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INSANITY OR THE STATUS QUO?

By Michael E. Bird, MSW, MPH

It has been said that the definition of insanity is doing the same thing over and over and expecting a different outcome. If ever there was a time for doing something different, that time has arrived. And not too soon, with major changes in the health care and managed care systems, the downsizing of Indian Health Service (IHS), and the contracting out of funding by tribes to provide their own services. Presently, 35 percent of the IHS budget is contracted out; this trend will continue with some unforeseen consequences.

In Indian country there's a real need to look beyond IHS and the Bureau of Indian Affairs if tribes are to be successful in this market driven economy. Not only is there a national community, we are now talking about a global community – one that offers an opportunity to share and learn from other indigenous communities throughout the world. There's a whole world of opportunity, albeit not without some risks.

As the first Indian president of the American Public Health Association (APHA) in its 128-year history, I would like to offer some concrete suggestions that might be of use to tribal communities, as well as suggestions to non-Indians who are committed to changing the status quo.

First and foremost one has to get out there! For me that started with making an effort to find out who was out there doing things that might be relevant to my community and the people back home. I joined the New Mexico Public Health Association and have been a member for 16 years. I began by looking outside of the box that Indians have placed themselves in (and have also been placed in by others). I actually joined because I believed that the more people you know, the better off you are and the more you can offer to everyone.

My first assignment was to develop a recruitment brochure. I stayed with it and made it a priority to volunteer and make things happen. I have to say that there were some

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people who made it known that they were not necessarily as liberal as they would like to have others believe. But I stayed and did the work, built the relationships and eventually was elected to a number of offices, including president of the state affiliate. This was clearly of benefit when I ran for president of APHA with the endorsement and support of my New Mexico affiliate.

Second, invest in building relationships with all people, but especially with those outside of the systems in which you are comfortable. Remember that most real relationships are built on very basic values such as respect, trust, inclusion, and reciprocity. If you live those values and work hard, most people will want to work with you and will be supportive. I have discovered that there are a number of people out there who genuinely want to do the right thing but don't know where to start. There are also some people who know what to do but won't start. Don't waste time on the latter because life is too short. Work with those who are real, which becomes evident over time. Most importantly, be real yourself!

"I have discovered that there are a number of people out there who genuinely want to do the right thing but don't know where to start. There are also some people who know what to do but won't start. Don't waste time on the latter because life is too short."

For those who want to work with Indian people and communities, I would suggest again, "Be real!" If ever there was a community that recognizes what is real and what isn't, it is the Indian community. Five hundred years has taught us a great deal about human nature.

There was once a time when things were done to us, and a time when things were done for us. Hopefully, we are at a time and place in a new century where all people will recognize that it needs to be done with us! This is critical in building viable, collaborative working relationships.

Look toward building long-term relationships, not just the completion of a dissertation, project, or contract. Then you will have the basis for a real working relationship. If you're just looking at your own needs, expectations and goals, you will be disappointed.

Recognize that most (if not all) of what you have been taught or assume is probably incorrect. Beware of self-proclaimed experts who profess to know all there is to know about Indian communities. Most people in those communities admit that they themselves are trying to figure out what the questions are, let alone the answers. Get out there. Work with the people. Question all that you have learned, and be open to learning from the people.

Critical to understanding a people is understanding their history and culture. Who are they, what are they, and where did they come from? There's a great deal of truth in the phrase, "If you've seen one Indian tribe, you've seen one Indian tribe." In the same manner, "If you've met one Indian, you've met one Indian!"

Why should non-Indians work with Indians? Actually, I think that it goes to something very fundamental to the soul and spirit of this country. I believe that most Americans who have some basic understanding of this country's beginning understand that we have yet to deal with some very fundamental contradictions between our ideals and reality. The reality over and above the horrendous statistics indicates that, "…The extent of the poverty among the nation's 2.3 million Indian people is unmatched among any other populations in the United States." (*A Forum on the Implications of Changes in the*

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Michael E. Bird

Health Care Environment for Native American Health Care, The Henry J. Kaiser Family Foundation)

The reality is that the founding fathers of this country, in order to establish a more perfect union that provided them with life, liberty and happiness, displaced a people who had occupied this continent for thousands of years and denied those people their lives, liberty, and happiness. For those who have doubts, I suggest reading *American Holocaust* by David Stannard, who documented the fact that 180 million Native peoples in both South and North America died as a result of contact.

This massive dispossession produced the basis for the disparity we see today. Not that dispossession is limited to land, but for American Indians and indigenous populations it was the most fundamental factor producing conditions that created disparity. I believe that most Americans recognize that there has been and continues to be something fundamentally wrong with the fact that the first people of this land are the last people when it comes to benefiting from that land and this country's many blessings.

