Improving Health Outcomes in American Indian/Alaska Native Communities: Why Investment from Local Stakeholders is Crucial to the Tribal Consultation Process

By Miranda Jones
University of Utah

American Indian/Alaska Native (AI/AN) peoples experience significant health disparities in comparison to the general United States population. This is complicated by the fact that AI/AN communities' health concerns are often not addressed equitably compared to other racial/ethnic minority populations. The aim of this paper is to review concerns about AI/AN peoples' health within the context of existing tribal consultation processes in the United States federal government. Tribal consultation is important in building on-going channels of communication between the federal government and the 567 federally recognized tribes. Suggestions are made about best practices that would better utilize the consultation process to improve health for indigenous peoples. The main conclusion of this research is that the Department of Health and Human Services (HHS) tribal consultation process needs to include community-based participatory research (CBPR) and health promotion practices, which directly involve local stakeholders, because it will lead to better outcomes for American Indian/Alaskan Native communities.

Introduction

In an ongoing effort to improve a historically traumatic relationship between indigenous populations and the United States government, the federal government has established legally mandated tribal consultation practices with American Indian/Alaskan Native populations. Of specific note is the tribal consultation process of the Department of Health and Human Services. The current department tribal consultation process requires that any policy affecting the 567 federally recognized tribes be presented to AI/AN tribal leadership and solicited for comment before publication, as stated on the Department's website:

Before any action is taken that will significantly affect Indian Tribes it is the HHS policy that, to the extent practicable and permitted by law, consultation with Indian Tribes will occur. Such actions refer to policies that:

1. Have Tribal implications, and
2. Have substantial direct effect on one or more Indian Tribes, or
3. On the relationship between the Federal Government and Indian Tribes, or
4. On the distribution of power and responsibilities between the Federal Government and Indian Tribes

While the sovereignty of indigenous peoples and the outline of a government-to-government relationship are established by "numerous treaties, laws, Supreme Court decisions, and Executive Orders," the process of tribal consultation is affirmed mostly by Executive Orders (Health and Human Services, 2010). What this means is the process of tribal consultation is largely at the whim of increasingly polarized politics.

A constantly evolving tribal consultation is vital not only to continue to mend the rocky relationship between the two governments, it is also because as an ethnic/racial population, the indigenous peoples of the United States of America have significant health disparities compared to other populations in the United States. The U.S. federal government, specifically the Department of Health and Human Services, is required to consult with "Indian Tribes" before taking action that will significantly affect them, yet they are not required to incorporate them. Though leadership for the strategic planning team at the Department of Health and Human Services prioritized the concerns of indigenous peoples, it is unclear in the consultation policy document what kind of mandated accountability to these comments exists. It is evident that the federal government is reaching out to this community, but listening passively can only make so much impact. As it stands, the tribal consultation process is a mere pacifier and does not serve as real representation of AI/AN voices. Additionally, there is not a legal requirement for AI/AN leadership to be involved in development of policies that impact them "significantly," only to comment after they have been created and before implementation. It is imperative to improving the health outcomes of indigenous populations in the United States of America that we begin to include these community members in conversations about policy development rather than just asking for feedback.

In the past, some federal government policies have negatively

impacted health outcomes for indigenous peoples of the United States. To ensure that the federal government positively impacts tribal communities, it is critical to include these populations in the conversation. Ultimately, the best spokespeople for improving these poor health outcomes are those who are exposed to these factors negatively impacting their health. The tribal consultation process is a step in the right direction because it attempts to have a sense of duty to indigenous populations, but the policy is missing the mark when it comes to meaningful participation. The Department of Health and Human Services Tribal consultations need to include community-based participatory research (CBPR) and health promotion practices, which directly involve local stakeholders, because it will lead to better outcomes for American Indian/Alaskan Native communities.

AI/AN Health: The Environmental, Nutritional, and Geographic Contexts of Health Disparities

Health concerns among the AI/AN community are diverse. Many issues of environmental injustice, nutritional equity, and unequal access to comprehensive health services have uniquely negative implications for indigenous populations. Though the indigenous populations of the United States of America are resilient, there are key health areas that could be significantly improved through better investments by the federal government. In the article, "The 'In-Between People': Participation of Community Health Representatives in Diabetes Prevention and Care in American Indian and Alaska Native Communities," Satterfield D, DeBruyn L, Santos M, Alonso L, and Frank M. present an argument that the disruption of indigenous peoples' relationships with traditional food and tribal lands can be thought of as being at the heart of health disparities, operating through the mechanism of loss of the high fiber diet and opportunity for physical activity (Satterfield et al, 2016).

