAVIP). This
program was designed to prepare American Indian and Alaska Native students to remain in the academic pipeline and pursue careers in the health professions and biomedical research.

In June 2009, FDA exhibited at the Society of American Indian Government Employees Training Conference (SAIGE). SAIGE’s mission is to promote recruitment, retention, development, and advancement of American Indian and Alaska Native government employees and to ensure equal treatment under the law. FDA informed participants on its activities, employment opportunities, and worked to create interest and increased membership on its advisory committees. FDA also shared consumer health information.

In summer 2009, FDA hired five interns from the Washington Internships for Native Students (WINS) program sponsored by the American University. The internships provided students with experiential learning opportunities in fast-paced and real world-settings.

**Technical Assistance Provided to Native American Communities in FY 2009 through FY 2012**

- Arizona Department of Health - In July 2011, CTP staff met with the program manager (tribal liaison) in the Arizona Department of Health Services’ Division of Public Health Services to learn more about their work with the Inter Tribal Council of Arizona.
- Association of American Indian Physicians (AAIP) – In August 2011, CTP staff met with the Executive Director and staff from the Association of American Indian Physicians (AAIP) in order to learn about the AAIP’s mission and activities as well as provide an overview of the Center.
- Chehalis Tribe – In August 2011, the ORA Pacific Region Office (PRO) retail food specialist met with members of the Chehalis Tribe Gaming Commission (Washington State). The purpose of the meeting was to discuss retail food safety procedures and the Retail Food Program Standards.
- Cherokee Nation – In February 2011, the ORA Southwest Region (SWR) Retail Food Specialists responded to a food safety question from the Environmental Health Specialist, Office of Environmental Health, Cherokee Nation. The inquiry focused on using a "self-contained bioreactor" that uses an "organic decomposition product" and water to decompose food waste.
- Cherokee Nation Policy Action Institute - In September 2011, CTP attended the Healthy Communities Tribal Policy Action Institute hosted by the Cherokee Nation. CTP staff met with health legislative officer for the Cherokee Nation, the tobacco cessation coordinator for the Lumbee Tribe (NC) and tribal affairs staff from the Oklahoma Department of Health.
- Chickasaw Nation – In April 2011, the ORA-SWR retail food specialist responded to a food safety inquiry from the environmental health officer, Chickasaw Nation’s Office of Environmental Health and Engineering. The inquiry focused on out-of-state caterer serving over a 1,000 breakfasts meals twice weekly to seniors outside the Windstar Casino.
- Chickasaw Nation – In July 2011, ORA-SWR Retail Food Specialist provided refresher training on the FDA Food Code to the Chickasaw Nation Office of Environmental Health and Engineering, Ada, OK. The Chickasaw Office Environmental Health and Engineering...
satisfactorily completed standardization field training resulting in renewing their FDA Standardized Inspection Officer Certificate.

- **Chickasaw Nation** – In October 2011, The Office of Regulatory Affairs (ORA) Southwest Region retail food specialists responded to food safety questions from the Chickasaw Nation Office of Environmental Health and Engineering about operating bars in casinos.

- **Coeur d'Alene Tribe, Idaho - Environmental Health** - The Coeur d'Alene Tribe enrolled in the Voluntary National Retail Food Regulatory Program Standards. The ORA-PRO Retail Food Specialist met with the tribal sanitarian to enroll in the program, and to begin work on the tribe's self-assessment.

- **Crow Agency, Montana - Environmental Health Services** – ORA-PRO Retail Food Specialist worked with the Crow Agency Sanitarian on the Voluntary National Retail Food Regulatory Program Standards. The Crow Agency was the first tribal jurisdiction to enroll in the retail standards.

- **Gila River Indian Community – American Indian and Alaska Native Stakeholder Discussion session** – In June 2011, CTP hosted a stakeholder discussion session with American Indian public health officials in the Gila River Indian Community. The Lieutenant Governor of the Gila River Indian Community provided opening remarks.

- **Inter-Tribal Council of Arizona, Inc. (ITCA)** - In May 2011, CTP staff met with the health promotions coordinator in the Inter Tribal Council of Arizona to learn more about the ITCA and provide background about the Center.

- **Jamestown S’Klallam Tribe** – In September 2011, the ORA-PRO retail food specialist contacted the Jamestown S’Klallam Tribe (Washington State) to assist with food code adoption and to orientation to the Retail Food Program Standards.

- **Lac du Flambeau Band of Lake Superior Chippewa Tribe** – In 2011, ORA Central regional office (CRO) supported the Lac du Flambeau Tribe’s retail food safety program by implementation of the FDA Voluntary National Retail Food Regulatory Program Standards. ORA-CRO’s retail food specialist will continue to provide guidance and support as the Tribe moves toward completing their baseline survey on the Occurrence of FoodborneIllness Risk Factors. ORA-CRI efforts also included assistance and guidance to the tribe in their effort toward making improvements to meet Standard No. 3: Inspection Program Based on HACCP Principles.

- **Mashantucket Pequot Tribe** – In 2011, the FDA Northeast Region’s retail food specialist provided technical assistance to the Mashantucket Pequot tribal health department located in Connecticut. The technical assistance focused on Food Code interpretation, retail food safety, reduced oxygen packaging of food, food establishment plan review and compliance issues. The retail food specialist also supported the Mashantucket Tribe in their continued participation in the FDA Voluntary National Retail Food Regulatory Program Standards.
• Mohegan Tribe – In 2011, ORA-NER continued support for the Mohegan Tribe’s improvement of their retail food safety program for implementation of the FDA Voluntary National Retail Food Regulatory Program Standards. The ORA-NER retail food specialist focused on food employee hygiene including dissemination of the FDA Employee Health and Personal Hygiene Handbook and addressing various food safety technical issues.

• National Congress of American Indians – In December 2010, the CTP met with the National Congress of American Indians (NCAI) to exchange information on missions. CTP and the NCAI explored collaborations and discussed the Family Smoking Prevention and Tobacco Control Act. CTP discussed various CTP events that would interest or impact on American Indian and Alaska Natives. CTP staff also discussed the tobacco statute, strategies for outreach to American Indians and Alaska Native tribes, the proposed FDA Stakeholder Discussion Series and CTP compliance and enforcement initiatives.

• National Native Commercial Tobacco Abuse Prevention Network – In November 2010, CTP met with staff from the National Native Commercial Tobacco Abuse Prevention Network to learn about the organization and discuss the CTP Stakeholder Discussion Series.

• Potawatomi Tribe – In November 2010, the ORA-CRO’s Retail Food Specialist provided technical assistance to the Potawatomi tribal casino food service in Milwaukee, Wisconsin. The two days of technical assistance focused on the state of the art reduced oxygen packaging of food and provided assistance to casino food service staff, State Department of Agriculture regulatory staff as well as the City of Milwaukee Health Department.

• Seneca Manufacturing Company and Skookum Creek Tobacco Company – In December 2010, CTP hosted a Stakeholder Discussion session for tobacco product manufacturers and growers. Then representatives from two tribal-owned tobacco product-manufacturing companies participated in the discussion – Seneca Manufacturing Company and Skookum Creek Tobacco Company.

• Squaxin Island Tribe – In November 2010, CTP met with members of the Squaxin Island Tribe (Washington State), as representatives of the Tribe and the tribal-owned tobacco company, Skookum Creek Tobacco Company. The purpose of the meeting was to discuss enforcement of the Family Smoking Prevention and Tobacco Control Act.

• Squaxin Island Tribe – Office of Regulatory Affairs, Pacific Regional Office (ORA-PRO) interacted with the Squaxin Island Tribe, Gaming Commission (Washington State). Squaxin Island enrolled in the Voluntary Retail Food Program Standards, (Retail Program Standards) since September 2005. The Tribal Council adopted the 2001 FDA Food Code in June 2005 as their regulatory foundation. The FDA Pacific Region retail food specialist has provided field training to the gaming agent conducting inspections for the tribe along assistance with program assessment.

• Viejas Tribe – The ORA-PRO hosted the FDA Voluntary Programs Standards Initiative. Viejas has been enrolled in the Voluntary Program Standards Initiative from 2008 to 2011. The VPSI offers continuous improvements toward best practices for an effective and efficient Food Safety Program. The Tribe participated in a two and one-half day Self-Assessment workshop, in September 2011, at the Los Angeles District Office. This workshop was designed to help jurisdictions complete their program self-assessment using the Program Standards.
• Yukon Kuskokwim Health Corporation – In March 2011, the Center for Device Radiological Health (CDRH) worked with the Yukon Kuskokwim Health Corporation (YKHC) to register an oxygen generator. YKHC is a 501(c) (3) nonprofit tribal health organization operating under Title V of the Indian Self-Determination and Education Act. YKHC operates the Yukon Kuskokwim Delta Regional Hospital (YKDRH), a 50-bed Indian Health Service hospital, in Bethel Alaska. The YKHC service area is located in a rural section of western Alaska. The hospital in Bethel is 500 miles west of Anchorage and is the only hospital in a 75,000 square mile area. Yukon Kuskokwim Health Corporation also provides basic health care at 48 tribally owned clinics at villages throughout their service area. Bethel separated from the Alaska road and rail system by several mountain ranges and is accessible mostly by air.

Health Promotion and Disease Prevention

National
In FY 2012, FDA promoted outreach efforts to populations most affected by health disparities through partnerships agreements, cooperative agreements, and memoranda of understanding (MOU).

• University of Hawaii Hilo – FDA’s Office of External Relations and the Office of Minority health collaborated to establish the first research collaboration with the University of Hawaii (UH), College of Pharmacy. UH will use its research expertise in clinical pharmacology, translations science and health disparities to examine diabetes medication use among Native Hawaiians and Asian Pacific Islander Americans. OMH funded a one-year postdoctoral fellowship to examine medication therapies and health outcomes for Asian Pacific Islanders and Native Hawaiians and its implications for FDA’s regulatory decision-making.

• University of Hawaii Manoa – FDA’s Office of External Relations and Office of Minority Health collaborated with the University of Hawaii, Office of Public Health Studies to explore policies and regulations related to cancer and tobacco disparities, including mentholated products among Native Hawaiians and Pacific Islanders. OMH funded a one-year pre-doctoral fellowship to support this work.

• University of Nebraska – FDA’s Office of External Relations and the Office of Minority Health collaborated with the University of Nebraska Medical Center identify scientific and collaborative research opportunities, outreach and education initiatives. The purpose of these opportunities is exploring issues of health disparities, regulatory science, and health literacy needs in Indian Country, through UNMC's Rural Health Education Network.

National Shellfish Sanitation Program

In FY 2012, through the National Shellfish Sanitation Cooperative Program, the Food and Drug Administration, state regulatory agencies, and the shellfish industry worked together to keep
molluscan shellfish (such as oysters, clams, and mussels) safe for consumption by adhering to strict controls on their growing, harvesting, processing, packaging, and transport.

- Pacific Rim Shellfish Sanitation Association is a science-based forum to discuss relative shellfish sanitation control issues, scientific technologies, and academic advances relating to the shellfish industry. This forum is open to all western (Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon, Washington, and Canada) tribes and or first tribe nations. Washington State Treaty Tribal interests are represented on the Association as a voting member of the Board of Officers. All tribes are invited participants to be on the Board and/or attend the bi-annual conference.

- Washington State Department of Health Vibrio parahaemolyticus Advisory Committee - This committee meets annually and serves as policy development for the sanitary control of shellfish for Vibrio parahaemolyticus. Control of Vibrio parahaemolyticus (a marine bacterium of potential health consequence) is a risk-based management directive under the National Shellfish Sanitation Program. The Northwest Indian Commission as part of the federally recognized Washington State Tribal Consent Decree Agreement represents fourteen Washington State Tribal interests on this committee. The tribes formally recognize the FDA and the Washington State Department of Health Office of Shellfish and Water Protection as the Shellfish Control Authority for compliance to the National Shellfish Sanitation Program and Model Ordinance. The tribes are actively involved in these discussions and decisions relating to the health of tribal members and their customers. These tribal initiatives provide opportunities to American Indian tribes to have meaningful and timely input in developing regulatory policies that have substantial direct effects: (1) on the states and tribes; (2) on relations between the national government, the states and tribes; and (3) on distribution of power and responsibilities among the various levels of government and tribes.

**Family Smoking Prevention and Tobacco Control Act**

In FY 2012, the Family Tobacco Control Act granted the FDA the authority to regulate tobacco products. The FDA then established the Center for Tobacco Products to regulate the manufacture, marketing, and distribution of tobacco products to protect public health and to reduce tobacco use by youth. The Family Smoking Prevention and Tobacco Control Act authorizes the FDA to: (1) require disclosure of tobacco product Ingredients; (2) create standards for tobacco products; (3) restrict tobacco sales, distribution, and marketing, and (4) require stronger health warnings on packaging and in advertisement.

- Inter-Tribal Council of Michigan – CTP attended “A Promise National Conference” sponsored by the Inter-Tribal Council of Michigan and the Inter Tribal Council of Arizona.
- Mohegan Reservation – CTP participated in the Center for Disease Control and Preventions meeting in Uncasville, Connecticut to network and gain insight on tribal tobacco issues.
  National Congress of American Indians - CTP attended the National Congress of American Indians annual meeting in Sacramento, California to gain information on how
to work with tribes and about the numerous tribal cultures. There were sessions held on outreach, government-to-government relations, and health disparities and on building relations with tribal communities.

- National Indian Health Board – The Food and Drug Administration’s (FDA) Center for Tobacco Products (CTP) attended the National Indian Health Board – 2012 National Tribal Public Health Summit. CTP began a series of ongoing conference calls with staff from the National Indian Health Board. CTP shared information on the Family Smoking Prevention and Tobacco Control Act and the Center for Tobacco Products’ regulatory authority.

- National Native Network – CTP participated in a webinar for the National Native Network. CTP’s Offices of Policy and Office of Compliance and Enforcement provided a presentation on “Understanding the Tobacco Control Act.” CTP provided an overview of the Family Smoking Prevention and Tobacco Control Act to tribal leaders, tribal organizations, federal and state partners. CTP held the “Second Listening Session on Disparities,” for representatives from the Nation Native Network and many other organizations representing disparate populations.

**National Retail Food Program**

FDA is the lead federal agency of the National Retail Food Program. The Program includes FDA and other federal, state, local, and tribal regulatory agencies, industry, and academia. The program focuses on strategies to leverage and enhance the food safety and defense capacities of state, local, and tribal regulatory retail food protection Technical Assistance programs. The program’s collaboration with food service and retail food industries is essential to maintaining of effective food safety management systems. The program’s mission impacts over 2,300 state, local, tribal, and territorial regulatory jurisdictions, encompassing over 27,000 regulators; 960,000 restaurants, which serve more than 70 billion meals and snacks each year, with sales topping $604 billion; 215,000 supermarkets, small grocery stores, and convenience stores; over 101,000 public and non-profit private schools (grades K-12), which served 5 billion lunches, and 214 million after school snacks in 2009; 5,795 hospitals; and 17,000 nursing home facilities.

In FY 2012, FDA’s Center for Food Safety and Applied Nutrition (CFSAN) collaborated with IHS to provide a comprehensive health service delivery system for approximately 1.9 million American Indians and Alaska Natives who belong to federally recognized tribes in 35 states. About 345 federally recognized tribes have food service operations on their lands. CFSAN and IHS’s Office of Environmental Health to manage regulating food establishments located on tribal lands. The coalition developed public health prevention systems for food safety within federal programs. Coalition members collaborated to improve the overall food safety and food defense capabilities of participating agencies through sharing of non-sensitive information and resources.

**Funding Opportunities Available to Native Americans in FY 2009 through FY 2012**

Although FDA did not award grants to tribes between 2009 and 2012, tribes are eligible for several funding opportunities. FDA does not award tribal specific grant opportunities. The
tribes are eligible for all of our grants if they meet the eligibility requirements – excluding sole sources and some limited competition announcements. The FDA competitive programs are:

- Food and Drug Administration – Research (93.103)
- Food Safety and Security Monitoring (93.448)
- Ruminant Feed Ban Support Project (93.449)
- Food Safety Security Monitoring Project
The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services (HHS), is the primary federal agency for improving access to health care services for the people who are economically, geographically, or medically vulnerable. Comprising six bureaus and 10 offices, HRSA provides leadership and financial support to health care providers in every state and U.S. territory. HRSA grantees provide health care to medically vulnerable individuals living with Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), pregnant women, mothers, and children. HRSA supports the training of health professionals and the improvement of systems of care in rural communities. HRSA oversees organ, bone marrow, and cord blood donation; supports programs that compensate individuals harmed by vaccination; and maintains databases that protect against health care malpractice and health care waste, fraud, and abuse.

HRSA shares many priorities with the American Indian and Alaska Native (AI/AN) and Native Hawaiians and Pacific Islanders (NH/PI) communities, including but not limited to, reducing the burden of disease, increasing health professional workforce development, increasing health information technology investments in health care facilities that serve AI/ANs and NH/PIs, and improving access to funding and grant opportunities. Tribes, tribal organizations, and the U.S. Pacific territories and freely associated states are encouraged to apply for HRSA funding opportunities for which they are eligible that support these priorities.

HRSA leadership participates in the Secretary’s Tribal Advisory Committee as well as the Intradepartmental Council on Native American Affairs and the various sub-groups to strengthen our relationships with the AI/AN communities.

In March 2012, HRSA updated its current Tribal Consultation Policy. The goal of this policy includes, but is not limited to, eliminating health disparities of AI/AN by increasing access to quality health care; increasing the supply of caring and culturally competent primary health care providers in Indian Country and Alaska; engaging in an interagency, continuous, and meaningful consultation; and advancing the social, physical, and economic status of federally-recognized Indian Tribes. This policy serves as a guide for tribal participation in HRSA policy development to the greatest extent practicable and permitted by law. As part of HRSA’s ongoing commitment to Indian Country’s health care needs, HRSA conducted a tribal consultation listening session at the National Indian Health Board Consumer Meeting on September 24, 2012. The listening session provided a forum for over 100 tribal leaders and partners to give feedback on HRSA’s programs regarding the health care issues that impact Indian Country. Additionally, the listening

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7 For the purposes of this report, Native Hawaiians and Pacific Islanders (NH/PIs) are considered within the definition of “Native American.”

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session allowed tribal leaders the opportunity to provide input to HRSA staff to help plan for a full HRSA Tribal Consultation meeting in March 2013.