Historically there have always been many people who have for a variety of reasons chosen to work with American-Indian populations. Their reasons were often times more reflective of themselves than the people they choose to work with. What one can only hope for is that they took that opportunity to learn from the people. When you're out there out of your niche, group or comfort zone one has the opportunity to see things through someone else's eyes and as a result can really learn how to see the world in a different way. It also can allow you to appreciate what you value and believe in. Hopefully that will allow us to all appreciate our common humanity. •

Michael E. Bird assumed the one-year presidency of APHA during the Association's 2000 Annual Meeting last November in Boston.

"I believe that most Americans recognize that there has been and continues to be something fundamentally wrong with the fact that the first people of this land are the last people when it comes to benefiting from that land and this country's many blessings."

Building Long-Term Relationships

Between and Among Indian and Non-Indian Governments and Organizations: A Call to Action

By Vincent Lafronza, EdD, and Donna Brown, JD, MPH

Turning Point Holds Historic Indian Health Forum

"Relationship is the key to everything," APHA President Michael Bird told participants in the Turning Point Indian Health Forum 2000. He added, "If you want a different outcome, you have to do something different."

In late September of 2000, partnerships convened in Albuquerque, NM, to participate in the first Turning Point Indian Health Forum. The Forum was held to advance collaborative activity between tribal and non-tribal governments and organizations in

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order to strengthen public health delivery systems serving American Indians and Alaska Natives living on or off reservation lands. A theme that emerged from discussions at the forum was that a large number of untapped opportunities exist for collaboration between tribal governments, state and local public health agencies, and community-based organizations in taking measures to improve community health and quality of life.

Tribal law expert Sam Deloria of the American Indian Law Center in Albuquerque debunked many myths about barriers to collaboration. Pointing out that although federal law determines the right of tribes to govern themselves in their own territory, Deloria repeatedly reminded participants that the door has always been wide open to innovative intergovernmental agreements between and among governments across local and state levels. There is no federal barrier. As Deloria stated, "Everything can be done cooperatively once you decide on jurisdiction." The only missing ingredient is the mutual understanding and trust needed to create and sustain the relationships that make such agreements possible and successful.

Deloria also explained that agreements between tribes and local or state governments to cooperate in providing public health and health care services, to exchange information, or to collaborate in improving quality of services, need not be wholly formal or enforceable. It is often preferable to begin collaboration efforts on a voluntary basis, realizing that partnership activities won't work if both parties do not believe efforts are worthwhile. A memorandum of understanding or simple joint planning can solve some problems. But even those straightforward approaches will not occur unless someone takes the first step and opens a discussion. Once again, the lesson is simply that relationships form the basis of collaboration. A growing number of collaborative arrangements between and among tribal and non-tribal governments and organizations are available as replicable models. Deloria suggested that national organizations can serve as clearinghouses for such models. Examples of such arrangements range from health data sharing agreements across jurisdictions to law enforcement coverage and policies.

"State and county policies frequently are made in the absence of tribal voices, often in violation of federal treaties outlining required expectations for tribal government involvement."

Through this experience, partnerships learned that two significant areas of collaborative activity can advance relationship-building efforts. The first relates to the ubiquitous lack of understanding about and familiarity with tribal health delivery systems, and more specifically, the obstacles that inadequate understanding create with respect to collaboration among state, county and tribal governments and organizations. For instance, state and local governments and other non-tribal organizations frequently lack specific knowledge about how tribal governments make decisions and how programs are developed, implemented and evaluated. In particular, issues of tribal sovereignty are not well understood by non-tribal governments and organizations. State and county policies frequently are made in the absence of tribal voices, often in violation of federal treaties outlining required expectations for tribal government involvement.

Second, findings from the Turning Point planning phase repeatedly demonstrate the unavailability and inadequacy of health information related to health status at a local level. In states with tribal communities, these obstacles are further complicated by confusion over ownership, confidentiality and capacity issues associated with data collection systems.

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Most Turning Point partnerships, and especially those serving American-Indian and Alaska-Native populations, have expressed dissatisfaction with the availability of information that enables them to identify and address community health issues appropriately. Existing data, often derived from state and federal sources, are neither timely nor disaggregated to a useful level. Most regularly available data reported through vital statistics registries monitor health outcomes. These data are often of limited value in the actual design of program and policy development, as they typically do not describe the actual causes of morbidity and mortality. Moreover, data collected at a state level often fail to address issues the tribes care most about, such as information required to work across the many disciplines that interrelate to produce health. Few tribal communities currently have the capacity to generate the level of information that is needed to improve health, including information related to the physical, social, and spiritual well-being of a community. Non-tribal communities often face these same challenges.

When Turning Point issued the *Call for Letters of Intent* in 1996, the vision for program activity focused largely on strengthening partnership activity among participating state and local governments, non-governmental organizations, and community-based organizations. Like most public health programs in the U.S., the initiative's original design did not adequately anticipate or promote partnership activity *specifically* among tribal, state and county governments and others involved in public health service delivery. But tribal organizations indeed were interested in participating in this effort, and the Turning Point National Advisory Committee and National Program Offices were delighted when several tribes submitted letters of intent and full Turning Point proposals. In fact, tribal participation in Turning Point activity has permanently changed the public health infrastructure landscape, with tribal public health agencies now active partners and members of the National Association of County and City Health Officials (NACCHO).