Though there is a wide range of health areas that could be considered, the focus here is on diabetes, obesity, and cardiovascular disease. These illnesses represent chronic conditions that have a high degree of potential responsiveness from tribal consultation efforts, leading to a significant potential for cost saving intervention. Additionally, there is large potential for tribal consultation, using a health promotion and community based participatory focus, to translate to success in other health areas such as substance abuse and mental health issues.

Diabetes, Heart Disease, and Obesity

Data from the Office of Minority Health (2017) reveal several health challenges for AI/AN individuals. American Indian/Alaska Native adults have a higher prevalence of diabetes than white adults, as shown in Figure 4 in Appendix A (at the end of this report). Data from 2004-2008, presented in Figure 5 in Appendix A, reveal AI/AN women have a higher prevalence of diabetes death rates than non-Hispanic white women. American Indian/Alaska Native youth and adults have a higher prevalence of obesity than non-Hispanic whites (shown in Figure 1 in Appendix A). AI/AN adults also have a lower prevalence of engaging in regular leisure-time physical activity than white adults (presented in Figure 2).

These differences extend to important risk factors for diabetes and cardiovascular disease. Data presented in Figures 6 and 7 show these differences for coronary heart disease and high blood pressure. In 2014, heart disease was the "leading cause of death among American Indians and Alaska Natives" accounting for 3,288 deaths (Center for Disease Control, 2017). The most extreme death rates, for heart disease, are located largely in South Dakota, North Dakota, Wisconsin, and Michigan. American Indian/Alaska Native adults have a higher prevalence of high blood pressure and cigarette smoking than white adults (Center for Disease Control, 2017). Cardiovascular diseases pose a dire threat to the health of tribes, through heart disease and lung cancer.

Lung Cancer and Smoking

Two of the leading concerns for cardiovascular disease in tribal communities are high rates of obesity and tobacco use. The Substance Abuse and Mental Health Services Administration (SAMHSA) reported in 2013 that "43.8% of American Indian/Alaska Native adults reported current use of commercial tobacco (Substance Abuse and Mental Health Services Administration, 2013)." Also reported was that "AI/AN youth and adults have the highest prevalence of cigarette smoking among all racial/ethnic groups in the U.S." (Substance Abuse and Mental Health Services Administration, 2013). The Centers for Disease Control and Prevention reported that among racial and ethnic groups, smoking during pregnancy was highest among AI/AN (26%) (Center for Disease Control, 2017). Not only were rates of smoking during pregnancy highest amongst American Indian/Alaska Native females but also for smoking after delivery (40.1%).

Liver Disease and Substance Use

Substance use is a significant challenge in developing healthier communities amongst tribes. Tobacco use, via cigarettes, has been shown to lead to cardiovascular disease and alcohol has led to chronic liver disease. In 2009, the Indian Health Service compared American Indian/Alaska Native peoples' rates of chronic liver disease with the rest of the United States population and found rates as being 4.8 to 1 (Indian Health Services, 2017). Alcohol is not only the major cause for high rates of chronic liver disease in AI/AN communities, alcoholism itself is a disease that heavily impacts native populations.

Environmental Concerns

When discussing health disparities, environmental issues provide a context for health issues. Of top concern for tribal communities living in Indian Country are the numerous environmental

crises taking place on their land. After over a century of hard rock mining there are more than 160,000 abandoned mines that span the western side of the United States of America (Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, South Dakota, Utah, Washington, and Wyoming); the majority of which are on Native American lands. Native Americans that live near abandoned uranium mines have "an increased likelihood of developing multiple chronic diseases linked to their proximity to the mine waste and activities bringing them in contact with the waste." Traditional lifestyles for members of tribal communities include using local plants for "sustenance, ceremonial or medicinal purposes," as well as, "drinking from historically used water sources," which ultimately can increase risk of exposure to mine wastes that now contaminate these sources (Lewis, Hoover, MacKenzie, 2017).

