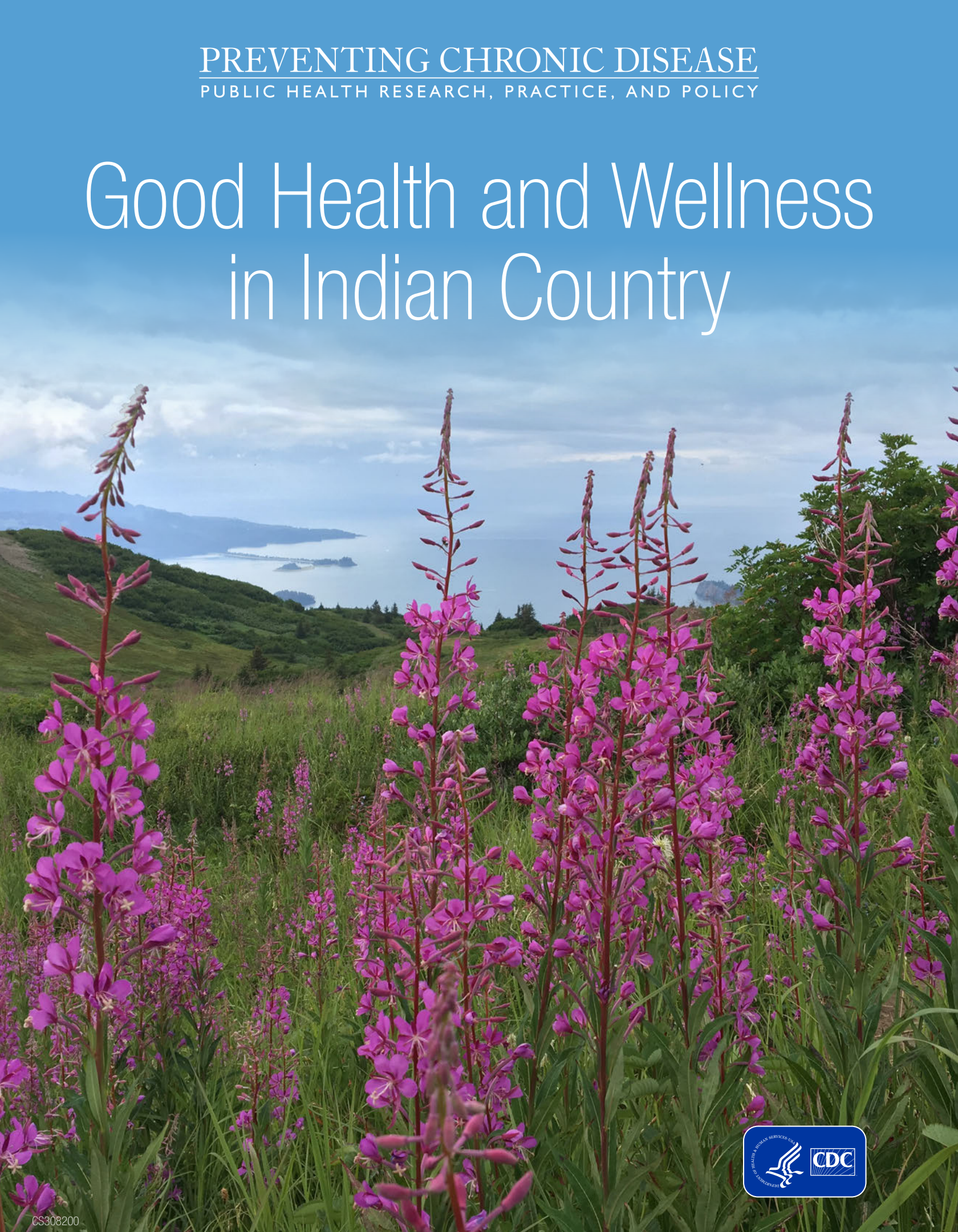
PREVENTING CHRONIC DISEASE
PUBLIC HEALTH RESEARCH, PRACTICE, AND POLICY

Good Health and Wellness in Indian Country



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Preventing Chronic Disease (PCD) is a peer-reviewed public health journal sponsored by the Centers for Disease Control and Prevention and authored by experts worldwide. PCD was established in 2004 by the National Center for Chronic Disease Prevention and Health Promotion with a mission to promote dialogue among researchers, practitioners, and policy makers worldwide on the integration and application of research findings and practical experience to improve population health.

PCD's vision is to serve as an influential journal in the dissemination of proven and promising public health findings, innovations, and practices with editorial content respected for its integrity and relevance to chronic disease prevention.

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GUEST EDITORIAL

Good Health and Wellness in Indian Country: A New Partnership and Approach

Ursula E. Bauer, PhD, MPH[1]; David K. Espey, MD[2]

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The health and wellness of American Indians and Alaska Natives has steadily improved since the dark days of the mid-twentieth century, when population levels reached an all-time low and termination of sovereign status threatened tribal existence (1). During the past 50 years, the federal government's extension of basic rights, such as the free exercise of religion, and activism, court victories, and deployment of tools for economic development by American Indians and Alaska Natives have ushered in a period of growth and resurgence. As sovereign peoples, however, American Indians and Alaska Natives have not escaped broader societal trends in health and disease, such as the epidemics of alcohol and tobacco use, the obesity epidemic that emerged in the late 1980s and 1990s and was followed by increases in rates of type 2 diabetes, and the challenges of opioid and other substance misuse that have plagued the country in the 20th and 21st centuries.

The Centers for Disease Control and Prevention's (CDC's) Good Health and Wellness in Indian Country (GHWIC) seeks to build on a new sense of possibility in Indian Country. This new sense of possibility is producing Native-owned businesses, developing and marketing Native cuisine, supplying traditional Native foods to government food distribution programs, expanding the number of Native language speakers through immersion programs, and, in so many other ways, lifting up vibrant, persistent, and resilient cultures. As Andrade et al describe in this collection of articles on Indian wellness in *Preventing Chronic Disease*, the GHWIC program strives to incorporate "tribal wisdom to protect and promote physical, mental, and spiritual wellbeing; . . . [to] work upstream addressing drivers of poor health through culturally appropriate practices; and [to solve] the problem of funding only a small number of tribes to do disease-specific work in favor of a holistic approach that reaches deeply and widely into Indian Country" (2). Over time and with additional investment by Congress, the initial GHWIC cooperative agreement grew into a portfolio of programs that addresses public health gaps, unleashes the power of traditional practices, and deploys a holistic approach to chronic disease prevention.

As anyone who seeks to build something permanent, useful, and relevant knows, the first step is to build community. This holds for public health programs as much as for community centers, neighborhood health clinics, and grocery stores in a food desert. If the community is not together, if it is not functioning cohesively, if it does not possess a shared vision and sense of possibility, whatever structure or program is being built will struggle in its purpose to provide possibility, bring the community together, and address a community need (3). Thus, a first step for GHWIC was to bring the GHWIC grantees together and undertake the hard work of community building. As described by Williams et al, GHWIC embarked on this process by establishing a community of practice and enlisting the support of the University of New Mexico Extension for Community Health Outcomes (ECHO) platform and approach. "ECHO combines evidence-based education, workforce development, and collaborative problem solving to increase practitioners' capacity in specialty areas. The model uses videoconferencing and subject matter expertise to facilitate case-based learning among practitioners and to share best practices" (4). Although the ECHO model was originally established to support health care delivery, GHWIC adapted it to support a community of practice that democratizes access to and disseminates peer solutions in service of chronic disease prevention and health promotion in Indian Country.

With community building underway, progress could be made toward two essential goals of GHWIC: to reach *deeply* into Indian Country and to reach *widely* into Indian Country. As described by Andrade et al, the GHWIC program sought to address critical weaknesses in previous CDC work in Indian Country: the problem of so many federally recognized tribes and insufficient human and financial resources to support them all (2). One of the many innovations of GHWIC is funding individual tribal nations directly and funding tribal organizations with area-wide reach to

serve and support most or all of the tribes or villages in their service areas. Two articles in this collection showcase this approach. Alonso et al describe the rich array of interventions implemented by the Winnebago Tribe of Nebraska, driven by a community assessment and with the engaged support of tribal government and tribal members to institutionalize supports for healthy behaviors (5). With direct funding, the grantee made extraordinary progress on a diverse range of health improvement strategies. Redwood et al describe an ambitious approach to serving Alaska Natives that reaches across a large area and many villages. Using existing networks, the Alaska Native Tribal Health Consortium provides knowledge, tools, and resources to network members who implement policies, systems, and environmental improvements across the state that, to date, have supported the health and wellness of 46,000 Alaska Natives (6). These grantees are just two examples of how the GHWIC program reaches deeply and widely, through a dual funding model, into Indian Country.

No CDC program is complete without robust evaluation. For GHWIC, evaluation is being conducted at 3 levels: the individual grantee, the area, and across Indian Country. Each grantee is responsible for demonstrating the impact of its work by collecting performance measures on access to healthy and traditional foods and their preparation; practices and policies to increase physical activity; and development, implementation, or enhancement of commercial tobacco-free policies. Grantees also developed success stories that qualitatively and visually highlight their activities or programs. Tribal Epidemiology Centers (TECs) in each administrative area of the Indian Health Service support area-wide evaluations. These evaluations demonstrate progress toward health improvements and include regional briefs and policy briefs that summarize changes that have occurred across the area as a result of GHWIC funding and support. The Urban Indian Health Institute conducts the program-wide or nations-wide evaluation, demonstrating the impact of the cooperative agreement on progress toward health outcomes in Indian Country as a whole. As Lawrence and James explain, the evaluation framework draws on indigenous approaches and recognizes the importance of culture to American Indian and Alaska Native health, of local context and community knowledge in documenting program progress, and of locally tailored metrics to ensure adherence to tribal protocols and cultural priorities (7). With the first 5 years of the GHWIC program set to close in September 2019, Lawrence and James present evaluation findings from the first 3 years of the program and share important examples of the increase in opportunities for healthy behaviors, drawn from traditional tribal practices, that GHWIC supported among grantees and across Indian Country. For example, as a result of GHWIC efforts during 2014–2017, approximately 15,000 American Indians and Alaska Natives in 16 tribal or village settings benefited from low-sodium nutrition guidelines and 77 new tribal settings promoted healthier food (7). Similarly, during the same period, more than 14,500 American Indians and Alaska Natives increased access to physical activity through GHWIC and 91 new policies that promote physical activity (7). Further evaluation is being conducted by other CDC programs. Although the GHWIC program is still underway as these articles go to press, they document early outcomes and the promise of future strong results for the GHWIC approach.