In the majority of Turning Point states, there are many federally recognized tribes (federal recognition status of sovereign nations means these tribes have a special, legal relationship with the U.S. government. For additional information regarding sovereignty, visit the U.S. Bureau of Indian Affairs Web site www.doi.gov/bureau-indian-affairs.html.) Across the original 14 Turning Point states, approximately one-third of Turning Point partnerships serve communities with considerable American-Indian and Alaska-Native constituents. Only two Turning Point partnerships, the Gila River Indian Community, located in Arizona, and the Albuquerque Service Unit Indian Health Board, serving six tribes and an Urban Indian Program in the Albuquerque area (Alamo Navajo Community, Jemez Pueblo, Isleta Pueblo, Sandia Pueblo, Santa Ana Pueblo, Zia Pueblo, and First Nations Community Health Source, respectively), are comprised of tribal partnerships representing federally recognized sovereign nations living on reservation lands. Yet other partnerships, such as the Montana-based Fort Peck Health Coalition and the Flathead Community Partnership, are county-based efforts that share their borders with sovereign tribes. The Cherokee County Health Coalition represents a formal alliance between the Cherokee Nation, Cherokee County local government, and a local hospital and university. Additionally, urban Indians are represented in cities such as Portland, OR; Tulsa, OK; Chicago; and New York City.

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Changing Roles of Tribal Governments: Indian Self-Determination and Self-Governance

As we begin the new century, well over 3,000 public health agencies serve most of our states, regions, counties, territories and cities, as well as a wide range of other governmental and private/non-profit organizations and community groups. While too often overlooked, a tribal health infrastructure currently serves over 558 federally recognized tribes. The tribal system has grown considerably, beginning with the establishment of a federal Indian health system – the Indian Health Service (IHS) – one of several agencies that comprise the U.S. Department of Health and Human Services.

In recent years, under the Indian Self-Determination and Education Assistance Act, Public Law 93-638, tribes increasingly assume more control over their resources with the intent to strengthen their capacity to protect and improve the health of American Indians and Alaska Natives. This federal legislation promotes the decentralization of services originally provided by IHS. It is critical for tribes to maintain the right to assume control over these programs. However, the increasing movement to build tribal capacity is resulting in the decentralization of services originally provided by the IHS. Moreover, this decentralization is unfolding against a backdrop of increasing centralization of services provided by state, county and private sector medical and public health delivery systems across the U.S.

Clearly, these forces have significant impact on and opportunities for collaborative public health practice across all levels of government, and most especially where services are being provided across multiple jurisdictions, such as state, county, reservation lands and urban areas where many American Indians and Alaska Natives live. Tribes must continually balance the need to develop local capacity for long-term benefit (which is the core of legislation 638) with the more immediate risk of losing needed medical services currently provided by IHS. Such balancing of resources requires complex strategic planning couched in economies of scale methodologies, which often do not adequately account for cultural variations among tribal communities.

Building Foundations for Collaboration

There is much to be learned from working with American Indians and Alaska Natives. These are people of rich cultures and ancestries who bring highly valuable perspectives and resources to partnerships. But the westernized American way of life, coupled with America's poor track record regarding its treatment of Indian peoples, has not laid foundations that facilitate ready-made partnerships. There is great work to be done.

NACCHO is learning that this work can be accomplished through genuine interest, honest dialogue, real commitment, and willingness to respect tribal sovereignty. Nationally, NACCHO has begun exploring opportunities for fostering relationship building and collaboration with tribal governments and organizations. The social and economic costs of increasing disparities in health and other social phenomena among Americans as a collective community adversely affect and challenge everyone. NACCHO strongly

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encourages all those working in public health and community development arenas to consider the vast possibilities for mutually beneficial collaboration and reach out to build relationships, recognizing the importance of great care and respect for cultural differences.

NACCHO often has an opportunity to contribute to discussions of new federal laws and policies affecting the public's health. We have begun to ask such questions as, "How might this policy affect tribal entities?", "Who is missing from this decision table?" and "How might provisions be made to assure that tribes, as well as other governmental entities, will benefit from this new program or policy?" These perspectives require a new way of doing business. We hope to leverage the lessons we are learning to build a greater public awareness that addressing tribal health issues collaboratively, and realizing the mutual benefits of jointly addressing health and quality of life issues of tribal and non-tribal populations, is a vast untapped resource in public health practice.

Establishing long-term relationships between and among Indian and non-Indian peoples is a fundamental necessity to ensure better health and quality of life outcomes for future generations of all Americans. This work is not optional. It is our legal and ethical obligation and therefore, our immediate responsibility. It is not easy work, and it takes much time. Perhaps the most important lesson that NACCHO has learned is a simple lesson indeed: Indian communities represent significant components of the public health and health care delivery systems capacities and for far too long have been left out of this collective work. Let us embark on this collaborative journey together, and let us commit to long-term efforts so that tomorrow's children will find themselves in a more harmonious, respectful, and healthier society. •

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Donna Brown is the government affairs counsel for NACCHO.