The Centers for Disease Control and Prevention and Health conducted a study in 2000 to assess the impact of miners working in uranium mines (National Institute for Occupational Safety, 2012). In this study, participants were divided between white and non-white (of the 757 miners, all but four were Native American, mainly Navajo) to observe the role, if any, that race may play in risk associated with exposure. Cause of death was analyzed specifically for strong evidence of an exposure-response relationship with radon progeny, the different radioactive products of decay of radon gas, in the mines (Canadian Coalition for Nuclear Responsibility, 2017). The researchers concluded that exposure to radon progeny (formerly known as radon daughters) was experienced by working miners but also possibly community members as well, and was connected with mortality from lung cancer, tuberculosis, pneumoconiosis, and other lung diseases.

Nutritional Challenges

Lack of fertile land for agriculture, coupled with the existence of food deserts (defined as usually impoverished areas without access to fresh produce and health foods) presents a very challenging nutritional landscape for American Indian/Alaska Native peoples. Not only does the land and available resources nearby impact this population's ability to make healthy nutritional choices, this community also must straddle the complicated duality between culture and modern knowledge. The traditional, post-colonial diet of American Indian/Alaska Native communities creates vulnerabilities for developing both diabetes and cardiovascular disease.

The United States government provided food rations for American Indian/Alaska Native communities in the late 1800's, which included white flour, processed sugar, and lard. This has created a custom culinary staple, known as fry bread, which is rooted in current tribal culture. Fry bread has become a symbol for many urban indigenous peoples of both the strength of survival as well as the pain of inequality and lack of adequate resources. One slice of fry bread, the size of a large paper plate, has 700 calories and 25 grams of fat (Smithsonian, 2008). There has been a lot of discussion amongst AI/AN peoples about the role of fry bread for their people. Some feel as though the fry bread tradition plays an integral role in powwows and other intertribal gatherings. Others, such as Indian writer and activist Suzan Shown Harjo, claim that fry bread is "emblematic of the long trails from home and freedom to confinement and rations" (Smithsonian, 2008). Whether on the side of preserving tradition through fry bread or feeling as if fry bread is the root of all native health challenges, this controversial tradition is leading the conversation about nutrition in tribal communities.

Poor nutrition has ripple effects throughout the entire tribal community, from diabetes to obesity to cardiovascular disease. This knowledge can create a sense of hopelessness for tribes as they try to improve their health outcomes (Satterfield et al, 2016). A study in Oklahoma assessed the perspectives of American Indian women who were 19 to 45 years old and had prior gestational diabetes, which is a type of diabetes that develops during pregnancy. Though the study was limited to 26 participants, not a large enough sample size to depend on, the clear attitudes expressed by the women are worth noting. The participants of this study felt that they would "inevitably develop diabetes, cardiovascular disease, or both; however, they were optimistic that they could delay onset with lifestyle change" (Jones et al, 2015). The CDC reports that "American Indian and Alaska Native adults are twice as likely to have diagnosed type 2 diabetes as non- Hispanic whites" as discussed earlier in this paper.

Geographic Concerns

As of 2010, approximately 70 percent of American Indians and Alaska Native peoples live in urban areas, which represents an increase from 38% in 1970 to 60% in 2000 (United States Census, 2010). Yuan and colleagues (2014) observe that despite this emerging trend, AI/AN peoples can be thought of as an "invisible minority" as their health concerns are not addressed equally to other ethnic minority populations. Only 25 percent of urban AI/AN people reside in counties served by urban Indian health programs (Urban Indian Health Institute, 2013). Yuan also observed that urban AI/AN peoples' needs differ from those in reservation-based communities along two key dimensions. First, AI/AN peoples in urban areas might have less understanding of traditional practices as relocation to urban areas has disrupted traditional culture, yet there are no other structures in place to provide support. Second, there is an absence of sovereign governing bodies to provide valuable support to identifying and safeguarding individual rights to health care access. For these reasons, awareness of the potentially unique health and well-being concerns are important to keep in mind when considering the federal government's role in tribal consultation planning and implementation.