When the inaugural GHWIC program was launched in 2014, tribal health leaders serving on CDC's Tribal Advisory Committee asked the agency to learn about tribal practices used by Indian people to keep their communities healthy and well. A second article by Andrade et al describes the process by which CDC embarked on this assignment and the exciting Tribal Practices for Wellness in Indian Country program, launched in 2018, that resulted from listening, learning, engaging, and understanding (8). Thanks to years of collaboration with the Tribal Advisory Committee and tribes, CDC was ready to deploy new Congressional funding to support the Tribal Practices grant program. Between the launch of the GHWIC program in 2014 and the Tribal Practices program in 2018, CDC was able, again with generous support from Congress, to robustly support TECs to build their public health authorities and increase their capacity to serve the public health needs of tribes in their service areas. Although TECs have been well-integrated into the work of GHWIC from the initial planning of the program, funding had lagged and TECs were stretched until additional resources became available in 2017 to support their critical work.

With the addition of the Tribal Epidemiology Centers Public Health Infrastructure program and Tribal Practices for Wellness in Indian Country program to the initial GHWIC program, the Good Health and Wellness in Indian Country portfolio now supports individual tribes, tribal organizations, urban Indian centers, and TECs to prevent chronic disease and promote health in ways that reflect indigenous culture and heritage, build on American Indian and Alaska Native strengths and resiliency, and implement what tribes and villages know will keep their people healthy and well. The collection of articles in *Preventing Chronic Disease* chronicles the GHWIC journey, from conception to behavioral outcomes, as new programs launch and the first 5 years of the GHWIC program come to a close. Together, the programs provide a model for public health practice across the country and around the world that seeks to be relevant to the people being served, to uplift culture and respect local knowledge, and to institutionalize sustainable health improvements.

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The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

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PUBLIC HEALTH PRACTICE BRIEF

A Holistic Approach to Chronic Disease Prevention: Good Health and Wellness in Indian Country

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Summary

What is already known on this topic?

Federal agencies typically fund and support only a small number of federally recognized tribes to address chronic diseases and require grantees to focus on evidence-based approaches, without flexibility for cultural adaptation and approaches aligned with tribal practices.

What is added by this report?

We implemented an innovative, holistic approach to supporting scores of tribes to apply effective strategies by building on tribal practices that keep people well and adapting Western chronic disease prevention programs.

What are the implications for public health practice?

This program offers a model that other agencies could adapt to support tribes and tribal organizations to build on their cultural strengths and more effectively prevent disease and promote health.

Abstract

The National Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control and Prevention funds the agency's largest investment in Indian Country, Good Health and Wellness in Indian Country. This 5-year program, launched in 2014, supports American Indian and Alaska Native communities and tribal organizations to address chronic diseases and risk factors simultaneously and in coordination. This article describes the development, funding, and implementation of the program. Dialogue with tribal members and leaders helped shape the program, and unlike previous programs that funded a small number of tribes to work on specific diseases, this program funds multiple tribal entities to reach widely into Indian Country. Implementation included culturally developed and adapted practices and opportunities for peer sharing and problem solving. This program identified approaches useful for the Centers for Disease Control and Prevention, other federal agencies, or other organizations working with American Indians and Alaska Natives.

Background

American Indian and Alaska Native communities have strengths retained and adapted from their culture over thousands of years. They also share a history of adversity from centuries of European colonization (1). This adversity is among the reasons why good health and wellness have eluded many American Indians and Alaska Natives. Despite 20th-century improvements in water, sanitation, control of infectious diseases, and improved nutrition in American Indian and Alaska Native communities, new challenges to health have emerged, reflecting both the legacy of colonization and prevailing trends in the wider society, including changes in diet and physical activity patterns and use of commercial tobacco and alcohol. Obesity is common in many American Indian and Alaska Native communities (2). Obesity has contributed to the epidemic of type 2 diabetes (3), with widespread consequences for individuals and families living in these communities. Commercial tobacco use is prevalent, particularly among Great Plains tribes and Alaska Native villages (4), leading to high rates of cancer (5), heart disease (6) and stroke (7). American Indians and Alaska Natives have the highest rate of chronic liver disease linked to alcohol misuse and viral hepatitis (8), as well as high rates of substance abuse (9), unemployment (10), despondency (11), domestic violence (12), mental illness (13) and suicide (14). To build healthier native communities, in light of these many health challenges, tribal elders and health leaders have sought to draw on strong connections to culture, heritage, and community and pair them with funding and support for culturally appropriate programs from federal agencies. (15). The Substance Abuse and Mental Health Services Administration's National Tribal Behavioral Health Agenda is a case in point, created with extensive input from tribal leaders and in collaboration with governmental and nongovernmental organizations. This approach uses tribal cultural practices, efforts to connect American Indians and Alaska Natives to culture and heritage, and Western evidence-based practices to

improve health and wellness in partnership with native communities (11).

Similar to other federal agencies, the Centers for Disease Control and Prevention (CDC) provides funding for health promotion and disease prevention programs through competitive grants and cooperative agreements to states and to smaller jurisdictions, such as cities and counties, and to federally recognized tribes. However, federal agencies are challenged to provide funding and support to a large proportion of tribes because of the sheer number of federally recognized tribes — currently 573 — eligible for such assistance. The result is that many funding opportunities for which tribes are eligible usually are awarded to only a small proportion of tribes. In addition, these funding opportunities typically have not permitted adaptation of supported approaches to the unique and diverse cultures and traditions in Indian Country. This lack of permitted adaptation has limited tribal interest in applying for funding and in the utility and effectiveness of the funding when awarded. In this article, we describe CDC's Good Health and Wellness in Indian Country (GHWIC) program, which offers a holistic, coordinated approach to chronic disease prevention and health promotion, including culturally adapted approaches for American Indian and Alaska Native communities (16,17), and supports a larger number of tribes (more than 100) than has typically been supported (fewer than 10).

History of NCCDPHP's Tribal Portfolio and Evolution of GHWIC

CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) has invested in public health programs in Indian Country since the early years of the center's creation in 1988. Until 2014, these programs funded small numbers of tribes and tribal organizations for disease-related prevention and control activities, and focused first on cancer prevention and control, then type 2 diabetes, and more recently on tobacco use prevention and control. These investments in tribes and tribal organizations accomplished important work. However, these efforts were smaller and less coordinated than is desirable given the large number, diversity, and geographic spread of tribes and tribal organizations, and the breadth of chronic disease prevention and control work to be done. Thus, these efforts struggled to achieve measurable, population-wide progress on chronic disease outcomes.

For 5 years, from 2008 to 2013, with financial support from the Indian Health Service (IHS), NCCDPHP shifted the paradigm with the launch of the Traditional Foods program, designed to resurrect and improve healthy traditional diets to prevent and manage type 2 diabetes (18). The program was groundbreaking in 3 ways: it drew on indigenous knowledge and supported indigenous ways of living to protect and promote health; it funded a larger number of tribes than had been previously funded (17); and it worked more aggressively to disseminate successful practices beyond grantees in a single 5-year program (18). The program expanded the cultivation of healthy foods and revived and extended skills in traditional food gathering, production, and storage. Ultimately, the Traditional Foods program led the way for Good Health and Wellness in Indian Country (GHWIC) (19), a new NCCDPHP program, grounded in a collaborative approach to working with tribes, villages, and tribal organizations, and drawing on traditional tribal practices.

A 5-year program that began in late 2014, GHWIC implemented lessons from the Traditional Foods program, including supporting culturally developed and adapted practices and working to disseminate approaches and practices in an IHS service area and across Indian country. GHWIC was also shaped by several years of listening to and dialogue with CDC/Agency for Toxic Substances and Disease Registry's (ATSDR's) Tribal Advisory Committee, and listening sessions and visits with tribes and tribal leaders in Indian Country. The program sought to address key lessons from these encounters: incorporation of tribal wisdom to protect and promote physical, mental, and spiritual wellbeing; avoidance of a disease-management approach to instead work upstream addressing drivers of poor health through culturally appropriate practices; and solving the problem of funding only a small number of tribes to do disease-specific work in favor of a holistic approach that reaches deeply and widely into Indian Country.

GHWIC Program Design, Funding, and Implementation

Four divisions in NCCDPHP contributed funds to the GHWIC Program. The Division for Heart Disease and Stroke Prevention and the Division of Diabetes Translation each provided $6 million, the Office on Smoking and Health provided $2.8 million, and the Division of Nutrition, Physical Activity, and Obesity provided $1 million. Because chronic diseases such as heart disease and type 2 diabetes are driven, in large part, by poor nutrition, lack of physical activity and tobacco use, awardees were able to use program funds from the 4 divisions to implement effective, culturally appropriate interventions to improve these health behaviors and contribute to long-term disease prevention outcomes (16,17). Awardees developed and implemented a single, cohesive work plan — instead of 4 separate work plans — that invested a critical mass of resources in a holistic set of interventions to prevent chronic disease and promote health, including reviving traditional healthy foods, physical activity, and connecting tribal members to community and culture to support healthy behaviors.

The GHWIC program funded tribes, villages, tribal organizations, and Tribal Epidemiology Centers (TECs) through a tiered approach to maximize funds throughout Indian Country. Twelve tribes were funded to use community-chosen and culturally adapted policies, systems, and environmental improvements to achieve GHWIC's long-term goals to reduce the prevalence of obesity, death, and disability from tobacco use, type 2 diabetes, heart disease, and stroke. Eleven tribal organizations provided leadership, technical assistance, and resources to more than 100 tribes and tribal organizations in their IHS administrative areas and to funded tribes (20). Eleven TECs served tribes, villages, and tribal organizations in each IHS administrative area to evaluate GHWIC interventions and demonstrate program impact. One TEC, the Urban Indian Health Institute, coordinated the national evaluation by providing evaluation expertise to other TECs, tribal organizations, tribes, and CDC (20).

Providing opportunities for problem solving and sharing knowledge among peers was a priority for the program. Awardees planned 2 resource meetings, which were critical to developing the grantee-driven identity of GHWIC and to position grantees as resources, mentors, and guides for each other. CDC and awardees jointly planned a midpoint meeting in which awardees presented and reflected on their work, discussed program midpoint outcomes, and received training and technical assistance from CDC and each other. CDC adapted the Extension for Community Healthcare Outcomes (ECHO) model to build and support a community of practice among GHWIC awardees (21). The ECHO model is an evidence-based education, workforce development, and collaborative problem-solving intervention that strengthens knowledge and practice in the field (22). Although the ECHO model was originally developed to improve health care practice, CDC recognized an opportunity to adapt the model to a new public health context in Indian Country, as a way to foster knowledge sharing and peer-to-peer technical assistance among grantees. GHWIC ECHO sessions are culturally tailored by using awardee guidance to create opportunities for peer-to-peer learning and collaboration. The model develops knowledge and capacity among awardees, using technology (multipoint video conferencing and internet) to facilitate sharing best practices and troubleshooting challenges, providing case-based learning through awardee presentations and providing technical assistance and training from subject matter experts.

As a result of ECHO learning and sharing, awardees are more effectively implementing policy, systems, and environmental changes to prevent chronic disease in their communities (21). CDC's GHWIC program was one of the first adaptations of the ECHO model to a public health context that identified and disseminated ideas, innovation, wisdom, and practice across a group of peers, with less direct knowledge dissemination from the "hub" (CDC) to the "spokes" (the awardees). Instead, awardees regularly exchanged roles, serving as spokes or hubs, depending on topic and experience.