Support Provided to Native American Communities from FY 2009 through FY 2012

Bureau of Clinician Recruitment and Service
Indian Health Services (IHS) and HRSA continue to work together to increase utilization and availability of the NHSC Program as a recruitment tool to fill health professional vacancies at IHS sites. Since the beginning of FY 2012, 97 new IHS, Tribal Clinic, and Urban Indian Health Clinic sites have been automatically approved as a result of the May 2011 policy clarification allowing for the auto-approval process for IHS sites to become NHSC eligible sites. As of September 30, 2012, there were a total of 588 tribal clinical sites devoted to providing health care to AI/ANs and offering loan repayment to eligible clinicians practicing at these sites. In addition, the Affordable Care Act permits these sites to qualify as NHSC sites, extending the ability of IHS tribal facilities to recruit and retain primary care providers by utilizing NHSC scholarship and loan repayment incentives. Furthermore, 305 NHSC clinicians served in IHS program sites, and 27 NHSC clinicians serving in tribal facilities self-identified as AI/AN in FY 2012.

The NHSC is a national program, and Pacific Basin jurisdictions are included in all program recruitment, placement, and retention activities. In FY 2012, NHSC supported nine physicians, one nurse practitioner, three physician assistants, and one certified midwife in the Pacific region.

Bureau of Health Professions8
The Guam/Micronesia (G/M) Area Health Education Center (AHEC) Program-University of Guam School of Nursing Program was established in 2009 and supports three AHECs: Guåhan (Guam) AHEC, serving the island territory of Guam; Republic of Marshall Islands (RMI)/College of Marshall Islands AHEC, serving the U.S. affiliated RMI; and Federated States of Micronesia (FSM) AHEC, serving three of the four states within FSM. The Yap AHEC, which is affiliated with the University of Hawaii, Pacific-Basin AHEC, serves the fourth state of FSM. The G/M AHEC Program emphasizes community-based, in-country (local), and inter-island training for health professions students and health care providers while enhancing health career education and the recruitment pipeline from high school to community college levels. The G/M AHEC Program has played a significant role in improving the public health capacity and infrastructure in the region, including the development of an innovative public health training pipeline program. This program provides a career ladder from a Certificate of Achievement to a Master of Public Health degree. The G/M AHEC Program has also established strong collaboration with the Centers for Disease Control and Prevention and the Pacific Islands Health Officers Association (PIHOA) to support training in public health capacity building.

8 The Bureau of Clinician Recruitment and Service merged with the Bureau of Health Professions to become the Bureau of Health Workforce on June 3, 2014. This report reflects the work of the Bureaus in FY 2012.
In September 2012, the G/M AHEC Program received supplemental funding from the Department of the Interior to build on existing systems and to support strategic nursing workforce and infrastructure development activities that focus on strengthening nurse training programs and the nursing leadership pipeline in the U.S. Affiliated Pacific Islands (USAPI). Specifically, this project focuses on the following jurisdictions: FSM, RMI, the Republic of Palau, and the Commonwealth of the Northern Mariana Islands (CNMI).

The Pacific Basin HRSA AHEC Program-University of Hawaii, John Burns School of Medicine Program was established in 1995 and supports nine AHECs: Big Island AHEC located in Hilo; Na Lei Wili AHEC located in Lihue; Palau AHEC located in Koror; Huli Au Ola AHEC located in Kaunakakai; CNMI AHEC located in Saipan; Yap AHEC located in Kolonia, FSM; Waimanalo AHEC located in Waimanalo; American Samoa AHEC located in Pago, Pago; and Waianae AHEC located in Waianae. The Pacific Basin AHEC Program focuses its programmatic activities to improve the diversity, distribution, supply, and quality of the health professions workforce in the Pacific in five specific areas: 1) recruiting underrepresented minority students to health science careers; 2) training students in rural and underserved areas, often in interdisciplinary teams; 3) recruiting providers to rural areas and providing activities to improve retention; 4) providing and facilitating community-based health education; and 5) providing distance learning options across the region for health information and education. Partners in this effort include schools, health care and government organizations, workforce investment agencies, rural health associations, and community-based organizations in the region.

The California-Pacific Public Health Training Center (CALPACT) Program addresses the urgent and growing regional need for a well-trained and expanded public health workforce, responsive to the health needs of almost 9.5 million people in Northern California, Central California, Hawaii, and the USAPI. CALPACT defines a collaborative partnership among the following accredited institutions: the School of Public Health at the University of California, Berkeley; the Office of Public Health Studies at the University of Hawaii, Manoa; the Department of Public Health Sciences at the University of California, Davis; and the Central Valley Health Policy Institute at California State University, Fresno. The offering focuses on three themes that align with the core strengths of the partner schools and addresses the priority needs of public health professionals, organizations, and communities in their region. These themes are to strengthen leadership and management competency and performance, expand the effective use of emerging new media and communication tools, and develop organizational capacity to more effectively address health issues of diverse and underserved populations.

The purpose of the Pacific Islands Geriatric Education Center (GEC) is to improve the health of the geriatric population of Hawaii and the Pacific Basin by maximizing resources to build the health care work force in the region and to integrate interdisciplinary team care into clinical practice. The Pacific Islands GEC is located at the John A. Burns School of Medicine at the University of Hawaii, Honolulu. To deliver this education and training, the GEC has formed a consortium with Kapiolani Community College and PIHOA, also located in Honolulu. The Pacific Islands GEC depends upon the region-wide network represented by the University of Hawaii and PIHOA to accomplish activities in five areas: improving the training of health professionals in geriatrics, developing and disseminating curriculum relating to the treatment of
the health problems of elderly individuals, supporting the training and retraining of faculty to provide instruction in geriatrics, supporting continuing education of health professionals who provide geriatric care, and providing students with clinical training in geriatrics in nursing homes, chronic and acute disease hospitals, ambulatory care centers, and senior centers.

The Geriatric Academic Career Award (GACA) Program is an individual career development award. The University of Hawaii is a GACA awardee. One of the University of Hawaii’s project goals is to implement and teach interdisciplinary team care for nursing home patients with eating problems that is sensitive to the cultural values of patients, families, and health professionals. The project is to develop a model of care for eating problems in the nursing home and a culturally competent interdisciplinary team training curriculum to provide the interdisciplinary training to health professionals.

HRSA supports tribal colleges and universities by providing education infrastructure support through student scholarships and nurse workforce outreach and enrichment activities that promote diversity. Likewise, there are multiple programs in the USAPI that support professional development between the current health and public health workforce in the region and strengthen or develop educational and training programs that bolster the health professional pipeline.

The purpose of the University of Utah Comprehensive geriatric Education Program (CGEP) is to provide an accessible Registered Nurse (RN) to Master of Science (MS) track whereby nurses with an associate degree can progress seamlessly to a master’s degree in Teaching Nursing (geriatric focus) or in Care Management Nursing (geriatric focus). The grantee has developed an extensive network of relationships with the five Tribal nations in Utah to facilitate the enrollment of Native American nurses. The grantee has also worked with community colleges that enroll large numbers of Native Americans to secure practicum placements for the nurses in the RN to MS track and to foster employment opportunities after graduation.

**Bureau of Primary Health Care**

HRSA’s Bureau of Primary Health Care Health Center Program grantees served over 266,000 AI/ANs and almost 223,000 NH/PIs, according to the 2012 Uniform Data System, an increase of 55,000 AI/ANs and 48,000 NH/PIs since 2009. In FY 2012, 26 organizations received both Community Health Center Program and IHS funding (19 tribal organizations and seven Urban Indian Health Program organizations). HRSA supports community health centers in all six USAPI jurisdictions, with two sites in FSM.

On May 1, 2012, HRSA announced awards from the Health Center Capital Development – Building Capacity Program. Awards were made for approximately $629 million to 171 existing health centers across the country for longer-term projects to expand their facilities, improve existing services, and serve more patients. This program was intended to expand access to an additional 860,000 patients. Two Tribal and Urban Indian Health Program grantees were awarded a total of $6.76 million in funding under this opportunity.

On May 1, 2012, HRSA announced awards from the Health Center Capital Development – Immediate Facility Improvements Program. Approximately $99.3 million was awarded to
227 existing health centers to address pressing facility and equipment needs. Three Tribal and Urban Indian Health Program grantees were awarded a total of $1.4 million in funding under this opportunity.

On June 20, 2012, HRSA announced awards from the Health Center New Access Points Program. Eligible applicants included public or nonprofit private entities, including tribal, faith-based, and community-based organizations who meet health center funding requirements. Awards were made for approximately $128.6 million to 219 health centers to expand access to care for more than 1.25 million additional patients by establishing new health center service delivery sites across the country. Four Tribal and Urban Indian Health Program grantees were awarded a total of $2.4 million in funding under this opportunity.

On September 27, 2012, HRSA announced $44.4 million in supplemental funding awards to 810 health center program grantees. These awards support the practice changes necessary for patient-centered medical home recognition and support increasing rates of cervical cancer screening in health centers. Twelve existing Tribal and Urban Indian Health Programs were awarded $55,000 each.

The Native Hawaiian Health Care Systems (NHHCS) Program is authorized under the Native Hawaiian Health Care Improvement Act of 1988, which was reauthorized under the Affordable Care Act. Under NHHCS, grantees are charged to improve the quality of health among the Native Hawaiian people through health education, disease prevention, case management, enabling services, and primary health care services. In FY 2012, NHHCS grantees received a total of $13 million to fulfill this charge.

In December 2011, HRSA announced $14 million to support the nation’s school-based health centers, allowing existing school-based programs to expand capacity and modernize their facilities. These awards were given to 45 school-based health centers in 29 states, including $233,000 to the Southeast Alaska Regional Health Consortium.

**HIV/AIDS Bureau**

In August 2012, HRSA announced two Ryan White HIV/AIDS Part C Early Intervention Service Program grants to programs serving AI/AN communities in Anchorage, Alaska. The Anchorage Neighborhood Health Center received $379,218, and the Alaska Native Health Consortium received $487,500. Both service providers received funding for 3-year project periods to provide comprehensive HIV primary medical care and support services to persons with HIV disease. In addition, the Alaska Native Health Consortium received a Part C supplemental award for $38,000 for HIV early intervention services. The Anchorage Neighborhood Health Center has been providing HIV services since 1991, and the Alaska Native Health Consortium has provided services since 2001.

The Secretary’s Minority AIDS Initiative Fund provides support for the AI/AN Education and Training for Healthcare Providers Serving Tribal Areas and Communities. This is a collaborative initiative between HRSA and IHS and will increase understanding among leaders in Indian Country about the risk HIV poses in their communities, reduce stigma, assist AI/AN
communities as they implement HIV testing programs, and prepare providers to co-manage (with HIV care experts) AI/AN patients newly diagnosed with HIV.

This initiative is implemented through the national network of AIDS Education and Training Centers (AETCs). HRSA’s HIV/AIDS Bureau funded 8 regional AETCs (together they encompass 38 states) to participate in this AI/AN project to provide training, consultation, technical assistance (TA), and capacity building. These activities were intended to achieve the following goals: 1) strengthen organizations serving AI/ANs and NH/PIs to implement or enhance HIV testing, screening, and care and treatment programs; 2) increase the number of IHS, tribal, urban, and other AI/AN- and NH/PI-serving clinicians who routinely perform HIV risk assessments, screening, testing, diagnosis, and treatment in AI/AN and NH/PI populations; 3) reduce the rate of new HIV infections of AI/ANs and NH/PIs in the U.S.; and 4) reduce the percentage of AIDS diagnoses when first testing positive for HIV infection within AI/AN and NH/PI communities. This effort responds to the growing HIV/AIDS crisis in rural and urban AI/AN and NH/PI communities by supporting special training and capacity building.

The Pacific AIDS Education and Training Center, an affiliate of the University of California, San Francisco, has 15 local sites in California, Arizona, Hawaii, and Nevada that provide services in their local regions. The Hawaii AETC (HAETC) provides training and TA in Hawaii and the six USAPI jurisdictions. The HAETC-trained clinicians, are based in their home Pacific Island jurisdiction and provide local training to increase HIV clinical knowledge and skills, including HIV testing, among local providers. HAETC collaborates with the Ayuda Foundation of Guam to support the local clinical trainers as well as clinical training for Guam. Training activities include 1 hour didactic presentations and train-the-trainer conferences in Honolulu for USAPI-based trained providers. The goal is to increase the number of local health care providers who are educated and motivated to provide culturally sensitive and appropriate HIV counseling, diagnosis, treatment, and medical management and to help prevent high risk behaviors that lead to HIV transmission.

Maternal and Child Health Bureau
In July 2012, HRSA, in partnership with the National Initiative for Children’s Healthcare Quality (NICHQ), marked the culmination of the first phase of the Healthy Weight Collaborative (HWC). The second component of the HWC was a virtual learning community where up to 40 teams will apply the lessons learned from the first teams and test new interventions in their own communities. In phase two, four teams self-declared tribal as their focus area, and of these four, three are tribal entities. The following tribal teams participated:

- Ho-Chunk Nation Health Department in Wisconsin
- Taos Clinic for Children and Youth in New Mexico
- IHS, Turtle Mountain Band of Chippewa Indians in North Dakota

The Turtle Mountain Chippewa North Dakota team expressed interest in spreading their work with tribal communities across the nation to foster sustainability of their HWC project and create opportunities for inter-tribal collaborations. In response, HRSA worked with NICHQ and other HHS staff to initiate a Tribal Healthy Living Workgroup. Tribes led the group, with federal and NICHQ staff serving in a facilitative and TA-related role only.

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Under the Affordable Care Act, Congress created the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) to support voluntary, evidence-based home visiting services for at-risk pregnant women and parents with young children up to kindergarten entry. A total of $700 million was appropriated for the program between FY 2010 and 2012, including a 3 percent set-aside ($21 million) for grants to tribes, tribal organizations, and urban Indian organizations. In FY 2012, awards under the Tribal Home Visiting program totaled approximately $10.5 million, and included new awards to six tribal entities along with non-competing continuations to 19 existing Tribal Home Visiting grantees. State and territory grantees also serve AI/AN families.

The Community Integrated Services Systems/State Early Childhood Comprehensive System grant program works to improve the physical, social, and emotional development during infancy and early childhood; eliminate disparities; increase access to needed early childhood services by engaging in systems development integration activities; employing a collective impact approach to strengthen communities for families and young children, and improving the quality and availability of early childhood services at both the state and local levels. In FY 2012, this program supported projects in CNMI, Guam, and the Republic of Palau, totaling $450,000.

The Title V Maternal and Child Health (MCH) Services Block Grant program has operated as a federal-state partnership for over 75 years. Title V provides a broad mandate for the provision of quality health care for all mothers and children in the nation, including children with special health care needs. The purpose of this program is to provide and assure that mothers and children (in particular those with low income or with limited availability to health services) have access to quality MCH services. Specifically, the Title V MCH Services Block Grant program seeks to accomplish the following:

- reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children;
- increase the number of children (especially preschool children) appropriately immunized against disease;
- promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for low income, at-risk pregnant women;
- promote the health of children by providing preventive and primary care services for low income children;
- provide rehabilitation services for individuals who are blind or have disabilities under the age of 16 receiving benefits under Title XVI, to the extent medical assistance for such services is not provided under Title XIX.

In FY 2012, this program supported all six USAPI jurisdictions, totaling approximately $2.5 million. For more information on the Title V MCH Block Grant program, please visit the HRSA website: [http://mchb.hrsa.gov/programs/titlevgrants/index.html](http://mchb.hrsa.gov/programs/titlevgrants/index.html).

The Comprehensive Hemophilia Diagnostic and Treatment Centers Program is one of the Special Projects of Regional and National Significance with the purpose of providing outpatient comprehensive care for people with hemophilia and their families through an integrated regional
network of centers in the diagnosis and treatment of hemophilia and related bleeding disorders. This program includes an option for people with clotting disorders. In FY 2012, this program provided funds of $2,000 via a regional network to the Guam Comprehensive Hemophilia Care Program.

Launched in 1993, the State Systems Development Initiative (SSDI) facilitates the development of state level infrastructure, which in turn supports the development of systems of care at the community level. The SSDI Program is designed to complement the Title V MCH Services Block Grant Program and to combine the efforts of state MCH and Children with Special Health Care Needs agencies. The SSDI projects must concentrate on the Title V Block Grant ongoing needs assessment, performance/outcome measures, and Health Status Indicators. The SSDI program supported all six USAPI jurisdictions in the Pacific, totaling approximately $527,000 in FY 2012.

The Universal Newborn Hearing Screening (UNHS) Program funds the development and implementation of jurisdiction-wide UNHS and intervention programs: screening before 1 month old, diagnosis before 3 months old, and enrollment in a program of early intervention before 6 months old. UNHS supported all six USAPI jurisdictions in the Pacific, totaling approximately $1.4 million in FY 2012.

The Emergency Medical Services for Children (EMSC) Program funds projects in American Samoa, CNMI, and Guam. The purpose is to improve the quality of health care for children by assuring health professionals are trained and equipped to medically manage, treat, and transport pediatric patients and assuring the expeditious transport and transfer of children to a definitive care facility. Each of the jurisdictions is reassessing the availability of pediatric medical control 24/7, pediatric equipment on patient care units, and inter-facility transfer agreements and guidelines. They are also continuing efforts to assure that pediatric recognition systems for medical emergencies and trauma are in place; pediatric continuing education is required prior to recertification of Basic Life Support and Advanced Life Support providers; and the EMSC Program establishes permanence. The State of Hawaii co-hosted the Hawaii Emergency Medical Services Information System conference in conjunction with the Pacific Islands EMSC Regional meeting. The conference/meeting enabled networking and information sharing of resources between the Pacific Basin jurisdictions, central to improving the quality and enhancing the process of transferring pediatric patients to specialty health care facilities. In FY 2012, the EMSC program provided $390,000 in support to the U.S. territories.

The Family-to-Family Health Information Centers (F2F HICs) provide health information, referrals, education, and support to families of children and youth with special health care needs (CYSHCN) and the professionals who serve such children. There is an F2F HICs in each of the 50 United States and the District of Columbia. Many of the F2F HICs serve Native American families or partner with other organizations to find ways to better serve families of CYSHCN in Tribal communities. For example, in FYs 2009 - 2012, F2F HIC activities included working with “cultural brokers” from Tribal communities to connect with work study students at Tribal colleges on seven of Montana’s reservations. Students from these colleges were hired to coordinate the development of parent/professional groups to address issues for CYSHCN on the

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reservations. Additionally, parent leaders within North Dakota’s four major reservation areas were trained to collaborate and identify the community needs of families of CYSHCN. The North Dakota F2F HIC also worked with Tribal CYSHCN families, who chose to move off their reservations, to find resources (i.e. donations for diapers, medications, and housing). In Washington (state), the F2F HIC and the State’s Tribal Vocational Rehabilitation Services partnered to identify cultural brokers who worked with the F2F HIC to develop a “Decision Making Booklet,” which was used to assist families from culturally diverse communities to effectively navigate health systems and services for CYSHCN.

