GOOD HEALTH AND WELLNESS IN INDIAN COUNTRY

YEAR 3 Comprehensive Report

Measuring the Value and Impact of Good Health and Wellness in Indian Country (GHWIC)

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
EPIDEMIOLOGY CENTER

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Acknowledgments

The Alaska Native Tribal Health Consortium is located on the lands of the Dena'ina people.

We wish to thank all the recipients and subawardees of GHWIC for their hard work during the first three years of this cooperative agreement. We also wish to thank the Centers for Disease Control and Prevention (CDC) for their collaboration and feedback to create this report as part of the national GHWIC evaluation.

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Executive Summary

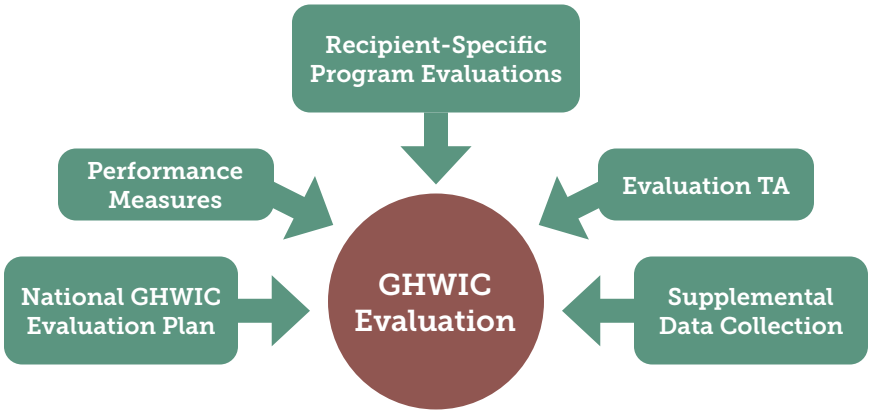
The Year 3 Comprehensive Report provides an overview of the Good Health and Wellness in Indian Country (GHWIC) program and evaluation results for Year 3. The GHWIC program, funded by the Centers for Disease Control and Prevention (CDC), aims to improve the health of American Indian and Alaska Native (AIAN) populations by focusing on reducing the rates of commercial tobacco use, diabetes, heart disease, stroke, and obesity among AIAN individuals and communities.

GHWIC Program

The GHWIC program consists of three components: Component 1 (C1) funds directly awarded Tribes, Villages, and urban Indian organizations (UIOs) to work on GHWIC strategies; Component 2 (C2) provides subawards to additional Tribes, Villages, and UIOs to implement GHWIC strategies; and Component 3 (C3) serves as the Coordinating Center for GHWIC supporting C1 and C2 recipients. The program includes 28 recipients through these components, including 16 C1 recipients, 11 C2 recipients, one C3 recipient. For Year 3, 95 subawardees around the country received funds through C2 recipients to work on the GHWIC strategies.

GHWIC Evaluation

The evaluation of the GHWIC program focuses on monitoring the implementation of policy, systems, and environmental changes (PSE) and community-clinical linkages (CCL) strategies. The National GHWIC Evaluation Plan was designed to assess the intermediate outcomes of the program and highlight evidence-based approaches and activities. The evaluation approach is participatory and guided by the CDC Framework for Program Evaluation, incorporating culturally responsive and Indigenous evaluation.

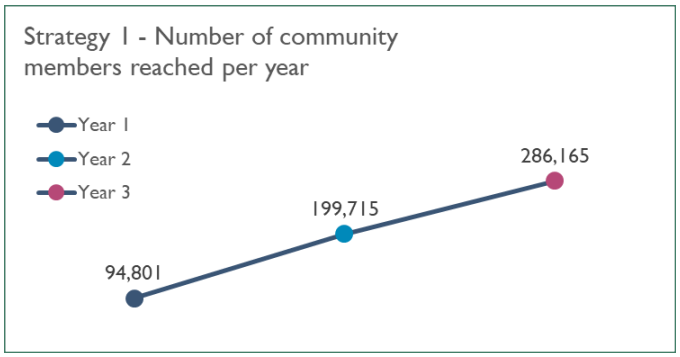


The GHWIC evaluation consists of five elements: (1) the National GHWIC Evaluation Plan, (2) Performance Measures, (3) Recipient-Specific Program Evaluations, (4) Evaluation Technical Assistance, and (5) Supplemental Data Collection. Results for the Year 3 evaluation centers on data from performance measures, annual evaluation reports, and supplemental data collection.

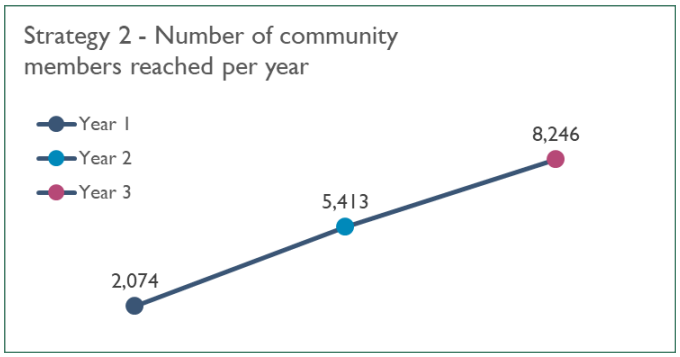
Evaluation Results

This report focuses on the evaluation findings for each of the four GHWIC strategies: Obesity Prevention, Commercial Tobacco Prevention and Control, Diabetes Prevention, and Heart Disease and Stroke Prevention. The report highlights the activities, reach, interventions, and outcomes of each strategy, along with selected success stories and identified challenges and barriers to implementation. For Year 3, the cumulative reach includes the total number of community members reached through the first three years for each strategy, and Year 1 data serves as the baseline to compare subsequent years of GHWIC.

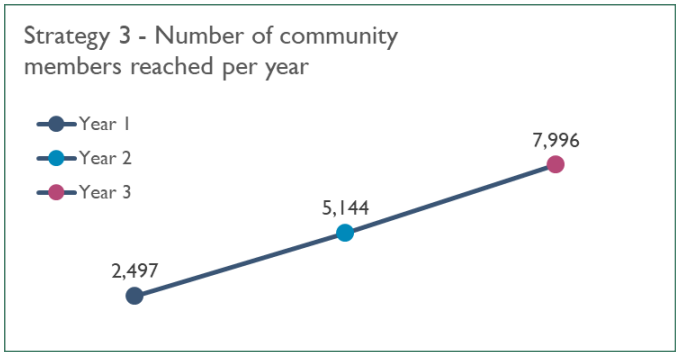
Strategy 1 (Obesity Prevention)
Recipients worked to increase access to nutritious foods, physical activity, and breastfeeding. Programs used various interventions for this work such as policy development, nutrition education, and infrastructure improvements. The reach of Strategy 1 increased over the first three years, with a cumulative Year 3 total of 286,165 AIAN community members—3 times higher than Year 1.



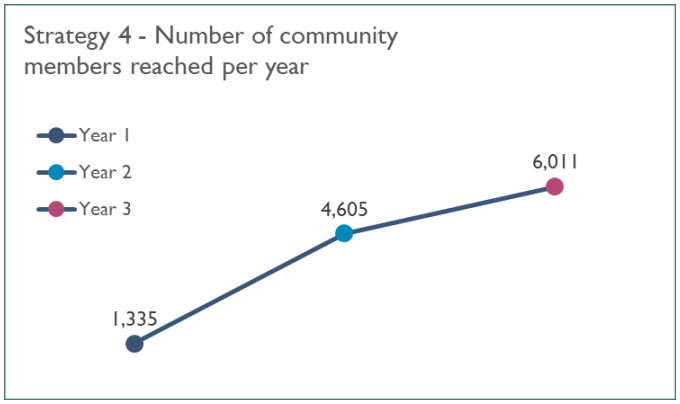
Strategy 2 (Commercial Tobacco Prevention)
Recipients worked on policy, system, and environmental changes (PSE) to prevent and control commercial tobacco use by focusing on commercial tobacco-free policies and access to cessation treatment. Programs used partnerships to advance policy work and offered smoking cessation services. The Year 3 cumulative reach of 8,246 community members enrolled in cessation programs is 4 times higher than Year 1.



Strategy 3 (Diabetes Prevention)
The focus is on expanding access to the National Diabetes Prevention Program (NDPP). GHWIC recipients used a variety of approaches for this strategy, including prediabetes education, culturally-conscious education, and furthering NDPP work. The reach of Strategy 3 increased over the first three years, with a cumulative Year 3 reach of 7,996 community members—3.2 times higher than Year 1.



Strategy 4 (Heart Disease and Stroke Prevention)
GHWIC recipients reported progress in increasing trainings and engagement of Community Health Representatives(CHRs), expanding referrals to self-management and treatment programs, and increasing community-clinical linkages. The reach of Strategy 4 increased over the first three years, with a cumulative reach of 6,011 community members in self-management and treatment programs—4.5 times higher than Year 1.



Conclusion

This report concludes by discussing the overall progress of the GHWIC strategies, the support provided by C2 and C3 recipients, and the challenges faced in program implementation. It provides a comprehensive overview of the evaluation findings and demonstrates the efforts made to improve the health and wellness of AIAN communities through the GHWIC program.

Overview of the GHWIC Program

Good Health and Wellness in Indian Country (GHWIC) DP19-1903 is the Centers for Disease Control and Prevention's (CDC) largest investment to improve American Indian and Alaska Native (AIAN) health. The goal of this funding opportunity is to reduce rates of death and disability from commercial tobacco use, diabetes, heart disease and stroke, and reduce the prevalence of obesity and other chronic disease risk factors and conditions in AIAN peoples and communities.

GHWIC Strategies

GHWIC strategies build upon national efforts to increase the health impact in Indian Country through evidence-informed policy, systems and environmental change (PSE), and community-clinical linkage (CCL) strategies and activities. The GHWIC program focuses on the following strategies:

- **Strategy 1:** Implement evidence-informed and culturally adapted PSE to prevent obesity.
- **Strategy 2:** Implement evidence-informed and culturally adapted PSE to prevent and control commercial tobacco use.
- **Strategy 3:** Implement evidence-informed and culturally adapted CCL to support type 2 diabetes prevention.
- **Strategy 4:** Implement evidence-informed and culturally adapted CCL to support heart disease and stroke prevention.