Implication for Public Health Practice

GHWIC is CDC's largest investment to date in Indian Country and the first CDC funding opportunity designed to support American Indian and Alaska Native communities and tribal organizations to address multiple chronic diseases and risk factors simultaneously, and in coordination. Developed and implemented following the recommendations and requests of the CDC/ATSDR's Tribal Advisory Committee, GHWIC is an example of CDC's commitment to support chronic disease prevention and health promotion in collaboration with tribal partners. GHWIC provides a rich opportunity to identify approaches that might be useful for CDC, other federal agencies, or other organizations to be more effective working in or planning to work in Indian Country.

Key among the lessons learned through the implementation of GHWIC is the approach of funding administration-area–level tribal organizations that can expand the reach of limited resources to many more tribal partners than is possible by funding individual tribes directly. More than 100 tribes received CDC funding indirectly through GHWIC recipients (20). This model is expected to have benefits beyond simply serving as a mechanism to increase the reach of limited funding. By supporting an administration area or regional tribal organization to provide leadership, resources, technical assistance, and evaluation support, the tribal capacity and infrastructure gained are local and more tailored to the needs of local tribes. Increased funding for administration-area–level partners also provides employment and workforce development opportunities for local tribal members, as well as practical experience in chronic disease prevention and wellness promotion.

CDC and other federal agencies are accustomed to using uniform approaches to support states, tribes, local jurisdictions, and territories in addressing diseases or risk factors in categorical funding announcements (23). These approaches can be barriers to more integrated, customized, and culturally relevant efforts to prevent chronic disease and promote wellness. By combining funding from several divisions at CDC, GHWIC was able to encourage tribal partners and CDC staff members who supported them to take a more integrated approach in the development and implementation of chronic disease prevention programs that share common risk factors (eg, obesity, tobacco use, lack of physical activity). However, CDC program staff members note that practical challenges remain. Providing coordinated and consistent technical sup-

port across multiple program areas continues to be a challenge, even as doing so is critical to support a more effective approach and is a more effective model of collaboration with tribal partners.

As CDC staff members observed, some tribal partners, particularly those unaccustomed to CDC cooperative agreements, struggled to meet requirements of federal grants. Despite great health needs and concerns in their communities, some grantees were unable to spend their award in a timely fashion for reasons including time-consuming approval processes in their tribes, difficulty recruiting staff, staff turnover at CDC or among tribal partners, and difficulty deciphering complex federal reporting requirements. These challenges are not unique to tribal awardees, but they must be attended to and might require additional assistance, flexibility, and new approaches to support tribal partners and achieve success.

Finally, GHWIC established a foundation for CDC to build on in 2 new initiatives to support tribes and tribal partners in chronic disease prevention, health promotion, and other health programs in Indian Country. One program, launched in 2017, funds the TECs to strengthen their public health capacity and to better support the public health needs of the tribes in their regions (24) and is funded at $42 million for 5 years. The second program is Tribal Practices for Wellness in Indian Country (TPWIC), a $15 million 3-year program, launched in 2018, that provides funding to 21 tribes and 16 urban Indian organizations. This program incorporates approaches and strategies identified by American Indian and Alaska Native leaders and supports cultural and traditional practices that build strength and resilience and support healthy behaviors (15).

Implementation of GHWIC marked an important shift in CDC's support of American Indian tribes and Alaska Native villages as they strive to prevent chronic disease and promote health in ways that are relevant to them. By deploying a holistic approach to address multiple chronic diseases and risk factors simultaneously, by expanding the reach of limited funding through tiered funding and subawards, by supporting tribal practices that keep people well, and by adapting Western chronic disease prevention approaches, GHWIC offers a new model for health and wellness in Indian Country. Programs such as GHWIC support tribes and tribal organizations to build on their cultural strengths and more effectively address threats to health and wellness in Indian Country.

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ESSAY

Creating a Public Health Community of Practice to Support American Indian and Alaska Native Communities in Addressing Chronic Disease

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Across the lifespan, American Indian and Alaska Native (AI/AN) people have higher rates of chronic disease, injury, and premature death than some racial/ethnic groups in the United States (1,2). For example, AI/AN adults have a higher prevalence of obesity, are twice as likely to have diabetes, and are more likely to be current smokers than their non-Hispanic white counterparts (3). Rates of death due to stroke and heart disease are also higher among AI/ANs than among members of some racial and ethnic groups (4,5).

Recognizing AI/AN communities have their own cultural strategies for chronic disease prevention and control, the Centers for Disease Control and Prevention (CDC) created the Good Health and Wellness in Indian Country (GHWIC) program to integrate the knowledge those communities possess into a coordinated approach to healthy living and chronic disease prevention. The program also sought to reinforce efforts in Indian Country to advance policy, systems, and environmental (PSE) improvements to make healthy choices easier for all community members.

CDC launched GHWIC in 2014 as a 5-year, $78-million initiative and funded 23 recipients (Figure). To prevent and control diabetes, cardiovascular disease, and other chronic diseases, 12 tribes (Component 1 recipients) implemented community-selected strategies to reduce commercial tobacco use and exposure, improve nutrition and physical activity, and link community programs to clinical services. GHWIC also supported 11 tribal organizations (Component 2 recipients) to provide leadership, technical assistance, and resources to AI/AN tribes in each administrative area of the Indian Health Service. Eleven tribal epidemiology centers and the Urban Indian Health Institute supported GHWIC's surveillance and evaluation activities (6).

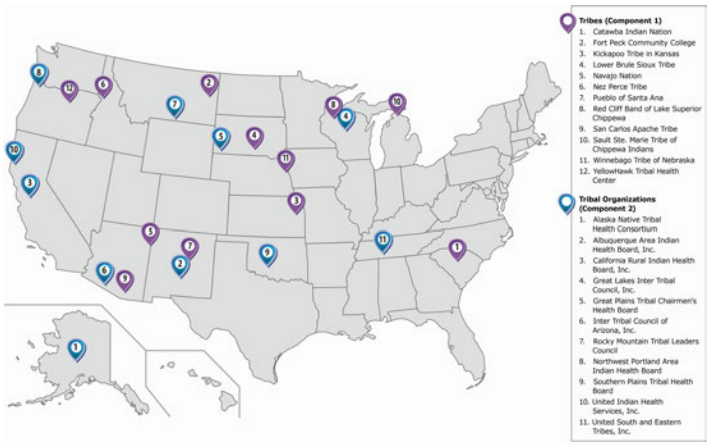

Figure. The 23 recipients of the Good Health and Wellness in Indian Country program, funded in 2014 by the Centers for Disease Control and Prevention.

Using the ECHO Model for Public Health Practice

The ECHO model (Extension for Community Healthcare Outcomes) was created at the University of New Mexico in 2003 to build provider capacity in hepatitis C treatment in underserved communities (7). ECHO combines evidence-based education, workforce development, and collaborative problem solving to increase practitioners' capacity in specialty areas (5). The model uses videoconferencing and subject matter expertise to facilitate case-based learning among practitioners and to share best practices (5). During a typical ECHO session, after a brief didactic lecture, providers from multiple clinical sites present their patient

cases to a multidisciplinary team of mentors for discussion, feedback, and collaborative problem solving and patient health management (5).

GHWIC was the first program to adopt the ECHO model for public health practice to increase public health practitioners' capacity in evidence-based chronic disease interventions by building and supporting a virtual community of practice among GHWIC recipients. A community of practice refers to a group of people engaged in collective learning and problem solving in a particular area of interest or work. According to Wenger and Trayner, a community of practice has 3 key characteristics: the topic or domain; the group or community of learners; and the practices that emerge from the community of practice (8). For GHWIC, the domain was chronic disease prevention in AI/AN communities; the group comprised GHWIC tribal public health workers, CDC staff, and other partners; and the practice captured stories, successes, and lessons learned.

CDC partnered with Project ECHO in the first year of GHWIC, and in collaboration with the Urban Indian Health Institute, CDC launched 2 types of GHWIC–ECHO sessions to support program objectives. The first type was a monthly videoconference held separately for Component 1 and Component 2 recipients, which included representatives from CDC and the Urban Indian Health Institute. Each session was co-led by a CDC facilitator and a Project ECHO liaison. Early sessions included a didactic presentation on an intervention or resource, such as a CDC framework for a community health needs assessment given by CDC or an invited partner organization, followed by 2 or 3 recipients who shared their experiences on the topic. The facilitator invited recipients in advance to share their experiences during the session to encourage discussion. The second type was the quarterly "All Hands" GHWIC–ECHO session, which included all recipients. CDC invited external organizations to provide a brief presentation about resources and partnerships of interest to GHWIC recipients in the All Hands GHWIC-ECHO sessions. For instance, 1 session included a presentation by a member of the Southcentral Foundation, who gave an overview of the Nuka System of Care, an innovative customer-owned model for providing health care in Alaska. CDC invited subject matter experts to join both types of sessions as needed. For example, for a discussion of challenges in community buy-in of a tobacco cessation program, a tobacco cessation expert from CDC and a tribal community were invited to describe resources and possible solutions.

Evaluating the GHWIC–ECHO Sessions

Recipients who participated in the GHWIC–ECHO sessions self-reported that using the videoconferencing platform helped them build relationships with their counterparts and that seeing each other on camera strengthened connections that were beneficial both on screen and when they met in person. Participants indicated that the platform's chat feature was useful and that the sessions were used as a means to start conversations and exchange resources both publicly and privately. AI/ANs have cultural communication customs that include not interrupting elders who are speaking. One tribal member commented that the chat feature accommodated this cultural custom by allowing tribal participants to ask questions without interrupting the speaker during a GHWIC-ECHO session. The videoconference platform also allowed participants to simultaneously view documents, slides, and other media on a shared screen.

In addition, a GHWIC–ECHO Workgroup, comprising the facilitator, GHWIC recipients, and staff members of CDC, Project ECHO, and the Urban Indian Health Institute convened monthly to review the previous GHWIC–ECHO session and discuss evaluation results, priority topics, and ideas for increasing engagement in GHWIC–ECHO sessions.

From January 2015 through June 2015, post-session evaluations were collected via an online survey that included 4 questions on a Likert scale about the quality and value of the GHWIC–ECHO sessions. The evaluation response rate averaged 18% during the 6-month period.

Evaluation Results

Of the 126 responses to the online survey, 55% of respondents rated the overall quality and value of the GHWIC–ECHO sessions as either excellent or very good, 36% rated sessions good, and 9% rated them fair.

Early evaluation results indicated a need to revamp the sessions to give recipients more opportunities to actively participate and that the sessions needed to better incorporate the unique knowledge, perspectives, and experiences of tribal participants. Overall, the evaluation indicated that the initial sessions over-emphasized presentations by CDC staff members and did not fully reflect how tribes share and communicate.