F2F HICs, in partnership with the HRSA-funded National Center for Family/Professional Partnerships (NCFPP) and the National Center for Cultural Competence, brought sensitivity skills and tools to the F2F HICs as they conducted outreach to Tribal groups. During the first quarter of FY 2013, in honor of National American Indian Heritage Month, NCFPP staff disseminated the PBS documentary special that was filmed on the Navajo Reservation, titled “Sun Kissed,” to all of the F2F HICs and Family Voices State Affiliate Organizations (SAOs). The NCFPP also worked with the New Mexico F2F HIC and the Education for Parents of Indian Children with Special Needs (EPICS) organization to plan activities for Native American families in the state. As a result of this linkage, NCFPP conducted co-training with the New Mexico F2F HIC for EPICS-served families on types of health care financing (e.g., medical waivers, Medicaid, Indian Health Service contracts), eligibility, how to apply for these services, where to apply, and what services they provide.

In FY 2009, the CYSHCN Project of the National Center for Cultural Competence supported the travel, lodging, and registration costs for two family members from the Navajo Nation's Diné for Our Children to attend and participate in the 2009 Family Voices National meeting convened May 2009 in Washington, DC. There were four teams of families in four service areas. These teams have developed partnerships with Indian Health Service (IHS), public education, and social service. Families have brought their unique cultural perspective to the health care system and are assisting IHS to better serve families and children. Each team was charged with developing toolkits for families during the hospitalization experience and kits to welcome new families to the community of children with special health care needs. A Nationwide steering committee meets quarterly; shares experiences and successes; and continually tackles tough social issues and plan strategies with the family teams. Youth have coalesced and have formed the Navajo Chapter of the Youth Action Council of AZ-NM and have begun to participate in Fast Track Training of transition to adulthood. A team of 25 families across Navajo land have been trained as interviewers and are conducting the Navajo version of the National Children’s Health Care Survey (for children with special health care needs). DOC Parent Leaders hosted their second Navajo Nation-wide DOC Summit.

The Traumatic Brain Injury (TBI) Program is comprised of two distinct grant initiatives. The first is the State Implementation Partnership Grants (IPG), which provides grants to states, territories, the District of Columbia, Puerto Rico, and the American Indian Consortium. IPG recipients are structured to identify barriers to services faced by individuals with TBI and initiate system changes to increase access to services for these individuals. Each grantee adopts a unique approach towards increasing access to TBI services by building on a distinctive service
delivery infrastructure. To sustain the service delivery infrastructure beyond the federal funding, IPG recipients create maintenance plans for such efforts to remain in place beyond the grant period. Protection and Advocacy (P&A) grants, are issued to P&A organizations established under part C of the Developmental Disabilities Assistance and Bill of Rights Act to enable such systems to provide training, legal consultation, advocacy, and legal representation to individuals with TBI. American Samoa, CNMI and Guam grantees are focused on providing self-advocacy skills to individuals with TBI and their families, as well as information and referral and litigation support services.

**Federal Office of Rural Health Policy**

HRSA’s Federal Office of Rural Health Policy continues to encourage tribes, U.S. territories, and the freely associated states to apply for rural health funding opportunity announcements. In FY 2012, the Rural Health Information Technology Program funded a total of $900,000 to tribal organizations and $300,000 to the Commonwealth of Northern Mariana Islands to focus on the implementation of health information technology in rural America. The Small Health Care Provider Quality Program funded a total of $496,096 to tribal organizations to focus on providing quality improvement activities around diabetes, obesity, and cardiovascular disease. In FY 2012, a Rural Health Network Development Planning Grant funded health information technology efforts for $85,000 to promote the development of integrated health care networks in Guam.

**Technical Assistance (TA) Provided to Native American Communities from FY 2009 through FY 2012**

In FY 2012, HRSA continued to provide TA outreach to all potential HRSA applicants with a focus on first time or previously unsuccessful applicants and disadvantaged, vulnerable, and underserved communities, including Native American communities, to enable them to compete more effectively for HRSA funds.

**Bureau of Clinician Recruitment and Service**

Two of the three NHSC Virtual Job Fairs held in 2012 supported recruitment for health professional vacancies at IHS or tribal sites. A June 2012 Virtual Job Fair included IHS representing multiple sites and 60 jobs in five states; one-quarter of the 24 presenting sites participating in the September 2012 Virtual Job Fair represented tribal sites, including IHS and five sites from Alaska.

Since June 2012, the state leads within the Bureau of Clinician Recruitment and Service’s Division of Regional Operations have reached out to more than 380 IHS, tribal, and urban sites within their regions. The goal was to raise awareness and IHS, tribal, and urban site participation levels in the NHSC, underscore the importance of securing a Health Professional Shortage Area (HPSA) score, and finally to explain the NHSC Job Center and the importance of using this tool to help them with their recruitment needs. While IHS, tribal, and urban sites are automatically approved as NHSC sites, it is still important for them to work with HRSA’s Shortage Designation Branch toward an effective HPSA score. An accurate HPSA score will enable the sites to recruit NHSC Scholars who are placed in HPSAs with scores of 16 or higher.
as well as take advantage of the NHSC Loan Repayment Program to recruit new providers to their sites. The site’s HPSA score is a funding preference for the issuance of NHSC Loan Repayment Program awards.

The Bureau of Clinician Recruitment and Service’s Division of Nursing and Public Health administers the Native Hawaiian Health Scholarship Program (NHHSP) through a cooperative agreement with Papa Ola Lokahi, Inc. (POL). The purpose of the NHHSP is to increase the supply of Native Hawaiian health care professionals trained in various disciplines and specialties (as identified through an annual workforce needs assessment to Native Hawaiians in the State of Hawaii) in order to improve the overall health outcomes of Native Hawaiians. HRSA provided TA in the review and approval process of scholarship applications resulting in a total of 15 scholarships awarded in FY 2012.

POL develops placement plans with each NHHSP scholar following completion of their training. Specifically, POL facilitated employment placement of the awarded scholars by assisting with employment readiness, communicating with employment sites regarding scholar availability, and facilitating interviews, placement, and relocation of scholars. Some settings to which scholars were placed include community health centers in the State of Hawaii, private/non-profit practices, Hawaii’s Department of Health, and private practice within the State of Hawaii in order to fulfill their service obligations.

**Bureau of Health Professions**
HRSA’s Bureau of Health Professions has been engaged in many outreach and TA activities to target minority-serving institutions with nursing programs, including tribal organizations. The focus has been on organizations that have no prior experience applying for training grants or have not been successful with securing a training grant. Throughout FY 2012, HRSA made over 100 contacts with tribal health profession programs to make them aware of potential funding opportunities. HRSA staff met with the National Indian Health Board staff on three occasions to discuss ways to improve outreach, increase participation in the Bureau of Health Professions grant programs, and review strategies to encourage tribal schools to pursue necessary program accreditation, which continues to be a major barrier for securing grant funding.

**Bureau of Primary Health Care**
HRSA supports programs in the Pacific to provide TA assistance in the region. The Pacific Island Primary Care Association (PIPCA) works with all six of the Pacific jurisdictions and is based in Honolulu, Hawaii. PIPCA provides training and TA to community health centers on a statewide or regional basis. Likewise, PIHOA provides TA in developing and applying for grants.

HRSA also supports state-wide training and technical assistance to health centers in Hawaii. HRSA funds the Hawaii Primary Care Association (HPCA) to provide training and technical assistance to Hawaii’s statewide network of health centers with the goal of expanding access and sustaining high quality health care for over 130,000 people.
In addition, in September 2009, HRSA provided funding for a National Cooperative Agreement to the Association of Asian Pacific Community Health Organizations (AAPCHO) to provide training and technical assistance to health centers nationwide on the health care needs of Asian American, Native Hawaiian and other Pacific Islanders. In September 2011, AAPCHO was awarded a 3-year National Cooperative Agreement to continue their national training and technical assistance program. With this funding, AAPCHO provided assistance to health centers in Hawaii and in the Pacific Islands relating to health center program requirements, performance improvement, and strategic planning assistance.

**Maternal and Child Health Bureau**
The Western States Regional Genetics Services Collaborative (WSGSC) is one of seven Regional Genetics and Newborn Screening Service Collaboratives across the nation. The Collaborative develops and coordinates multi-state and territory activities to improve coordination, access, follow-up, and quality assurance for newborn screening and genetic services. Participating states and territory in the WSGSC are Alaska, California, Guam, Hawaii, Idaho, Oregon, and Washington. Collaborative stakeholders include public health genetics and newborn screening leaders, primary care providers, family advocates, and genetics specialists. The Collaborative continues to recognize gaps in genetic and newborn screening services in Guam and provides TA and approximately $40,000 per year to assist Guam to enhance services. Genetic specialists in Hawaii are funded by the Collaborative to provide genetics and metabolic services via in-person outreach clinic visits and telephone consults to Guam. In FY 2012, telegenetics capability was added to help deliver newborn screening and genetic services. The activities of the WSGSC also help improve care coordination by community public health nurses and social workers for families with children with genetic disorders. The Collaborative continues to provide assistance to Guam in developing a territory-wide data tracking system and short term follow-up program for infants identified through newborn screening for confirmatory testing. Guam now reviews problematic newborn screening results for follow-up with the Hawaii Newborn Screening Program and the Hawaii-based genetic specialists. Issues of insurance coverage of newborn screening and testing continue to be addressed by the Collaborative.

**Office of Federal Assistance Management**
During FY 2012, HRSA, through its TA Outreach Workgroup, continued to provide outreach to all potential HRSA applicants with a focus on first time or previously unsuccessful applicants and disadvantaged, vulnerable, and underserved communities, including tribal entities, to enable them to compete more effectively for HRSA funds.

In FY 2012, HRSA rolled out its new Grants TA website, which contains links to all relevant TA outreach products. HRSA’s marketing and communication outreach strategy is to continually inform potential applicants and target audiences, including tribal audiences, about HRSA’s series of TA products that are archived on the TA outreach website. HRSA conducts and coordinates Grants TA calls on a regular basis throughout the year in an effort to provide continuing guidance and instruction to our grantee community, including Native American communities.

**Office of Global Health Affairs**

FY 2009-2012 Congressional Report
The Regional Collaborative for the Pacific Basin (RCPB) serves as a regional health policy body for the six USAPI jurisdictions. The Regional Collaborative is intended to serve as a formal mechanism to discuss common health interests, problems, and concerns; to promote and enhance a regional approach for cost-effective sharing of resources, information, and human expertise to advance health care improvements in the region; and to provide TA. The RCPB is currently advancing regional plans to improve human resources for health (HRH), addressing non-communicable diseases, and providing grants management assistance. This initiative has resulted in the establishment of an accredited Associate Degree Program in Public Health in Palau; HRH competency assessment, development, and training for all 10 USAPI sites; provision of continuing education for over 70 health professionals in isolated areas; and an expanded partner network in the Pacific committed to improving the health and public health pipeline. The RCPB also advanced a regional plan to address non-communicable diseases through adoption of national-level policies. The RCPB was also instrumental in securing approximately $2.6 million in grants to support the USAPIs since 2010.

RCPB also serves as a regional Primary Care Office (PCO) representing the six jurisdictions. The Pacific PCO fosters collaboration and provides TA to organizations/communities interested in expanding access to primary care for underserved populations in the USAPI; supports needs assessment/sharing of data; promotes workforce development for the NHSC and safety net; and supports the jurisdictions’ shortage designation applications and updates. In 2012, the Pacific PCO updated the health professional shortage area designation for American Samoa, Guam, and FSM.

Office of Regional Operations
Throughout FY 2012, HRSA’s 10 regional offices provided a forum to identify opportunities for HRSA staff to improve support for tribal stakeholders. The regional office in Dallas, Texas, conducted a TA outreach visit to the Alabama-Coushatta Tribe in Livingston, Texas, as part of its effort to help tribal entities better understand the HRSA grant application process. HRSA’s Office of Regional Operations (ORO) continues to explore ways to partner with IHS area offices to meet the health care needs of AI/AN communities.

To help increase access to quality health care services and reduces health disparities among AI/ANs, ORO conducted over 60 substantial contacts with numerous tribal members and/or leaders, tribal organizations, and other groups throughout the U.S. that serve tribal members. This was accomplished through a combination of site visits, consultations, other face-to-face meetings, and teleconferences.

ORO staff from nine HHS regional offices participated in the HHS Tribal Consultation Sessions convened by the regional directors, which involved participating in conference calls to help plan the sessions, prepare and deliver presentations, answer questions during the meeting, and follow up on issues raised during the event. As a result of these consultations, ORO helped plan and conduct a number of significant events with salient outcomes. These included a partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) to arrange for training of 18 primary care providers in Alaska to become certified to treat tribal members with opioid addiction in primary care settings; collaboration with the North and South Dakota state...
maternal and child health staff, as well as the Great Plains Tribal Chairman’s Health Boards, to conduct two Forums on the Prevention of American Indian Mortality attended by 100 participants; and collaboration with SAMHSA, IHS, and other HHS operating divisions to plan and conduct a Tribal Prescription Drug Abuse Prevention Summit attended by more than 90 tribal representatives from states in the Region V/Bemidji Area.

Additional topics and issues of concern to tribes and addressed by the OROs staff during the course of the year included the Affordable Care Act; behavioral health care services; diabetes; emergency room utilization; federally-qualified health center designations; planning and operations; grant opportunities available from HRSA (how to apply for and serve as reviewers); health workforce shortage designations; health care for Urban Indians; HWC; Healthy Start program; HIV prevention services; MIECHV; NHSC site designations and recruitment of scholars and loan repayers; oral health services; pediatric asthma; 340B Drug Pricing Program, prescription drug diversion and abuse; school-based clinics; and telehealth services.

As a result of these efforts by the ORO staff, numerous tribes received new HRSA grants to support the delivery of health care services to their members, gained additional information about the HRSA grant programs they are eligible to apply for and best strategies on how to apply, received additional health care services for their members, and obtained new information resulting in increased awareness about critical health issues affecting their members.

**Funding Provided to Native American Communities FY 2009 through FY 2012**

<table>
<thead>
<tr>
<th>Targeted/Discretionary Funding:</th>
<th>FY 2009 Dollars Provided</th>
<th>FY 2009 ARRA Dollars Provided</th>
<th>FY 2009 Total Award Dollars</th>
<th>FY 2010 Award Dollars</th>
<th>FY 2011 Award Dollars</th>
<th>FY 2012 Award Dollars</th>
</tr>
</thead>
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<tr>
<td>$52,775,730</td>
<td>$24,217,628</td>
<td>$76,993,358</td>
<td>$53,686,144</td>
<td>$59,318,932</td>
<td>$49,618,391</td>
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</tr>
</tbody>
</table>
The mission of the IHS in partnership with AI/AN people is to raise their physical, mental, social, and spiritual health to the highest level. The IHS goal is to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to all AI/AN people. The IHS mission and goal are based on its foundation to uphold the Federal Government’s obligation to promote healthy AI/AN people, communities, cultures, and to honor and protect the inherent sovereign rights of tribes.

Grant program support provided to Native American Communities in FY 2009 through FY 2012

- **Child and Youth Program (CYP)** - The purpose of the CYP was to assist federally recognized tribes and urban Indian organizations in promoting health practices, and addressing unmet needs of children and youth.
- **Elder Care** - This grant program was designed to provide support for the development of AI/AN Long Term Care services, with funding for either assessment/planning or program implementation.
- **Epidemiology and Disease Prevention** - The purpose is to support Tribal Epidemiology Centers (TEC) and public health infrastructure through the augmentation of existing programs with expertise in epidemiology and a history of regional support.
- **Health Promotion and Disease Prevention (HPDP)** - HPDP grants were awarded and funded to implement proven or promising injury intervention projects that are based on addressing local injury problems.
- **IHS Tribal Management Grants** – The IHS Tribal Management Grant Program is intended to build the management capacity of tribes and tribal organizations. The goal is to improve their management systems and capacity to assume the programs, services, functions, and activities of the Federal Government under the Indian Self Determination and Education Assistance Act, (ISDEAA), P.L. 93-638.
- **Indian Women’s Health Demonstration** – The purpose of the demonstration was to address a health facility's capacity to improve access to behavioral health (BH) care for American Indian and Alaska Native (AI/AN) women and female adolescents who are at risk of experiencing domestic violence and sexual assault (DV/SA) and the associated trauma.
- **Methamphetamine Suicide Prevention Initiative** – The purpose of this initiative was to provide targeted resources for methamphetamine and suicide prevention and intervention services to tribal communities in Indian Country with the greatest need for these projects.
- **National Indian Health Outreach and Education** - The goal is to coordinate and conduct consumer centered outreach and education, training and technical assistance on a national scale for the 565 federally-recognized tribes and tribal organizations on the changes and authorities of the new legislation for the ACA and the IHCIA.
• National Native American EMS Association - An independent, intertribal organization established to provide both educational and technical support for its members; evolutionary in nature, but is intended to provide the leadership in meeting the educational and technical support needs of EMS providers serving AI/AN people.

• Native American Research Center for Health - Tribes and tribal organizations build a research infrastructure, including a core component for capacity building and the possibility of reducing the many health disparities so prevalent in AI/AN communities.

• Office of Clinical and Prevention Services: National HIV Program – The purpose is to identify best practices to enhance HIV testing, including rapid testing and/or conventional HIV antibody testing, and to provide a more focused effort to address HIV/AIDS prevention in AI/AN populations in the United States.

• Oral Care & Prevention – The purpose is to assist IHS, tribal, and urban dental programs to address the Department of Health and Human Services Healthy People 2010 oral health objectives, the IHS Division of Oral Health Government Performance and Results Act (GPRA) oral health objectives, and the IHS Director’s current health initiatives.

• Public Health Nursing – The purpose is to improve specific health outcomes of an identified high risk group of patients through a community case management model that utilizes the PHN as a case manager.

• Special Diabetes Program for Indians – Beginning in 1998, the Special Diabetes Program for Indians (SDPI) grant program provided annual funding to 333 non-competitive grant programs to begin or enhance diabetes prevention programs in Indian communities, as well as to address diabetes treatment. The result has been the creation of innovative, culturally appropriate strategies that address diabetes. The SDPI funds have enhanced diabetes care and education in AI/AN communities, and built an infrastructure for diabetes programs.

• Tribal Self-Governance – The purpose is to provide resources to tribes to help defray the costs involved in and preparing for the Tribal Self-Governance Program negotiations process.