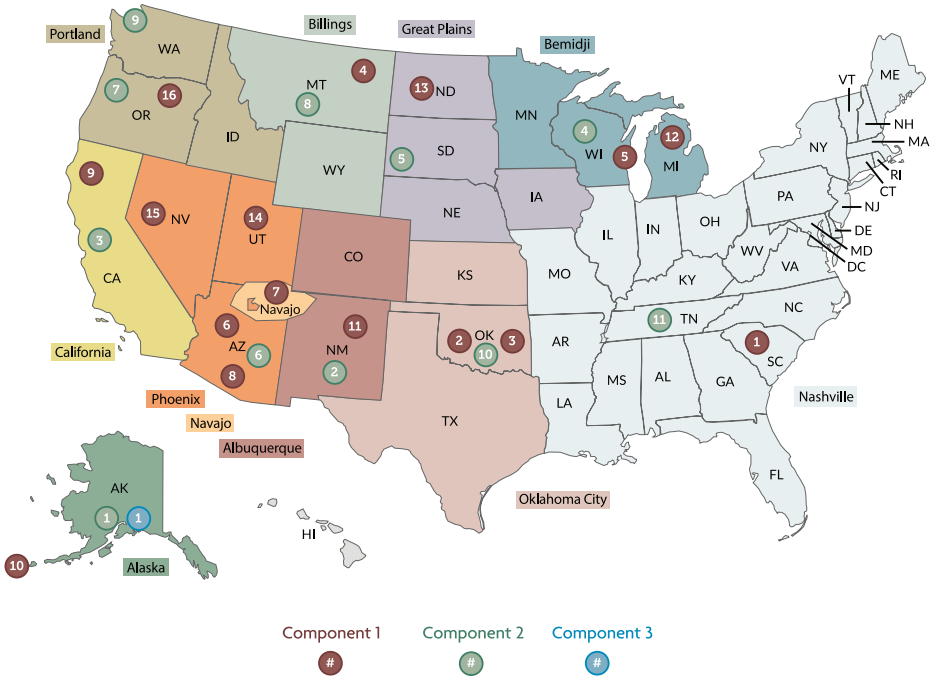
Policy, systems and environmental change (PSE) are population level strategies with the potential to impact the general population and specific subgroups with higher risk for chronic illnesses.

Community-clinical linkage (CCL) are connections between community and clinical sectors to improve population health.

The Reach of GHWIC

GHWIC DP19-1903 includes three separate components awarded to 28 recipients (see Figure 1):

- **16 Component 1 (C1) recipients** – directly funded Tribes and urban Indian organizations are funded to implement the four GHWIC strategies in AIAN Tribal communities, urban Indian areas, and Villages;
- **11 Component 2 (C2) recipients** – Tribal and urban Indian organizations providing leadership, technical assistance, training, and resources to AIAN Tribes, Villages, and other Tribal organizations within their Indian Health Service (IHS) Areas, including disseminating subawards annually to Tribes and other Tribal and urban Indian organizations;
- **One Component 3 (C3) recipient** – the Alaska Native Tribal Health Consortium (ANTHC) Alaska Native Epidemiology Center in Anchorage, AK serves as the Coordinating Center for GHWIC (CCG). In this role, the CCG collaborates with the CDC to monitor and report on progress toward achieving the expected outcomes of the GHWIC program. The CCG supports C1 and C2 recipients through technical assistance, trainings, and community of practices.
- **95 C2 subawardees** – For Year 3, the GHWIC program reach also included the work of 95 C2 subawardees from around the country (refer to Appendix A: GHWIC Year 3 Subawardees).



IHS Area	Component 1	Component 2
Alaska	Qawalangin Tribe of Unalaska 10	Alaska Native Tribal Health Consortium 1
Albuquerque	Santo Domingo Tribe – Kewa Health Outreach Program 11	Albuquerque Area Indian Health Board 2
Bemidji	Gerald L. Ignace Indian Health Center, Inc. 5 Sault Ste. Marie Tribe of Chippewa Indians 12	Great Lakes Inter-Tribal Council 4
Billings	Fort Peck Community College 4	Rocky Mountain Tribal Leaders Council 8
California	Pinoleville Pomo Nation 9	California Rural Indian Health Board, Inc. 3
Great Plains	Three Affiliated Tribes 13	Great Plains Tribal Chairmen's Health Board 5
Nashville	Catawba Indian Nation 1	United South and Eastern Tribes, Inc. 11
Navajo	Navajo Nation – Community Health Representatives Program 7	–
Oklahoma City	Central Oklahoma American Indian Health Council, Inc. 2 Cherokee Nation 3	Southern Plains Tribal Health Board Foundation 10
Phoenix	Native Americans for Community Action, Inc. 6 Urban Indian Center of Salt Lake 14 Washoe Tribe of Nevada and California 15	Inter-Tribal Council of Arizona, Inc. 6
Portland	Yellowhawk Tribal Health Center 16	Northwest Portland Area Indian Health Board 7
Tucson	Pascua Yaqui Tribe of Arizona 8	–
Urban Indian Health Service Areas – national	–	Urban Indian Health Institute - A Division of the Seattle Indian Health Board 9

Figure 1: GHWIC Recipient Locator Map and Key

GHWIC Program Evaluation

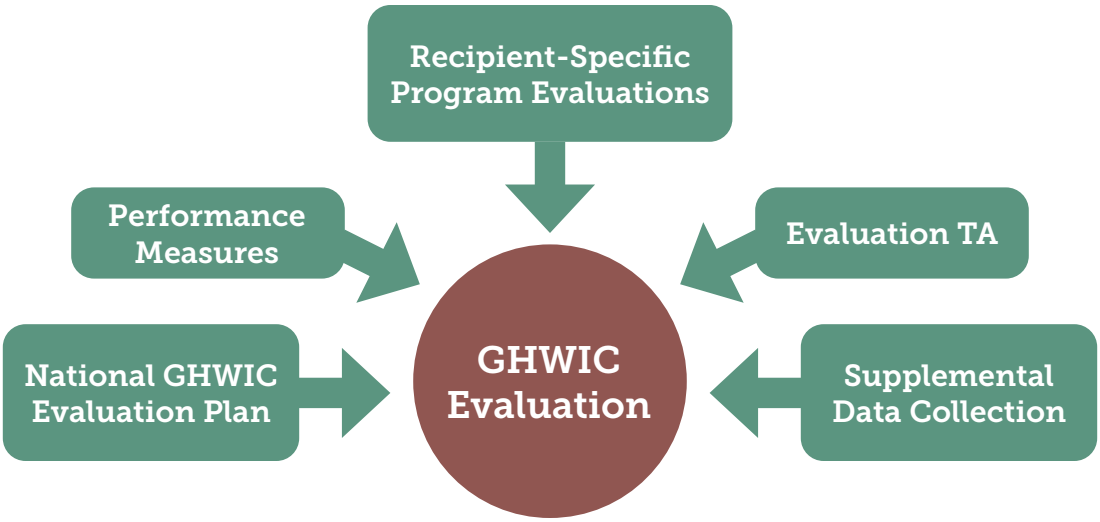
The GHWIC Evaluation focuses on monitoring the progress recipients have made in implementing PSE and CCL strategies to promote health and prevent chronic illness within AIAN and urban Indian communities (see Appendix B: GHWIC Program Logic Model). The GHWIC program logic model, which serves as a road map to link the strategies and activities to the short-term, intermediate, and the long-term goals of the program, guides the overall evaluation.

Approach

The GHWIC Evaluation uses several participatory approaches guided by the CDC Framework for Program Evaluation and includes culturally responsive evaluation and Indigenous evaluation. For example, the evaluation incorporates culturally responsive evaluation approaches and promotes Indigenous-led evaluation methods that prioritize community-driven indicators through recipient-specific evaluations. The recipient-specific program evaluations account for culturally grounded and locally derived methods of knowledge sharing such as storytelling that are not often incorporated into Western evaluations designs.

The CCG and the CDC collaborated to develop and coordinate the implementation of the ***National GHWIC Evaluation Plan*** with input and feedback from CDC Divisions funding GHWIC, members of the GHWIC Evaluation Advisory Group (EAG), and GHWIC recipients. Note: the *National GHWIC Evaluation Plan* was finalized by the middle of Program Year 2, published in June 2021, and implemented by July 2021.

Figure 2: Elements of the GHWIC National Evaluation



The GHWIC Evaluation uses a mixed methods design to aggregate, analyze, and synthesize data across five methodological components: 1) the *National GHWIC Evaluation Plan*; 2) Performance Measures; 3) Recipient-Specific Program Evaluations; 4) Evaluation Technical Assistance (TA); and 5) Supplemental Data Collection (see Figure 2).

The *National GHWIC Evaluation Plan* uses data collected across the other four components to assess the implementation, outcomes, and impacts of the GHWIC strategies and activities across funded recipients and subawardee communities.

Data Sources

This **Year 3 Comprehensive Report** responds to the overarching evaluation and performance measurement strategy outlined in the **Notice of Funding Opportunity (NOFO)** for GHWIC DP19-1903. Data collection for Program Year 3 (September 30, 2021 - September 29, 2022) is guided by the component-specific evaluation questions for each GHWIC component award (refer to Appendix C: GHWIC Evaluation Questions). The CCG and the CDC collaborated to collect annual evaluation data from GHWIC C1, C2, and C3 recipients and to share the results from the Year 3 annual evaluations.

This Comprehensive Report focuses on three major components of the GHWIC Evaluation:

1) Performance Measures, also referred to as Annual Performance Measure Reports (APMRs)
2) Recipient-Specific Program Evaluations, also referred to as Annual Evaluation Reports (AERs)
3) Supplemental Data Collection in the form of program success stories.

Annual Evaluation Reports

Recipients submitted three types of annual reports in Year 3: APMRs, AERs, and success stories. First, APMRs are quantitative performance measure reports, which assess the intermediate and long-term outcomes for the GHWIC program. APMRs consist of population estimates for interventions or counts obtained from data sources that include attendance lists, sign-in sheets, event registrations, monthly meeting notes, program reports, internal databases, and other sources. Next, AERs are narrative reports summarizing the implementation progress and short-term outcomes of local GHWIC program evaluations collected from GHWIC recipients. Finally, success stories are supplemental data collection consisting of recipient submitted photos/videos and narratives collected through the CCG's Success Story project. The supplemental data collection is a voluntary data submission component for the overall GHWIC evaluation to include qualitative data to complement required evaluation components.