In response to recipients' feedback, CDC modified the GHWIC–ECHO session format to promote greater engagement and a more conducive environment for recipients to exchange knowledge and solutions with each other. Significant changes included topic selections based on priorities and interests expressed by recipients through the post-session evaluations; shifting from CDC to recipient presentations as the primary focus of each session; recruiting an American Indian session facilitator with GHWIC and public health expertise; and circulating discussion ques-

tions to recipients before the sessions to encourage more robust discussions. The facilitator also used a web-based polling application as a tool to increase engagement and interaction among participants by inviting them to respond to questions via the web or text message. Poll questions included "ice-breakers" (eg, "Who do you think will win the Super Bowl?") and questions related to program activities (eg, "Who should be a part of team-based care?").

The newly formatted monthly sessions included a recipient presentation of his or her GHWIC project as a case. Examples of cases included a presentation on community health assessments, a plan for a tribal food sovereignty coalition, and ideas for building healthy communities through PSE change strategies. The quarterly All Hands sessions continued to feature external partners for presentations of interest to the GHWIC recipients. However, presentations were selected on the basis of recipients' topic interests, and session facilitators briefed partners in advance on how to correlate their presentation to GHWIC. For example, a representative of the National Park Service described how the Rivers, Trails, and Conservation Assistance program applied to GHWIC's work to promote physical activity.

Culturally Tailoring the ECHO Model for Public Health Practice

After the GHWIC–ECHO session format was revised, the post-session evaluation responses to the question "What did you like most about the ECHO session?" included the following: "The interaction and problem solving as well as shared video presentation." "The focus on what tribes are doing to implement GHWIC. These monthly calls have gotten so much better and so much more applicable to our work. Thank you for the shift in focus!" "I thought ending the recording after the presentation was a significant improvement! There seemed to be much more interaction."

From August 2017 through January 2018, evaluations were conducted online after each session to assess the quality and value of the new format. During this period, the online evaluation consisted of 6 questions on a Likert scale, and of the 339 participants, 14% responded. Of the 47 respondents, 34 (72.3%) rated the overall quality and value of the newly formatted sessions as excellent or very good, 13 (27.7%) rated the sessions as good, and none rated the sessions as fair or poor. Overall, recipient feedback, measured through online evaluations from January 2015 through January 2018, indicated a shift in recipient satisfaction with the GHWIC-ECHO session format.

Applications of Exchanged Knowledge to GHWIC work

Recipients reported exchanging new ideas for implementing culturally tailored PSE approaches to improve health and wellness in their communities. By Year 3 of GHWIC, tribal recipients had adopted policies in more than 100 settings to promote healthy behaviors (9). GHWIC recipient Yellowhawk Tribal Health Center promoted access to healthy foods in 37 settings and frequently exchanged ideas during the GHWIC–ECHO sessions about gardening classes and ways to promote their community garden (7). The presentation on their community garden and greenhouse project as well as a food sovereignty presentation by the American Indian Health and Family Services, a sub-recipient of Great Lakes Inter-Tribal Council, Inc, resulted in the formation of a sustainable food systems workgroup comprising GHWIC recipients that met quarterly via videoconference.

The California Rural Indian Health Board, Inc, provides another example of how knowledge exchanged on GHWIC–ECHO sessions was applied to GHWIC work. They shared their "Tribal Policy, Systems, and Environmental Strategies for Preventing Chronic Disease" toolkit during a GHWIC–ECHO session that included examples of PSE strategy options for various sectors of tribal communities. As a result, the Southern Plains Tribal Health Board and the Great Lakes Inter-Tribal Council, Inc, used the California Rural Indian Health Board's toolkit to guide their sub-recipients in shifting from individual-based interventions, such as health fairs and fun run events, to sustainable PSE interventions, like tobacco-free policies and breastfeeding initiatives. This knowledge exchange helped sub-recipients better align their activities with the objective of the GHWIC program to address chronic disease outcomes through PSE interventions.

Lessons Learned and Future Directions

After the GHWIC-ECHO session format was adjusted, the quality and applicability of the sessions improved. Session planning and participation improved by pivoting from the use of external experts to tribal public health staff members sharing best practices and arranging for an American Indian GHWIC–ECHO session facilitator.

A unique challenge to ensuring robust recipient participation relates to the inherent structural hierarchy of CDC as the funder and tribes and tribal organizations as the recipients of funding, as well as the complex history between tribal governments and the federal government (8). Acknowledging the complex tribal–feder-

al government history is critical to creating a safe space for tribal recipients to share their work. GHWIC–ECHO session planners strived to take this history into account and modified the GHWIC–ECHO session format to accommodate these dynamics (10).

This experience demonstrates that adopting the ECHO clinical model for public health practice is possible. Inter-peer relationship building is a critical component of the ECHO model application for public health practice, particularly in a tribal setting where trust and relationships are the foundation for sharing information. Staff members from CDC and Project ECHO also observed that when working with AI/AN partners it is important to garner their input during the planning phase to ensure that the GHWIC–ECHO sessions are culturally appropriate and useful for tribal partners.

Verbal communication, body language, eye contact, and gestures are all forms of communication, and videoconferencing enables these forms of communication in a group setting for a richer interaction than what is possible in an audio conference call. Videoconferencing facilitates communication by humanizing conversation, thus contributing to the formation of a community of practice (10).

In this novel application of the ECHO model to a public health context, success was defined by tribal partners who found value in the GHWIC–ECHO sessions and engaged in the sessions, participated in topic discussions, or connected with peers after sessions. The adapted ECHO model built a community of practice where AI/AN peers established relationships, exchanged knowledge of best practices at the community level, and shared resources with each other as well as CDC staff members. The experience of adopting the ECHO model for public health practice and culturally adapting it created a blueprint for how to initiate and support a community of practice among AI/AN peers committed to chronic disease prevention in their communities and shows promise for future expansion to other public health settings.

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PUBLIC HEALTH PRACTICE BRIEF

Obesity and Diabetes in the Winnebago Tribe of Nebraska: From Community Engagement to Action, 2014–2019

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Summary

What is already known on this topic?

Policies, systems, and environmental (PSE) changes are evidence-based interventions known to lead to lasting public health improvements.

What is added by this report?

PSE improvements can be culturally relevant, can be led by tribal health leadership working respectfully with community members and across sectors to meet expressed community needs, and can solve practical problems that constitute everyday barriers to health and healthy behaviors.

What are the implications for public health practice?

Public health practitioners may consider flexible, locally led approaches to improving health outcomes that build on the expressed needs of the community.

Abstract

The Winnebago Tribe of Nebraska implemented interventions to promote the health of their people, focusing on community-selected and culturally adapted policies, systems, and environmental (PSE) improvements to reduce the prevalence of obesity and type 2 diabetes. The interventions were implemented as part of the Centers for Disease Control and Prevention's (CDC's) 2014–2019 Good Health and Wellness in Indian Country program. The Winnebago Tribe used CDC's CHANGE community health assessment tool to prioritize and direct their interventions. They integrated findings from a community health assessment tool with observations from tribal working groups and implemented 6 new evidence-based PSE interventions. Their successful approaches — selected by the Winnebago community, culturally relevant, and driven by scientific assessment —demonstrate the value of flexibility in CDC grant programs.

Introduction

Of the 9.4% of the US population who had diabetes in 2015, most (90%–95%) had type 2 diabetes (1). The prevalence of diabetes in the United States is highest among American Indian/Alaska Native adults: in 2015, prevalence was 14.9% among men and 15.3% among women aged 18 years or older (1). The age-adjusted prevalence of diagnosed diabetes among American Indian/Alaska Native adults varies by region, from a low of 6.0% in Alaska to a high of 22.2% in some areas of the Southwest (1). Obesity is a major risk factor for type 2 diabetes and is itself associated with serious health risks (2). According to the National Health and Nutrition Examination Survey, during 2011–2014, 17.2% of people aged 2 to 19 met the definition of obesity (body mass index [BMI] >95th percentile), including 20.5% of adolescents and young adults aged 12 to 19. During that study period, the prevalence of obesity among adults was 36.0% (3). With obesity and diabetes affecting the health of so many Americans and disproportionately affecting American Indians and Alaska Natives, finding culturally relevant ways to implement effective interventions is essential (4). The Winnebago Tribe of Nebraska sought to do just that.

Background

The Winnebago Tribe of Nebraska reservation is home to 2,694 residents and located in rural northeastern Nebraska and northwestern Iowa, 20 miles south of Sioux City, Iowa, and 80 miles north of Omaha, Nebraska, on both sides of the Missouri River. Most residents live on the western side in or near the village of Winnebago. Almost 40% of the population is younger than 20 years, and 18% are aged 20 to 34 (5). During the 2013–2014 school year, 429 children attending a school in the Winnebago public school district or the St. Augustine Indian Mission School in kindergarten through 12th grade were screened for risk factors

associated with type 2 diabetes, including BMI. Of these children, 232 (54.1%) had a BMI in the 85th percentile or higher (indicating overweight or obesity). This information drove the priorities of the Winnebago Tribe's Good Health and Wellness in Indian Country (GHWIC) grant from the Centers for Disease Control and Prevention, a 5-year cooperative agreement launched in 2014 (6). The tribe conducted a community health assessment, convened a cross-sector work group, and implemented a community action plan consisting of community-chosen and culturally adapted interventions to improve policies, systems, and environments (PSE) to promote health, with a focus on obesity and diabetes across the age span. The GHWIC program encouraged several risk-reduction strategies, such as reducing commercial tobacco use, increasing healthful nutrition and regular physical activity, improving health literacy, and deploying the National Diabetes Prevention Program (7) and the Million Hearts hypertension control strategy (8).

The Good Health and Wellness in Indian Country Program

The Winnebago Tribe used CDC's Community Health Assessment aNd Group Evaluation (CHANGE) tool to conduct a survey to understand the community's needs and priorities (9). The tool consists of 5 sectors: community-at-large, community institution/organization, health care, school, and worksite. The Winnebago Tribe convened a cross-sector work group to review CHANGE findings, identify assets and needs in each of the 5 sectors, and prioritize strategies and activities to achieve outcomes of importance to the community. For example, survey results for the community/organization sector showed that 42.7% (38 of 89) of children screened in Head Start had overweight or obesity. This led the Winnebago Tribe to select infant nutrition and parental education as a priority. The community health assessment also identified challenges, such as insufficient housing for community members, inconsistent tobacco-free policies in tribal buildings, absence of nutrition standards across tribal nutrition and food programs, and absence of a tribal employee wellness policy. The cross-sector working group reviewed 15 sets of data collected with the CHANGE tool and prioritized the following core GHWIC intervention areas: physical activity, nutrition, tobacco, chronic disease management, and leadership, with a focus on PSE strategies for implementation. To ensure continued community buy-in, key community members continued to participate in the cross-sector working group and engage in each new step of implementing the community action plan. This community buy-in helped ensure that the plan met needs of the community. Progress toward program implementation and completion is documented through an annual performance report and telephone calls between CDC project officers and program staff members.

Outcomes

The Winnebago Tribe of Nebraska achieved outcomes across the PSE strategies they implemented.