The IHS Division of Grants Management and Operations (DGOP) provided the following technical assistance to Native American Communities FY 2009 through FY 2012:

• In FY 2009, IHS grant officials provided over 25 training sessions in the areas of: financial reporting, carryover, cost principles, and Grants.gov. All of the agencies funding opportunities were posted on the HHS Grants Forecast tool https://extranet.acf.hhs.gov/hhsgrantsforecast. One hundred percent of our funding opportunities both synopsis and full announcements were posted on Grants.gov www.grants.gov. New features were added to the grants policy and operations website to highlight, current news, and added the forecast link to the site notices were sent to over 200 existing grantees alerting them to participate in training opportunities that were being offered throughout the year.

• In FY 2010, over 22 training sessions to over 450 IHS program officials (headquarters and regional areas), tribes and non-tribal grantees were provided. Training topics included Grants.gov Systems User Training, Funding opportunity announcement process, the objective review process, HHS/IHS financial management requirements, pre and post award
requirements, guidance on matters relating to grants operations, and various other HHS/IHS grants policies.

- In FY 2011 over 54 training sessions to over 750 IHS program officials (headquarters and regional areas), tribes and non-tribal grantees were provided. Training topics included Grants.gov systems user training, funding opportunity announcement process, application review module system, Grant Solutions System, HHS/IHS financial management requirements, pre and post award requirements, guidance on matters relating to grants operations, and other various HHS/IHS grants policies.

- In FY 2012, over 78 training sessions were provided to over 789 IHS program officials (headquarters and regional areas), tribes and non-tribal grantees. Training topics included information on searching for new funding opportunities, how to navigate within the Grants.gov systems, the Application Review Module System, Grant Solutions System, HHS/IHS financial management requirements, pre and post award requirements, discretionary grants cycle, objective review training, grants closeout training, various other grants operations, and policy topics.

### Tribal Management Grant (TMG) Program and Special Diabetes Program for Indians (SDPI) From FY 2009 to FY 2012, TMG included 110 grant awards, in 11 IHS Areas, representing 18 states; SDPI included 363 grant and sub-grant programs in IHS, Tribal and Urban Indian health programs in all 12 IHS Areas, representing 35 states.

<table>
<thead>
<tr>
<th></th>
<th>FY 2009 Amount</th>
<th>FY 2010 Amount</th>
<th>FY 2011 Amount</th>
<th>FY 2012 Amount</th>
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<tr>
<td>IHS Tribal Management Grants</td>
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### Other Funding Opportunities FY 2009 - 2012

<table>
<thead>
<tr>
<th>Program</th>
<th>FY 2009 Amount</th>
<th>FY 2010 Amount</th>
<th>FY 2011 Amount</th>
<th>FY 2012 Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child &amp; Youth Program</td>
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<td>$1,724,577</td>
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<td>Elder Care</td>
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<td>Epidemiology and Disease Prevention</td>
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<td>Health Promotion &amp; Disease Prevention</td>
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<td>Injury Prevention</td>
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<td>$2,565,000</td>
<td>$2,778,033</td>
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<td>Indian Women’s Health Demonstration</td>
<td>$300,000</td>
<td>$599,979</td>
<td>$299,979</td>
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<tr>
<td>Program</td>
<td>FY 2009 Amount</td>
<td>FY 2010 Amount</td>
<td>FY 2011 Amount</td>
<td>FY 2012 Amount</td>
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<tr>
<td>--------------------------------------------------</td>
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</tr>
<tr>
<td>Methamphetamine Suicide Prevention Initiative</td>
<td>$8,145,732</td>
<td>$15,113,552</td>
<td>$11,506,451</td>
<td>$7,807,755</td>
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<tr>
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<td>National Indian Health Outreach and Education</td>
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<td>Office of Clinical And Preventive Services: National HIV Program</td>
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<td>$445,500</td>
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<td>Public Health Nursing</td>
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<td>$1,186,856</td>
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<td>Oral Care &amp; Prevention</td>
<td>$999,996</td>
<td>$500,000</td>
<td>$499,000</td>
<td>$498,000</td>
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<tr>
<td>Tribal Self-Governance</td>
<td>$264,979</td>
<td>$284,717</td>
<td>$180,000</td>
<td>$502,275</td>
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<tr>
<td><strong>Grand Total</strong></td>
<td><strong>$21,094,871</strong></td>
<td><strong>$47,078,591</strong></td>
<td><strong>$50,738,821</strong></td>
<td><strong>$22,395,320</strong></td>
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</tbody>
</table>
The National Institutes of Health (NIH) is the steward of biomedical and behavioral research for the Nation. The mission of the NIH is to seek fundamental knowledge about the nature and behavior of living systems and to apply that knowledge to enhance health, lengthen life, and to reduce illness and disability. The NIH accomplishes its research goals with a competitive grant-award process to colleges and universities, medical schools, local and state governments, and other research institutions that foster fundamental creative discoveries, innovative research strategies, and their applications. The NIH works towards its mission by conducting and supporting research:

- On the causes, diagnosis, prevention, and cure of human diseases;
- On the processes of human growth and development;
- On the biological effects of environmental contaminants;
- On the understanding of mental, addictive, and physical disorders; and
- In directing programs for the collection, dissemination, and exchange of information in medicine and health, including the development/support of medical libraries, health information specialists, and other information technology.

The prevention, diagnosis, and treatment of diseases and conditions that disproportionately affect American Indian/Alaska Native/Native American (AI/AN/NA) communities are a priority for the NIH. Toward that end, the NIH conducts and supports biomedical and behavioral research, promotes capacity-building programs, supports health promotion education, and advances the translation of research findings into AI/AN/NA tribes and communities. Expanding the diversity of the research workforce to include more AI/AN scientists, researchers, and health professionals is another important goal of the NIH. This report highlights a selection of the activities the NIH supported, or participated in, during FY 2009 through FY 2012 that are relevant to AI/AN/NA communities.

Support Provided to Native American Communities in FY 2009 through FY 2012

National Center on Minority Health and Health Disparities (NCMHD) supported a number of Community-Based Participatory Research Projects (CBPR) to develop and implement interventions to reduce health disparities among American Indians/Alaska Natives (AI/ANs). Two projects specifically targeted AI/AN youth populations. The NCMHD Elluam Tungiinun (Toward Wellness) Project was a collaboration between researchers at the University of Alaska Fairbanks and the Yukon-Kuskokwim Health Corporation to create and implement an

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9 The NIH data represent activities from 2009-2011.
10 In 2010 NCMHD was redesignated as the National Institute on Minority Health and Health Disparities (NIMHD) by the Patient Protection and Affordable Care Act (P.L. 111-148). This report uses both acronyms depending on the timeframe.
intervention program to reduce suicide risk and underage drinking among Yup’ik Eskimo youth living in the Yukon Kuskokwim Delta. The *Healing of the Canoe* Project was a partnership between the Port Gamble S’Klallam and Suquamish Tribes of Washington State and the University of Washington. This community-based intervention emphasizes cultural and community identity to address risk factors to prevent or reduce alcohol use and substance abuse among tribal youth. NCMHD partnered with the University of Kansas Medical Center, the Heart of America Indian Center, the American Indian Council, and Johnson County Community College to support *All Nations Breath of Life*, a CBPR smoking cessation program among AI/ANs in the Kansas and Missouri areas. NCMHD also supported the *Native Navigators and the Cancer Continuum* that addressed the continuum of cancer care among American Indians in three American Indian communities in Colorado, South Dakota, and Michigan.

NIH Loan Repayment Programs (LRP) attracted health professionals to careers in clinical, pediatric, health disparities, or contraception and infertility research. NCMHD administered two of the five programs LRP Programs at NIH. The Loan Repayments for Health Disparities Research (HD-LRP) and Loan Repayments for Clinical Researchers from Disadvantaged Backgrounds (ECR-LRP) were the primary recruitment tools for AI/AN/NA/HN/PI students interested in pursuing careers in biomedical research or health professions. These programs promoted a diverse scientific workforce from health disparity, medically underserved and disadvantaged communities. The Loan Repayment Programs provided up to $35,000 per year to qualified doctoral degree professionals in exchange for two years of service in health disparities research or clinical research.

In FY 2009, NCMHD supported seven Loan Repayment Program (LRP) researchers who implemented interventions to reduce health disparities among American Indians/Alaska Natives (AI/ANs). Three of the projects specifically targeted AI/AN youth population. One researcher studied the contextual factors that place Lummi American Indian youth at higher risk for unintended pregnancies, suicide, inter-personal violence, and substance abuse. The *Healing Horse Program* was a Black Hills State University initiative that sought to evaluate a culturally based equine-assisted mental health intervention among the various Northern Plains American Indian youth. Another LRP awardee at the Portland State University evaluated *Nak-Nu-Wit*, a culturally relevant intervention of mental health care for AI/AN children, youth, and their families.

The NCMHD Research Endowment program at the University of Montana (*UM-CHPBS Endowment Fund Program*) promoted minority health and health disparities research capacity-building as it: (1) strengthened the research infrastructure through the renovation of facilities, the purchase of state-of-the-art instruments and equipment, and the upgrade of information technology; (2) recruited a diverse faculty and created challenging courses in such topics as research methodology and health disparities; and (3) focused on the recruitment and retention of students that are underrepresented in the scientific workforce. The *UM-CHPBS Endowment Fund Program at the University of Montana* has been instrumental in advancing over twelve separate health disparities research projects, including an assessment of the role of pharmacogenomics in American Indian populations as it applies to cancer and the optimal use of cancer chemotherapeutic agents. As a means to enhance the recruitment and training of
American Indians at the professional and graduate level, two new Native American Research Labs (NARL) in the College of Biomedical and Pharmaceutical Sciences and in the Division of Biological Sciences offered research experiences to over 50 American Indian undergraduates from tribal colleges and other institutions designed to foster continuation on to PhD training.

NCMHD as part of its Social Determinants of Health Initiative supported a research project, Addressing Diabetes/CVD Health Disparities among American Indians: A Transdisciplinary Approach, at the University of Colorado Denver. The purpose of the project was to assess the viability and sustainability of an intervention utilizing two electronic tools: (1) one for increasing exercise and (2) one for tracking diet and exercise among overweight/obese American Indian/Alaska Natives living in urban areas. The project (1) determined whether introduction of electronic devices leads to decreased risk for diabetes and cardiovascular disease; (2) assessed the social determinants of resultant changes in diabetes and cardiovascular disease risk using sociobehavioral theories; and (3) placed the investigations of effectiveness in a larger translational framework by exploring aspects of reach, adoption, and implementation in order to understand issues of viability and sustainability of this and comparable interventions. This clinical trial, funded under the American Recovery and Reinvestment Act of 2009, was implemented in two Indian Health Service-funded Urban Indian Health Centers (Denver and Albuquerque). By focusing on diabetes and cardiovascular disease within larger theoretical frameworks, the study holds the promise for broad public health findings.

In FY 2009, NCMHD also provided support for the Center of Excellence at the University of South Dakota, School of Medicine (USD), Center for Disabilities (CD), which has several partners: Black Hills State University; The Aberdeen Area Tribal Chairmen's Health Board; The Montana-Wyoming Tribal Leaders Council; and Sinte Gleska University. The Community Outreach and Information (COID) Core disseminated information and applied research findings to meet the needs of tribes and provided technical assistance, training and support to tribal health and physical activities programs to conduct community child health needs assessments and to develop tribally-tailored programs to prevent and reduce childhood obesity. This COE conducted research on Cultural Resilience and Adolescent Risk Behaviors by young Indian people. It investigated the role of prenatal alcohol exposure in the risk for Sudden Infant Death Syndrome (SIDS), stillbirth, and Fetal Alcohol Syndrome (FAS) by tracking Indian children through age four. USD research faculty provided consultation and training to Sinte Gleska University faculty on research design and methodology, which led directly to health disparities research projects based on tribal needs and the development of associated resource materials.

In FY 2009, NCMHD provided support for the University of Oklahoma Center for American Indian Diabetes Health Disparities that sought to reduce and eventually eliminate the excess mortality, morbidity, and quality of life and culture lost due to diabetes. The center also focused on maternal health, infant mortality, and obesity. Studies included Early Markers of Pre-eclampsia in American Indians with Type 2 Diabetes, Insulin Resistance and Glucocorticoid Treatment of Inflammatory Diseases of High Prevalence among American Indians, and American Indian Diabetes Beliefs and Practices: Maternal Care, Infant Mortality, and Adherence. In addition, the center provided instruction and support for conducting practical research to address diabetes within their health care settings to a cadre of nurses from American
Indian clinics and hospitals in Oklahoma and Kansas. The Community Engagement/Outreach Core supported the Native Youth Preventing Diabetes summer camp that is open to all Oklahoma American Indians ages 8 to 12 years. Preliminary findings on diabetes beliefs, knowledge, and practice among American Indian young women, including pregnant women, showed that health care providers did not provide them with enough information about the risks of developing diabetes during pregnancy, and how these risks may be minimized. Most participants acknowledged that diabetes creates maternal and fetal health risks but their understanding of the disease process of diabetes was so vague that behavioral risk prevention recommendations were not experienced as logically connected to the disease process. For patients already diagnosed with gestational diabetes, there was a like inability to connect diabetes self-care recommendations with maternal and fetal health risks. Thus for both a lack of understanding may defeat or contribute to the lack of adherence to risk prevention recommendations or to diabetes self-care recommendations.

Under the National Center for Research Resources’ (NCRR)\(^{11}\) COBRE program, the Center for Alaska Native Health Research (CANHR) at the University of Alaska Fairbanks employed a collaborative research model working with Yup’ik Eskimo and other Alaska Native communities, tribal health care organizations and individuals to frame research questions, develop methodologies and procedures, and interpret and apply data to prevention and treatment of diabetes, cardiovascular diseases, mood disorders and substance abuse. In 2009, CANHR received American Recovery and Reinvestment Act of 2009 funding from NCRR to join with other NIH-funded Alaska research projects to combine Alaska Inupiat and Yup'ik health research data sets representing almost 4,000 people, giving scientists a better understanding of Alaska Eskimo's health risks and protections.

In 2009, NCRR entered into a multi-year agreement with the Indian Health Service (IHS) to co-fund a major national study of community-based participatory research (CBPR) approaches for addressing health disparities in Indian Country through a Native American Research Centers for Health (NARCH) grant to the National Congress of American Indians Policy Research Center, with sub-awards to the University of New Mexico and the University of Washington. The project sought to determine conditions under which CBPR in Native communities was most effective. It resulted in a testable model of CBPR practice, produced site-specific and aggregate reports about promoters and inhibitors of CBPR in Native communities, and allowed for the comparison of Native data to data from other communities of color.

The National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) supported several projects at American Indian institutions in 2009, which continued from FY 2007 through FY 2008 including:

- A grant to Keweenaw Bay Ojibwa Community College in Michigan supported the Diabetes Education and Science to Instruct Native Youth Project to improve health

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\(^{11}\) NCRR was dissolved in 2011 by P.L. 112-74. Programs that were run by NCRR were reassigned to other NIH Institutes and Centers.
attitudes and behaviors of Native people, use protective cultural knowledge and community support to enhance health/science education, and empower youth to become proactive about their health, education and leadership potential in the community. The goal was to inspire youth to pursue careers in science and health, and return to teach and influence the community.

• A grant to Haskell Indian Nations University in Kansas entitled “Applying Bloom's Taxonomy in Diabetes and Science Education in Tribal Classrooms.” Researchers developed a constructivist-based K-6 diabetes curriculum with an emphasis in the area of taxonomic learning objectives based on the research of educational psychologist, Dr. Benjamin Bloom. The curriculum was grounded on inquiry-processing skills in the science and health strands while integrating in American Indian and Alaska Native cultures. This project, built upon a unique partnership between the Royal Valley Public Schools, Hoyt/Mayetta, Kansas, and the Haskell Indian Nations University, Elementary Teacher Education Program, developed the curriculum.

• Several grants to implement at the community level the NIH-supported Diabetes Education in Tribal Schools Program. A grant to Cankdeska Cikana Community College in North Dakota established a K-12 diabetes-based science education curriculum developed on the Spirit Lake Sioux Nation reservation for all reservation schools. The curriculum included activities that teach the value of exercise, and proper diet within the culture of the Spirit Lake Sioux traditions. The science focused on nutrition, digestion, metabolism, anatomy, physiology, and genetics where appropriate and reservation health data.

A grant to the Southwestern Indian Polytechnic Institute in New Mexico fostered collaboration between the Institute and Jemez Valley Schools, Jemez's Indian Education Programs, and Jemez Pueblo to develop a science-based diabetes prevention education curriculum for students in grades 7-12 that were aligned with national and state teaching standards and benchmarks. The curriculum design enhanced the understanding and appreciation of this devastating disease by the development of culturally appropriate activities and career awareness opportunities.

The objective of a grant to Fort Peck Community College in Montana was to improve the health status of Fort Peck Reservation residents by reducing diabetes and diabetes-related complications in the population. The project also sought to increase the number of American Indians who pursue higher education and careers in the science, health and science education fields. The method for achieving these objectives was to strengthen science and health education in the public schools by integrating diabetes-centered material into the existing curricula. The focus developed curricula for students in grades K-6. Traditional Native American culture, values and knowledge were incorporated into the curriculum. Fort Peck Community College will also maintained communication with tribal colleges developing diabetes-centered curricula for the middle and high school levels in an effort to support continued education in this field at the secondary level.
A grant to the Stone Child College in Montana for its “Healthy Journey Rebirth Project” researched, developed, and field tested a culturally-appropriate science-based prevention curriculum for K-12 tribal schools, provided the necessary training for teachers to implement the curriculum, stimulated the interest of students in diabetic’s science and related health careers, and collaborated with other tribal colleges and universities and local tribal collaborators in the development of the curriculum.

A grant to the Northwest Indian College in Washington enabled revision of the Lummi Tribal School's (LTS) entire curriculum, adding diabetes to the curriculum of grades 7-12, and was replicated in several other tribal schools. The modified “Interrupted Time Series with Switching Replication” permitted a valuable formative evaluation, and rigorous evaluation of impact, of the curriculum.

A grant to Leech Lake Tribal College in Minnesota conducted the “Woodlands Wisdom Project,” a Confederation of the College of Menominee Nation, Turtle Mountain Community College, Leech Lake Tribal College, Fond du Lac Tribal and Community College, Lac Courte Oreilles Ojibwe Community College, White Earth Tribal and College and the University of Minnesota. The Project addressed chronic health issues in American Indian communities through culturally-responsive programs of teaching, research and community connections. The goal of the Project was to create a regional community consciousness around how food and nutrition impacts community, family, and individual health and well-being.