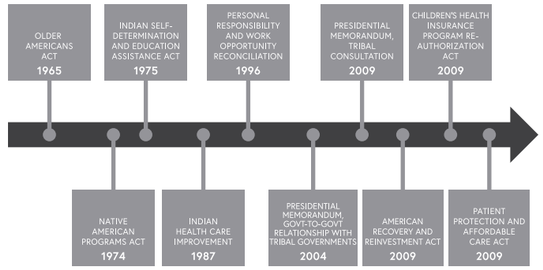
Tribal Consultation: Current Models of Communication between the Federal Government and American Indian/Alaska Native Communities

As discussed, AI/AN populations experience unique health disparities that are important to address in order to improve and ensure the health of current and future generations of indigenous peoples. An opportunity to improve the health of AI/AN populations is by using the current practice of tribal consultation and building off the current policy with increased opportunities for shared participation by stakeholders from both AI/AN populations and the federal government. Tribal consultation is an official means of communication that provides a platform for respectful dialogue between the United States federal government and 567 federally-recognized tribes. The Department of Health and Human Services defines "true and effective consultation" as a process that results in "information exchange, mutual understanding, and informed decision- making on behalf of the Tribal governments involved and the Federal Government" (Health and Human Services, 2011). Consultation with tribes has been upheld through Presidential Memoranda (1994, 2004, and 2009), an Executive Order (131715 in 2000), and several pieces of legislation. Through this process, the U.S. government is able to inventory existing legislation that supports AI/AN communities as well as identify resources that could be strengthened. By addressing gaps in supportive infrastructure for American Indians/Alaska Native peoples, the United States government upholds accountability to this population. The Department of Health and Human Services states that the "goal of this policy includes, but is not limited to, eliminating health and human service disparities of Indians, ensuring that access to critical health and human services is maximized, and to advance or enhance the social, physical, and economic status of Indians" (Health and Human Services, 2011).

The Department of Health and Human Services, as well as the federal government as a whole, plays a crucial role in addressing these health concerns by maintaining their dedication to the practice of tribal consultation. Not only will this continued effort improve health outcomes for AI/AN communities, it is also mandated by the law through Executive Orders and legislation that supports health promotion activities, which includes a consideration of community-based participatory research models. Departments in the federal government that oversee issues related to health, such as the Department of Health and Human Services, should consider evidence-based strategies and subsequent data when working to strengthen tribal consultation and AI/AN health outcomes.

Consultation between tribal communities and the federal government is supported by legislation passed as early as 1965, with the Older Americans Act, to as recently as 2010 with the Patient Protection and Affordable Care Act, P.L. 111-148, 124 Stat. 119 (HHS Consultation Policy).

There remains much that can be done to elevate and refine the practice of tribal consultation to better function as an important form of health promotion in AI/AN communities. The fact that tribes function as sovereign nations presents an opportunity for



This timeline provides key legislation and executive orders relevant to the Department of Health and Human Services Tribal Consultation Policy.

a significant effect on the health of tribal citizens (Jernigan et al, 2015). The next section provides important examples of the promise of an enhanced partnership between the federal government, in this case in the realm of the Department of Health and Human Services programs and sponsored research, and indigenous peoples. This will model how healthcare can be more effective with increased culturally competency.

The Department of Health and Human Services: Brief List of Current Programs that Impact American Indian/Alaska Native Communities

The United States government has been working to improve these health disparities. The Special Diabetes Program for Indians (SDPI) was established by Congress in 1997 to provide "funds for diabetes prevention and treatment services" through Indian Health Services (National Indian Health Board, 2017), which included a toolkit for diabetes prevention. Though the U.S. government has created programs for diabetes prevention in AI/AN communities, there is room for improvement. One of the current challenges in diabetes prevention is the ongoing need for culturally competent techniques, as there is a current disconnect between traditional physiological prevention techniques and techniques informed by consultation with AI/AN stakeholders. For example, the National Institute of Diabetes and Digestive and Kidney Disease (NIDDK) Diabetes Prevention Program (DPP) research showed "that a small amount of weight loss, achieved through lifestyle changes, could prevent the onset of type 2 diabetes in diverse populations-including American Indian people" which does not address the impact of culture on diet and exercise in tribal communities (National Institute of Diabetes and Digestive and Kidney Diseases, 2017). Findings from a recent analysis (Lagisetty et al, 2017) reinforce that cultural tailoring is necessary for successful diabetes intervention. The work of Lagisetty et al. indicates that targeted diabetes interventions with culturally appropriate messaging can lower associated diabetes risk factors.