Public health nursing referral policy. This policy addresses a key CHANGE finding: community members recently discharged from area hospitals are lost to follow-up, resulting in chronic disease exacerbation. The Winnebago Tribal Health Director approved the Winnebago Public Health Nursing Referral Policy for Hospital Discharge in April 2017. This policy provides instructions to medical facilities in the Sioux City area for Winnebago residents who are discharged. The policy asks "all discharging facilities to forward their discharge referrals and instructions specific to the diagnosis or procedure, labs, summaries, medication prescriptions, and durable equipment prescriptions to the Winnebago IHS [Indian Health Service] Social Worker and/or Nurse Case Manager." Winnebago patients are then contacted by the Winnebago IHS social worker and public health nursing department for follow-up and post-hospital visits to prevent complications and hospital readmission.

As a result of this policy, the tribe reported reduced hospital readmissions, improved continuity of care and follow-up with Winnebago health care resources, and improved health education for the discharged patient and family. Relevant to this policy change is that on July 1, 2018, the Winnebago Tribe of Nebraska under Title V of the Indian Self Determination Act (Self-Governance) assumed the governance of the Winnebago Indian Health Service Hospital. The Hospital was renamed the 12 Clans Unity Hospital on that date. This administrative change will help ensure policy sustainability by removing potential interagency barriers between policy design and implementation.

Allow community health representatives (CHRs) access to IHS electronic health records. CHRs visiting patients in homes and other nontraditional health care settings are often the first people to spot issues amenable to outpatient management. However, CHRs lack official channels for communicating critical actions to promote health and prevent illness and injury. Furthermore, CHRs were not authorized to enter clinical findings and measures into IHS electronic health records (the Resource and Patient Management System), limiting their ability to share information with health care providers. The new Winnebago policy specifies procedures for CHRs to enter information into the patient's IHS electronic health record.

This policy will improve case management. It will also create early intervention opportunities for patients referred to CHRs by health care providers working for the Winnebago Public Health Department or IHS and improve chronic disease management, pa-

tient follow-up, communication between CHRs and health care providers, and referrals to community resources. The policy, officially adopted in September 2017, was implemented in beta format in February 2019.

Tribal sugar-sweetened beverage (SSB) tax initiative. Recognizing the contribution of sugary drinks to obesity and diabetes and the interest in addressing the availability of SSBs identified in the community health assessment, and after reviewing data and information gathered through the GHWIC program, the Winnebago Tribe proposed taxing SSBs to the Tribal Council's vice chairman in October 2018. Such a tax would reduce consumption and provide revenue for public health interventions. The proposal applies to SSBs sold by retailers within the exterior boundaries of the Winnebago Indian Reservation at a rate of $0.02 per fluid ounce. Milks, infant formula, and beverages for medical use are exempt. The tribe proposes to use resources collected under the new law to fund nutrition and physical activity interventions.

If the policy is adopted and implemented, the tribe anticipates outcomes will be consistent with those of localities, states, other countries and other tribes that have implemented similar policies. Development of this policy has been slow and thoughtful because of the support needed from retailers and the details of tracking and collecting taxes. The Winnebago Tribal Council continues to consider this proposal and the potential health and economic impact of such a tax.

Infant and childhood obesity prevention health education program. To prevent overweight and obesity in infancy and early childhood, the Winnebago Tribe is using education and prevention initiatives aimed at parents and grandparents who are direct caretakers. The Winnebago Public Health Department implemented complementary health education efforts addressing each stage of life, with mutually reinforcing messages across all tribal programs. The Winnebago Tribe implemented age-appropriate health education for child caregivers in 7 settings:

- the Educare parent education room (Educare is a model for early childhood education [10]);
- office visits to the tribe's registered dietitian;
- Educare Head Start, Winnebago Public School K–2nd , and St. Augustine K–2nd receiving the *Eagle Book* series (stories for young children that highlight the wisdom of traditional ways of health [11]);
- middle and high school classes at Winnebago Public School and middle school classes at St. Augustine Indian Mission School using the *Youth Staying Healthy* curriculum (an IHS curriculum used by health care professionals to provide diabetes prevention education to children aged 8–12 and their family members in one-on-one or group settings [12]);
- the Senior Center Lunch and Learn program;
- the Winnebago Indian Health Service/Twelve Clans Unity Hospital, integrated into health fairs, prenatal nutrition, and physical activity education; and
- the Native Lifestyle Balance Program at the Little Priest Tribal College.

Outcomes of these interventions are being evaluated as part of the Good Health and Wellness in Indian Country project, concluding in September 2019. Preliminary qualitative and quantitative process outcomes suggest improvements in knowledge and attitudes among participants.

Winnebago Tribe healthy foods and beverages policy. The community health assessment revealed that the ready availability of poor food choices, along with SSB availability, likely contributes to high levels of obesity in the community. In 2016, the Winnebago Public Health Department adopted and implemented a healthy food and beverages policy. Initial discussions of the cross-sector working group showed support for a policy prohibiting SSBs and low-nutrition ("junk") foods from being served at Winnebago Tribe of Nebraska workplaces and events, fundamentally changing the quality of foods and beverages offered.

The shared understanding and resolve of the community to address nutritional drivers of chronic disease is expected to lead to changes in attitudes and behaviors and to improve health outcomes related to nutrition, obesity, and chronic diseases over the long term.

CDC-recognized type 2 Diabetes Prevention Program. The Winnebago Tribe was one of the original participating sites in the type 2 diabetes prevention demonstration project, Special Diabetes Program for Indians. The study results, published in 2013, demonstrated the feasibility of implementing a lifestyle intervention in diverse American Indian and Alaska Native communities to prevent or delay onset of type 2 diabetes in adults at high risk (13). As part of GHWIC, the Winnebago Tribe implemented the Native Lifestyle Balance curriculum and pursued CDC recognition as part of CDC's National Diabetes Prevention Program. With support and technical assistance from the Great Plains Tribal Chairmen's Health Board, Winnebago trained 3 lifestyle coaches and received pending recognition from CDC's Diabetes Prevention Recognition Program. With support from the American Association of Diabetes Educators, 2 reimbursement specialists (staff members trained to bill for reimbursable type 2 diabetes prevention services) were trained, increasing the potential for long-term sustainability of this proven type 2 diabetes prevention program. Effective implementation of the program over the long term has the potential to change the trajectory of type 2 diabetes among the Winnebago.

Pedestrian safety and built environment. In collaboration with the Winnebago Public School, the Village of Winnebago, and the Winnebago Tribe, the Nebraska Department of Roads installed rectangular flashing beacons signaling pedestrian crossings at key downtown locations to facilitate safe street crossing, including crossings to health promotion facilities and services. Additionally, in 2018, a traffic circle was funded for construction by the Nebraska Department of Roads after findings of the community health assessment prompted telephone calls to state officials about speed reduction measures on State Highway 77, which bisects the reservation. Construction of the traffic circle is currently underway, with completion anticipated in fall 2019.

These measures have the potential to increase safe pedestrian activity in this high-traffic area of the reservation and to build additional demand for further walkability improvements.

Implications for Public Health Practice

The Winnebago Tribe of Nebraska nurtured opportunities provided by the GHWIC program to create PSE improvements addressing obstacles to good health in response to information provided by community leaders and residents. By adapting GHWIC resources and tools to local processes and approaches and keeping community needs front and center, the Tribe introduced, implemented, or completed effective PSE improvements that, over time, will lead to improved health outcomes. The process undertaken by the Winnebago Tribe was one of rich, ongoing community engagement, shaping CDC's tools to be relevant to the tribe's health goals while helping tribal members take action to advance those goals. The result is an array of improvements driven by the expressed needs of the tribe, accomplished through mutually respectful collaboration and generous support from the community.

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PUBLIC HEALTH PRACTICE BRIEF

Improving the Health of Alaska Native People Through Use of a Policy Change Model and Capacity Building

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Summary

What is already known on this topic?

Policy, systems, and environmental (PSE) improvements help support healthy behaviors. Despite the benefits of improving PSE factors, public health program staff are generally not trained in PSE-change skills.

What is added by this report?

Training and technical assistance activities increased Alaska tribal staff members' ability to effect PSE change, resulting in 30 PSE improvements across the state.

What are the implications for public health practice?

Providing consistent, intensive technical assistance and focused trainings to increase self-efficacy were critical elements that helped staff move beyond traditional programmatic thinking and one-on-one clinical care. The use of digital storytelling was also a powerful tool that melded traditional Native storytelling with modern technology to enhance PSE change efforts.

Abstract

Public health training often includes program and education development but not policy, systems, and environmental (PSE) strategies. The Alaska Native Tribal Health Consortium's Good Health and Wellness in Indian Country program works to build tribal PSE change capacity. Trainings included community health assessment, facilitation and leadership engagement, policy and systems, and digital storytelling. From 2014 to 2017, 30 PSE changes were made: 3 tobacco-free healthcare organization policies; 2 tobacco-free tribal resolutions; 1 tobacco-free school district policy; 3 healthy food policies and environmental changes; 4 improvements in patient-provider communication; 13 prediabetes, obesity, and/or tobacco screening and referral policies; 3 improvements to health care facility signage; and 1 Baby-friendly Hospital application, protecting the health of 46,000 tribal community members. Targeted training and technical assistance moved tribal staff from a focus on direct services to population-based improvements. This increased self-efficacy may increase the sustainability of chronic disease public health efforts and improve tribal health.

Background

Alaska Native people have significantly higher rates of chronic disease than non-Hispanic white people in the United States, and multiple health disparities exist between these 2 populations (1). Modifiable chronic disease risk factors, including unhealthy diet, physical inactivity, and tobacco use, are also common (1). Access to affordable groceries, fresh fruits and vegetables, and medical, dental, and behavioral health care services are limited in most rural or remote Alaska Native communities. Despite these challenges, Alaska Native people are strong and resilient, with traditions and values that facilitate a culture of health (2).

Changing the policy, systems, and environmental (PSE) factors that affect where people live, work, and play is increasingly being used nationally to support healthy behaviors and increase program sustainability after grant funding ends (3–5). Despite the benefits of improving PSE factors, public health program staff are generally not trained in PSE-change skills such as assessing community needs, developing policy, engaging stakeholders, countering resistance, navigating the policy landscape, working with nontraditional partners, or advocating for changes. These skills are important for ensuring that policy makers adopt, implement, and maintain PSE changes (6,7). In this article, we describe activities that increased tribal staff members' ability to effect PSE change, outcomes of those efforts, and recommendations for others doing similar work.

Good Health and Wellness in Indian Country Program

The Alaska Native Tribal Health Consortium (ANTHC) works in partnership with regional tribal health organizations (THOs) to promote health among Alaska Native people. THOs are responsible for providing care to the people in their region, and in most areas they are the only health care providers available. Services range from primary and emergency care services and behavioral and dental health care to health promotion programs. In 2014, ANTHC began a 5-year Good Health and Wellness in Indian Country (GHWIC) program to reduce rates of chronic diseases and their modifiable risk factors among Alaska Native people. The program focuses on supporting healthy behaviors through community-chosen and culturally adapted PSE approaches.