The NIDDK began a new diabetes prevention project in FY 2009. A grant to the University of Nevada, Las Vegas, American Indian Research and Education Center conducted a community-based, participatory, translational research study entitled "Life in BALANCE" (Balancing Actions, Lifestyle, Autonomy, Nutrition, Community, and Environment). This two-year planning project was a prelude to a large-scale, multi-site, cohort study of effective diabetes prevention among urban (non-reservation) American Indians and Alaska Natives. This study provided knowledge and information regarding strategies for diabetes prevention and provided a foundation for future research.

In FY 2009, the NIDDK’s Intramural Phoenix Epidemiology and Clinical Research Branch (PECRB) in Phoenix, Arizona, continued to develop and apply epidemiologic methodologies in the investigation of diabetes and kidney disease; plan and conduct field studies and clinical and laboratory research in these diseases; and conduct field studies including collaborative clinical investigations on selected populations—primarily American Indians—in the U.S. and in other countries. Since 1963, the PECRB conducted cooperative research efforts with the Pima Indians of the Gila River Indian Community in Phoenix. The Pima Indians have the highest prevalence of type 2 diabetes in the world. Research included molecular analysis of genes linked to diabetes, epidemiology and physiology of kidney and eye disease caused by diabetes, and gene expression profiling of insulin resistance and obesity in the Pima Indians.

In FY 2009, the NIH and CDC continued to lead the Department’s National Diabetes Education Program (NDEP), the leading federal government public education program that promotes
diabetes prevention and control. Launched in 1997, NDEP’s mission is to reduce the morbidity and mortality associated with diabetes. NDEP translates the latest science and disseminates information that diabetes is serious, common, and costly, yet controllable and preventable. More than 200 organizations and many volunteers joined with NDEP to help develop critical and effective initiatives and bring them to life. Consumer materials were tailored for groups at highest risk for diabetes—African Americans, Hispanics and Latinos, American Indians, Alaska Natives, Asian Americans, Pacific Islanders, and other older adults. American Indians and Alaska Natives leaders came together to develop a strong response to diabetes across their communities. Working closely with the Indian Health Service and the American Association of Indian Physicians and representatives from several tribes, this work group helped NDEP tailor messages for the American Indian community to get the word out about diabetes control and diabetes prevention. We Have the Power materials provided a positive affirmation of the ability to prevent or delay the onset of diabetes (http://www.ndep.nih.gov/media/Power_tips.pdf). Take Care of Your Heart, Manage Your Diabetes promoted the link between diabetes and heart disease and the importance of managing blood glucose, blood pressure and cholesterol to prevent or delay complications (http://ndep.nih.gov/resources/ResourceDetail.aspx?ResId=47).

The prevalence of type 2 diabetes in American Samoa is more than double that in the U.S. as a whole. The NIDDK is supporting a diabetes demonstration and control project grant to translate recent advances in diabetes care into clinical practice for the American Samoan community by improving methods of health care delivery and improving methods of diabetes self-management. The project will use the community health worker model to test an expanded diabetes care model. Community health workers (CHW) have frequently been used to serve as "bridges" between health care services and patients in poor ethnic minority communities. The outcomes at a one-year follow-up will include glycosolated hemoglobin (HbA1c), cardiovascular disease risk factors, diet and exercise behaviors, and adherence to diabetes care guidelines. The intervention builds upon best clinical practices for diabetes care by translating effective strategies to American Samoans.

In FY 2009, the National Institute of Allergy and Infectious Diseases (NIAID) supported research training and career development opportunities specifically targeted toward American Indians/Alaska Natives. The NIAID Intramural Research Opportunities (INRO) Program conducted several marketing activities specifically targeted toward AI/AN/NA’s. INRO enables students in populations underrepresented in biomedical science to become familiar with NIAID and its research training and career development opportunities from summer internship to postdoctoral research training programs. Qualified applicants for INRO have opportunity to conduct research work in various NIAID laboratories. Of the 192 applicants to INRO 2010, seven applicants were American Indians/Alaska Natives up from five last year. In addition, six more American Indian/Alaska Native students started applications to the INRO 2010 program. Two American Indians were selected to attend INRO 2010, one undergraduate senior and one PhD candidate. Each had at least three interviews with potential NIAID mentors for training programs. Additionally, one Native American student is being sponsored to conduct graduate studies in the Oxford-Cambridge Program, with laboratory placement in NIAID. The Associate Director of the Office of Training and Diversity participated in the Rural Alaska
Honors Institute during the summer of 2009 by tele-conferencing a presentation on biomedical research at NIAID, and training opportunities.

The Trans-NIH American Indian and Alaska Native Health Communications and Information Work Group continues to coordinate NIH efforts to develop and disseminate health information targeting American Indian and Alaska Native communities. In May 2009, the Work Group sponsored a half-day workshop for NIH communications staff on “Creating Collaborations: Partnering with Tribal Community Health Representatives for Health Research and Education.” The workshop was aimed at increasing understanding of the vital role Community Health Representatives (CHR) play in developing and disseminating health information and education programs to Native people. CHR (tribal employees who live and work in American Indian or Alaska Native communities nationwide serving as health educators and patient liaisons) presented information about their programs. The workshop concluded with a panel discussion that included the keynote speakers and Indian Health Service area office coordinators who provide consultation and technical assistance to CHR programs throughout the country.

To expand NIH’s ability to reach out to American Indians and Alaska Natives, the Work Group is partnering with the Indian Health Service to disseminate quarterly NIH information kits to approximately 1,700 Community Health Representatives (CHRs). The purpose of the mailings is to increase CHRs’ awareness that NIH has many free and low-cost science-based health information materials that could be very helpful to them and their communities. Since the inception of the project in January 2008, the NIH has sent approximately 7,000 information kits to CHRs in the areas of bone health, diabetes, physical activity, stroke, and sudden infant death syndrome. One health information kit included culturally relevant information on cancer prevention and education and was disseminated to more than 1,400 Indian country communities representing more than 250 tribes. Under the auspices of this program, NIDA sponsored the Dissemination of Drug Abuse Information to the Indian Health Service Community Health Representatives, an outreach effort that distributed drug abuse public health information to 1,500 community health representatives in March 2010.

As part of the Native American Research Centers for Health (NARCH) program, sponsored by the Indian Health Service, NIAMS is supporting efforts by the Chickasaw Nation Health System to improve the health status of Native Americans who suffer from rheumatic diseases. Researchers will establish the prevalence and overlap of rheumatic diseases in Oklahoma tribal communities, define the serologic and clinical features that characterize rheumatic diseases in tribal members (compared with Americans of European or African descent) to improve disease diagnosis and clinical care for Native Americans, and provide medical care to the local population through the program’s rheumatology clinics. Most genetic studies on rheumatoid arthritis and juvenile idiopathic arthritis have been in Caucasians, although American Indians have a higher prevalence, and more severe forms, of rheumatoid arthritis and juvenile idiopathic arthritis. Since 2005, NIAMS researchers have been examining genes that may contribute to this discrepancy, with the hope that their results will lead to the development of specialized diagnostic tests and improved treatments.
Since 2006, the NIAMS also has supported a study to assess the bone health of Navajo Nation members. The project’s purpose is to enable the Navajo Nation to plan screening and culturally appropriate education and intervention programs targeted towards the segments of the population that are at greatest risk for fracture or osteoporosis. This study is an important first step in surveillance of bone health of Navajo American Indians, and leverages resources that National Cancer Institute researchers developed as part of their Navajo EARTH Cohort Study.

Eliminating health disparities, developing Tribal research capacity and positive youth development are three important priorities of the National Cancer Institute (NCI). The institute is committed to reducing cancer health disparities among American Indians and Alaskan Natives (AI/AN). NCI is partnering with the Native American Research Centers for Health (NARCH). NARCH is carrying out research projects that are relevant to the needs of specific tribes in the AI/AN communities. Through the NARCH initiative, NCI funds several projects, including: (1) Improving American Indian Cancer Surveillance and Data Reporting; (2) Colorectal Screening Among the Lakota; (3) Breast Cancer Screening in Bemidji Area AI Women; (4) HPV Self-sampling to Improve Cervical Cancer Screening in AI Communities; and (5) Nicotine Excretion and Metabolism in Alaskan Natives (NEAM). These projects aim to increase the research capacity of AI/AN research institutions and to provide much needed outreach to reduce observed cancer health disparities in the AI/AN communities. The result is increased awareness about cancer screening, diagnosis and treatment with the ultimate objective of reducing cancer health disparities among AI/AN populations. NCI is currently funding three NARCH projects, including nicotine excretion and metabolism, as well as cigarette smoking cessation programs in Alaskan Natives. NCI uses these research projects to train and develop a cadre of AI/AN scientists and health professionals who would contribute significantly to the goals of reducing cancers that disproportionately affect these communities.

NCI also supports access to health services. The Walking Forward Program at the Rapid City Regional Hospital (RCRH) was first funded in 2002 by the NCI as one of six Cancer Disparity Research Partnership (CDRP) grantees. The goals are to increase the access and enrollment of minority/underserved populations onto NCI cancer clinical trials. The Walking Forward Program serves the American Indians (AIs) in the Northern Plains region living within the Rapid City community and three reservations in western South Dakota. The CDRP grant supports community research representatives (CRRs) of the Cheyenne River Reservation Sioux Tribe, the Pine Ridge Oglala Sioux Tribe, and the Rosebud Reservation Sioux Tribe, who live on the reservations and provide the public outreach, education, and recruitment activities necessary to provide access to cancer care and treatment on NCI cancer clinical trials opened at RCRH.

To foster relationships with the American Indian community and provide reliable, up to date information, the National Library of Medicine (NLM) collaborates with an American Indian user group to create the American Indian Health (AIH) Web portal http://americanindianhealth.nlm.nih.gov/. The Web portal is a unique, freely available site dedicated to issues affecting the health and well-being of all North American Indians. The AIH web site brings together pertinent health and medical resources, including consumer health information, the results of research, traditional healing resources, and links to other Web sites. Some of the information has been assembled from other NLM resources such as

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MEDLINE/PubMed and MedlinePlus. Other federal and non-profit health initiatives for American Indians, including those from the Indian Health Service (IHS) are included as resources as well as basic health information on common conditions and diseases. AIH aims to be an inclusive source of programs and health information for both consumers and health professionals serving American Indians. Throughout the year the American Indian Health user group exhibits at events such as powwows and health fairs to demonstrate how to use the portal and get user feedback from the American Indian community.

NLM collaborated with Alaska Medical Library at the University of Alaska, Anchorage (UAA), to support the Arctic Health Web site (www.arctichealth.org). The goal of the Web site is to bring together, in one location, information on diverse aspects of the Arctic environment and the health of northern peoples. It gives access to evaluated health information from hundreds of local, state, national, and international agencies, as well as from professional societies, universities and Alaska Natives and indigenous communities. The portal contains several resources for both researchers and consumers. The topic areas covered are: publications and research, environmental health, telehealth and telemedicine, traditional healing, health topics and links to government organizations and programs. Arctic Health makes several unique and special collections available on the Internet and continues to acquire these collections to preserve indigenous knowledge and practices. The Alaska Medical Library and a NLM representative presented a poster and exhibited at the International Congress on Circumpolar Health in July 2009.

The Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) project, Creating Partnerships in Identifying Health Needs of Foster Care Indian Youth is gathering and disseminating information to encourage Indian and non-Indian communities and service agencies to work together to develop strategies to reduce the mental and physical health burden often experienced by Indian youth transitioning out of foster care.

NICHD promotes access to and participation of Native Americans in HHS biomedical research programs through its Extramural Associates Research Development Award (EARDA), Diversity Supplements, and Academic/Community Partnership Conference programs. The Academic/Community Partnership Conference Series (U13) initiative has expanded eligibility to include TCUs and Indian/Native American Tribally-designated organizations. The aim is to build bridges and strengthen capacity to address health disparities among racial/ethnic populations. TCUs are uniquely positioned to contribute toward improving the health of Native American communities through research. The community partnerships focus on one or more of the following areas: infant mortality, SIDS, information dissemination, pediatric and maternal HIV/AIDS prevention, childhood/adolescent/adult obesity, health literacy, uterine fibroid tumors, and violence prevention. The Extramural Associates Program is a trans-NIH initiative designed to facilitate the development of institutional capacity in supporting the technical development of research grant programs, providing oversight and administrative management of grant awards, and fostering and facilitating ongoing research activities. The EA Program accomplishes its mission through EARDA grants that help develop and expand research capacity at TCUs.

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In FY 2009, NIDA continued to support research in Native American communities to assess patterns of substance abuse, prevention and treatment intervention strategies, and services. Examples of these projects include: Adolescent Marijuana Use in Native Americans, Community Partnership to Affect Cherokee Adolescent Substance Abuse, In-Home Prevention of Substance Abuse Risks for Native Teen Families, Evidence-Based Practices and Substance Abuse Treatment for Native Americans, Zuni MI/CRA Project, Vulnerability to Drug Abuse: Effects of Stressors and Stress, Ojibwe Pathways through the High School Years, Ecological Factors and Drug Use of Native Hawaiian Youth, Growth Curve Modeling of AOD Use Among Indian Adolescents, and HIV Prevention: Strengthening Aboriginal Youth. NIDA continues and has increased its support of the Native American Research Centers for Health (NARCH) program, aimed at capacity building, data collection, research training and infrastructure development for AI/AN researchers. Projects are supported through tribal organizations and address research priorities in drug abuse that have been identified by Native American communities.

The National Institute of Neurological Disorders and Stroke (NINDS) Alaska Native Stroke Registry (ANSR) project has been successful in obtaining the support and cooperation of the Alaska Native community, Alaska Native healthcare system, and tribal leadership structure. To date, more than 400 stroke events have been identified with a mean stroke rate of 120 strokes per year. The program has completed inter-rater reliability testing as well as systematic checks of abstracted data. The manuscript STROKE MORTALITY IN ALASKA NATIVE PEOPLE was accepted for publication in the American Journal of Public Health and was published in November 2009. In 2009, NINDS awarded this study a supplement through the American Recovery and Reinvestment Act (ARRA) to perform a door-to-door case-validation survey that will permit accounting for mild strokes, strokes in Alaska Natives that do not present to the Alaska Native Health Care System, or strokes that for other reasons were not identified by the surveillance system. The surveys administered during the case-validation surveys will be integral to the development of an Alaska Native stroke-intervention program. Researchers collected data on known atherosclerosis risk factors, health beliefs, medication adherence, and assessed interest and willingness to participate in a behavioral intervention through questionnaire and measurements. The results will be used to develop a new research proposal testing a targeted stroke prevention intervention.

NINDS also funds a Specialized Neuroscience Research Program (SNRP) at the University of Alaska, Fairbanks and two SNRPs in Hawaii. The SNRPs are cooperative agreement programs that support the development of research capacity and expertise at universities that serve minority communities. The SNRP at the UAF, which began in 2000 and is co-funded by NIMH, focuses on the topic of neuroprotection and adaptation, with particular emphasis on health topics of relevance to the Alaskan Native community. Approximately 20 percent of UAF students are underrepresented minorities and primarily Alaskan Native. Participation of underrepresented students in neuroscience research projects is actively encouraged. The UAF SNRP also supports mentoring of local high school students through the Alaska High School Science Symposium and the Alaska Summer Research Academy. Since the award, the number of neuroscience faculty at the UAF has increased from three to nine and two neuroscience faculty members have achieved tenure. The award has also supported the development of an optical imaging core, the
implementation of a neuroscience seminar series, an increase in research training of undergraduate and graduate students, and in an increase in publications and NIH and NSF grant submissions.

In 2009, one SNRP program in Hawaii organized a major symposium for the Hawai'i Addiction Conference/Asian American and Pacific Islander Workgroup Scientific Conference focusing on recent research and culturally relevant treatments among Asian Americans and Pacific Islanders. The health disparities SNRP is currently investigating changes in brain function induced by frequent cannabis use in rodent models and in humans, the brain effects of methamphetamine use and of exposure in utero, and is validating biological markers of cognitive impairment in HIV patients and meth users. The SNRP programs in Hawaii have led to the development of an interdisciplinary Neuroscience PhD program.

NINDS co-funded the development of a Native American High School Summer Program (NAHSSP) at Harvard along with NCRR, NIA, NIAAA, NIDA, NIGMS, and NIMH. Teams of students and teacher-chaperones from these four groups were selected by their own Hopi, Assiniboine/Sioux, Wampanoag, Native Hawaiian communities to attend the NAHSSP at Harvard for three weeks and participate in lectures on basic neuroscience and the scientific, psychosocial, and clinical aspects of substance abuse. Students developed presentations on some of the topics covered with the goal of presenting them to their local communities upon their return. Culturally relevant case-based tutorials, developed with community members, help communicate personal and social impacts of substance abuse and substance-abuse therapies. In 2009, NINDS and the other NIH partners continued to fund Phase II of this award, which included a rigorous evaluation of program achievements, continuation of education activities, and dissemination of evaluation results. NAHSSP continued to be held in 2009, and it hosted 23 high school students from all four communities, (as well as teacher/chaperones and adult community representatives familiar with the impacts of substance abuse on that community. Two culturally-relevant cases were presented: "Spotted Eagle’s Troubles" (a fictional case of abuse of alcohol, Percocet and methamphetamine, drugs of special importance at Fort Peck) and the newly-developed story "What’s going on with the Jacobs" (a fictional case of abuse of alcohol and a benzodiazepine tranquilizer, drugs of special interest in the Wampanoag communities). The Institute for Learning Innovation has been hired to help undertake the final evaluation. Preliminary outcomes of NAHSSP were presented at the 2009 Science Education Partnership Award (SEPA) Conference.

The National Institute on Aging (NIA) and the University of Oklahoma Norman supported the project, Exploring the Mistreatment of Native Elders. Elder mistreatment was vastly under-explored, and little was known about the prevalence/incidence of elder mistreatment in American Indian/Alaska Natives (AI/ANs). The available studies on elder mistreatment among this group suggested that the phenomenon was likely common, but rigorous studies on its prevalence/incidence were needed. The three specific aims of this grant were to: (1) explore the feasibility of conducting a study of the prevalence/incidence of mistreatment among rural and urban Native elders, and identify measurement approaches that can be employed in a pilot study; (2) conduct a pilot study of the prevalence/incidence of mistreatment among Native elders in order to evaluate the usefulness and effectiveness of several methods of measuring mistreatment.

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and (3) use the information generated to develop recommendations for future research that estimates the prevalence/incidence of elder mistreatment in AI/AN communities. The grant produced a series of recommendations for future research on the prevalence/incidence of American Indian and Alaska Native elder mistreatment that were informative, useable, and grounded in real-life experience.