Year 3 Recipient Submissions

In Year 3, all 28 GHWIC recipients submitted annual evaluation data by December 31, 2022, which consisted of APMRs and AERs. A total of 28 AERs were submitted by recipients to CDC via email, and a total of 28 APMRs were submitted to the CCG via the Research Electronic Data Capture (REDCap) platform at ANTHC. REDCap is a secure, open source, web-based survey and database software developed by Vanderbilt University and now maintained through the international REDCap Consortium. In addition to APMRs, 12 recipient success stories were submitted to the CCG in Year 3 via the REDCap platform. These stories have been highlighted on the public facing website **GHWIC.org** and in this report to highlight program implementation successes across all GHWIC strategies.

Methods

Quantitative data collected via APMRs for Year 3 were analyzed using descriptive statistics. REDCap and Microsoft Excel were used for the analysis of Year 3 performance measures, including cumulative totals, percent improvement calculations, and annual target analysis. Year 1 APMR served as the baseline data to measure GHWIC growth and to monitor the progress of GHWIC programming and reach. For this analysis, Year 3 APMR data were compared to baseline data to calculate the percent improvement for Year 3 (refer to Appendix D: Year 3 Performance Measure Results). Additionally, Year 3 APMR data were compared to targets set by recipients to determine performance changes and the extent to which programs met their annual targets. The extent to which recipients met their Year 3 targets set in the prior program year were summarized for each GHWIC strategy and activity (refer to Appendix E: Year 3 Target Summary).

For Strategy 1 (Obesity Prevention), population estimates were reported for two of the three performance measures (PM) under this strategy. For PM 1 (nutrition) and PM 3 (physical activity), GHWIC

recipients have the option to use census data or population estimates as a data source when actual counts are not feasible and the intervention is intended to have community-wide reach (refer to graphs in Appendix D: Year 3 Performance Measure Results).

Qualitative data collected through recipient AERs were analyzed using thematic coding and descriptive narrative using the qualitative data analysis software ATLAS.ti (version 9). Year 3 AER data were analyzed to identify promising practices and success stories, types of interventions recipients utilized, and challenges encountered within each strategy. The analysis provided insights into the extent to which the activities implemented for each strategy improved outcomes for communities served with GHWIC programming.

GHWIC Program Evaluation Findings by Strategy

The Year 3 evaluation findings for this report are organized by the overarching GHWIC evaluation questions, which align with the GHWIC program's strategies and goals for all component recipients (refer to Appendix C: GHWIC Evaluation Questions). The four GHWIC strategies provide the foundation for evaluation results across all components:

- **Strategy 1:** Obesity Prevention
- **Strategy 2:** Commercial Tobacco Prevention and Control
- **Strategy 3:** Diabetes Prevention
- **Strategy 4:** Heart Disease and Stroke Prevention

GHWIC recipients worked across all strategies in Year 3 (see Figure 3). Almost all C1 recipients focused on Strategies 1, 3, and 4; while less than half worked in Strategy 2. The C2 recipients supported C2 subawardees to work across all four GHWIC strategies.

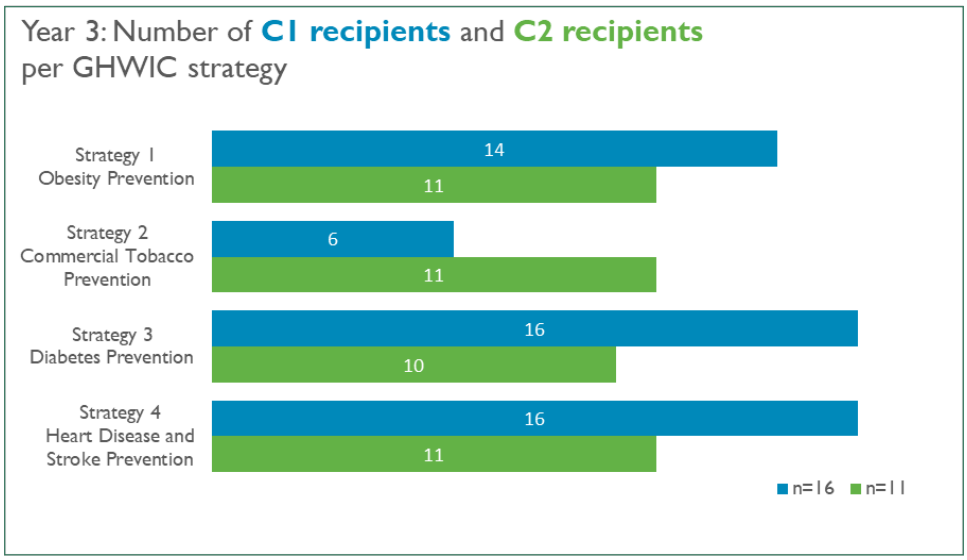


Figure 3: Number of C1 and C2 recipients per GHWIC Strategy in Year 3

This **Year 3 Comprehensive Report** contains progress made in each of the four main GHWIC strategies, answers to activity-specific evaluation questions, highlights of program implementation, and challenges encountered for implementation of each strategy.

For the following sections, results are shared for each activity within the strategy through performance measure results and selected success stories from C1 recipients, C2 recipients, and C2 subawardees. To conclude, we report how implementation of GHWIC strategies was supported by the C2 recipients and the C3 recipient.

GHWIC Strategy 1: Obesity Prevention

GHWIC Strategy 1 is comprised of the following three obesity prevention activities: to improve access to nutritious foods, to improve physical activity, and to increase breastfeeding support.

The majority (83-100%) of GHWIC recipients addressed obesity prevention in Year 3 (see Figure 4). GHWIC programs used a variety of obesity prevention interventions to reach community members, including policy development, nutrition education, physical activity promotion, and breastfeeding support services.

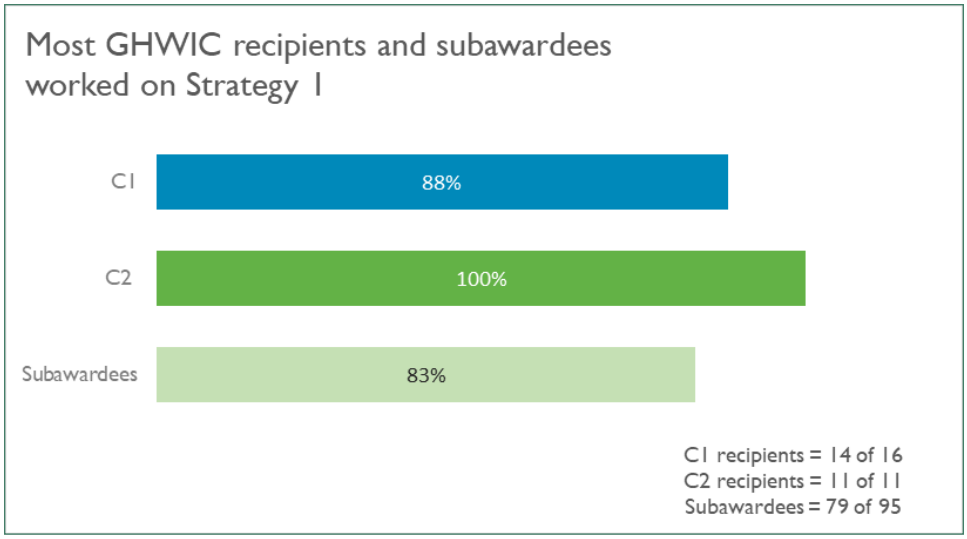


Figure 4: Percent of GHWIC recipients and C2 subawardees for Strategy 1, Obesity Prevention, in Year 3

For Strategy 1, GHWIC recipients attained a Year 3 cumulative reach of 286,165 AIAN community members. This reach is the direct result of the work from 14 C1 recipients and 79 C2 subawardees. The 11 C2 recipients addressed obesity prevention through site visits, training opportunities, technical assistance, and evaluation to support the work of C1 strategies and activities through C2 subawardees.

286,165

AIAN community members reached through GHWIC supported nutrition, physical activity, breastfeeding support, and related obesity prevention and control programs for the first three years of GHWIC.

Each C1 recipient and C2 subawardee within GHWIC can select one or more activities—nutrition, physical activity, or breastfeeding support—within Strategy 1 (see Figure 5). The C1 recipients were spread relatively evenly between all three activities; however, many C2 subawardees chose to focus on nutrition (64 of 95) and on physical activity (43 of 95) through policy, system, and environmental changes (PSE), while fewer subawardees (12 of 95) chose to focus on breastfeeding support services.

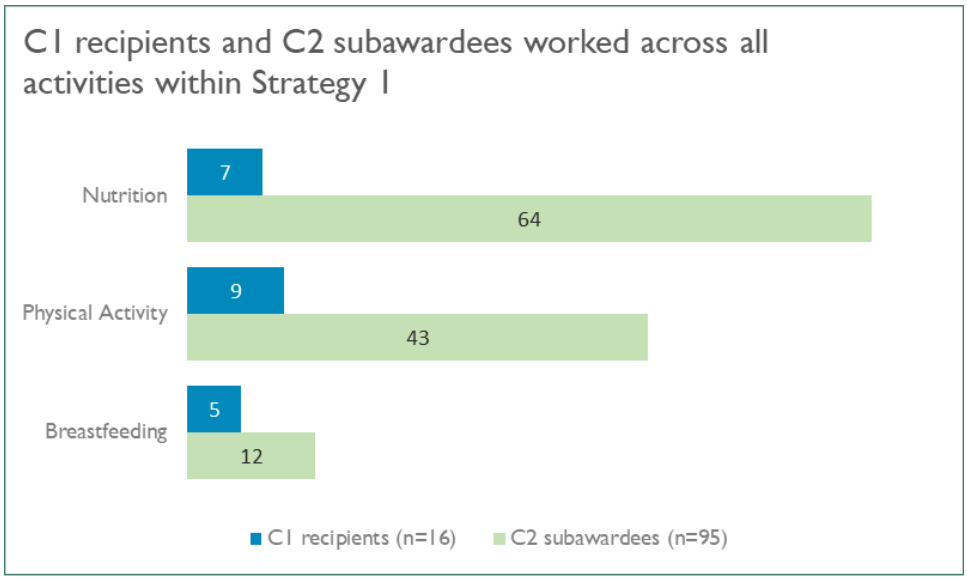


Figure 5: Number of C1 recipients and C2 subawardee program implementations per Strategy 1 activities in Year 3

GHWIC recipients and C2 subawardees used a variety of approaches to address obesity prevention (see Figure 6). This figure focuses on the most common interventions in Strategy 1: nutrition promotion, physical activity promotion, and food pantry distribution. Some examples of Strategy 1 interventions from recipients' Year 3 work include community gardens, trail improvements, food and beverage policy work, and breastfeeding education.