To achieve the goals of the program, ANTHC worked with 5 regional THOs in Alaska to increase access to traditional and healthy foods, increase physical activity, reduce tobacco use, improve health literacy, promote breastfeeding, and enhance chronic disease prevention and control. These THOs are responsible for providing care to 28% of the Alaska Native population living in 93 small communities (with an average population of ~440) (8).

Capacity Building and the Policy Change Model

All regional THO GHWIC staff had extensive experience in providing clinical and health promotion services such as diabetes management but minimal or no experience in making PSE change. Many policy change models exist (9), but ANTHC chose the Rede Group's policy change process model (Figure) to help systematically focus GHWIC training activities.

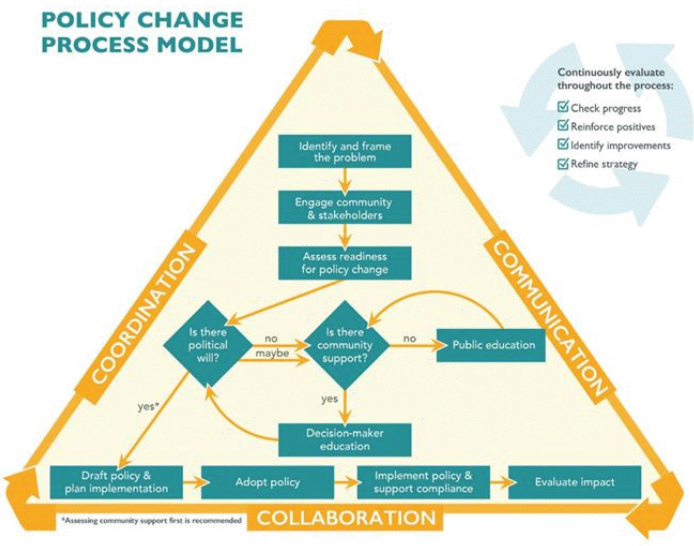

Figure. Policy change process model developed by the Rede Group (http://redegroup.co). The image is reproduced with permission from the Rede Group.

This model outlines 9 steps for policy change as well as a process for feedback loops and evaluation: it was general enough to allow for adaption to the tribal context of the GHWIC program. Regional THO GHWIC and ANTHC GHWIC staff attended 2-day to 4-day long trainings (15–25 participants per training). Trainees then used the PSE change skills at their THO and the tribal communities that their THO serves.

The first 3 steps of the policy change model focus on 1) identifying and framing the problem, 2) engaging the community and stakeholders, and 3) assessing readiness for policy change. Before the start of GHWIC, program staff members were familiar and comfortable with interacting with patient populations but less knowledgeable about identifying broader community health needs and priorities. To support partner sites and build capacity, ANTHC used the community health assessment training of the National Association of County & City Health Officials' Mobilizing for Action through Planning and Partnerships. Participants learned a systematic approach for conducting community health assessments that resulted in new public health system assessments in THO communities and provided direction to focus PSE change efforts. The next 2 training sessions were facilitated by Technology of Participation (ToP) trainers (https://icausa.memberclicks.net). ToP provides training in structured participatory facilitation methods to help strengthen the capacities of organizations and communities. The first training session focused on how to effectively

engage community members and stakeholders and build consensus despite competing priorities. The second training session covered strategic planning and how to build a 5-year program logic model to focus annual program activities.

Step 4 of the policy change model is to assess political will and community support. To build capacity in this area, the fourth training was led by the Midwest Academy, which provides civic engagement skills training to help achieve social, economic, and racial justice (www.midwestacademy.com). Participants learned approaches for identifying which constituencies and decision makers to engage to reach their goals. THO staff members use the training to learn how to think strategically, analyze power dynamics and political will of decision makers, build support within their community and organization, and strengthen their ability to make PSE improvements.

The focus of Step 5 in the policy change model is to assess the education and outreach needed for decision makers and for the public. Initially program staff were challenged about how to communicate the value of PSE changes. To help build these skills, and drawing on the rich history of Alaska Native storytelling, ANTHC hosted a digital storytelling workshop. Digital storytelling melds traditional storytelling techniques with technology to create short videos (3 minutes) that include audio, photographs, artwork, and music to tell a person's story (10). During the workshop, THO staff members created digital stories to celebrate existing healthy policies, including a workplace that had breastfeeding policies to support new mothers. Other stories highlighted PSE changes needed to improve healthy behaviors, such as expanding health screenings and referrals and developing an organizational healthy food policy (anthctoday.org/epicenter/wsh.html).

THO staff members used digital stories for educating and engaging leadership and stakeholders within their organization. For example, one organization had passed a tobacco-free campus policy but had not yet implemented it. A THO tribal staff member created a digital story explaining how she and her children had to walk through cigarette smoke to get to their clinic appointments and how she hoped that tribal leadership would implement the policy as soon as possible. The digital story was shared with leadership, who set a date for policy implementation.

The last 4 steps of the policy change model are drafting policies and planning implementation, adopting policies, implementing policies and supporting compliance, and evaluating the impact of the policy change. For these 4 steps, the ANTHC GHWIC program provided ongoing intensive technical assistance and training sessions to regional THOs. This assistance and training covered such topics as health data provision, survey creation and analysis, focus group guide development, and draft policy language and editorial assistance, and it included an organizational health literacy assessment tool and other tools for assessing baseline policies and systems. More than 400 requests for technical assistance were completed in the first 3 years of the program alone.

Building Public Health Capacity to Implement PSE Changes Among Alaska Native People

The skill and ability among THO staff members in Alaska to navigate the PSE change process within their organizations and communities has increased greatly since the start of the program in 2014. Across training opportunities, program staff members reported that these opportunities helped enhance their ability to identify, implement, and promote the use of PSE changes to improve population health. GHWIC staff members noted that the training on advocating for change, countering resistance, and engaging with leadership helped to strengthen their efforts to promote PSE changes more than traditional public health approaches that focus primarily on awareness building and education.

As a result of program efforts, 30 PSE changes were made. These changes included a tobacco-free policy at a health care organization (n = 3); a tobacco-free tribal resolution (n = 2); a tobacco-free policy in a school district (n = 1); a healthy food policy and environmental changes (n = 3); changes in patient–provider communication (n = 4); screening and referral policies for prediabetes, obesity, and/or tobacco (n = 13); changes in health care facility signage (n = 3); and an application for a Baby-Friendly Hospital designation (n = 1). These policies now protect the health of more than 46,000 tribal members and THO employees.

Implications for Public Health Practice

Program staff members emphasized the importance of staying organized, having a multidisciplinary steering group, and including important stakeholders in the PSE change process, although some PSE changes took longer than expected because of external factors (eg, board priorities, changes in electronic record systems). Tribal leaders felt that the PSE changes made by the program had immediate positive impact on their organizations, including reducing tobacco use on the campuses of health care facilities, improving clinical quality measures, and serving as an "overall cultural change and shift." Leadership noted the importance of using a strategic approach to introduce new policies and spending time gaining support.

The ANTHC GHWIC program activities have made significant PSE contributions to the health of Alaska tribal communities. These successes are all the more remarkable for occurring in small

organizations providing multiple health services to remote tribal communities. Providing consistent, intensive technical assistance and focused trainings to increase self-efficacy were critical elements that helped staff move beyond traditional programmatic thinking and one-on-one clinical care. We recommend similar skill building and technical assistance for other tribal or public health organizations seeking to do PSE change work. The use of digital storytelling was also a powerful tool that melded traditional Native storytelling with modern technology to enhance PSE change efforts. PSE changes are often complex, involve multiple levels of an organization or community, and take more time to establish than traditional programs. Building these changes into organization norms and culture may substantially increase the sustainability of chronic disease public health efforts, leading to improved tribal health in the future.

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PROGRAM EVALUATION BRIEF

Good Health and Wellness: Measuring Impact Through an Indigenous Lens

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PEER REVIEWED

Summary

What is already known on this topic?

American Indians and Alaska Natives suffer disproportionate health disparities and chronic disease rates compared with other populations. To address disparities, a history of mistrust between tribal communities and the federal government regarding evaluation and other data-driven practices must be confronted.

What is added by this report?

We describe an Indigenous Evaluation Framework, emphasizing indigenous core values and knowledge, used to evaluate a federally sponsored initiative to prevent chronic disease in Indian Country.

What are the implications for public health practice?

Our work improves public health practice by reinforcing how indigenous ways of gathering knowledge are as valid and effective as Western methods.

Abstract

In 2014, the Centers for Disease Control and Prevention (CDC) commissioned the Urban Indian Health Institute (UIHI) to coordinate a multifaceted national evaluation plan for Good Health and Wellness in Indian Country (GHWIC), CDC's largest investment in chronic disease prevention for American Indians and Alaska Natives (AI/ANs). GHWIC is a collaborative agreement among UIHI, CDC, tribal organizations, and individual tribes. In collaboration, UIHI and CDC drew upon an indigenous framework, prioritizing strength-based approaches for documenting program activities, to develop a 3-tiered evaluation model. The model incorporated locally tailored metrics, adherence to tribal protocols, and cultural priorities. Ultimately, federal requirements and data collection processes were aligned with tribal strengths and bidirectional learning was promoted. We describe how UIHI worked with tribal recipients, tribal health organizations, Tribal Epidemiology Centers, and CDC to develop and implement the model on the basis of an indigenous framework of mutual trust and respect.

Introduction

The Centers for Disease Control and Prevention (CDC) launched Good Health and Wellness in Indian Country (GHWIC) in 2014 to reduce American Indian and Alaska Native (AI/AN) health disparities, including commercial tobacco use, obesity, and disability and premature death as a result of diabetes, heart disease, and stroke. GHWIC sought to build an overall evaluation plan by using an indigenous framework to match the locally tailored, culturally driven program approach. Historically, research and evaluation efforts have abused and exploited AI/AN communities, such as in the 1979 Barrow alcohol study that published negative reports about Inupiaq villages without consulting those communities (1). Pervasive mistrust of these practices has limited AI/AN partnerships with federal agencies (2), explaining why AI/AN communities are reluctant to collaborate with external organizations that claim they want to help improve tribal health (1). Joan LaFrance states in *Reframing Evaluation: Defining an Indigenous Evaluation Framework*, "The field of evaluation draws heavily on research methodologies that can be considered invasive when imposed by outside funding agencies" (3). CDC collaborated with tribal communities by using an indigenous approach to create a 3-tiered evaluation model that combines indigenous knowledge and values with Western evaluation practices.

Purpose and Objectives

The overall purpose of GHWIC was to create an AI/AN-owned and AI/AN-centered public health initiative designed to meet AI/AN needs, allowing recipients to take charge of their communities' health while achieving chronic disease prevention and health promotion outcomes. Within this purpose, 4 evaluation objectives were identified: 1) share successes and lessons learned across Indian Country and beyond, 2) report outcome data to GHWIC communities for feedback and guidance on program implementation

and improvement, 3) expand the evidence base for chronic disease prevention in Indian Country, and 4) support opportunities for future funding to promote AI/AN community health programs.