The NCI supported Network for Cancer Control Research among American Indian/Alaska Natives Population, a collaborative group of native and non-native researchers and educators who exchanged information on cancer control research and who sought to improve community links to NCI’s researchers, other federal agencies, NCI’s Cancer Information Service, and the American Cancer Society. Network members authored a monograph that provided a comprehensive description of the cancer burden in the AI/AN population in the U.S., combining cancer incidence data from the Centers for Disease Control and Prevention’s (CDC) National Program of Cancer Registries (NPCR) and NCI’s Surveillance, Epidemiology, and End Results (SEER) Program, along with record linkages and geographic factors. Meetings occurred annually in the spring (March/April) and fall. National conferences are held every three years.

NIDA and NICHD made presentations to the Health Research Advisory Council (HRAC) on March 18, 2010. The HRAC was established to provide the Department of Health and Human Services (HHS) a venue for consulting with tribes about health research priorities and needs in AI/AN communities and for developing collaborative approaches in addressing these issues and needs. NIDA gave a presentation on past activities, current initiatives, and future plans. NIDA also discussed research needs with Council members. NICHD’s presentation discussed the inclusion of American Indians in the National Children’s Study and provided the group with an update on its Healthy Native Babies Project. This project was created in 2009 to develop culturally-appropriate Sudden Infant Death Syndrome (SIDS) risk-reduction messages for AI/AN families. This project is also designed to provide local support and offer training to health care providers and community health and outreach workers.

NIDDK staff participated in meetings of the Indian Health Service’s (IHS)-Tribal Leaders Diabetes Committee (TLDC), which provides leadership, guidance, and recommendations to IHS and other government agencies on diabetes and related chronic health conditions among AI/ANs. The TLDC continues to have great interest in the progress of the NIDDK-led Diabetes Prevention Program follow-up study (DPPOS) and the participating AI sites, as well as pride in the role that the TLDC had in initiating the development of the NIDDK’s Diabetes Education in Tribal Schools (DETS) Program. It is considered to have major importance for AI children and tribal communities. This interaction has led to the TLDC being committed to work towards implementation and wide dissemination of the DETS Program.

NHLBI – Honoring the Gift of Heart Health (HGHH). The NHLBI, in collaboration with the IHS Health Promotion and Disease Prevention Program, funded a total of ten pilot projects beginning FY 2007 and continuing through FY 2009. In FY 2010, NHLBI worked with each pilot project to finalize submitted project data for analysis and prepare final reports. Each of the ten pilot projects planned, implemented, and conducted evaluation activities using a community-based approach. This approach integrated the use of community health workers and community health educators to conduct education and outreach activities to prevent and control CVD risk.
The primary intervention tool used was the NHLBI's "Honoring the Gift of Heart Health" manual and its associated tools. In FY 2011, final project reports and associated data from the pilot projects were submitted. The NHLBI has begun to synthesize and analyze submitted data and is in the process of developing summary reports. The HGHH Materials Development Workgroup members served as field reviewers and advisors in the revision of two documents: the Alaska Native Easy-to-Read booklet and the HGHH Manuals for American Indians and Alaska Natives. Partners within this workgroup also provide valuable guidance in the development of materials that support planning and development of project activities. Revisions of the two documents continued in FY 2011.

Members from the NHLBI Division for the Application of Research Discoveries (DARD), the IHS Health Promotion, Disease Prevention Program, and the IHS Native American Cardiology Program met in FY 2010 to provide feedback on an as needed basis. Teleconference, e-mail, and in-person meetings were held at the IHS Headquarters on a quarterly as-needed basis. The NHLBI, in collaboration with the IHS Health Promotion and Disease Prevention Program, funded a total of ten pilot projects beginning FY 2007 and continuing through FY 2009. In FY 2010, NHLBI worked with each pilot project to finalize submitted project data for analysis and prepare final reports.

Each of the ten pilot projects planned, implemented, and conducted evaluation activities using a community-based approach. This approach integrated the use of community health workers and community health educators to conduct education and outreach activities to prevent and control CVD risk factors. The primary intervention tool used was the NHLBI's "Honoring the Gift of Heart Health" manual and its associated tools. Ultimately, the NHLBI and the IHS, in partnership with each pilot project, will disseminate their findings through publications, conference presentations, and web-based literature. These activities support and extend the IHS, Tribal, and Urban Indian Health Program's existing CVD prevention and control efforts as well as the NHLBI's efforts to address health disparities in minority and underserved populations.

NHLBI – We Can! (Ways to Enhance Children's Activity & Nutrition) Partnership. We Can! is a national public education program from the NIH to help prevent obesity among youth ages 8 to 13. We Can! reaches parents and caregivers in home and community settings with educational materials and activities to encourage healthy eating, increase physical activity, and reduce screen time. The NHLBI’s We Can! Program staff continued to provide technical assistance to the Cherokee Nation Healthy Nation Program by guiding tribal staff to We Can! web-based resources and by providing hardcopy materials and resources as needed. The Cherokee Healthy Nation Program continues to be a part of the We Can! network and is privy to messages that are sent to all members of the We Can! network. NHLBI We Can! staff will continue to explore additional partnership activities with the Cherokee Healthy Nation Program.

To tackle the burden of obesity, the Cherokee Nation developed local media strategies to: (1) Promote healthy food and beverage choices; (2) Limit unhealthy food and beverage availability in schools; (3) Implement farm-to-school programs; (4) Adopt quality education in schools; (5) Increase safe, attractive, and accessible places for physical activity; (6) Adopt procurement and purchasing policies to reduce the price of healthy foods; (7) Develop prompts
for healthy food and beverage items and implement menu labeling; (8) Reduce the cost of
recreation services; and (9) Expand activity groups in workplaces, community gathering places,
parks, and neighborhoods. The NHLBI’s We Can! Program staff successfully planned and
conducted a We Can! Parent Program webinar training session for Cherokee Healthy Nation
staff and Oklahoma State Health Department staff, with a total of 11 participants taking part in
the webinar. The intent of training participants was for them to explore potential opportunities to
integrate parent-focused activities into their programming.

In FY 2011, a total of 91 participants from all Alaska regions participated in a We Can!
Program training, including representatives from 28 tribal-affiliated entities serving a primarily
Alaska Native (AN) population. Attendees included health care providers and staff, public
school staff, and administrators, coordinators and instructors of after-school programs, public
health program coordinators, academic researchers, health insurers, and nutrition educators.
Participants received hands-on training on We Can! curricula for parents and youth and heard
innovative ideas to help launch and strengthen the program. The NHLBI’s We Can! Program
staff will continue to provide technical assistance to programs that implement We Can!
programming into their communities and will work closely with the Alaska Native Tribal Health
Consortium and the Alaska Physical Therapy Assistant Health and Wellness Committee as they
plan to host a second regional training.

Technical Assistance Provided to Native American Communities in FY 2009 through FY
2012

The National Center for Research Resources’ (NCRR) IDeA program also supports the Center of
Biomedical Research Excellence (COBRE) Initiative. COBREs are thematic multidisciplinary
centers that augment and strengthen institutional biomedical research capacity. The COBRE
supported research program at the Pacific Center for Emerging Infectious Diseases Research at
the University of Hawaii Manoa targets Asian American and Pacific Islander populations.
Recent publications address rheumatic fever in American Samoa and the molecular
epidemiology of dengue in Hawaii. Another COBRE program, the Center for Alaska Native
Health Research (CANHR) at the University of Alaska Fairbanks employs a collaborative
research model working with Yup’ik Eskimo and other Alaska Native communities, tribal health
care organizations and individuals to frame research questions, develop methodologies and
procedures, and interpret and apply data to prevention and treatment of diabetes, cardiovascular
diseases, mood disorders and substance abuse.

The Research Centers in Minority Institutions (RCMI) program provides grant support to
predominately minority institutions that offer doctorates in health or the health-related sciences
develop the infrastructure for biomedical research. The RCMI program at the University of
Hawaii Manoa provides resources to conduct research on diseases that disproportionately impact
Native Hawaiian populations such as acute rheumatic fever and Kawasaki Disease. There are
currently studies that are assessing the role of specific bacteria, Group A streptococci (GAS), in
the high incidence of acute rheumatic fever (ARF) in Hawaii, especially among Samoans. The
objectives of the research are to identify GAS types responsible for ARF and to determine the
responses to these specific infections so that improved prevention strategies and treatments may
be developed. Kawasaki Disease (KD) is an acute illness of young children which is more common in Hawaii and Japan than any other location in the world. RCMI investigators are using genetic approaches to determine if increased susceptibility to the disease in Native Hawaiians is genetically based.

The RCMI program also supports a community-based observational study on the development of metabolic syndrome (MS) in overweight Native Hawaiian and Samoan children. The study goals are to: (1) determine the prevalence of metabolic syndrome in overweight Native Hawaiian and Samoan youth; (2) examine the pattern of physical and laboratory markers associated with metabolic syndrome in high-risk children; and (3) examine the relationship between maternal gestational diabetes, birth weight, and growth rate in the first three years of life with the development of MS. RCMI investigators have developed many prevention programs that focus on childhood obesity including the first eating disorders and obesity (EDO) prevention program implemented in Hawaii to address a spectrum of weight and body image issues in boys; a Healthy Body Image (HBI) curriculum designed to promote healthy lifestyles among 4-6th graders; and studies aimed at comparing perspectives about body size, food-related behavior, and exercise attitudes among Hawaiian teens.

As part of the The Native American Research Centers for Health (NARCH) program, sponsored by the IHS, the National Institute of General Medical Sciences (NIGMS) provides funds for research and student development. Applications are reviewed and awards are made and managed by IHS using funding from various Institutes. NIGMS provides some funding to 10 of the NARCH grantees, generally to the training or core functions of the NARCH. Categorical Institutes generally fund the research projects and promoting good will among the tribes. A number of tribal members have continued their education. One is now an assistant professor.

As a part of the Surveillance, Epidemiology and End Results (SEER) Program, the National Cancer Institute (NCI) provides funding and technical support to the New Mexico Tumor Registry (NMTR) for the reporting of cancer cases among all residents of New Mexico, including American Indians and Alaska Natives. Due to NMTR's experience and expertise in collecting data from Indian Health Service facilities, and because several of these facilities serve both New Mexico and Arizona residents, NMTR is providing technical assistance to the Arizona Cancer Registry by collecting AI/AN cases from IHS facilities in both states. This NCI-supported activity has enabled the Arizona registry to report more complete case counts for American Indians and Alaska Natives. NCI's Surveillance Research Program will continue to support the collections of data on Arizona Indians.

The Alaska Native Tumor Registry (ANTR) became a part of NCI’s Surveillance, Epidemiology and End Results (SEER) Program in 2001. The ANTR received technical assistance for a number of years until it met SEER's quality standards. The ANTR publishes cancer rates and analyses, which are distributed statewide to medical providers, tribal health board members, and key tribal personnel. The ANTR published “Cancer in Alaska Natives 1969–2003: 35-Year Report” in 2006. The ANTR has submitted its data to the SEER Program annually and the data have been used for several national reports, including the Annual Report to the Nation on the Status of Cancer, and a 2008 monograph, published by the journal Cancer, on cancer rates.
among American Indians and Alaska Natives. In 2009, NCI renewed its interagency agreement with ANTR (through the Indian Health Service) to continue collecting cancer data on Alaska Natives residing in Alaska.

Also, NCI's Surveillance Research Program is partnering with the Cherokee Nation of Oklahoma to fund a pilot cancer registry with the goal of building an infrastructure that conforms to SEER standards in case finding, patient follow-up, data processing, data reporting, and quality assurance. The target population includes all American Indians residing in the Cherokee Nation’s 14-county tribal jurisdictional service area that are eligible for health care through tribal or Indian Health Service (IHS) facilities. A memorandum of agreement between the Cherokee Nation Cancer Registry (CNCR) and the Oklahoma Central Cancer Registry has enabled the registries to collaborate and share needed data. Data from the Cherokee Nation Cancer Registry were used to obtain funding from CDC to establish the Cherokee Nation Comprehensive Cancer Control Program. Data from CNCR has been successfully submitted to NCI using the new SEER data management system. CNCR continues to expand its data collection capacity and reported its results at the annual meeting of SEER Principal Investigators in November 2009.

Through the Community Networks Program (CNP), the NCI funds a number of CBPR projects in Hawaii and the Pacific Islands, namely the ‘ImiHale – Native Hawaiian cancer Network; the American Samoa Community Cancer Network (ASCCN); and, the WINCART: Weaving an Islander Network for Cancer Awareness, Research and Training Program. The overall goal of the 'Imi Hale - Native Hawaiian Cancer Network is to reduce cancer incidence and mortality among Native Hawaiians by maintaining and expanding an infrastructure that: (1) promotes cancer awareness within Native Hawaiian communities; (2) provides education and training to increase cancer prevention and control research by Native Hawaiian researchers; and (3) facilitates the application of evidence-based information to the reduction of cancer health disparities through policy development and implementation and translation of data into cancer prevention and control practice.

The Network, housed at Papa Ola Lokahi1, will collaborate with key partners at the community, state, and national levels to provide support systems and expertise to: (1) provide a core organizational infrastructure; (2) increase utilization of proven interventions to reduce disparities; (3) increase the number of Native Hawaiians participating in community-based research to reduce cancer health disparities through recruitment, training, and mentorship; (4) promote research that focuses on the spectrum of issues relevant to cancer health disparities, with an emphasis on developing interventions that can be used in and by Native Hawaiian communities; and (5) provide evidence-based information on reducing cancer health disparities to decision and policy makers at the community, local, state, and Federal levels.

The American Samoa Community Cancer Network (ASCCN) aims to reduce cancer incidence and mortality in the U.S. Territory of American Samoa. The ASCCN will work toward this goal by: (1) promoting cancer awareness within American Samoan communities; and (2) initiating a cancer research and training program to develop indigenous Samoan researchers. ASCCN will provide support systems and expertise to increase the number of research grants addressing cancer in American Samoa and establish a culturally appropriate process to support scientifically
rigorous research that is respectful of American Samoan cultural beliefs, practices, and customs. This collaboration among three agencies—the Lyndon Baines Johnson Tropical Medical Center 1, American Samoa Community College, and American Samoa Department of Health—provides a forum to address the disproportionate cancer burden on American Samoans and their need for self-determination and control of their own health.

The goal of WINCART: Weaving an Islander Network for Cancer Awareness, Research and Training at California State University at Fullerton is to reduce preventable cancer incidence and mortality among five Pacific Islander communities (Chamorros), Marshallese, Native Hawaiians, Samoans, and Tongans) in Southern California. WINCART aims to: (1) identify multilevel barriers to cancer control among Pacific Islanders; (2) improve access to and utilization of existing cancer prevention and control services for these communities; (3) conduct community-based participatory research; (4) increase the number of Pacific Islander researchers through training, mentorship, and research projects; (5) sustain community-based education, training, and research activity via enhanced government and organizational collaborations; and (6) disseminate research to aid in the reduction of health disparities among Pacific Islander communities. Research activities will focus on obesity, tobacco, cancer screening, survivorship, and recruitment of Pacific Islanders into clinical trials. The Network will work with the Cancer Information Service to develop culturally and linguistically appropriate educational materials.

Infrastructure Building in the Pacific Rim and U.S. Territories.

In FY 2009, as in previous years, the NCI will continue to support data collection on Native Hawaiians and other Pacific Islander populations through the SEER Program. Such data will continue to inform researchers about cancer risks, incidence, prevalence and mortality among the various population groups.

In FY 2009, National Library of Medicine (NLM) provided support to the development of information technology services and training to the Chickasaw Nation. The mission of the Environmental Health Information Partnership is to enhance the capacity of minority-serving academic institutions to reduce health disparities through the access, use and delivery of environmental health information on their campuses and in their communities. The participating institutions receive training in the use of NLM's databases and electronic resources and participate in meetings where information about scientific issues, government and non-government programs, and funding opportunities is shared. The Chickasaw Health Information Center (CHIC) project and NLM worked with Computercraft, a science and technology company owned by a member of the Chickasaw Nation to implement a consumer health information center in the Carl Albert Indian Health Facility in Ada, OK. The Chickasaw health system provided space and access to physicians, nurses, and other health facility staff. Computercraft developed and hosts the website, and developed a mobile kiosk. NLM provides training for staff and providers and guidance about effective information provision practices. A new consumer information center exists in the health facility with a trained staff member to assist users. Participants in the program have implemented information access and use activities on their reservations or within their communities. One participant now heads a tribal company that has a contract with NLM for digitization services. Three tribal colleges participate in NLM's...
Environmental Health Information Partnership along with HBCUs and Hispanic Serving-Institutions. Recent meetings have focused on global health and US-Mexico Border health issues. In addition, modest funding is available annually to enable each participating institution to carry out outreach projects. This program has helped these institutions incorporate use of NLM resources in their curricula and in community outreach projects. The program continues supporting the institutions in expanding their use of quality information and information technology and expanding their research capacities.

The Arctic Health Web site (www.arctichealth.org) is a collaborative effort between the Alaska Medical Library at the University of Alaska, Anchorage (UAA), and the National Institutes of Health, NLM Outreach and Special Populations Branch. The goal of the Web site is to bring together, in one location, information on diverse aspects of the Arctic environment and the health of northern peoples. It gives access to evaluated health information from hundreds of local, state, national, and international agencies, as well as from professional societies, universities and Alaska Natives and indigenous communities. The portal contains several resources for both researchers and consumers.

The NIAMS participates in the planning and implementation of the annual Patty Iron Cloud Program for the National Youth Initiative for Biomedical Research (sponsored by the National Center on Minority Health and Health Disparities). As part of the program, American Indian and Alaska Native students receive special lectures and guided tours of NIAMS labs and research facilities, and are encouraged to apply for NIAMS training programs.

For over 10 years, the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) staff has provided significant and ongoing technical assistance to the Indian Health Service (IHS) for their Special Diabetes Program for Indians (SDPI; http://www.ihs.gov/MedicalPrograms/diabetes/index.cfm?module=programs), for which staff serve in an advisory capacity and as a resource for associated future programs. Staff represents NIDDK on the IHS-Tribal Leaders Diabetes Committee (TLDC), which provides leadership, guidance, and recommendations to IHS and other government agencies on issues related to diabetes and related chronic health conditions among American Indians and Alaska Natives, and provide the TLDC updates related to Institute activities affecting American Indian people. The TLDC continues to have great interest in the progress of the NIDDK’s Diabetes Prevention Program follow-up study (DPPOSS) and the participating American Indian sites, as well as pride in the role that the TLDC had in initiating the development of the Institute’s Diabetes Education in Tribal Schools (DETS) Program, which is considered to have major importance for American Indian children and tribal communities. This interaction has led to the TLDC being committed to work towards implementation and wide dissemination of the DETS Program.