NACCHO

mission

NACCHO is the national organization representing local public health agencies (including city, county, metro, district, and tribal agencies). NACCHO works to support efforts which protect and improve the health of all people and all communities by promoting national policy, developing resources and programs, and supporting effective local public health practice and systems.

Turning Point Partnerships

Focus on Relationships to Improve Indian Health

By Ray M. (Bud) Nicola, MD, MHSA, Kathleen E. Perkins, MPA, Nancy Thomann, MPH

Some state and local Turning Point partnerships have significant relationships with Indian nations as collaborators and partners in the health improvement process. Here are a few examples of Turning Point partnerships with a special focus on Indian health.

Improving Relationships in Arizona

The Arizona Turning Point Project included a special section in its Public Health Improvement Plan that called for the strengthening of working relationships between tribes and state/county public health agencies with the goal of improving the health status of Native Americans in Arizona. The state Turning Point Steering Committee has as members the public health director of the Gila River Indian Community, the Native-American liaison for the Arizona Department of Health Services, and two county representatives who are developing improved relationships with the tribes and county health departments.

"State and local agencies frequently do not understand the sovereignty issue of Indian nations that requires government-to-government relationships. This frequently makes it difficult to develop working relationships with the tribes."

Current relationships in Arizona between public health agencies and tribes range from non-existent to merely telephone contact. Why? Many of the 19 reservations in the state may cover two or more counties, cross boundaries into other states, and in one case, straddle an international boundary. In addition, since the federal Indian Health Service (IHS) provides health care services to many tribes, state and county public health agencies feel that Native Americans in their areas are already being provided with adequate health care and do not require additional services. State and local agencies frequently do not understand the sovereignty issue of Indian nations that requires government-to-government relationships. This frequently makes it difficult to develop working relationships with the tribes.

During the past year two major successes occurred to advance dialogue between tribes and public health agencies. First, in June 2000, the Gila River Indian Community (GRIC) and the Arizona Department of Health Services signed a data sharing agreement. This document is the first of its kind in Arizona, and the two organizations have received the "Project of the Year" award from the Arizona Rural Health Association and the Arizona Rural Health Office at their annual conference last July, for having negotiated this agreement. Under the agreement GRIC will receive the same data and information that the state provides to county health departments in Arizona. GRIC may well model for other tribes the benefits of working collaboratively with the state health department. Second, the tribes and the county health agencies met for the first time ever at the Annual Retreat of the Arizona County Health Officers Association in August, 2000. Presentations were made by representatives of both groups, resulting in the formation of a small workgroup to develop strategies to improve relationships between the tribes and county health departments. While much work remains to be done, these first steps can lead to the improved provision of public health services for all in these communities.

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Maine Turning Point, State Agency, and Tribes Working Together

Each state and tribe is different and Maine is no exception. Maine tribes are typical for New England, but have many differences from Indian nations in the western U.S. The state government and the five Maine tribes have been working to improve relationships and improve the health of their Native-American populations.

Here are a few facts about Maine tribes. The tribes include: MicMac (federally recognized less than 10 years ago), Houlton Band of Maliseet (federally recognized less than 10 years ago), Passamaquoddy - Indian Township, Passamaquoddy - Pleasant Point, and Penobscot. The total tribal membership in Maine is about 6,500 according to the 1990 census. Each of the five tribal governments has a tribal health center staffed by a combination of National Health Service Corps, local and native staff. IHS does not run any facilities in Maine. Although there are five areas of tribal lands, only three of these are "reservations." Maine tribal governments do not have as much autonomy and power as the western tribes. The assimilation began with the pilgrims and thus externally visible efforts to save tribal identity, such as the Indian Land Claims lawsuit of the 1970s, are a relatively recent phenomenon of the 20th century.

The Maine Turning Point (MTP) director recently joined tribal health directors and health planners at their quarterly meetings and visited three of the five tribal health centers to discuss Turning Point ideas, learn more about tribal programs, and establish relationships. Three of the tribal health directors are MTP "partners." A member of the Steering Committee represents a fourth tribe and also works for a mental health agency that serves all five tribes. The MicMac health director has been one of the most active "partners" participating on list-serves and in other ways. His public appreciation and endorsement of MTP communication efforts among the tribal health directors has helped to begin other relationships, especially with the Indian Township health director.

There are a number of state-level activities with the tribes. The Maine Department of Human Services (DHS) Bureau of Health designated a lead liaison to the tribal health departments who conducted a health needs assessment in 1999. In addition, MTP and state DHS Bureau of Health are directing tobacco settlement funding to the tribes to provide for culturally specific tobacco prevention and control initiatives. The state DHS Bureau of Health is also working with tribes on Hepatitis C and heart disease. Maine tribes regularly share vital statistics, death records, and other health data with the DHS Bureau of Health.