A recent effort to interdict in the issue of cardiovascular dis-

eases involves the "Million Hearts" Initiative (Health and Human Services, 2016). This program was funded by HHS and utilized culturally appropriate language and sought leadership input from AI/AN voices. This program aimed to assess an approach to reduction in the ten-year predicted risk of atherosclerotic cardiovascular disease (ASCVD) by implementing cardiovascular preventive strategies to manage the "ABCS" (aspirin therapy in appropriate patients, blood pressure control, cholesterol management, and smoking cessation) (Tomaselli et al, 2011). This initiative identifies that American Indians and Alaska Native peoples die from "heart diseases at younger ages than other racial and ethnic groups in the United States," and that "36% of those who die of heart disease die before age 65"(Hunter, 2015).

In 2010, President Barack Obama signed the Tribal Law and Order Act which amended the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (Indian Health Service, 2017). This expanded "the number of Federal agencies who are required to coordinate their efforts on alcohol and substance abuse issues in American Indian/Alaska Native communities"(Indian Health Service, 2017). Additionally, the federal government, via Indian Health Services, offers resources to help tribes develop a Tribal Action Plan (TAP). One of the ways the Tribal Action Plan assists tribal communities is that it "assesses the scope of the tribe's alcohol and substance abuse problems" as well as identifying and aligning "available resources and programs focused on prevention and treatment" (Indian Health Service, 2017) The reason that the Tribal Law and Order Act was significant was because it affirmed the Obama administration's commitment to working with indigenous peoples.

In addition, addressing the misuse of alcohol in Indian Country is a very important step in creating healthier tribal communities. The objective of the Alcohol and Substance Abuse Program (ASAP), created by the Indian Health Service, is "to reduce the incidence and prevalence of alcohol and substance abuse among the American Indian and Alaska Native (AI/AN) population to a level that is at or below the general U.S. population" (Indian Health Service, 2017). The programs within the Alcohol and Substance Abuse Program work to improve access to behavioral health services by means of "telebehavioral health methods, and by providing a comprehensive array of preventative, education, and treatment services" (Indian Health Service, 2017).

Community-Based Participatory Research and the Health Promotion Approach: Investing in Local Stakeholders to Improve Health Outcomes for AI/AN Populations

There have been important examples of federal involvement in research using culturally targeted approaches to reducing important health disparities in AI/AN communities. One approach that could be leveraged as a way to extend and enrich the process of tribal consultation is to imbed the practice in a community-based participatory approach. Community-based participatory research is defined as a collaborative approach involving partners across the research process where partners contribute expertise and share the decision making process (McOliver et al, 2015). Community-based participatory research can also be an important health promotion approach in AI/AN communities and can be thought of an important process to empower individuals to increase control and improve health (Green & Kreuter, 1990). In order to understand the possible impact of implementing these techniques, it is vital to acknowledge key health disparities in tribal communities, as well as their origins.

Community-based participatory research is a powerful tool for addressing health disparities experienced by AI/AN populations and can also be seen as an important component of tribal consultation, as argued by Jernigan and colleagues (2015). Community based participatory research is a framework that brings together health education, research, and social action and rests on the activities and principles of co-learning, determining mutual benefit, and long term collaborative commitment to dialogue by the parties involved. Endorsed by the Institute of Medicine (2012), this approach recognizes the value of regarding tribal nations as equal partners who should inform health promotion activities with traditional knowledge rooted in community priorities where local stakeholders are active partners in research and interventions.