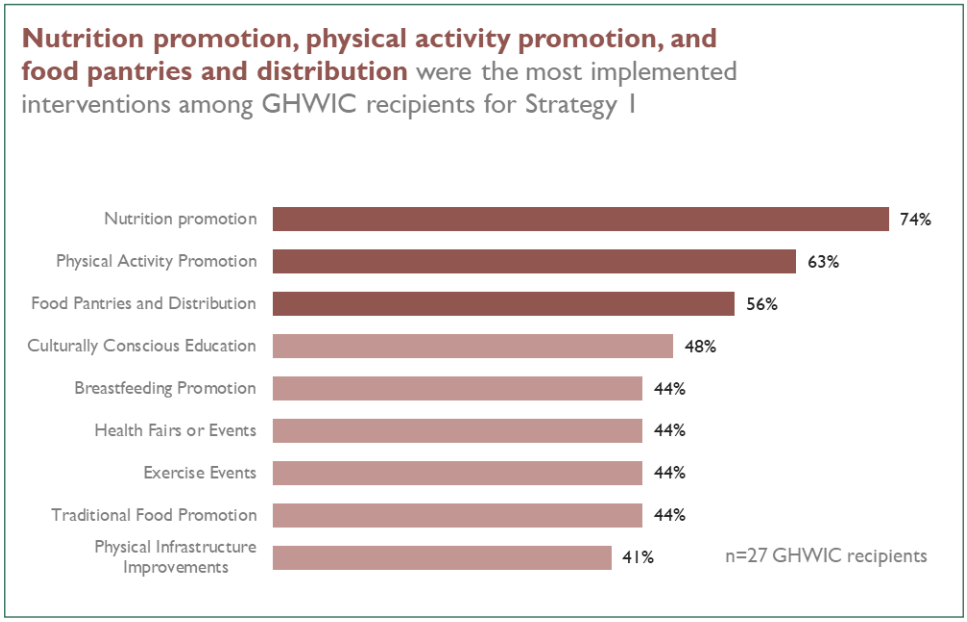


Figure 6: Percent of recipients (C1 and C2 combined) per Strategy 1 interventions in Year 3

All three Strategy 1 activities – nutrition, physical activity, and breastfeeding – experienced growth in community reach for the first three years of GHWIC (see Figure 7). The following sections will detail each activity's Year 3 cumulative reach in comparison to the Year 1 baseline, along with selected success stories to highlight implemented programs.

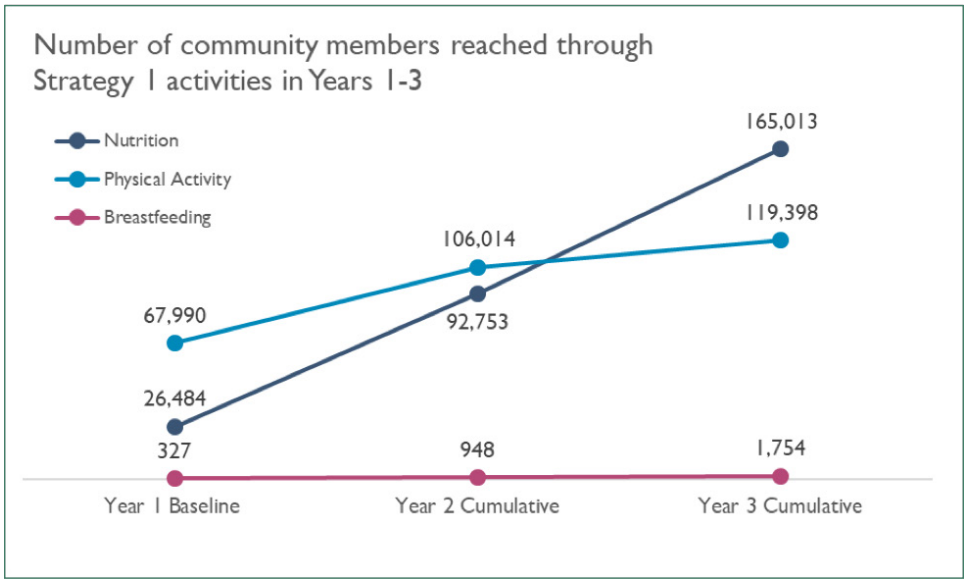


Figure 7: Number of community members reached through nutrition, physical activity, and breastfeeding in Years 1-3 of GHWIC

Activity: Nutrition

***Evaluation Question**: How have the number and percentage of AIAN people with access to places that sell or distribute healthy foods and beverages in the community been improved?*

165,013

AIAN people with improved access to places in their communities that sell or distribute healthy and traditional foods and beverages.

This Year 3 total is 6.2 times higher than in Year 1 (see Figure 8).

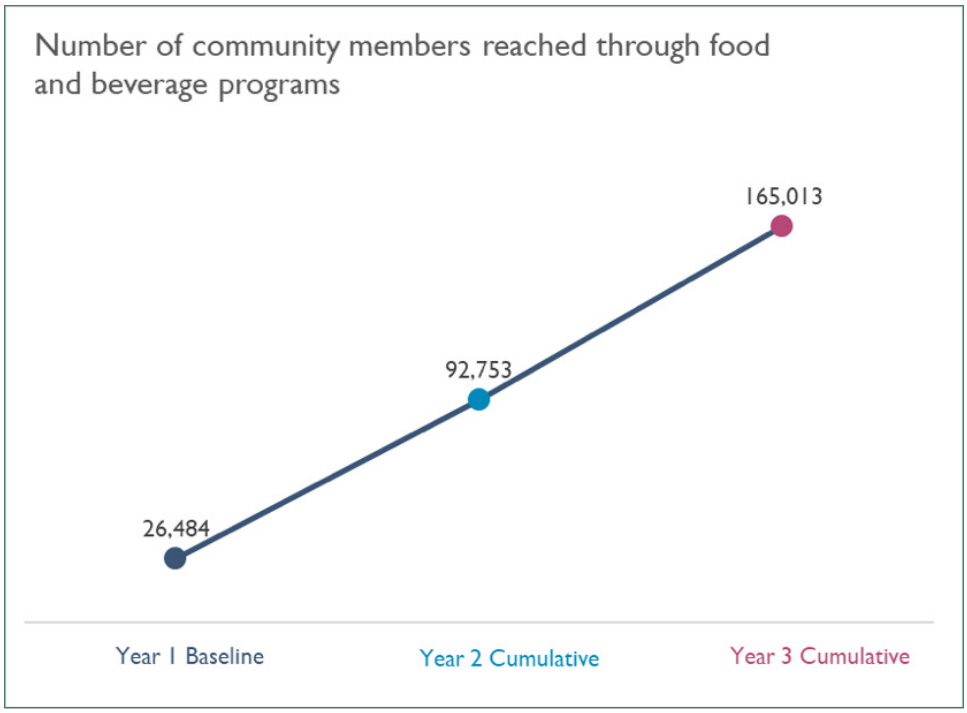


Figure 8: Community reach by program year for Nutrition

In Year 3, GHWIC programs reached 72,260 additional individuals for this activity compared to Year 2. This reach is the direct result of work from seven C1 recipients and 64 C2 subawardees, where many focused on traditional and healthy food promotion through food policy work, nutrition education, and food distribution at local food pantries.

Nutrition Success Stories

The following success stories highlight the types of interventions and programs implemented through GHWIC to increase access to healthy foods and beverages in the Tribal communities they serve.

- **Three Affiliated Tribes** created a *Food Access Survey* to understand customer's shopping experience in a Convenience Store (C Store) on the Fort Berthold Indian Reservation. The Food Access Survey set out to identify potential ways to expand the availability of healthy food and beverage options in the area; 11% of the population completed the in-person survey. The GHWIC project staff presented the results to the Tribal Council Representative and the C Store Manager. The survey results indicated respondents would be willing to purchase fresh fruits and vegetables if they were offered. In response, the C Store Manager put forth considerable effort to offer healthier food options in the C Store, including driving several miles to a larger town to purchase non-perishable foods at a lower cost. This effort has had an impact in expanding access to healthier foods in this community and demonstrates that healthy foods will be purchased if available.

- **Blackfeet Nation**, a subawardee of the **Rocky Mountain Tribal Leaders Council** operates their *Food Pharmacy Program* to make healthy food more accessible to their community and to give participants the skills and knowledge to eat well. The program is a unique partnership between a Tribal health clinic, the Southern Peigan Health Center (SPHC), and a community non-profit Food Access and Sustainability Team (FAST) Blackfeet. Participants are referred to FAST Blackfeet from the clinic if they have a diet-related disease diagnosis and are experiencing food insecurity. The program provides participants access to nutrition counseling, group cooking classes, fresh fruit and vegetable vouchers, and specialized food boxes (see Figure 9).

Figure 9: FAST Program (Blackfeet Nation)

Activity: Physical Activity

***Evaluation Question**: How have the number and percentage of AIAN using safe places for physical activities across the life span been improved?*

119,398

AIAN people with improved access to safe places for physical activity in their communities.

This Year 3 reach is 1.8 times higher than in Year 1 (see Figure 10).

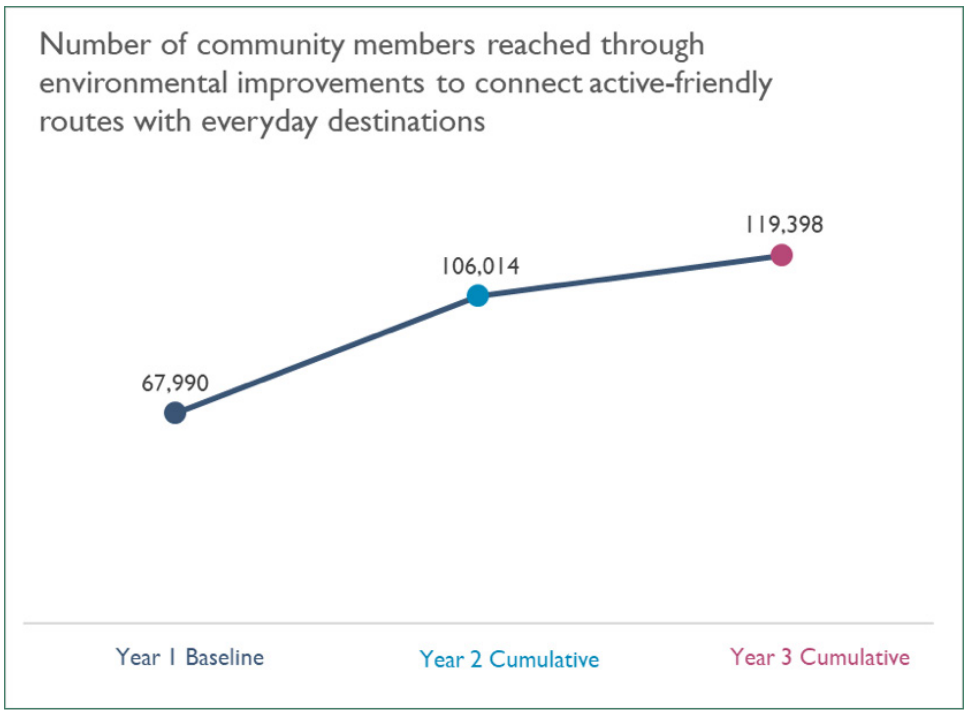


Figure 10: Community reach by program year for Physical Activity

In Year 3, GHWIC programs reached 13,384 additional community members for this activity compared to Year 2. This reach is the direct result of work from nine C1 recipients and 43 C2 subawardees, where many focused on improving trail systems, hosting exercise events, and promoting safe routes and physical activity opportunities within the community.