The tribal health centers in Maine represent Maine's only "full-service health departments." The three municipal health departments that exist in Maine do not provide as wide a range of services as those operated by the tribes. The MTP focus on infrastructure is especially crucial due to Maine's lack of a sub-state public health infrastructure, thus the tribal health departments are an interesting model as well as a point of comparison. The emergence of these full-service health departments appears to have had a great impact on health outcomes. Preliminary data show real improvement in health outcomes. The tribes have already given us an example of improving health by improving the public health infrastructure.

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Much of MTP's initial work has been about process and relationship building, which has led staff and tribal members to anticipate excellent prospects for working together in the years to come.

Cherokee County, OK, Develops a New Model for Community Health

Can separate sets of agencies serving a non-Indian community and an Indian nation change decades old practice and begin to work together to serve the whole community? That is exactly what has happened over the past eight years in Tahlequah, Cherokee County, OK, a community that is one-third Native American, where in 1994, city and tribal leaders met to talk about mutual goals and working together. Initially the Cherokee County Health Department, the Tahlequah City Hospital, IHS' Hastings Hospital, and the Cherokee Nation's Public Health Department met as an informal coalition. When a community-wide outbreak of hepatitis appeared, agencies worked together for the first time and pooled resources to prevent further spread. And when there was an explosion of tuberculosis in the migrant worker population, agencies again banded together to form a joint strategy. By 1998 the Community Health Coalition had expanded to include 15 different agency members – and now has as many as 50 members including residents and community leaders.

So it was no surprise when the Turning Point Initiative was first announced in 1996 that the Cherokee County community was prepared to think "outside the box" about how best to improve the health of non-Indian and Indian populations living together in the community. The Community Health Coalition decided to formalize themselves as a Health Services Council, acting as the governmental health authority for the county with four equal partners – the Cherokee County Board of Commissioners, the Tahlequah City Hospital, the Northeastern State University, and the Cherokee Nation. These four organizations, along with a fifth at-large partner, became the governing members and were joined by several ex-officio members including the Cherokee County Health Department. Turning Point affirmed the direction the Community Health Coalition had taken and allowed agencies to build on early successes to identify a successful structure for long-term sustainability and collaboration. Turning Point also helped provide team members with essential skills: insight into how other people were working; how to resolve conflicts; how to work together as a team; leadership development skills; and understanding ways to access community opinion.

Since the creation of the Health Services Council, the agencies have worked together on a comprehensive health assessment during 1999 that led to a Public Health System Improvement Plan outlining policy and action targets. Target areas include a Safe Kids Coalition, distribution of the influenza vaccine, cancer screening, maternity and migrant clinics, and many more efforts. Working together has made changes in the way that agencies think and speak of themselves – going from "us" and "them" to "we." Language and topics in health promotion campaigns are more culturally sensitive. The Council

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worked with the university to create a Rural Health Institute, working on ways to improve health in rural areas.

Collaboration has led to changes on a statewide basis also. State legislation was recently passed to create a Center for Rural Development that combines the Rural Health Institute with a Community Development Institute, an Economic Development Institute, a Rural Education Institute, and a Technology Institute. This new state agency will address quality of life issues using a broad perspective. The Health Council's collaborative efforts are not complete. For example, the state cancer registry does not include Cherokee Nation data, but the Nation and the Council are currently working on a data exchange agreement. In addition, the Council is looking at the feasibility of a community health center.

Changes to more collaborative ways of working together have led to changes in ways of thinking about the health of the community. Who could have imagined the progress that has been made in a brief eight-year period? •

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Beyond Tribal Self-Determination:

A Model Health Department

By Teresa Wall, BSN, MPH, and Merle Lustig, MPH

Background

In 1998, the Gila River Indian Community Department of Public Health (GRDPH) in Sacaton, AZ, began implementation of a W.K. Kellogg Foundation grant awarded and administered through the National Association of City and County Health Officials (NACCHO). The grant, entitled *Turning Point: Collaborating for a New Century in Public Health,* became the catalyst for GRDPH to achieve its longstanding vision of transforming the tribal health department into a model for other health departments. This was to be accomplished by incorporating the values and public health concerns of a sovereign Native-American community with the core public health functions and health department structure found in the state, county, or local governmental systems throughout this country.

The Turning Point initiative set three goals addressing core functions. First, GRDPH would identify the components of a system to monitor the Community's health status. Second, the health department would determine areas needing regulation by tribal ordinance, and outline, draft, and adopt such ordinances. Third, the health department would explore development of a memorandum of agreement with the Arizona Department of Health Services (ADHS) to address areas of mutual concern and cooperation between the two governmental entities.

The following sections describe steps the GRDPH took to achieve its vision.

Assessment

The GRDPH has responsibility for tracking health information and disseminating it to the Community (Tribal) Council and residents. One of the first steps taken by GRDPH was to envision a system capable of monitoring the Community's health status.