The National Institute on Drug Abuse (NIDA) provided funding to support the American Indian Research Scholars Mentorship Program, a research development program sponsored by NIDA’s American Indian/Alaska Native Researchers and Scholars Work Group. The workgroup also developed a website which is hosted by the One Sky Center. In addition, NIDA formed an American Indian/Alaska Native Coordinating Committee consisting of internal NIDA staff, to expand coordinated efforts to address drug abuse in AI/AN communities while simultaneously
working with extramural scientists. By increasing available data, research infrastructure, research opportunities, and technical assistance, this committee aims to increase the pipeline of investigators and promote trust between the community and academic partners. In 2009, NIDA officials, including the NIDA director, met with the Aberdeen Area Tribal Chairman's Health Board in South Dakota to discuss the current state of substance abuse and other health concerns and also identify areas for intervention and research among Northern Plain Tribes. NIDA staff participated in the Northwest Portland Area Indian Health Board’s American Indian and Alaska Native Summer Research Training Institute and provided technical expertise and assistance to emerging investigators attending the 38th Annual Association of American Indian Physicians 38th Meeting and National Health Conference.

In 2009, Neurological Disorders and Stroke (NINDS) continued to support major research capacity building projects such as the basic neuroscience SNRPs at the University of Alaska, Fairbanks and at the University of Hawaii, Manoa, as well as programs supporting infrastructure development for health disparities research through the health disparities SNRP at the University of Hawaii, Honolulu, and the Alaska Native Stroke Registry.

The National Institute of Dental and Craniofacial Research (NIDCR)

- Provided a second year of support to the Center for Native Oral Health Research (CNOHR), University of Colorado Denver in FY 2009. The Center focuses on oral health concerns of American Indians and Alaska Natives (AI/ANs), with an initial focus on Early Childhood Caries (ECC) – a severe form of caries that is particularly prevalent in AI/AN children. The Center is testing two service delivery interventions to prevent ECC. The first is with Southwestern American Indian children and families who are enrolled in Head Start programs. Tribal community members are trained to apply fluoride varnish and deliver oral health education to the children at the Head Start Centers, and parents receive oral health education as well. In the second intervention, tribal community service providers provide culturally appropriate behavioral intervention sessions in the homes of caregivers of Northern Plains Indian infants.
- In FY 2009 and 2010, NIDCR supported two summer research interns with an interest in AI/AN oral health - one of whom is Native American, the other was the postdoctoral research of a Pacific Islander investigating craniofacial development.
- In FY 2009, NIDCR continued to support research at the University of Iowa that seeks to identify behavioral, environmental, growth and dietary risk factors for early childhood caries (ECC) among infants and toddlers within the Northern Plains Indian nation. Within the United States, the population groups with the highest levels of ECC are Native American Indians and Alaska Natives (AI/AN), and this research should allow the development of a more targeted strategy for preventing ECC in this high-risk population.

The Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD)

- The Academic/Community Partnership Conference initiative has expanded eligibility to include TCUs and Indian/Native American Tribally designated organizations. The grant aims to build bridges and strengthen capacity to address health disparities among racial/ethnic minority populations. TCUs are uniquely positioned to contribute toward
improving the health of American Indian communities through research. The community partnerships may focus on one or more of the following areas: infant mortality; SIDS; techniques for outreach and information dissemination; pediatric and maternal HIV/AIDS prevention; childhood, adolescent, and/or adult obesity; health literacy; uterine fibroid tumors; and violence prevention.

Sponsored the Healthy Native Babies across the United States (SD, AK, MT, MN, and OR). The project aims to educate Northern Tier American Indians and AI/AN communities about Sudden Infant Death Syndrome (SIDS). NICHD provided outreach through 14 training sessions in 2009. A workbook is being developed to provide a fact sheet about SIDS, training modules and techniques, social marketing strategies, and action steps for reducing SIDS.

The Intramural NIAID Research Opportunities (INRO) Program is an exploratory/outreach program aimed at recruiting research trainees from populations underrepresented in biomedical research. INRO marketing includes direct listserv communication and tailored e-mails to AIs/AN intermediaries, such as the American Indian Graduate Center and the National Indian Education Association, print ads, support and presence at key conferences, and ongoing relations with AI collegiate partners. Of the 192 applicants for INRO 2010, seven were from AI or AN populations. Of those, two attended INRO and subsequently signed on for a research traineeship at NIAID.

NIMHD coordinates the annual visit of AI/AN students to the NIH campus through the Patty Iron Cloud National Native American Youth Initiative. In addition, other Institutes such as NIAMS, NIA, and NIBIB participate in the program by providing staff support as mentors and presenters for this academic enrichment program. NNAYI is designed to prepare AI/NA high school students to continue their education and to pursue a career in the health professions and/or biomedical research. The students spend one week in Washington, D.C. and come to NIH for two days, touring NIH laboratories and attending lectures by NIH staff.

The Alaska Interest Group discussed efforts to improve collaboration and strategies to enhance current AN research activities, particularly those related to health disparities and research capacity building. This Trans-NIH group included representatives from NHLBI, NCRR, NICHD, and NCI. This resulted in a partnership between the Alaska Native Stroke Registry, funded by NINDS, and the NCRR-funded Center for Alaska Native Health Research, both of which involve extensive engagement among tribal communities and leaders.

The NIDA-OBSSR is Building Bridges: Advancing AI/AN Substance Abuse Research Workshop was held in October 2010. It targeted emerging AI/AN researchers and their tribal partners. The meeting showcased state-of-the-science AI/AN substance abuse research, identified future research needs, and provided both academic and tribal partners with training and technical assistance in NIH grant writing and partnership development.

The Tribal College Faculty and Tribal Health Professionals Development Project will increase the capacity in basic epidemiology research among tribal college or university faculty and tribal health professionals. The study will develop and conduct skill-building workshops to enhance research capacity. These skills will be applicable immediately to their current positions in the health field. This project, which began in FY 2010, is building capacity among tribal college
faculty and tribal health professionals working in health research and other health fields. The project also seeks to foster relationships between academic institutions and tribal communities.

The Research Initiative for Scientific Enhancement (RISE) supports faculty and student development activities, which can include on-campus or off-campus workshops, specialty courses, travel to scientific meetings, research experiences at on-campus or off-campus laboratories, and evaluation activities. RISE also offers some support for institutional development, which includes limited funds for the renovation or remodeling of existing facilities to provide space for an investigator to carry out developmental activities, purchase equipment, and develop research courses. Current RISE tribal support has been given to Haskell Indian Nations University and Salish Kootenai College.

NIDA provided support for an AI student to attend the Johns Hopkins Center for American Indian Health Winter Research Institute (January 2010). NIDA also provided support for five students to attend a drug abuse epidemiology course at the Northwest Portland Area Indian Health Board Summer Research Training Institute for American Indian/Alaskan Native (AI/AN) Health Professionals. Goals of this activity included promoting pipeline of investigators, increasing technical assistance, and increasing NIDA accessibility.

The NLM Workgroup Meeting for NLM Exhibition Program on Native American Concepts of Health and Illness was convened with representation from varied tribes on September 29-30, 2010, at NLM to obtain advice on the scope, content, and implementation of the planned NLM exhibition on “Native American Concepts of Health and Illness.” Participants included AIs, ANs, and Native Hawaiians drawn from tribal and Western medical, health, and cultural leaders. Participants discussed a variety of ideas, topics, and perspectives for possible use in the exhibition. Additional meetings may be scheduled for FY 2011.

The 22nd Annual Native Health Research Conference, sponsored by NCI, NIDA, NIDCR (July 27-30, 2010 – Rapid City, South Dakota) was themed “Translating Research into Policy and Practice in Native Health” and included as attendees researchers, health care providers, administrators, educators, Tribal Review Board members, indigenous students in training, policy-makers, and tribal leaders who conduct or are involved with health research in Native American (NA) communities. The purpose was to enhance the ability to advance biomedical, behavioral, and health services research for the benefit of Native communities, as well as to showcase recent health research projects and efforts undertaken in Indian Country.

NCI provided support for the conference and conducted a workshop at the conference on CBPR. NIDA provided financial support for workshops and supported student travel awards and supported two research symposia addressing substance use in Native communities during this conference (July, 2010). The program also included an overview of the NIDCR’s Health Disparities Research Program and funding opportunities with a presentation by a NARCH grantee. In addition, an oral health panel supported by the NIDCR was convened by the University of Colorado Denver’s Center for Native Oral Health Research that focused on varied aspects of the conduct of oral health research with AIs from the perspectives of a researcher,
dentist, dental student, community member, and institutional review board (IRB) chair – all of whom are Native American.

Through NIDA’s American Indian/Alaska Native Mentoring Program at the Blending Addiction Science and Practice Conference, Albuquerque, New Mexico, Fourteen individuals were selected to participate in the mentoring program that provided technical assistance for grant development, seeded relationships, and increased NIDA accessibility for AI/AN researchers/communities (April 22-23, 2010).

Through the NARCH, NIDA provided support for four new projects in 2010. These included “Equine-Assisted Substance Use Prevention,” “Development of a Pain Rehabilitation Program for AIs with Chronic Pain,” “CBPR Approach to Preventing Intentional Injury,” and “Improving Health Research Skills for Trainees.” NIDA continued to support eight ongoing NARCH programs including studies of CBPR, tribal college substance use, native mothers and substance use, the oral history of sobriety, factors related to methamphetamine abuse, physical activity and drug use, intentional injury, and a family listening intervention.

The goal of the Roadmap to Healthy Communities: Understanding Indian Health project, sponsored by NIMHD, is to develop, implement, and evaluate a series of four annual conferences that will contribute to capacity building within AI tribes and urban AI communities of New Mexico to address their common and specific health care needs. The primary objectives for the conferences are to bring together tribal leaders and other key tribal members for a series of leadership and educational sessions. The conferences are designed to build health policy capacity within the tribes, create partnerships between tribes and with the University of New Mexico, Robert Wood Johnson Foundation Center for Native American Health Policy, and address shared and unique tribal health and health care issues. The conferences will be divided into four key components: (1) Understanding needs; (2) Building capacity; (3) Understanding health policy; and (4) Navigating tribes into the future.

NIDA began a series of web-based training focused on AI/AN substance abuse research. The first in this series of webinars, Alternatives to Randomized Clinical Trials for American Indian and Alaska Native Populations, addressed the importance of employing experimental designs that are appropriate to community needs and to a new generation of preventive interventions. Webinar presenters also highlighted other research designs that can be employed to evaluate interventions with scientific rigor (March, 2011).

NIDA provided support for a well-attended symposium held during the Society for Prevention Research Conference. The symposium highlighted the state of substance abuse prevention research among AI/AN populations. A strategic planning workshop on best practices for networking among AI/AN substance abuse investigators and the broader prevention science community was also held at this meeting (June, 2011).

The NIDA American Indian and Alaska Native Scholars group convened a one-day workshop at the Association of American Indian Physicians (AAIP). The purpose of the meeting was to
address questions related to developing and implementing research projects related to substance abuse in Indian Country (August, 2011).

NINDS program staff members attend annual meetings for the Association of American Indian Physicians (AAIP) and the Society for Advancing Chicanos and Native Americans in Science (SACNAS) to provide information to students on education and training opportunities. NINDS-sponsored scientific sessions focus on the latest cutting-edge neuroscience, bringing exposure to Native students and access to role model neuroscientists.

The National Library of Medicine (NLM) Environmental Health Information Partnership (EnHIP) strengthens institutional capacity to reduce health disparities through the use of information technology and environmental health information. The program includes three Tribal Colleges [Oglala Lakota College (South Dakota), Diné College (Arizona), and Haskell Indian Nations University (Kansas)]; the University of Alaska, Anchorage, serving a large population of ANs; 14 Historically Black Colleges and Universities (HBCU); and three Hispanic-Serving Institutions. This program has helped TCUs incorporate NLM resources in their curricula and community outreach projects.

NLM develops culturally appropriate web sites that focus on information to address health disparities among native populations. The American Indian Health (AIH) Web Portal (http://americanindianhealth.nlm.nih.gov) is dedicated to issues affecting the health and well-being of all North American Indians, and includes current research information and traditional healing resources. The Arctic Health Web Site (www.arctichealth.org), in collaboration with the Alaska Medical Library at the University of Alaska, Anchorage, brings together reliable information on diverse aspects of the Arctic environment and the health of northern peoples. A Native American Health page on MedlinePlus.gov, the Library’s main consumer health website, (http://www.nlm.nih.gov/medlineplus/nativeamericanhealth.html) can facilitate access to information on specific health concerns that affect NAs.

NLM’s Chickasaw Health Information Center (CHIC) (http://chicresources.net) is a public-private project jointly supported by NLM, the Chickasaw Nation, and Computercraft, a Chickasaw-owned science and technology company. CHIC is a consumer health information center in the Carl Albert Indian Health Facility in Ada, OK. Computercraft developed and hosts the CHIC website and also developed a mobile kiosk. NLM trains staff and health care providers, and provides instruction and guidance about effective information provision practices.

NLM’s Native American Information Fellowship Program teaches representatives from AI/AN/NA/NH communities about NLM. It also improves access to health information and technology for their communities. Fellows have participated from the Mandan, Hidatsa, and Arikara Nations (Three Affiliated Tribes); Ft. Berthold Reservation, North Dakota; the Nez Perce Tribe, Lapwai, Idaho; the Navajo Nation from Tuba City, Arizona. There have also been urban AI fellows; and three Native Hawaiian fellows.

NLM’s Exhibition on “Native Voices: Native Peoples’ Concepts of Health and Illness” presents exhibitions on current and historical topics in medicine. A new exhibition examining concepts
of health and medicine among contemporary AIs/ANs and Native Hawaiians opened at NLM in October 2011 (http://www.nlm.nih.gov/nativevoices/). The Native Voices exhibition, which grew out of meetings with Native leaders in Alaska, Hawaii, and the contiguous U.S., honors the Native tradition of oral history and establishes a unique collection of information. The exhibition explores the interconnectedness of wellness, illness, and cultural life through interviews with Native people, artwork, cultural objects, interactive media, and a healing totem created for the exhibition.

The 23rd Annual Native Health Research Conference was held on June 27-30 in Niagara Falls, New York. Both NIAA and NIMH participated in this conference. Individuals who were involved with, and use, health research in NA tribal communities attended the conference. The conference enhanced the collective ability to advance biomedical, behavioral, and health services research for their benefit. The NIAAA presented an invited plenary talk entitled, “Building a Culturally-Supportive Framework for the Indigenous Research Community: Engaging Future Generations of Alcohol Researchers.” NIMH staff participated in a mentorship breakout session and general session. As a result of the conference, NIMH identified and selected the United South and Eastern Tribes, Inc. and the Salish Kootenai College as new participants for the Mentorship in Mental Health Program.

NHLBI –

The purpose of the Tribal College Faculty and Tribal Health Professionals Development Project is to increase the capacity in basic epidemiology research among TCU faculty and tribal health professionals. NHLBI’s primary objective is to develop and conduct skill-building workshops to enhance research capacity. These skills will be applicable immediately to their current positions in the health field. The aim of this project is to build capacity among the tribal college faculty and tribal health professionals working in health research and other health fields. The project helps to foster relationships between academic institutions and tribal communities by providing a forum for collaboration.

The overall goal of the Summer Research Training Institute for AI/AN Health Professionals is to develop a cadre of highly trained AI/AN biomedical and health researchers who are sensitive to the culture and specific concerns of AI communities, and who can bring the benefits of academic research to these communities to reduce health disparities. The NHLBI Institute offers up-to-date classes on a variety of relevant topics on career advancement in AI/AN health-related research.

Funding Opportunities Available to Native Americans in FY 2009 through FY 2012

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FY 2009–2012 Report to Congress
The Substance Abuse and Mental Health Services Administration (SAMHSA) is the federal public health agency charged with improving the quality and availability of substance abuse prevention, addiction treatment, and mental health services. SAMHSA’s mission is to reduce the impact of substance abuse and mental illness on America’s communities. SAMHSA envisions a nation that acts on the knowledge that:

- Behavioral health is essential to health;
- Prevention works;
- Treatment is effective; and
- People recover from mental and substance use disorders.

In order to achieve this mission, in SAMHSA’s strategic plan for fiscal years (FY) 2011-2014, SAMHSA identified eight Strategic Initiatives to focus the agency’s work on improving lives and capitalizing on emerging opportunities. SAMHSA’s first set of Strategic Initiatives include: Prevention of Substance Abuse and Mental Illness; Trauma and Justice; Military Families; Recovery Support; Health Reform; Health Information Technology; Data, Outcomes and Quality; and Public Awareness and Support.

Support Provided to Native American Communities in FY 2009 through FY 2012

Center for Mental Health Services (CMHS)
CMHS supports grants to tribes and tribal communities in the following grant programs:

- **Cooperative Agreements for Comprehensive Community Mental Health Services for Children and Their Families Program (CMHI) – Systems of Care:** This six year program supported states, political subdivisions within states, the District of Columbia, U.S. territories, and Native American tribes and tribal organizations in developing integrated home and community-based services and supports for children and youth with serious emotional disturbances and their families by encouraging the development and expansion of effective and enduring systems of care. A “system of care” is an organizational philosophy and framework that involves collaboration across agencies, families, and youth for the purpose of improving access and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children and youth with a serious emotional disturbance and their families. Tribal colleges and universities were instrumental in some tribal systems of care projects, conducting needs assessments, facilitating strategic planning, and developing and presenting culturally specific wraparound training curricula for providers and community members. Tribal colleges often utilized distance-learning technology to partner with other universities, to enable students to stay in
the community and pursue advanced degrees. Post-secondary student populations often faced emotional/behavioral barriers to course completion such as substance abuse, suicidal behaviors and competing family responsibilities. These students represent important sources of future providers to their own communities.

- **CMHI Circles of Care.** This three year program provided tribal and urban Indian communities with tools and resources to plan and design a holistic, community-based system of care to support mental health and wellness for their children, youth, and families. These grants increased the capacity and effectiveness of behavioral health systems serving AI/AN communities. As a result, Circles of Care grantees were equipped to reduce the gap between the need for behavioral health services and the availability and coordination of services for children and families in AI/AN communities. The Circles of Care grant program drew on the system of care philosophy and principles that are implemented in the CMHI Systems of Care Program.