GHWIC recipients include 12 federally recognized tribes and 11 tribal health organizations (THOs) that serve tribes in their Indian Health Service (IHS) service regions. The program operates at 3 interconnected levels: local communities (tribes), regions (typically, THOs or Tribal Epidemiology Centers [TECs] serving all or most tribes in their regions), and nationally (Indian Country-wide). The evaluation approach mirrors this program design with the Urban Indian Health Institute (UIHI) focusing on all AI/AN communities served and supporting all GHWIC recipients. CDC supports GHWIC recipients and provides data on GHWIC national outcomes, accomplishments, challenges, and progress.

Intervention Approach

The framework for the GHWIC initiative and evaluation approach began to take shape as early as 2011 when CDC's tribal advisory committee — a federally mandated committee to advise CDC on tribal matters — encouraged CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) to more thoughtfully address serious health disparities among AI/ANs while respecting and incorporating indigenous knowledge. As a result, NCCDPHP staff participated in the first CDC listening sessions with tribal health leaders and visited tribes and tribal organizations over several years before launching the GHWIC initiative. In these sessions and visits, tribal partners offered knowledge and wisdom to CDC staff on how federal funding does not take the AI/AN perspective into account and how tribes and CDC could work together. These activities helped to expand the Western approach to understanding health and disease and how to track progress toward improving health by integrating cultural values of indigenous communities. A key discussion point was the importance of identifying principles of program development and evaluation processes with the people and organizations served by CDC funds. CDC's understanding continued to evolve during the GHWIC program period, from 2014 through 2019, as recipients and CDC struggled with conflicting demands of meeting AI/AN cultural imperatives and required deliverables. Through collaboration, listening, and learning, GHWIC was eventually able to develop culturally sound programs and evaluation approaches tailored to specific indigenous cultural customs and tribal protocols.

The Indigenous Evaluation Framework describes the following 4 core values that were adapted by the GHWIC model (Table) (3):

1. **Centrality of the Community and Family** requires engaging the community when planning and implementing an evaluation, making evaluation processes more transparent, and highlighting the importance of community health in addition to individual achievements.
2. **People of Place** recognizes a tribal entity's relationship to land and history, how historical events have shaped current health conditions, and the uniqueness of place and history. What occurs in one place might not be generalizable to other situations or other locations.
3. **Recognizing Individual Gifts** prompts evaluators to take a holistic approach to evaluate while acknowledging that there are different ways of conducting evaluation.
4. **Upholding Personal and Tribal Sovereignty** embodies respect for tribal approval processes, building greater capacity within recipient communities and reporting findings in ways that are meaningful and impactful to recipients.

Integrating these values required federal partners and public health professionals to recognize the importance of culture in AI/AN health. Cultural centrality and mutual respect were critical to effectively implement the GHWIC initiative and its evaluation. The indigenous framework emphasizes the criticality of local context and community knowledge in documenting program gaps and successes. To accomplish federal goals while aligning data processes with tribal recipient values, GHWIC established a systematic approach to promote bidirectional learning for both program and evaluation implementation. Technical assistance (TA) was provided to recipients through the Evaluation TA Exchange Partners (EEPs) model. The EEPs model involved members of the GHWIC evaluation team, which included CDC and UIHI staff, to provide ongoing, one-on-one support to recipients throughout the cooperative agreement. EEPs were matched with recipients, based on outcomes, geography, and staffing capacity and worked with recipients through video conferences, site visits, and ad hoc communications to share guidance on evaluation plans, performance measurements, and annual report development.

Indigenous methods coupled with community-based participatory approaches emphasize transparency, equitable partnerships, and actionable objectives to promote sustainable change for improved health outcomes. Evaluation efforts that include community participation in the design, development, and implementation are more likely to effectively document long-term change and program gaps (3). UIHI and CDC integrated indigenous values and CDC priorities into the evaluation plan to create an approach that met the needs of diverse recipients and partners to assess impact and identify successful strategies for chronic disease prevention in tribal settings.

Evaluation Methods

The 3-tiered model (Figure) was developed as a guide to capture GHWIC progress and impact on improving tribal health and wellness. Evaluation questions were designed in close partnership with

CDC and UIHI to reflect activities at the local level, with tribes and THOs collecting local evaluation data (Tier 1). TECs collaborate with tribes and THOs within each IHS region to provide technical assistance and collect quantitative and qualitative data (Tier 2). UIHI reported aggregated data of all GHWIC recipients to CDC, while CDC reported aggregated data to its leadership and federal decision makers (Tier 3). At the local level, recipients tracked site-specific progress over time, including process and summative outcomes; TECs collected and assembled information from primary data collection and public databases. UIHI serves as the national coordinating center for evaluation across all partners, compiling and summarizing data, and ensuring the GHWIC evaluation honored core indigenous values and cultures. UIHI facilitated key data collection and management practices, documenting processes and outcomes as they aligned with tribal chronic disease prevention efforts.

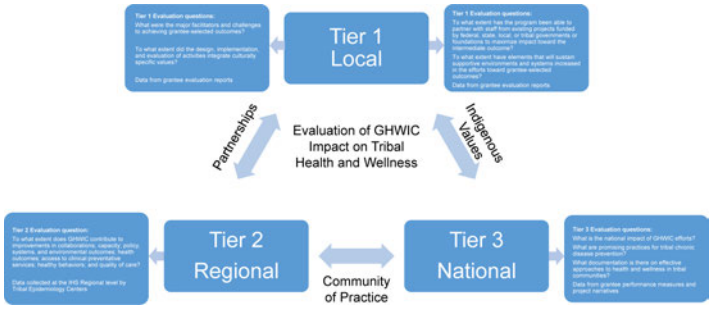

Figure. Conceptual diagram of the 3-tiered evaluation of Good Health and Wellness in Indian Country (GHWIC) impact on tribal health and wellness, with questions that are answered within each tier. Abbreviation: IHS, Indian Health Service. Figure was created by the Urban Indian Health Institute.

Results

In the early stages of the GHWIC initiative, UIHI, CDC evaluation staff, and recipient representatives identified a series of performance measures and evaluation outcomes that would contextualize GHWIC efforts, identify successful activities, and provide lessons learned for others supporting similar tribal health promotion programs. With these metrics, UIHI and CDC compiled findings and created reports documenting the regional and national impact of GHWIC. For example, aggregated data show that from 2014 through 2017, approximately 15,000 AI/AN people had better access to healthier foods through 16 new tribal settings with low sodium nutrition guidelines and 77 new tribal settings promoting nutritious foods (4). GHWIC recipients also built healthier and more active communities. More than 14,500 AI/AN people improved access to physical activity with 91 new policies promoting physical activity (5).

Implications for Public Health

The GHWIC indigenous framework placed recipient (Tier 1) knowledge at the forefront of developing effective and sustainable health interventions in tribal communities for a true reflection of the impact of those interventions. Implementing the 3-tiered evaluation model offered UIHI the ability to measure impact through an indigenous lens with collaborative decision making and bidirectional learning among tribal and federal partners. At the local level, recipients established evaluation indicators that best reflected the qualities of their cultural and community landscapes. At the regional level, THOs and TECs developed strong partnerships and trust with tribes in their regions, allowing them to collect and analyze local and regional data. Data from these 11 regions were then combined to assess national impact. However, the GHWIC evaluation had limitations. Because of the flexibility in performance measure selection, methods for data collection varied, making aggregate data assessment inclusive of all recipient activities difficult. In addition, not all tribal communities in the United States were represented in the GHWIC initiative. Despite these shortfalls, the GHWIC evaluation model provided an important framework for a tribal-CDC partnership to achieve increased AI/AN health and wellness.

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Table

Table. Core Indigenous Values That Guided the Good Health and Wellness in Indian Country (GWHIC) Project[a]

Core Indigenous Values	Definition	Indigenous Evaluation Examples
Centrality of the community and family	Engage the community when planning and implementing evaluation, making evaluation processes transparent. Understand that programs may focus on restoring community health and wellness and individual achievements.	• CDC participated in tribal listening sessions and used findings to shape GHWIC initiative. • CDC engaged GHWIC recipients in the evaluation development, planning, and implementation.
People of place	Recognize a tribal entity's relationship to its land, history, and historical events in relation to current health conditions and individuals affected. Respect and avoid generalizations among tribal entities, understanding that what occurs in one place may not translate to other situations or other places.	• CDC respected that all tribes and tribal organizations are unique. • Performance measure selection was flexible. • All are not the same, what works in one place might not work in another. • Programs were created in relationship to a specific community, its history, and its current situation.
Recognizing individual gifts	Use a holistic approach to evaluate while acknowledging that there are different ways of conducting evaluation.	• CDC respected that individual tribal chronic disease prevention programs operated according to local cultural context. • Tribal data are not always quantifiable, thus stories and storytelling (qualitative evaluation) are just as important and effective. • CDC, UIHI, tribes, and tribal health organizations offered multiple venues to showcase successes and learning opportunities such as UIHI story map, http://www.uihi.org/projects/good-health-wellness-in-indian-country/.
Personal and tribal sovereignty	Embody respect for tribal approval processes that build greater capacity in communities, and report findings in ways that are meaningful and impactful.	• All data, photos, stories and reports may be used only with proper tribal permissions and approvals by the tribes or tribal health organizations (see http://www.uihi.org/projects/good-health-wellness-in-indian-country/ for GHWIC reports) • Recipient feedback is solicited on evaluation reports and materials. • Tribes and tribal health organizations are consulted in the development of reports, ensuring reports are meaningful to tribal audiences and federal funders. • Communication was iterative, and approval was obtained from recipients regarding products before dissemination.

Abbreviations: CDC, Centers for Disease Control and Prevention; UIHI, Urban Indian Health Institute.
[a] Indigenous values and definitions from LaFrance (3).

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ESSAY

Tribal Practices for Wellness in Indian Country

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Expanding Understanding of Tribal Practices that Keep People Well

For American Indian and Alaska Native tribes and communities, cultural and traditional teachings and practices are important protective factors that provide their people with strength and resilience to lead healthful lives. Tribal leaders have expressed that these practices are not widely understood by federal agencies, and often are not supported with financial and technical resources. Tribes may choose not to apply for government funding opportunities because the practices that work best for their populations are not described in the funding announcement. In February 2015, the Tribal Advisory Committee (TAC) of the Centers for Disease Control and Prevention/Agency for Toxic Substances and Disease Registry (CDC/ATSDR) recommended that CDC convene a group of knowledgeable cultural advisors to increase understanding of the role of tribal practices to support physical, emotional, and spiritual well-being. The purpose was to craft specific language to include in CDC's funding opportunities to support implementation of these practices.