Previously, the Gila River Indian Community (GRIC) had to rely on both the Indian Health Service (IHS) and the state health department for data, which was often outdated and incomplete, and did not represent a true picture of the Community's jurisdictional area. GRDPH established a more direct method of receiving and analyzing the most current information available, assuring the data reflected the entire Community as defined by reservation boundaries. It also established a mechanism for infectious disease reporting and control among health care providers within and outside the Community.

Building a Data Collection System

In Arizona, as in other states, the state health department routinely collects data on all Arizona residents, including members and residents of the Native-American communities.

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The information collected on residents of the Gila River Indian Community is included in reports routinely shared with federal agencies, other state agencies, and the IHS.

As a result of the Gila River Turning Point Partnership, GRDPH took the initiative to develop a memorandum of agreement between the Gila River Indian Community and the ADHS addressing areas of mutual concern and cooperation, in this case, data sharing. In October 1998, staff from ADHS and the Gila River Indian Community began meeting. Subsequently, ADHS provided a data sharing template agreement, which Gila River reviewed and modified to fit the unique needs and concerns of a sovereign Native-American community, and then incorporated into the final agreement. In June of 2000, this unique agreement between the state health department and a Native-American tribal government was signed.

Because of the Data Sharing Agreement, GRDPH will receive six databases from ADHS' Bureau of Public Health Statistics. These six databases are: 1) birth certificates, 2) death certificates, 3) non-federal hospital discharge data, 4) birth defects registry, 5) cancer registry, and 6) communicable laboratory disease reports. GRDPH also agreed to provide ADHS with communicable disease reports for individuals residing within the Gila River Indian Community.

The Data Sharing Agreement was a truly collaborative project between ADHS and GRDPH. Based on this agreement, both entities received the University of Arizona Rural Health Office and the Arizona Rural Health Association's Project of the Year Award during the Association's annual meeting in July, 2000.

"It does not require many words to speak the truth."

Chief Joseph, Nez-Perce

Communicable Disease Surveillance

In order to monitor trends and control communicable diseases within the Community's boundaries, GRDPH undertook the development of a tribally based communicable disease surveillance system. This was the first of several reservation-wide surveillance systems whose purpose was to track incidence and prevalence of diseases within the Community and develop strategies for their control.

In March 1999, under the leadership of GRDPH, a work group composed of representatives from partner agencies convened to build a communicable disease surveillance program in the Gila River Indian Community. In the subsequent year, the work group designed a program that reflected the Community's needs and values, thus maintaining tribal sovereignty while incorporating sound principles of public health surveillance. Under the program's guidelines, providers on the reservation would send communicable disease reports directly to the Gila River public health officer who would be responsible for assuring that contacts are notified and outbreaks investigated.

In order to build GRDPH's assessment capacity, the health department established a new position titled database coordinator within the department's administration. The database coordinator reports to the public health officer and is responsible for establishing and maintaining appropriate databases, and entering data as it is received from the communicable disease reports submitted by Gila River health care providers. The database coordinator will monitor the data for trends, and produce written reports for the

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Community (Tribal) Council, Community members, and various local GRIC agencies.

The Gila River Indian Community believes that it is in its best interest to train a tribal member to assume the database coordinator's duties, realizing that person would be more likely to remain in the Community and in the health department, thus maintaining program continuity and efficiency. To accomplish this goal, the Community drew upon the expertise of the Center for Native American Health, a component of the University of Arizona's College of Public Health, that had previously established a Service Learning Institute Internship Program to assist tribal health departments. The Center uses an application process to identify staff members to train in essential public health functions and work on specific health-related projects of particular importance to the tribes. Thus, GRDPH selected an interested employee, who was accepted at the Center and graduated from the Service Learning Institute in May, 2001.

Policy Development

GRDPH has pursued its responsibility as a health department to serve the Community and safeguard its health by building capacity for comprehensive public health policies (see *The Future of Public Health*, Institute of Medicine, 1988).

In the last year, the Community identified a number of areas needing health policy development; the most immediate of which was a Communicable Disease Ordinance that would codify the elements of the Communicable Disease Surveillance Program. With assistance from a consultant and the Gila River Law Office, the work group drafted an ordinance that establishes GRDPH as the entity responsible for receiving and investigating reports of communicable disease within the Gila River Indian Community. This immediate notification will alert GRDPH to any disease outbreaks, allowing for prompt investigation and specified control measures to prevent their spread. The ordinance also establishes vaccination requirements for school attendance within the boundaries of the Gila River Indian Community and prohibits attendance at schools by children with certain communicable diseases. The ordinance will be brought to Community Council for approval after its review at the Community level.