The United States government has already used a community based participatory approach to extend the efforts of tribal consultation effectively in various sectors of the government. For example, the National Institutes of Health (NIH) has established the NIH Tribal Consultation Advisory Committee as a complementary mechanism for the exchange of information between National Institutes of Health and tribal representatives that will enhance existing nation to nation consultation activities. As a supplement to this effort, the National Institutes of Health have developed programs that support Native investigators by funding health research and interventions in tribal settings. One promising component of this initiative is the NIH Native Investigator Development Program which will train minority researchers in research methods so that there can be scientific researchers who are from the AI community. This initiative is poised to increase the number of native researchers who can be successful in applying for federal grant support. At present, available estimates suggest that only 41 AI/AN PhDs submitted major National Institute of Health grants (RO1 mechanism) over a six-year period (Jernigan, 2015). The training of Native American researchers has the potential to realize the outcome of native scientists who can truly work in consultation with tribal members to use community based participatory research techniques to address health disparities with rigorous methods that are sensitive to community based collaborative health goals.

One key issue when integrating community-based participatory research methods in tribal communities is the community capacity to sustain health intervention best practices beyond the timeline of a given intervention. Remedying this issue will take

training, which has been shown by a recent effort by Jernigan and colleagues (2014) that yielded promising results. Their effort involved the Community-Campus Partnership for Health at the University of Washington and was an evidence-based CBPR curriculum (called Developing and Sustaining Community-Based Participatory Partnerships: A Skill-Building Curriculum or CCPH). It was designed for both academic researchers and community partners and was adapted for use as a part of a partnership running from 2010 to 2013. The goal was to develop research capacity to conduct research in three tribal communities and two tribal clinics in northern California. The seven-part curriculum was grounded in considering indigenous ways of knowing into each unit. The project led to some important policy level outcomes. One such policy outcome was the development of a tribal review board that served the unique role of determining appropriate research partnerships that effectively involved and benefited the community in a culturally respectful manner. This group used the end of the program to host a large event where there was an organized effort to produce a participatory publication that had the effect of drawing diverse voices into academic research (Jernigan et al, 2014). Another important policy outcome was the documentation and new dialogue around the complex role that tribal health clinics play in research in AI/AN communities. In the future, the established practice of tribal consultation can be an important supplement to this effort of building native research capacity for improving health outcomes.

Communication about health promoting information is another promising potential use of tribal communication practices. Geana and colleagues (2012) analyzed data from a sample of approximately 900 AI peoples residing in the Midwest states to explore native preferences for channels of health messaging as well as how AI peoples use health information prior to and during clinic visits. One important finding is that members of the AI population rely heavily on community resources in addition to traditional media outlets as a source of health information. Consequently, to effectively move the dial on existing health disparities, partnerships with Indian Health Services that involve sustained culturally-tailored information campaigns will be best served by ongoing consultation between community stakeholders and members of various health organizations, including those in the federal sector. Ultimately, the messengers to AI/AN communities are just as important as the message.

The emerging trend of the majority of the AI population living in urban areas merits special attention in this section on promising evidence based strategies of reducing health disparities. At present the scientific community has lagged in their efforts in involving AI/AN peoples in research. Yuan (2014) notes that a PubMed literature review reveals that less than three percent of the research findings on AI/AN populations include data on urban AI populations. In response, they call for more engagement by diverse stakeholders in promoting research on and capacity among urban AI/AN communities. They call for the use of CBPR research as an important next step for improving the lives of AI/AN people living in urban areas.

Johnson and colleagues (2016) seem to anticipate this call for community-based participatory research health and needs assessment of urban AI peoples. Using a mixed method research design to identify urban AI residents in Tulsa Oklahoma, roughly 650 adults and youth were surveyed about their community attitudes and health beliefs. Tulsa represents one of the largest AI populations in the United States. Using sites such as the long standing Indian Health Care Resource Center (IHCRC) as an organizational hub for community activity, urban Indian voices were consulted on the issues of wellness programs, mental health priorities, and the identification of community challenges and needs. Of these stated challenges, alcohol abuse, diabetes, and obesity, as well as a lack of tribal resources and services were among the highest ranked. The project staff at this CBPR project implemented a research-training curriculum that served to increase the research capacity of this community. The project also established a health promotion network that is designed to leave a community-based infrastructure that can support ongoing collaborative work. This infrastructure can also be adapted to a tribal consultation model for future community-based health interventions in urban AI communities. This research is promising because it demonstrated how collaborative efforts between community members and research staff members can develop an enhanced system of care that can support and importantly extend the efforts of existing Indian health centers, which is important because existing health centers are relatively few in number so efforts such as those described in this program have the potential for much needed community extension of efforts.