Physical Activity Success Stories:

The following success stories highlight the types of interventions and programs implemented through GHWIC to increase access to safe places for physical activities in the community.

- **Santo Domingo Pueblo Kewa Health Outcome Program (KHOP)** improved plans and collaborated with partners in creating a safe space for families to gather as well as a safe space for community members to warm-up and stretch with access to two walking trail sites. These plans also created additional safe space for families to engage in physical activities while their kids participate in cross-country running. A crosswalk was also repainted to connect the two trails. KHOP placed cautionary signs to be aware of snakes, signs to discourage ATV use on trails, traffic signs to slow down and pay attention to trail users, "Do Not Litter" signs, and placed directional signs for trails as additional trail improvement measures (see Figure 11).

Figure 11: Physical Activity (Santo Domingo Pueblo Kewa Health Outcome Program)

- **The Santee Tribe**, a subawardee of **Great Plains Tribal Leaders Health Board**, promoted physical activity and other initiatives through their Santee Health and Wellness Center (Health Center). The Health Center built upon the successes of Year 1 and 2 and promoted activities through their social media app. The program designed sidewalks around its facilities for walking, jogging, and recreational use. Community members were invited to snap selfies of themselves using the sidewalk and to post them on social media as part of a "Healthy Selfie" contest. The Health Center also used its social media presence to promote the continued work of Coach Rozy, a local fitness leader providing in-person and virtual fitness classes to the community for chronic disease prevention efforts. The program approached all its work with *"utilizing a [self-determination theory] approach that emphasized the importance of self-management skills necessary for lifelong behavior modification sustainment."- C2 recipient AER.*

Activity: Breastfeeding

***Evaluation Question**: How have the number and percentage of breastfeeding mothers who use community services that support breastfeeding been improved?*

1,754

AIAN mothers who received improved community-based breastfeeding support services.

This Year 3 reach is 5.4 times higher than in Year 1 (see Figure 12).

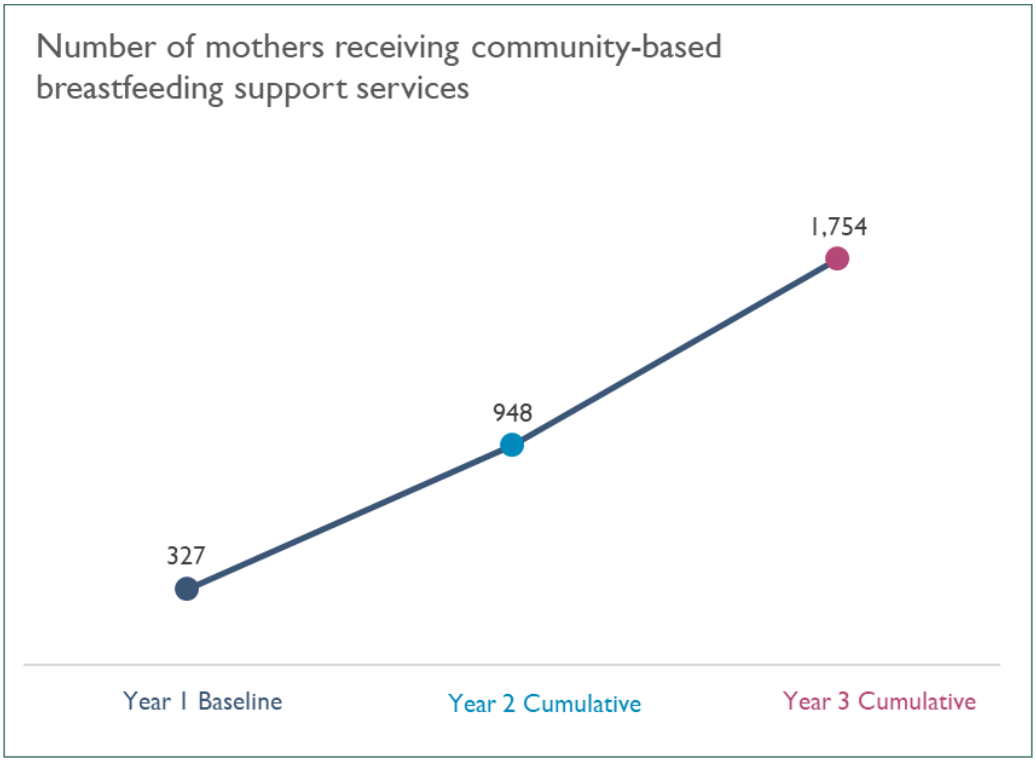


Figure 12: Community reach by program year for Breastfeeding

In Year 3, GHWIC programs reached 806 additional women for breastfeeding support compared to Year 2. This increase is the direct result of work from five C1 recipients and 12 C2 subawardees, where many provided breastfeeding and nutrition education, culturally appropriate lactation support, and infrastructure improvements. Some of the programs focused on prenatal education, social support services, breastfeeding referrals, and policy development to increase community reach around breastfeeding.

Breastfeeding Success Stories:

The following success stories highlight the types of interventions and programs implemented to increase the number of breastfeeding mothers who use community services that support breastfeeding.

- **Native Americans for Community Action (NACA)** continued their partnership with the local university, Northern Arizona University (NAU), and their Indigenous Studies Department to support breastfeeding activities. Through the partnership, they worked on increasing education and awareness around breastfeeding throughout the campus to encourage and support mothers who are part of the NAU community. They sent surveys to collect baseline data, created breastfeeding awareness signs, and put quick response (QR) codes on the signs to track the number of people that scanned them and used the resource guides. With these efforts, they noticed that there was a rise in the number of lactation rooms being utilized. In Year 3, they had over 40 people accessing their resource guides (see Figure 13).
- **The Oklahoma City Indian Clinic (OKCIC)** has established a coordinated prenatal education program – Eagle's Nest – that serves as the gateway to service for their expectant mothers. This program supports participants with meeting the physical, social, and emotional needs of mothers and their children of breastfeeding age. To prepare their expectant mothers to increase the likelihood of reaching breastfeeding goals, the program introduces the basics of breastfeeding and connects participants with the OKCIC lactation consultants. Progress in this program was assessed through referrals to Eagle's Nest, where there were at least 61 Eagle's Nest referrals in Year 3.

Figure 13: Breastfeeding Signs (Native Americans for Community Action)

Challenges and Barriers for Strategy 1

- Staffing continues to be a major challenge in Year 3. Recipients reported experiencing delays in programming and policy work due to high staff turnover with GHWIC funded staff positions. Progress was also slowed down due to staff turnover at partner and subawardee sites.
- Recipients also reported challenges in doing policy work. For some, the policy route was found to be complicated and a lengthy process. One recipient decided to move away from the policy route and focus instead on education. Another recipient found the task of writing and amending policies to be difficult and reaching consensus on policy language was also challenging.

GHWIC Strategy 2: Commercial Tobacco Control & Prevention

GHWIC Strategy 2 is comprised of two commercial tobacco prevention activities: to increase commercial tobacco-free policies and to improve access to commercial tobacco cessation treatment.

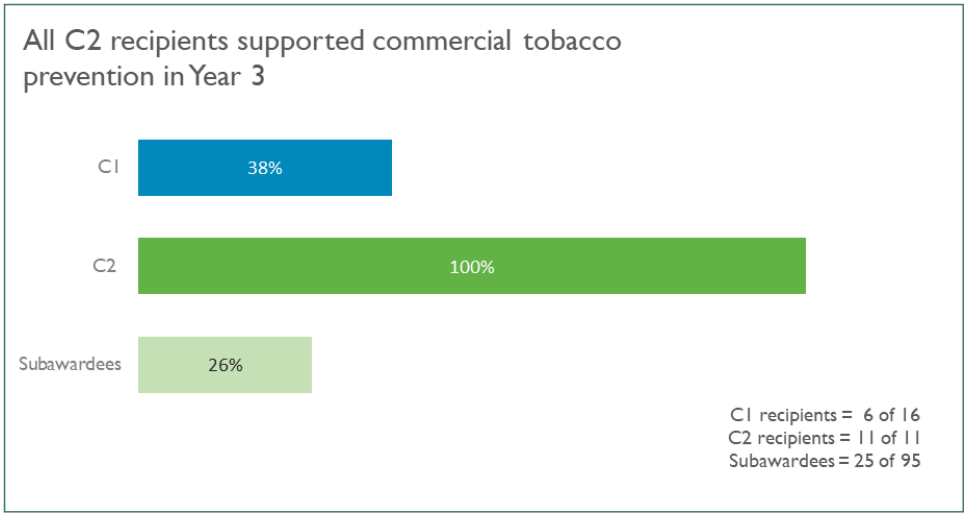


Figure 14: Percent of GHWIC recipients and C2 subawardees for Strategy 2, Commercial Tobacco Prevention, in Year 3

Each GHWIC recipient or C2 subawardee working on commercial tobacco prevention can choose to focus on one or both activities within Strategy 2. Figure 15 highlights the number of C1 recipients and C2 subawardees directly working on each Strategy 2 activity in Year 3.