Convening Cultural Advisors

CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) hosted 3 convenings in 2015 and 2016, in Indian Country and at CDC headquarters. Participants were nominated by CDC/ATSDR TAC members, 1 from each of the 12 Indian Health Service regions. Healthy Native Communities Partnership, Inc (HNCP), a native nonprofit organization with extensive experience providing culturally appropriate technical assistance and consultation to tribes and Native communities, facilitated the convenings.

HNCP's facilitation approach is uniquely designed for each group — integrating the needs and gifts of participants, the aims of the hosts, and appropriate cultural and traditional foundations for the purpose and location. TAC members, CDC staff, and HNCP clarified the rational and experiential aims for the convenings. Cultural advisors, nominated by the TAC, received personal invitations that included the need being addressed, purpose and expectations, how they were nominated, and meeting logistics.

In collaboration with CDC, the HNCP team designed a flow for each convening that built relationships and understanding among participants while integrating culture and tradition. A flexible agenda, without time constraints, showed the path the group would follow for each day. HNCP used visual and participatory processes to facilitate discussions, build trust, and create a welcoming, comfortable, and fun environment that encouraged candid discussion through an inclusive and respectful facilitation approach promoting connection to culture.

The first convening on Tribal Practices That Promote Health and Well-Being was hosted at a site operated by the Kalispel Tribe of Indians in Washington State. Cultural advisors from 10 Indian Health Service regions, 3 TAC members, 3 staff members from CDC and 1 from SAMHSA (the Substance Abuse and Mental Health Services Administration), and 3 American Indian facilitators from HNCP participated. Seated in a circle, participants were welcomed to the meeting by the host, the NCCDPHP's director at the time. The meeting began with a prayer song to help set positive intentions. One participant, who also chaired the CDC/ATSDR TAC at the time, shared the purpose and vision of the meeting. Through a series of trust-building activities, including one in which pairs exchanged traditional gifts and introduced their partners, participants began to connect with each other on multiple levels.

The group then shared their perspectives on how culture and community contribute to health, strength, and resilience for their people. They described the many forms this takes in terms of understandings, teachings, activities, gatherings, and practices at the local level by creating a simultaneous large group drawing titled *To be strong and resilient, how and when are people connected to*

culture and community? Each person explained their contributions to the drawing that served as the focus for subsequent discussions and development of understanding.

As facilitators led a conversation to organize categories of health-promoting practices, several members of the group expressed concerns about what kinds of cultural knowledge and practices were appropriate to share and which are sacred and must be protected. Trust issues with CDC as a US government agency were raised. The participant who chaired the CDC/ATSDR TAC at the time shared the background for this gathering, mentioned how it resulted from a request from the TAC, and discussed the importance to tribes of being able to include cultural and traditional approaches to wellness. He explained that they were not being asked to divulge their sacred traditional wisdom and thanked the group members for bringing up these important issues.

The first convening concluded with conversations and reflections on the day. In small groups, participants explored principles CDC should keep in mind while working together with tribes and Native communities throughout the funding process — proposal, review, implementation, and evaluation. The small groups shared their conversations, developed key themes, and identified next steps. Each participant agreed on the importance of meeting again. The group reflected on the day by expressing what went well with the convening and what could be improved for subsequent meetings, and closed with a prayer.

The second convening was held at a site operated by the Gila River Indian Community in Arizona. The convening began with a welcome, sharing of intentions, trust-building activities, establishment of group agreements, and sharing of hopes and expectations for the meeting. A visual storyboard helped to put the group's efforts in historical perspective and to clarify the roles of tribes, CDC, the TAC, HNCP, and the cultural advisors in this work. The participants then reviewed the examples of wellness-promoting activities, practices, and teachings that had been shared during the first convening and organized these into 7 themes and strategies. The convening closed with reflections, next steps for developing Notice of Funding Opportunity (NOFO) language at another meeting, and a prayer.

The third and final convening was held at CDC headquarters in Atlanta, Georgia. The group started with a prayer and a welcome, and then honored with words of remembrance a participant who had died. After a trust-building activity, participants reviewed their work, using a Four Directions Model (Figure), focused on Listening, Dialogue, Action, and Reflection.

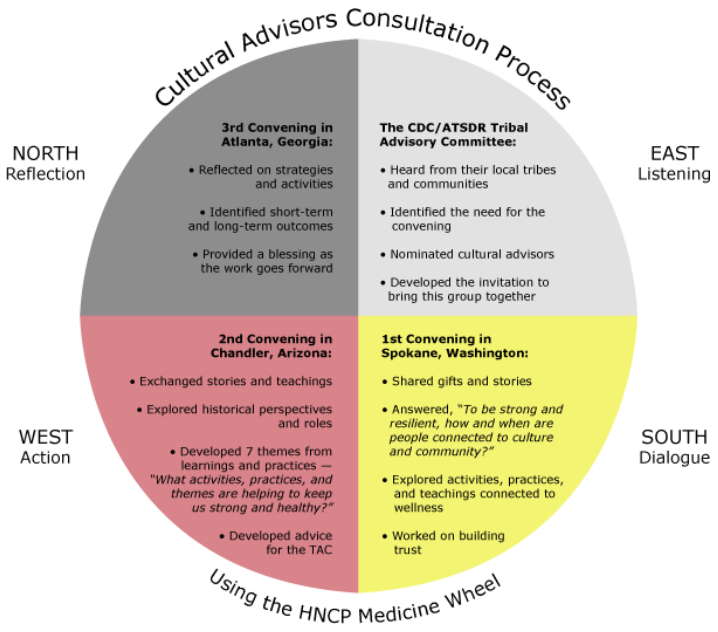

Figure. Cultural advisors consultation process. Abbreviations: CDC/ATSDR, Centers for Disease Control and Prevention/Agency for Toxic Substances and Disease Registry; HNCP, Healthy Native Communities Partnership; TAC, Tribal Advisory Committee.

Participants reviewed and revised the draft activity language under each of the 7 strategies and proposed short-term and long-term outcomes. Small work groups reviewed each of these and presented proposed changes to the full group, which came to a consensus on the revisions. After reflections on the day, the TAC chairman closed the meeting by providing a prayer for the group's work of creating language on cultural wellness practices and blessed the documents. The Table describes the 7 strategies and corresponding activities.

The results of these convenings go beyond the specific advice and work products delivered to the TAC. At the individual level, each of the participants made significant contributions to the group and participants learned from each other, shared stories and cultural knowledge, and were heard respectfully. Participants appreciated the opportunity for honest dialogue; sensitivity toward cultural knowledge, customs, and traditions; respect and understanding for boundaries; and the ability of the group to find common ground. As the group moved through the series of convenings, participants noted that they felt positively about the teamwork, how they were able to regroup and take a different direction, the levels of intensity and passion, being reminded of what's important, and having a vision of sustainability that reflects sovereignty. With persistence, respect, and a willingness to listen to each other, this group was able to define its own roles and complete important work together.

Results at the group and organizational level included 1) a large federal bureaucracy followed through respectfully on recommendations made by its TAC; 2) Tribal cultural advisors from different regions respectfully recognized their commonalities, differences, and boundaries; 3) the perception of federal agencies when working with Tribal cultures shifted to better understand their practices, strengths, and needs; and 4) small steps were taken toward developing trust and respect between tribes and federal agencies. Most importantly, at the level of tribes and Native communities, the work of the people who supported and participated in this important effort has the potential to revitalize cultural and traditional wellness practices leading to improvements in health, well-being, and resilience for the indigenous peoples of North America.

Funding Tribal Practices

The CDC/ATSDR TAC concurred with the language developed during the convenings. The language was included in a NOFO that was awarded by NCCDPHP in 2018. The 3-year funding opportunity will support the tribal practices identified by the convening group and build resiliency and connections to community and culture, which over time will reduce risks for chronic disease among American Indians and Alaska Natives. The long-term goals are to reduce morbidity and mortality attributable to heart disease, stroke, cancer, and diabetes. NCCDPHP is committed to including cultural and traditional practices as fundamental elements of future programs designed to improve American Indian and Alaska Native health.

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Table

Table. Strategies and Activities to Promote Tribal Health and Wellness

Strategies	Activities
1. Family and community activities that connect cultural teachings to health and wellness	Implement family-centered community activities and events working with community members and partners that teach, build upon, celebrate, and strengthen cultural and traditional practices and teachings.
	Establish or develop Native language activities for health education to promote and connect community health and Native language.
	Implement a culturally based, community-chosen activity that supports strategy 1.
2. Seasonal cultural and traditional practices that support health and wellness	Establish an annual community calendar of seasonal cultural and traditional events, celebrations, and activities that support and reinforce healthy practices.
	Support implementation of 1 or more seasonal and traditional cultural events, celebrations, or traditional harvest activities and engage community members and partners to make the event even healthier.
	Implement a culturally based, community-chosen activity that supports strategy 2.
3. Social and cultural activities that promote community wellness	Establish and/or strengthen community social and cultural activities focused on sharing cultural knowledge and practices and honoring the future through our people and youths, especially teachings of historical events, for mental and emotional well-being.
	Implement social and/or Tribal cultural activities incorporating opportunities to learn about traditional healthy food, physical activities, and lifestyle practices to enhance mental and emotional well-being.
	Implement a culturally based, community-chosen activity that supports strategy 3.
4. Tribal, inter-tribal, governmental, and nongovernmental collaborations that strengthen well-being	Partner with area tribes and Inter-Tribal Councils to strengthen opportunities to engage in healthy traditional, cultural, and educational activities.
	Collaborate on projects such as partnerships with community development financial institutions and other partners and sectors to increase culturally relevant economic and other opportunities.
	Implement a culturally based, community-chosen activity that supports strategy 4.
5. Intergenerational learning opportunities that support well-being and resilience	Establish or strengthen opportunities to encourage 2-way sharing and connect youths, adults, and elders to share knowledge about food, language, ceremonies, stories, places, technology, crafts, and play.
	Establish or strengthen opportunities for adults and elders to pass on Tribal, cultural, and other knowledge to children and young people and to other adults and elders.
	Establish and strengthen intergenerational programs that address historical trauma and that promote and enhance healing and resilience.
	Implement a culturally based, community-chosen activity that supports strategy 5.
6. Cultural teachings and practices about traditional healthy foods to promote health, sustenance, and sustainability	Establish or strengthen sustainable programs to gather, raise, harvest, produce, or preserve traditional healthy foods and provide those foods and beverages to individuals, families, schools, institutions, and others.
	Partner with Tribal, Inter-Tribal, governmental, and nongovernmental entities to produce and promote traditional diets, including foods and drinks to sustain health.
	Implement a culturally based, community-chosen activity that supports strategy 6.
7. Traditional and contemporary physical activities that strengthen well-being	Enhance, strengthen, or increase opportunities and supports for traditional and contemporary physical activity at schools, work sites, cultural and community events, and other venues.
	Enhance, strengthen, or increase traditional knowledge and history that supports traditional and contemporary physical activities at home, school, work sites, and cultural and community events.
	Build traditional or contemporary physical activity into strategies 1 through 6.
	Implement a culturally based, community-chosen activity that supports strategy 7.