One crucial aspect of any research or consultation activity is demonstrated movement in reducing an identified health disparity area. One such success story can be found in the work of the Department of Health and Human Services in collaboration with the Centers for Disease Control and Prevention (Johnson et al, 2016). The Traditional Foods Project, 2008 to 2014, was developed as a result of the Balanced Budget Amendment (Law 105-33) which established the Special Diabetes Program for Indians. This was administered by the Indian Health Service in consultation with the Tribal Leaders Diabetes Committee. This process included the voices of 400 tribal members representing 171 tribal nations to inform planning, implementation, and evaluation. Early results of this evaluation reveal promising observations that involve the significance of land, interest in Native American food pathways, respect for traditional knowledge, and most importantly sustained efforts beyond the end of the project that will serve to make important impacts on efforts to reduce rates of diabetes and improve wellness.

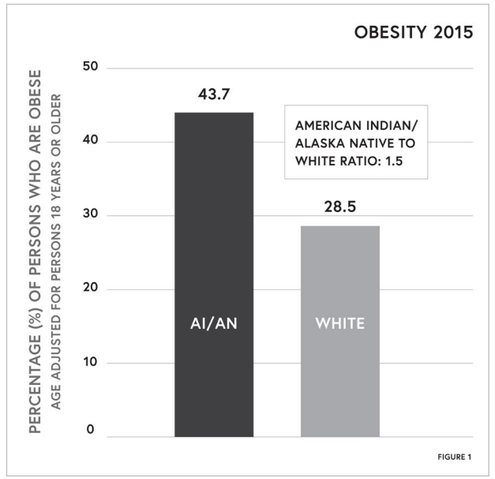
Conclusion: The Gap Between the Needs of AI/AN Communities and the Programs that Currently Exist in the Federal Government

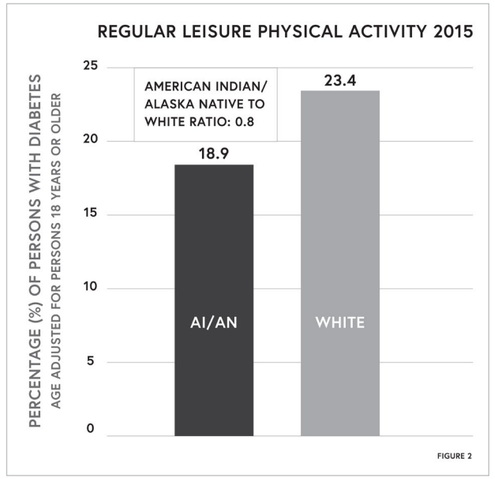
Currently, there are important health disparities that exist for the AI/AN population. American Indian/Alaska Native people have unique cultural needs and history that require culturally responsive approaches to ensure they are successful. This report has highlighted some of these health concerns and the full list of AI/AN specific health concerns is even longer. Adequately addressing these health concerns requires a comprehensive approach that will involve medical intervention, clinical care, effective medication, and health behavioral changes. A key component that will determine the success of these measures is the involvement of AI/AN people as patients, co-learners, health advocates, and scientists. The Department of Health and Human Services has a structure in place for tribal communication that could be improved by pairing it with a community-based participatory research model.

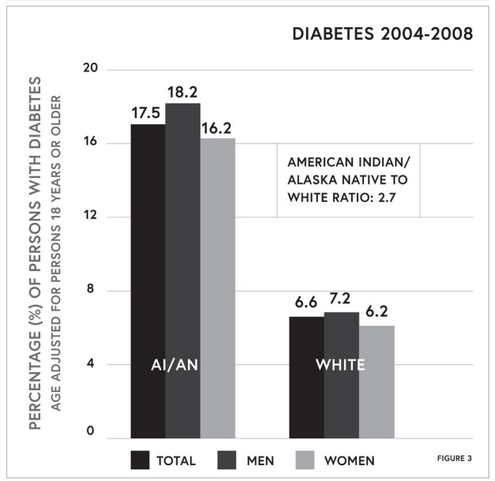
Given early success of this approach as a health promotion model with key health concerns such as obesity and diabetes, other health problems such as liver disease and substance abuse could be significantly lessened by making tribal consultation paired community based participation models and subsequently should be an important strategic goal going forward. Tribal consultation and culturally competent models are essential to ensure that federal intervention does not make outcomes for AI/AN communities worse. This consultation process between AI/AN communities and the United States federal government can be enhanced by the employment of health promotion models that directly involve local AI/AN stakeholders in the process. Pursuing this goal holds the potential for making significant strides in the health and wellbeing of American Indians and Alaskan Natives in the years to come.