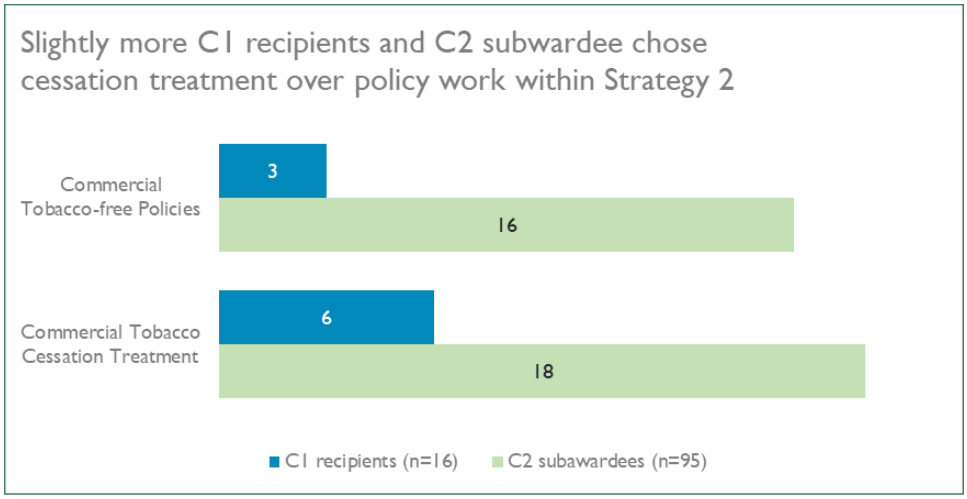


Figure 15: Number of C1 recipient and C2 subawardee program implementations per Strategy 2 activities in Year 3

GHWIC recipients and subawardees used a variety of approaches to address commercial tobacco prevention in Year 3 (see Figure 16). The most common interventions used were working with partners and coalitions to advance policy work and enrolling patients in smoking cessation therapies and counseling.

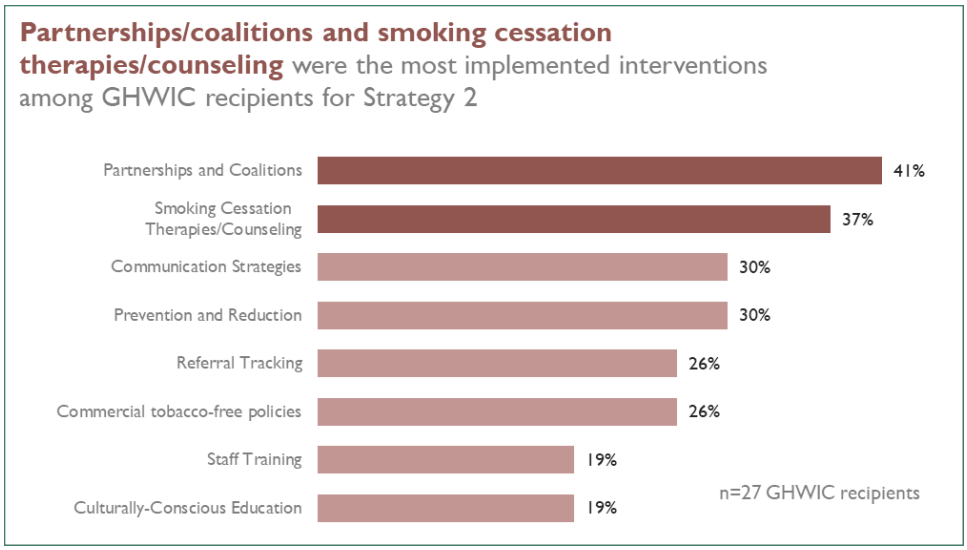


Figure 16: Percent of recipients (C1 and C2 combined) per Strategy 2 interventions in Year 3

Activity: Commercial Tobacco-Free Policies

Evaluation Question: *To what extent has the number and percentage of workplaces, restaurants, bars, casinos, schools, multi-unit housing, indoor and outdoor events, celebrations and gatherings that implement commercial tobacco-free policies increased?*

220

Workplaces, restaurants, bars, casinos, schools, multi-unit housing, indoor and outdoor events, celebrations and gatherings located in AIAN communities adopted or enhanced commercial tobacco-free policies.

This Year 3 total is four times higher than in Year 1 (see Figure 17).

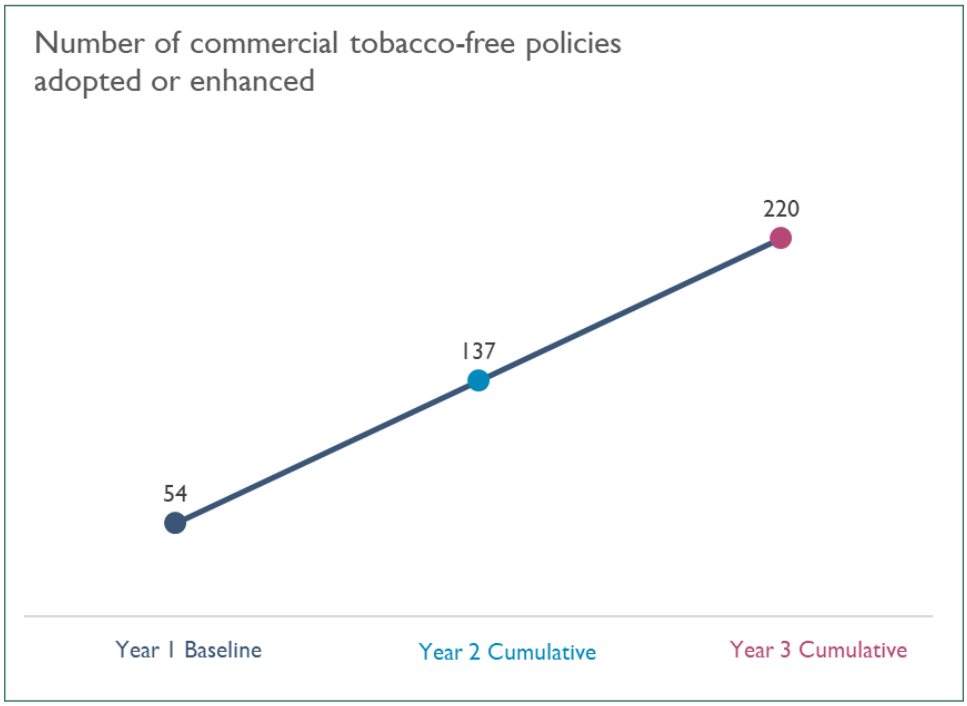


Figure 17: Growth by program year of Commercial Tobacco-free Policies

The additional 83 policies to prevent commercial tobacco use in Year 3 were due to the direct work of three C1 recipients and 16 C2 subawardees. Many of these policy efforts were supported and advanced by building partnerships and coalitions to further the policy making process.

Tobacco Policy Success Stories:

The following success stories highlight the types of strategies to increase implementation of commercial tobacco-free policies in communities prioritized by GHWIC.

- **Sault Ste. Marie Tribe of Chippewa Indians** Community Health staff actively worked on policy development and enhancement activities to address the critical need for tobacco-free policies. Community Health Educators drafted the language for an updated housing policy that aims for a minimum of 50% of Tribal housing units to be designated as "smoke-free." The following quote describes some of the progress made in Year 3:

> *"We've had open meetings on Zoom which was helpful because we are all located in different areas. We've looked through policies to see where changes were needed. We've amended the current smoke-free housing policy and are waiting feedback and approval. Soon we will present the amended policy to the Sault Tribe Housing Authority for review."*
>
> – C1 RECIPIENT Y3 AER

- A subawardee of **Great Lakes Inter Tribal Council** reported that Shooting Star Casino and Bagley Casino remain smoke-free due to Year 3 GHWIC work. The tobacco policy was strengthened and the Casinos continue to be smoke-free. With the consideration of possible leadership or staff turnover, keeping policies in place must be a priority. Promotion of commercial tobacco-free policies are shared in their Tribal newspaper:

> *"Our Tobacco Coalition meets monthly and has been very active in promoting policy and tobacco cessation via the Anishinaabeg Today."* – C2 RECIPIENT Y3 AER

Activity: Commercial Tobacco Cessation Treatment

Evaluation Question: *How have the number and percentage of commercial tobacco using patients who receive commercial tobacco cessation interventions been improved?*

In Year 3, GHWIC programs reach 2,833 additional community members for this activity compared to Year 2. This reach is the direct result of efforts from six C1 recipients and 18 C2 subawardees, where many focused on building partnerships, providing culturally relevant education, and producing culturally relevant tobacco cessation advertisements.

8,246

Commercial tobacco using AIAN patients received commercial tobacco cessation interventions.

This Year 3 reach is four times higher than in Year 1 (see Figure 18).

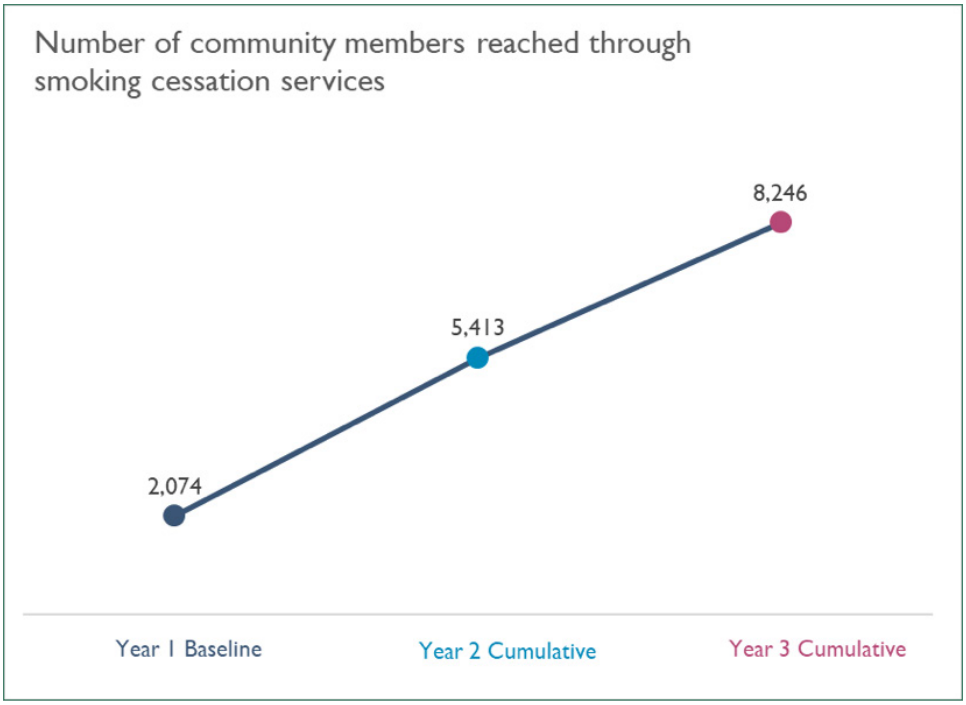


Figure 18: Community reach by program year for Smoking Cessation Services

In Year 3, GHWIC programs reach 2,833 additional community members for this activity compared to Year 2. This reach is the direct result of efforts from six C1 recipients and 18 C2 subawardees, where many focused on building partnerships, providing culturally relevant education, and producing culturally relevant tobacco cessation advertisements.