Conclusion

The challenges facing a tribal health department seeking to transform its vision and structure are significant. However, such transformation is essential in order to address the health disparities evident in specific ethnic groups, in this case Native Americans. The Turning Point initiative has invited GRDPH to examine how it serves its community and to make changes that will improve its effectiveness. As a tribal health department, Gila River Indian Community Department of Public Health welcomes this challenge and will continue to strive to achieve its vision for a healthy community. •

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Lessons from the Turning Point Experience

of the Albuquerque Service Unit Indian Health Board

By Cheri Lyon, MPH, and Colleen C. Whitehead, BSW, MMA

The purpose of the Albuquerque Service Unit Indian Health Board (ASUIHB) Turning Point three-year funded grant was to support planning and capacity building for public health in tribal communities and the service unit as a whole. The ASUIHB is comprised of representatives from the five Pueblo tribes of Jemez, Isleta, Sandia, Santa Ana and Zia, the Alamo/Navajo Chapter and First Nations Community Healthsource (representing the urban Native-American population).

In the grant's first year, the project focused on developing tribal leader capacity to understand the principles of public health and to identify key public health issues impacting tribes within the service unit. This was achieved by a two-day training for tribal leaders, health board members, and service unit executive committee members on "The Fundamentals of Public Health" taught by staff from the University of New Mexico (UNM) Public Health Program and the New Mexico State Health Department medical director. On-going meetings among tribal and service unit leaders discussing current public health issues followed this training.

The two main components of ASUIHB's Turning Point plan for year two focused on quarterly service unit wide educational meetings on leading local health issues, and the development of community specific public health capacity building plans for each individual community. The ASUIHB hosted a series of quarterly service unit wide Turning Point partnership meetings that centered on health issues surrounding children, adults, and the elderly.

For year three, the ASUIHB Community Public Health System Improvement Plan emphasized developing increased collaboration between the tribes. The objectives included conducting a meeting for tribal and Indian Health Service (IHS) health care providers working within the ASU on health care financing for American Indians and access to health care issues, and a follow-up working session for health care providers on Medicaid and Medicare specific issues.

There were numerous apparent outcomes achieved throughout the Turning Point collaborative during year three, including the creation of new benefits coordinator positions stationed throughout the service unit, which recognized the past obstacles for American Indians in accessing health benefits and entitlements. These positions enable people to obtain information and apply for on-site benefits in their communities, thus lowering and removing some of the physical and social barriers. Second, the Pueblos of Sandia and Santa Ana entered into a formal partnership to improve dental care to members of both these communities through the use of tribal financial support. Third, the Pueblos of Jemez and Sandia collaborated with the UNM Masters of Public Health

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Program in a community capacity study involving interviewing representative focus groups and individuals to identify factors related to health promotion in the community.

Also in the collaborative's third year, the ASUIHB sponsored two separate conferences, entitled *Improving Health Care in our Communities: Who Pays?*, which focused on health care financing for Native Americans. The participant profile ranged from health care providers to managed care representatives to tribal leaders. The second conference was geared towards nurses, doctors, pharmacists, dental assistants, medical records personnel, social workers, and health board members in Native-American communities.

"The circumstances surrounding the financing of health care for Native Americans is unique and presents its own set of issues and concerns."

Throughout these conferences, ASUIHB learned from a health board perspective that this issue is multi-faceted and very challenging with respect to all of the participants. There were many lessons learned since financing issues affect all aspects of health care delivery and there are many "players" on the field to become familiar with. The ASUIHB needs to understand the importance of learning who these people are, what they can provide, and what expectations they have. There are also many pitfalls associated with the financing of health care for all people. The circumstances surrounding the financing of health care for Native Americans is unique and presents its own set of issues and concerns. The urban Indian population and the Native-American tribes that are pursuing Public Law 93-638 (The Indian Self-Determination and Education Assistance Act, as amended) contracts are both struggling to meet their peoples' health care needs, oftentimes using the same funding sources for all populations. This Act allows recognized Indian tribes to pursue self-governance.

Throughout the three years, it became apparent that there were many lessons to be learned from a community perspective. First of all, most communities really need a substantial amount of education on health care financing. They need to understand where the funding comes from and the eligibility requirements. The communities need to become proficient in understanding the difference between Pub. L. 93-638, urban Indian health care, Medicaid, Medicare, managed care, and private insurance. The goal for the communities is to gain an understanding of all the facets of health care financing to maximize financing in order to provide the best possible health care to their communities. For that reason the conferences were critical because they provided an opportunity for many different people to learn not only the importance of financing but also different ideas on how to navigate the system.

Overall, the conferences have taught the ASUIHB that all communities and health boards are currently facing very similar issues with regards to health care financing. ASUIHB also learned that there are just as many solutions out there as there are problems, issues, and concerns.