The current policy for tribal consultation in the Department of Health and Human Services is an important starting point but there is still considerable room for improvement. There is a mandate that the Department must provide consultation with the 567 federally-recognized AI/AN tribes for any policy that impacts these communities. There is not however a mandate that the provided feedback must be incorporated or implemented. As it stands, the policy serves more as a tool of appeasement than restorative justice.

Appendix A:







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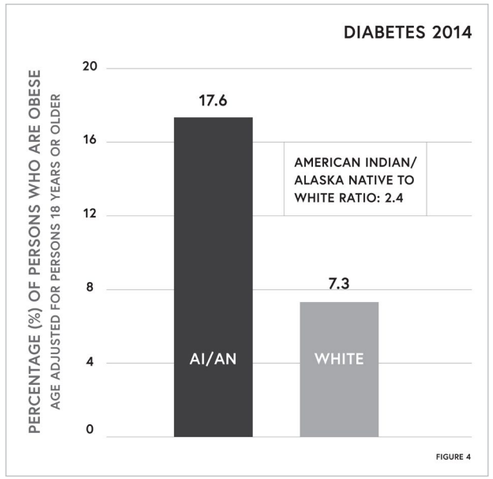

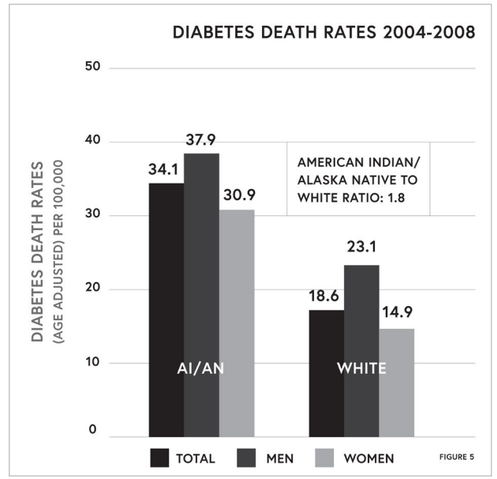

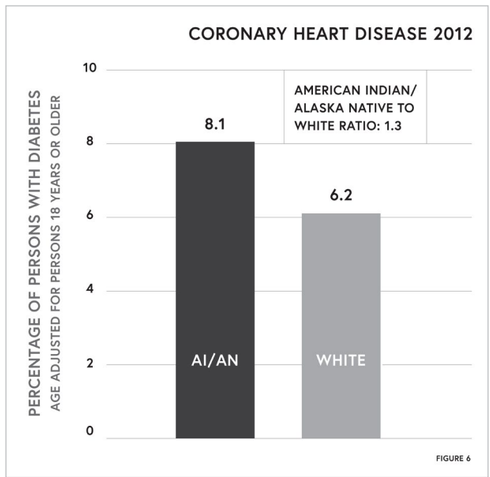

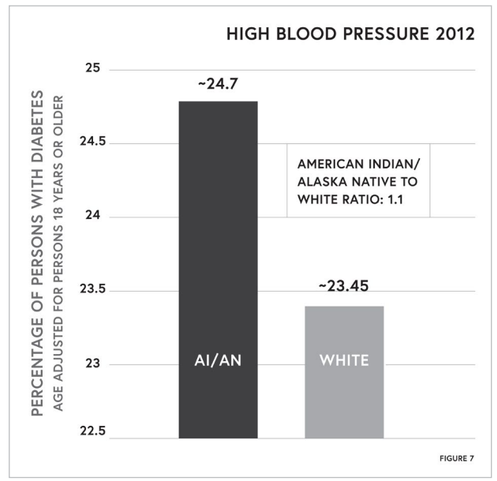

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