- **Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention.** This program built on the foundation of prior suicide prevention efforts in order to support states and tribes in developing and implementing statewide or tribal youth suicide prevention and early intervention strategies, grounded in public/private collaboration. Such efforts involved public/private collaboration among youth-serving institutions and agencies and included schools, educational institutions, juvenile justice systems, foster care systems, substance abuse and mental health programs, and other child and youth supporting organizations.

- **Garrett Lee Smith Campus Suicide Prevention Grant Program.** This program provided funding to institutions of higher education, including tribal colleges, to prevent suicide and promote mental health on college campuses through education, training, social marketing, partnerships and linkages to hotlines and other services. The goal of this grant was to assist colleges and universities, including tribal colleges and universities, in efforts to prevent suicide attempts and completions and to enhance services for students with behavioral health problems, such as depression and substance abuse, which put them at risk for suicide and suicide attempts.

- **Protection and Advocacy Program.** CMHS funded and oversaw the Protection and Advocacy for Individuals with Mental Illness Program (PAIMI) that advocates for individuals with mental illnesses. Protection and advocacy services included general information and referrals; investigation of alleged abuse, neglect, and rights violations in facilities; and use of legal, legislative, systemic, and other remedies to correct verified incidents. Anyone with a mental illness who resided or was discharged from a facility, such as a hospital, group home, homeless shelter, residential treatment center, jail, or prison, were eligible to receive these services through the PAIMI program.

- **Project Linking Actions for Unmet Needs in Children’s Health (LAUNCH).** Project LAUNCH was a cooperative grant program that sought to ensure that all young children,
especially those at increased risk for developing social, emotional, and behavioral problems, received the supports they needed to succeed. This investment in the healthy physical, social, emotional, cognitive, and behavioral development of young children formed the foundation for later success in school and life and serves to protect against negative outcomes such as school dropout, drug and alcohol abuse, delinquency, and a host of other physical, social, and emotional problems. Project LAUNCH worked in states and tribes to improve coordination and build infrastructure to promote the wellness of young children, and implemented best practices in early childhood mental health promotion. Project LAUNCH awarded six of its 35 grants to tribes and has AI/AN technical assistance (TA) and evaluation staff who provided culturally sensitive and appropriate TA.

Center for Substance Abuse Prevention (CSAP)

- **Prevention of Methamphetamine Abuse Program.** Methamphetamine continues to adversely affect families and communities and places a burden on the economy. To help address this problem, CSAP awarded two tribal grants to expand prevention efforts that addressed the problem of methamphetamine abuse and addiction in local communities: the Native American Health Center in the Oklahoma State Department of Health and the new Champions Project for the Cherokee National Behavioral Health Services. These programs planned educational activities related to the prevention of methamphetamine abuse and addiction and assisted local government entities in conducting outreach activities in rural and urban areas for youth. The goal of the methamphetamine effort is to prevent, reduce and/or delay methamphetamine abuse around the United States. In FY 2009, CSAP provided an administrative supplement to these tribal grantees to finalize the goals and close out their grants.

- **Strategic Prevention Framework-State Incentive Grant (SPF-SIG) Program.** The SPF-SIG grants provided funding to implement SAMHSA's Strategic Prevention Framework in order to prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking; to reduce substance abuse-related problems in communities; and, to build prevention capacity and infrastructure at the state/tribal and community levels. Through the SPF-SIG program, grantees provided the requisite leadership, technical support, and monitoring to ensure that communities were successful in implementing the five steps of the SPF. These steps are required program components, and all states/tribes/territories and communities were encouraged to build on existing infrastructure/activity, where appropriate. Grantees were expected to use the SPF framework to guide all prevention activity throughout the state/tribe/territory, and coordinate and/or leverage all prevention services, whether funded through the SPF-SIG or through other sources. During FY 2009, funding was provided to 12 tribes and tribal organizations under this program.

- **Twenty percent Prevention Set-aside of the Substance Abuse Prevention and Treatment Block Grant (SAPT BG).** The program provided funds to plan, carry out, and evaluate activities to prevent and treat substance abuse. The SAPT BG Program, legislated by Congress in 1981, was administered by CSAP and the Center for Substance Abuse Treatment (CSAT) and represented the largest source of federal funding to states for the prevention and treatment of
substance use disorders. It constituted a substantial amount of all states’ budgets for substance abuse programming. States had flexibility in determining how funds should be allocated to address local needs; however, to receive funding, states had to meet specific set-aside and maintenance of effort (MOE) requirements and conduct activities designed to achieve the 17 legislative goals of the program.

CSAT

CSAT continued to enhance treatment effectiveness for AI/AN clients in substance abuse programs by increasing the number of AI/AN communities that implemented evidence-based practices. These objectives entailed integrating and implementing a variety of substance abuse related activities through partnerships and outreach to AI/AN entities. For example, in FY 2009, CSAT awarded a total of $32 million in discretionary funding to 43 grantees providing treatment or treatment-related services to AI/AN populations. Major funded programs included: Access to Recovery (five grantees, $15,400,776); Screening, Brief Intervention and, Referral to Treatment (one grantee – Tanana Chief Conference, $2,126,220); Targeted Capacity Expansion (TCE) for AI/AN populations (15 grantees, $4,558,684); Addiction Treatment for the Homeless (three grantees, $1,199,311); TCE-HIV/AIDS (five grantees, $2,244,500); and, five Congressional Earmarks ($984,000). The balance of $2,810,486 from the SAPT BG went to two states (Alaska and Hawaii), one Indian tribe (Red Lake Band of Chippewa), and six U.S. territories. CSAT has several key discretionary substance abuse treatment programs that award grants to AI/AN communities. They are as follows:

- **Access to Recovery (ATR)**. ATR provides grants to states, tribes, and tribal organizations to carry out voucher programs that expand substance abuse treatment capacity and promote choice among clinical treatment and recovery support providers in order to facilitate client recovery from substance abuse. The objectives of the program are to expand treatment capacity by increasing the number and types of providers (including faith-based and grass-roots providers), to allow clients to play a more significant role in the development of their treatment plans, and to use vouchers to link clinical treatment with critical recovery support services such as child care, transportation, and mentoring.

- **Screening, Brief Intervention, and Referral to Treatment (SBIRT)**. This program integrates screening, brief intervention, and referral to treatment services within general medical and primary care settings. Research and clinical experience supports the use of the SBIRT approach to provide effective early identification of substance use or abuse, and initiating interventions within the primary care or general medical settings. Early identification can decrease total healthcare costs by arresting progression toward substance addiction. SBIRT also can identify persons with more serious problems and refer them to appropriate specialty substance abuse treatment services.

- **Addiction Treatment for the Homeless Program**. This program enables communities to expand and strengthen their substance abuse treatment services for homeless individuals with substance abuse disorders, or with co-occurring substance abuse disorders and mental illness. Program funds provide for expansion and strengthening substance abuse treatment services
for persons who are alcohol-dependent, have histories of public inebriation, engage in frequent emergency room visits, are frequently arrested, and who are homeless (including the chronically homeless).

- **Criminal Justice programs**, including the following: *Treatment Drug Courts*, which are designed to combine the sanctioning power of courts with effective treatment services to break the cycle of criminal behavior, child abuse/neglect, alcohol and/or drug use, and incarceration or other penalties; *Ex-offender Re-entry Initiatives*, which are designed to facilitate reintegration into the community by providing pre-release screening, assessment and transition planning in institutional corrections settings and linking clients to community-based treatment and recovery services upon release; and the *Adult Criminal Justice Treatment Program*, which targets individuals that are under some form of judicial or community justice supervision and who are substance-involved.

- **TCE Programs**. These programs provide grants to expand or enhance a community’s ability to provide rapid, strategic, comprehensive, integrated, community-based responses to a specific, well-documented substance abuse capacity problem. TCE projects also focus on urgent, unmet, and emerging treatment needs, while addressing cultural relevance in treatment and recovery services.

- **SAPT BG**. This program distributes federal funds to states, territories, the District of Columbia, and the Red Lake Band of the Chippewa Indian Tribe (Minnesota) to plan, carry out, and evaluate substance abuse prevention activities and treatment services provided to individuals, families, and communities impacted by substance abuse and substance use disorders. Factors used to calculate the allotments include total personal income, population data, total taxable resources, and a cost of services index factor.

- Additional grant programs supported with CSAP funding include: Pregnant and Post-partum Women, Family Centered Adolescent Treatment, and TCE -HIV/AIDS.

**Technical Assistance (TA) Provided to Native American Communities in FY 2009 through FY 2012**

**Center for Mental Health Services (CMHS)**

In FY 2012, CMHS exercised an optional task in a contract with Kauffman and Associates, Inc. (KAI), an Indian owned small business, to expand TA to other SAMHSA grant programs. KAI provides grantees with individual TA through phone calls, e-mails, and site visits. KAI also is contracted to coordinate grantees meetings, webinars, group conference calls and peer-to-peer TA opportunities. KAI was also tasked with developing a web site to house various materials to assist grantees funded under the CMHI Systems of Care and Circles of Care programs.

**Center for Substance Abuse Prevention (CSAP)**
The Native American Center for Excellence (NACE) provided technical assistance to 676 participants and focused on the individual needs of SPF-SIG grantees and eight additional Service to Science (STS) Academy participants. The STS Academy was conducted on February 24 to February 26, 2009. Eight programs completed the STS Academy. In addition, NACE provided:

- Eight Webinars, training over 145 participants.
- Four full-day trainings for SAMHSA Project Officers and other invited federal agency representatives, with a total of over 104 participants.
- One three-day onsite training to 15 State of Oregon Prevention Specialists preparing them to take the ICandRC Test resulting in a successful pass rate of 75 percent.
- One four-day Youth Gathering of Native Americans (GONA) training over 109 youth and community members.
- Seven trainings at national conferences, training over 291 participants.

TA is included in grantees’ annual funding amount. Each year, grantees attend a mandatory training to learn about the nuances in providing best practices in substance abuse prevention services for AI/AN communities.

Center for Substance Abuse Treatment (CSAT)

CSAT continued to enhance treatment effectiveness for AI/AN clients in substance abuse programs by increasing the number of AI/AN communities that implemented evidence-based practices. These objectives entailed integrating and implementing a variety of substance abuse related activities through partnerships and outreach to AI/AN entities.

- Native Aspirations is a contract service to provide TA to selected AI/AN communities at the highest risk for youth violence, bullying and suicide. The assistance consists of a planning framework using the tribal community’s culture with small grants awarded to assist in the development of evidence-based interventions.

- Native American Center for Excellence (NACE) is a TA contract primarily for SPF-SIG grantees and Service to Science Academy participants as well as general TA on AI/AN substance abuse prevention programs, practices, policies.

- The Fetal Alcohol Spectrum Disorders – Center for Excellence has an AI/AN awareness, prevention and treatment TA component.

- The Center for the Application of Prevention Technologies provides TA to Strategic Prevention Framework Tribal Incentive grantees specifically in relation to the use of epidemiological data in prevention planning.

- The Disaster Training and Technical Assistance Center provides assistance to plan and respond to mental health and substance abuse needs related to disaster events.
• Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) provides specific grant and training opportunities for tribes. Along with the states, federally recognized tribes are invited to submit applications for a policy academy and subsequent subcontract award. Focus is on policy, workforce development, financing, and other infrastructure changes that can help the state or tribe adopt and implement recovery supports and services.

Funding Opportunities Available to Native Americans in FY 2009 through FY 2012

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<tr>
<th>Programs</th>
<th>FY 2009 Dollars</th>
<th>FY 2010 Dollars</th>
<th>FY 2011 Dollars</th>
<th>FY 2012 Dollars</th>
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Other Funding Opportunities in FY 2009

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## LIST OF ACRONYMS

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<th>Acronym</th>
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<td>Association of American Indian Physicians</td>
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<td>AAMC</td>
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FY 2009–2012 Report to Congress
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<tr>
<td>NDRN</td>
<td>National Disability Rights Network</td>
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<td>NDWP</td>
<td>Native Diabetes Wellness Program</td>
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<tr>
<td>NEW</td>
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<td>NH</td>
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<td>NH/PI</td>
<td>Native Hawaiian and Pacific Islander</td>
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<tr>
<td>NHANES</td>
<td>National Health and Nutrition Examination Survey</td>
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<td>NHHSP</td>
<td>National Hawaiian Health Scholarship Program</td>
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<tr>
<td>NHLBI</td>
<td>National Heart, Lung, and Blood Institute</td>
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<td>NIA</td>
<td>National Institute on Aging</td>
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<td>NIAID</td>
<td>National Institute of Allergy and Infectious Diseases</td>
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<tr>
<td>NICCA</td>
<td>National Indian Child Care Association</td>
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<td>NICHD</td>
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<td>NIDA</td>
<td>National Institute on Drug Abuse</td>
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<td>NIDCR</td>
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<td>NIDDK</td>
<td>National Institute of Diabetes and Digestive and Kidney Diseases</td>
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<tr>
<td>NIEJI</td>
<td>National Indigenous Elder Justice Initiative</td>
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<tr>
<td>NIGMS</td>
<td>National Institute of General Medical Sciences</td>
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<tr>
<td>NIH</td>
<td>National Institutes of Health</td>
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<td>NINDS</td>
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<td>National Institute for Occupational Safety and Health</td>
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<td>NIYLP</td>
<td>National Indian Youth Leadership Project</td>
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<td>NLM</td>
<td>National Library of Medicine</td>
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<td>Navajo Nation</td>
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<td>NNAAPC</td>
<td>National Native American AIDS Prevention Center</td>
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<td>NNHAAD</td>
<td>National Native HIV/AIDS Awareness Day</td>
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<td>NPCR</td>
<td>National Program of Cancer Registries</td>
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<td>NPHPSP</td>
<td>National Public Health Performance Standards Program</td>
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<td>NPTEC</td>
<td>Northern Plains Tribal Epidemiology Center</td>
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<td>NRC4Tribes</td>
<td>National Resource Center for Tribes</td>
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<td>NSIP</td>
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<td>NTTPN</td>
<td>National Tribal Tobacco Prevention Network</td>
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</table>
PGO  Program and Grants Office
PHEx  Public Health Emergency Preparedness
PI  Pacific Islanders
PIC-NNAYI  Patty Iron Cloud National Native American Youth Initiative
PIHOA  Pacific Islands Health Officers Association
PIPCA  Pacific Island Primary Care Association
PLLN  Peer Learning and Leadership Network
PPD  Project Planning and Development
PPHF  Prevention and Public Health Fund
PRAMS  Pregnancy Risk Assessment Monitoring System
PREP  Personal Responsibility Education Program
PRO  Pacific Region Office
QUICWA  Quality Indian Child Welfare Act
RCD  Rural Community Development
RCMI  Research Centers in Minority Institutions
RCPB  Regional Collaborative for the Pacific Basin
REACH  Residential Energy Assistance Challenge Program
REACH US  Racial and Ethnic Approaches to Community Health
RH/MCH  Reproductive Health/Maternal Child Health
RHY  Runaway and Homeless Youth
RHYTTAC  Runaway and Homeless Youth Training and Technical Assistance Center
SAIGE  Society of American Indian Government Employees Training Conference
SAMHSA  Substance Abuse and Mental Health Services Administration
SAOs  State Affiliate Organizations
SCF  Strengthening Communities Fund
SDPI  Special Diabetes Program for Indians
SEARHC  Southeast Alaska Regional Health Consortium
SEER  Surveillance, Epidemiology, and End Results
SHI  School Health Index
SIDS  Sudden Infant Death Syndrome
SNAHC  Sacramento Native American Health Center
SNRP  Specialized Neuroscience Research Program
SSDI  State Systems Development Initiative
SSRHY  Support Systems for Runaway and Homeless Youth
STD  Sexually transmitted disease
Steps  Steps to a Healthier US
STIs  sexually transmitted infections
SUID  Sudden, Unexplained Infant Deaths
SUIDI  Sudden, Unexplained Infant Death Investigation
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>SWR</td>
<td>Southwest Region</td>
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<tr>
<td>T/TA</td>
<td>training and technical assistance</td>
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<td>TANF</td>
<td>Temporary Assistance for Needy Families Programs</td>
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<td>Training and Advocacy Support Center</td>
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<tr>
<td>TBI</td>
<td>Traumatic Brain Injury</td>
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<tr>
<td>TCAC</td>
<td>Tribal Consultation Advisory Committee</td>
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<td>TCP</td>
<td>Tribal Consultation Policy</td>
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<td>TEC</td>
<td>Tribal Epidemiology Centers</td>
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<td>TECC</td>
<td>Tribal EpiCenter Consortium</td>
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<td>TELI</td>
<td>Tribal Early Learning Initiative</td>
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<td>TIHA</td>
<td>Tribal Initiatives on HIV/AIDS</td>
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<td>TIMS</td>
<td>Technical Information Management Section</td>
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<td>TLC</td>
<td>Tribal Leaders Council</td>
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<td>TLDC</td>
<td>Tribal Leaders Diabetes Committee</td>
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<td>TMG</td>
<td>Tribal Management Grant</td>
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<td>TPP</td>
<td>Teen Pregnancy Prevention Program</td>
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<td>Tribal Maternal, Infant, and Early Childhood Home Visiting Grant Program</td>
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<td>Tewa Women United</td>
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<td>UCEEDD</td>
<td>University Centers for Excellence in Developmental Disabilities</td>
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<td>urban Indian health organizations</td>
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<td>UMKC</td>
<td>University of Missouri at Kansas City</td>
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<td>Universal Newborn Hearing Screening</td>
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<td>USET</td>
<td>United South and Eastern Tribes, Inc.</td>
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<td>U.S. Interagency Council on Homelessness</td>
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<td>UTTC</td>
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<td>Veterans Administration’s Pacific Island Health Care System</td>
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<td>VFC</td>
<td>Vaccines for Children</td>
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<td>WE INDIANS</td>
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<td>Women, Infants, and Children Program</td>
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<td>WINCART</td>
<td>Weaving an Islander Network for Cancer Awareness, Research and Training</td>
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<td>WISEWOMAN</td>
<td>Well-Integrated Screening/Evaluation for Women across the Nation</td>
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<td>WRIR</td>
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<td>WSGSC</td>
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<td>YEP</td>
<td>Youth Empowerment Program</td>
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<td>YKDRH</td>
<td>Yukon Kuskokwim Delta Regional Hospital</td>
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<td>Abbreviation</td>
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<td>YKHC</td>
<td>Yukon-Kuskokwim Health Corporation</td>
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<td>Youth Risk Behavior Survey</td>
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<td>YST</td>
<td>Yankton Sioux Tribe</td>
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