By the conclusion of year three, there were six main lessons learned through the use of each tribes' Community Public Health System Improvement Plan: 1) Recognizing the importance of establishing an advisory board, consisting of community members, with the responsibility of directing community initiatives towards health care improvements; 2) Understanding the inherent value and effective methods for obtaining community input and feedback for development of the plans; 3) The need to acknowledge changing roles

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and responsibilities and the effects on longstanding relationships, including how those changes contribute to the on-going need to maintain strong, collaborative working relationships among the tribes; 4) Dealing with the impact of turnover and discontinuity. In some of the partnership communities, turnover in staff and leadership interrupted the continuity of Turning Point participation and activities. In the future, it would be important to identify community individuals as well as staff who would have a high probability of being able to be involved on a long-term basis to reach out to different constituencies and communities. Such persons must have an awareness of the "big picture" in health care issues and trends at the community, area, state, and national levels; 5) Recognizing that leadership must be persistent in stimulating and reinforcing community interest and participation in health initiatives, and continuously provide information and follow-up; and 6) Acknowledging that some community people tend to be action oriented, and the long-range planning and capacity building of Turning Point was seen as abstract and not easily measurable in the short term.

Some possible future plans, based upon experience over the last three years, include developing a written document supported by all of the ASUIHB members that reflects the changing nature of the public health care system that clearly states the roles and responsibilities of its members in meeting the identified goals of the partnership; creating a cooperatively authored paper on the lessons learned in the reshaping of the local American-Indian health care system to reflect true equality in the leadership and ownership of the public health care system; and working towards increased meaningful collaboration between the tribes and local American-Indian organizations and the IHS, New Mexico state government, and other non-Indian health care agencies (e.g., managed care organizations, voluntary agencies, among others). •

"The earth and myself are of one mind."

Chief Joseph, Nez-Perce

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Indian Health Resource List

Environmental Health

- Indigenous Peoples Subcommittee of the National Environmental Justice Advisory Council, "*Recommendations Concerning the Environmental Health and Research Needs Within Indian Country and Alaska Native Villages*," Aug. 14, 2000.

Health Stats, Conditions, Research, etc.

- Devine, Nancy, "*Against the Odds: American Natives Endure Increased Health Risks and Diminished Care*," Healthy People 2010, March 13, 2000.
- Centers for Disease Control and Prevention, National Center for Injury Prevention and Control – *10 Leading Causes of Death, United States 1998, American Indian/AK Native*, www.cdc.gov/ncipc

"Let us put our minds together and see what kind of life we can make for our children."

Sitting Bull

Research, Funding and Development

- Indian Health Service, Native American Centers for Health – *NARCH Initiative Program Announcement*
- Poupart, John, To Build a Bridge: Working with American Indian Communities, American Indian Policy Center: Saint Paul, MN, 2000.
- Agency for Toxic Substances and Disease Registry, "*Working Effectively with Tribal Governments*," Office of Tribal Affairs, Spring 2000.
- Roosevelt County Health Department, *Tribal/Non-Tribal Memorandum of Agreements*

Policy, Government and Other Related Articles

- American Indian Research and Policy Institute, www.airpi.org
- New Mexico Department of Health, *Government-To-Government Policy Agreement*

Web-based Resources

Administration for Native Americans
www.acf.dhhs.gov/programs/ana

Affiliated Tribes of Northwest Indians
www.atni.org

American Indian Research and Policy Institute
www.airpi.org

AMERIND Risk Management Corporation
www.amerind-corp.org

Center for World Indigenous Studies
www.cwis.org

Department of Interior, Bureau of Indian Affairs
www.doi.gov/bureau-indian-affairs.html

Global Good Services
www.globalgoodservices.org

Healing of Nations–Suicide Prevention and Crisis Intervention
www.indian-suicide.org

Indian Health Service
www.ihs.gov

Indian Law Resource Center
www.indianlaw.org

INDIANnet
www.indiannet.indian.com

Indian Unity
www.indianunity.org

International Indian Treaty Council
www.treatycouncil.org

Intertribal Bison Association
www.intertribalbison.org

Mailing List for Tribal Governments (sovereign nations)
www.ncai.org/TribalDirectory/Tribaldirectory.htm

National Council of American Indians
www.ncai.org

National Gambling Impact Study Commission
www.ngisc.gov

National Indian Child Welfare Association
www.nicwa.org

National Indian Gaming Association (NIGA)
www.indiangaming.org

National Indian Health Board
www.nihb.org

National Native American AIDS Prevention Center
www.nnaapc.org

Native American Public Telecommunications
www.nativetelecom.org

Native American Rights Fund
www.narf.org

Native Threads
www.nativethreads.com

Northwest Portland Area Indian Health Board
www.npaihb.org

Office of the Associate Director for Minority Health
www.cdc.gov/od/admh

Senate Committee on Indian Affairs
www.senate.gov/~scia

The National American Indian Housing Council
www.naihc.indian.com

resources

Transformations In Public Health is a publication of the *Turning Point: Collaborating for a New Century in Public Health* initiative. The goal of this initiative is to transform and strengthen the public health infrastructure in the United States so that states, local communities, and their public health agencies may respond to the challenge to protect and improve the public's health in the 21st century. The National Association of County and City Health Officials (NACCHO) and the University of Washington School of Public Health and Community Medicine (UW) serve as National Program Offices for the initiative.

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