Tobacco Cessation Success Stories:

The following success stories highlight the kinds of interventions and programs implemented to increase referrals to commercial tobacco cessation interventions in communities prioritized by GHWIC:

- **Gerald L. Ignace Indian Health Center** utilized Community Health Workers (CHWs) to refer people to smoking cessation support. The CHWs have assembled smoking support bags for patients who wish to quit smoking and to prevent relapse. The bag contents are interchangeable, depending on the tools that the patient feels will help them best. There are items like stress balls, gum, hard candy, smoking inhalers, teas, and straws. The CHWs make up the bags based on the preferences of the patient. They then discuss available resources to aid in smoking cessation such as apps, the American Indian Quit Line, and other support services. The CHWs also discuss nicotine replacement therapies and help determine if based on the patient's habits and health conditions which one might be the best fit. The CHW partners with the patient to determine the support they need for their quit plan (see Figure 19).

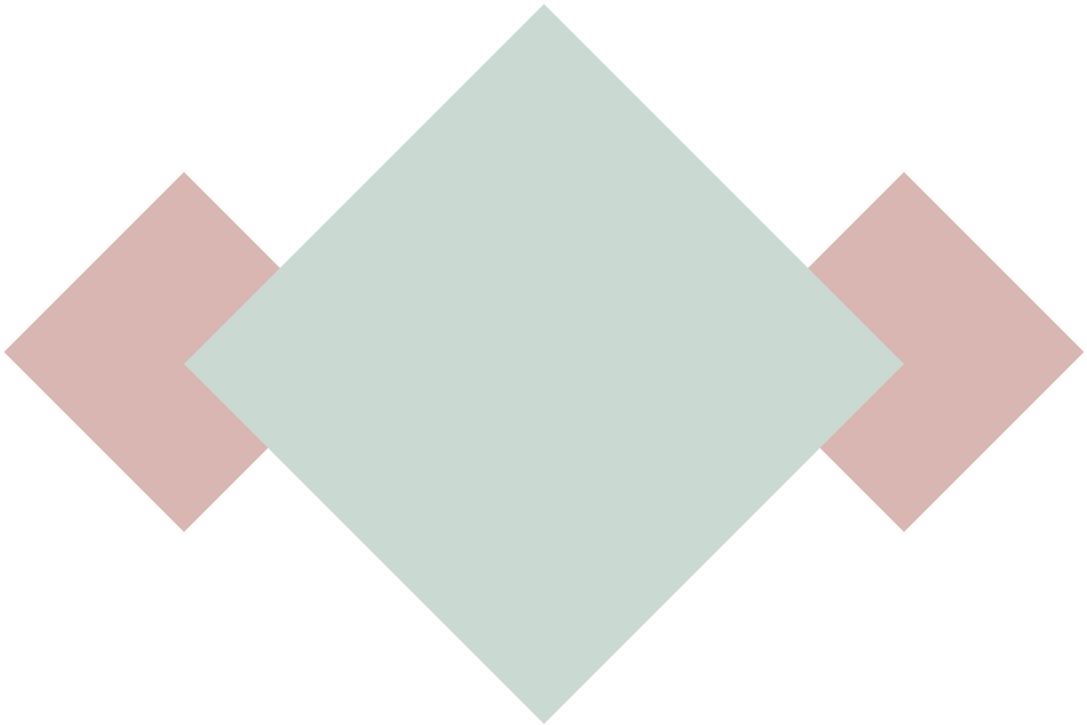
Figure 19: Tobacco Cessation Support Program (Gerald L. Ignace Indian Health Center)

- **Navajo Nation** increased their tobacco cessation work in Year 3 by recruiting 60 Community Health Workers (CHWs) into their program. Twenty-one CHWs completed BASIC-BTIS (Basic Tobacco Intervention Skills) of Native Communities training and 13 completed the INSTRUCTOR- BTIS training in Year 3. In addition, they completed a survey and the pre/post self-confidence test. The CHWs were instrumental in enhancing the referral system by distributing multiple flyers and brochures to clients, communities, and at health promotion events. The CHWs are now equipped to provide low-intensity smoking cessation interventions and use the materials to provide referrals to a nearby treatment facility.

Challenges and Barriers for Strategy 2

- Staff turnover and burnout were challenges reported within this strategy. One recipient shared the following staff testimonial:

> *"I'm tired, burnout is very real with this work...the program should have 4-5 tobacco treatment specialists. It is challenging working with addiction and quitting is really hard. Sometimes patients are difficult and sometimes unpleasant so it is very challenging. It is really great that we offer telemedicine, which helps if I can't get in touch with someone. But being short-staffed is a barrier if I lose touch with someone because I don't have the time to chase people down...I would like to do some sort of text reminder system."*
>
> – GHWIC RECIPIENT



GHWIC Strategy 3: Diabetes Prevention

GHWIC Strategy 3 is comprised of a single activity—to expand access to the National Diabetes Prevention Program (National DPP, also referred to as NDPP) lifestyle change program—and four sub-activities: (1) increasing awareness of prediabetes; (2) supporting prediabetes screening, testing, and referral; (3) establishing or expanding the reach of CDC-recognized type 2 diabetes prevention programs; and (4) developing culturally-relevant approaches to increase program participation and retention.

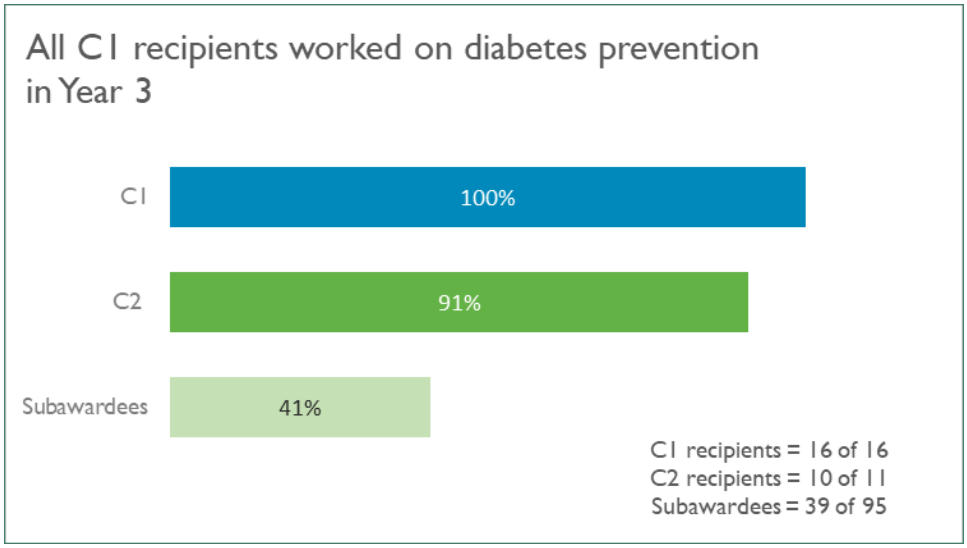


Figure 20: Percent of GHWIC recipients and C2 subawardees for Strategy 3, Diabetes Prevention, in Year 3

In Year 3, GHWIC recipients and C2 subawardees (see Figure 20) addressed diabetes prevention by focusing on expanding access to NDPP programs in Tribal communities.

GHWIC recipients and C2 subawardees used a variety of approaches to address diabetes prevention (see Figure 21). The most common interventions included prediabetes education, culturally-conscious education, and furthering NDPP work to address diabetes prevention for GHWIC. Other activities included prediabetes education in the community, supporting staff to complete Native Lifestyle Balance classes (a curriculum that is used as part the NDPP), and screening community members for prediabetes.

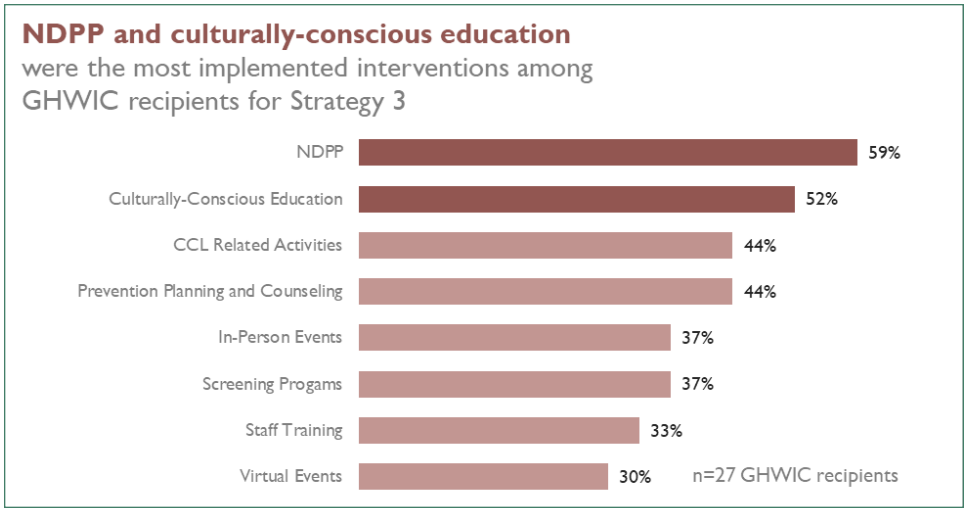


Figure 21: Percent of recipients (C1 and C2 combined) per Strategy 3 interventions in Year 3

Activity: Expand access to the National Diabetes Prevention Program lifestyle change program in Tribal communities

Evaluation Question: *To what extent has the number of adults at high risk for diabetes participating in the National Diabetes Prevention Program (NDPP) been improved?*

In Year 3, GHWIC recipients worked on diabetes prevention by expanding access to NDPP lifestyle change programs in Tribal communities.

7,996

AIAN individuals enrolled in recipient-supported NDPP or other types of type 2 diabetes prevention programs for the first three years of GHWIC.

This Year 3 reach is 3.2 times higher than in Year 1 (see Figure 22).

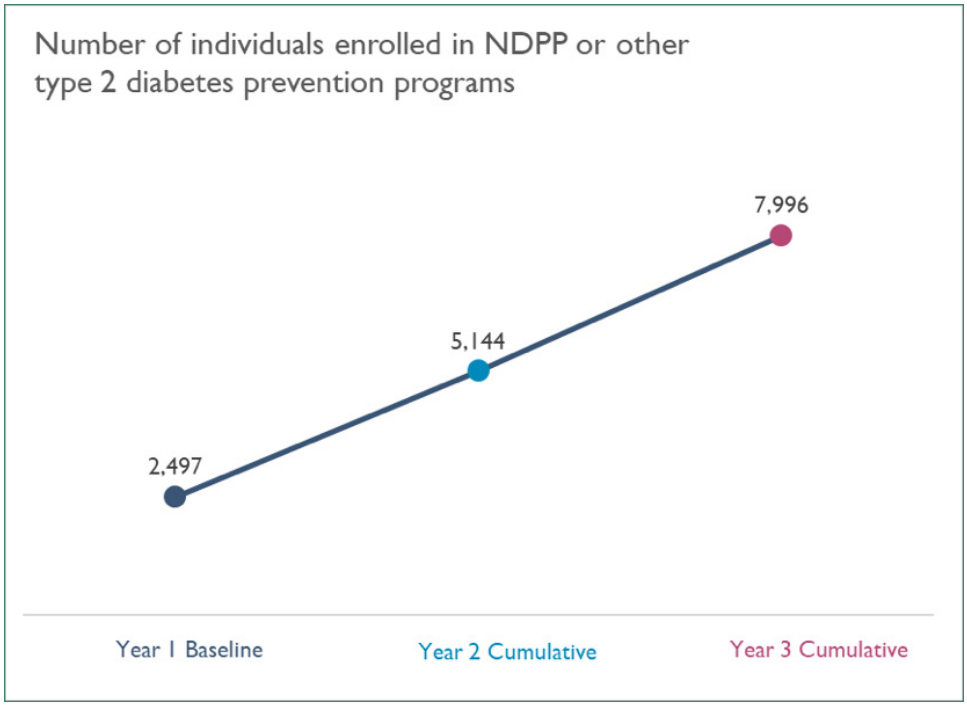


Figure 22: Community reach by program year for Diabetes Prevention

In Year 3, GHWIC programs reached 2,852 additional community members for this activity compared to Year 2. This increase is the direct result of work from 16 C1 recipients and 39 C2 subawardees, where many focused on staff training, developing culturally relevant materials, screening programs, and recruitment efforts.

Diabetes Success Stories:

The following success stories highlight the types of interventions and programs implemented to increase the number of individuals enrolling in NDPP or other types of type 2 diabetes prevention programs for communities prioritized by GHWIC.

- **Pascua Yaqui Tribe (PYT)** continued coordinating with the PYT Diabetes Prevention and Treatment Program and the Department of Language and Culture to plan culturally-relevant activities, health information, promotional items, and retention strategies. The work included refining and implementing an informational PowerPoint presentation with culturally-relevant handouts and coordinated materials with emphasis on lifestyle changes and healthy choices aimed at preventing and managing type 2 diabetes. The project team disseminated these materials and information in person and online via social media sites.
- **Catawba Indian Nation's** Wellness and IHS Clinic collaborated to deliver Catawba's first NDPP. This was a tremendous accomplishment for Catawba. The first cohort was small, but retention was high. Although there was staff turnover that affected implementation, a strong community-clinical partnership allowed the delivery of sessions virtually with the Clinic Registered Dietitian (RD) as a coach. The Food Sovereignty Coordinator also became a trained lifestyle coach to fill in gaps in staffing. Delivering virtually provided options for people to attend on their lunch hour without traveling and for distance learners, so those obstacles were eliminated, benefiting retention. The cohort concluded in April 2022 with the leadership of the Wellness Project Coordinator. Ultimately, three staff were trained as Lifestyle Coaches and thus were able to share facilitating duties.

Challenges and Barriers for Strategy 3

- COVID-19 continued to be a barrier to full implementation of NDPP in Year 3. COVID restrictions limited class sizes and participation in type 2 diabetes prevention programs,
- Overall recruitment and retention has been difficult for NDPP, and programs have experienced high dropout rates. One recipient reported that the working class population of the community does not have a very flexible schedule to complete the full NDPP.

> *"The course I feel is too long and I think it would be great if truly Tribal communities can really shape what this program should look like in their community."*
>
> – GHWIC RECIPIENT

- Recipient also reported that their NDPP were not ready for implementation in Year 3 due to staffing issues. Staff turnover and the time to fill open positions has delayed programming. Additionally, the time to get new staff completely trained for NDPP slowed down progress.

Figure 23: Berry Picking (Alaska Native Tribal Health Consortium)

GHWIC Strategy 4: Heart Disease and Stroke Prevention

GHWIC Strategy 4 includes three activities focused on engaging Community Health Representatives (CHRs), implementing team-based care, and developing culturally-relevant materials and approaches.

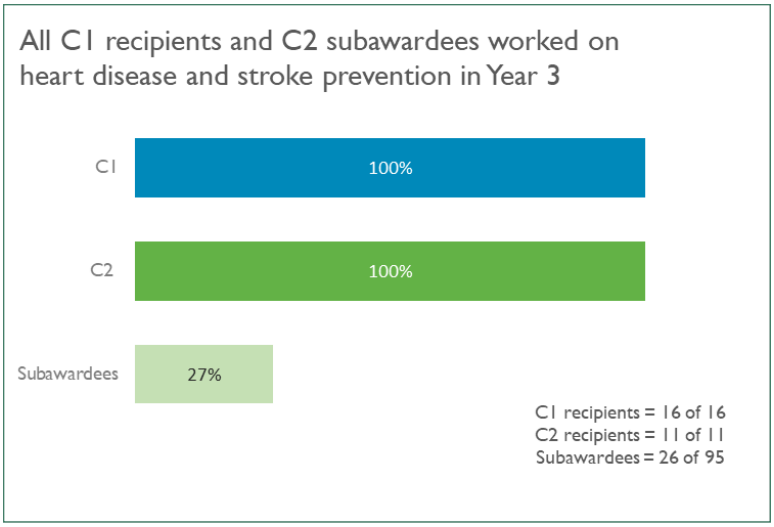


Figure 24: Percent of GHWIC recipients and subawardees for Strategy 4, Heart Disease and Stroke Prevention, in Year 3

In Year 3, all C1 and C2 recipients worked on Strategy 4 (see Figure 24). GHWIC recipients and C2 subawardees demonstrated increased growth in their work around heart disease and stroke prevention in Year 3. Programs reported various activities that were used to achieve outcomes: increasing trainings and engagement of CHRs, expanding referrals to self-management and treatment programs, and increasing community-clinical linkages.

GHWIC recipients and subawardees used a variety of approaches to address heart disease and stroke prevention (see Figure 25). The most common intervention for Strategy 4 included the use of coalitions and partnerships to advance CCL work, followed by community events to provide education and promote self-management programs and increasing capacity to provide team-based care.

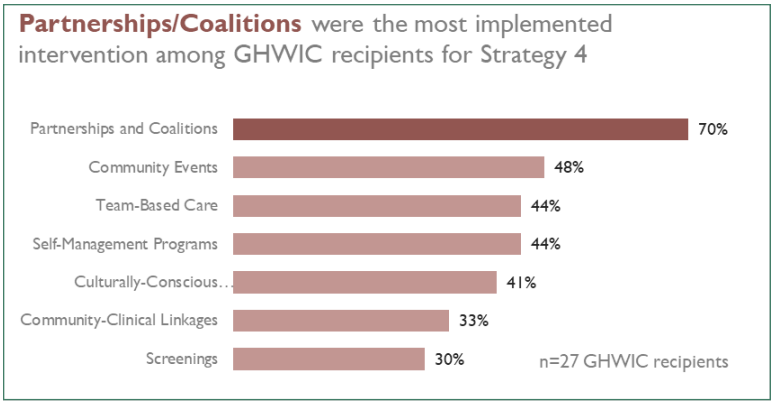


Figure 25: Percent of recipients (C1 and C2 combined) per Strategy 4 interventions in Year 3

Activities: Community health representatives, team-based care, and culturally relevant approaches for heart disease and stroke prevention

Evaluation Question: *To what extent has the number and percentage of patients with high blood pressure or high blood cholesterol engaged in self-management and treatment programs improved?*

6,011

AIAN patients with high blood pressure or high blood cholesterol engaged in self-management and treatment programs for the first three years of GHWIC.

This Year 3 reach is 4.5 times higher than in Year 1 (see Figure 26).

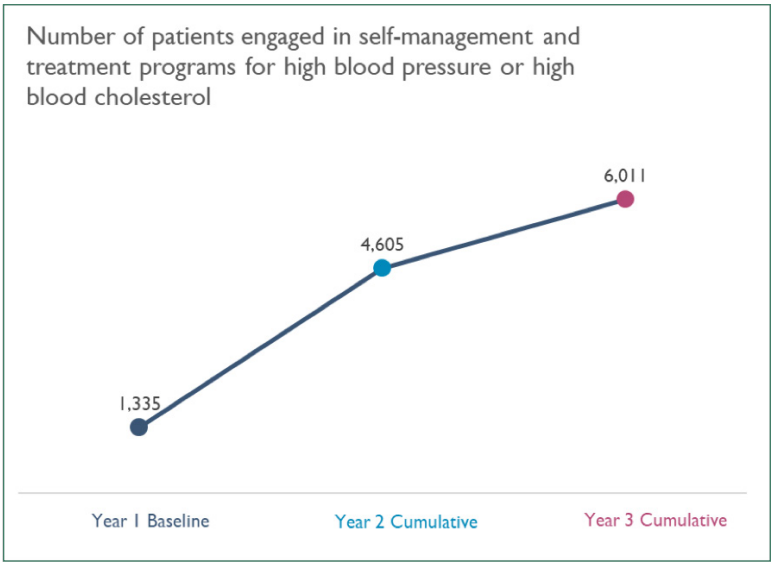


Figure 26: Community reach by program year for Heart Disease and Stroke Prevention

In Year 3, GHWIC programs reached 1,406 additional individuals for this strategy compared to Year 2. This reach is the direct result of work from 16 C1 recipients and 26 C2 subawardee programs, where many focused on producing culturally appropriate education, implementing self-management and screening programs, and hosting community events.

Heart Disease and Stroke Success Stories:

The following success stories highlight the types of interventions and programs implemented to engage AIAN participants in high blood pressure and high blood cholesterol self-management and treatment programs.

- **Native Americans for Community Action (NACA)** worked toward creating a linkage between NACA's Family Health Center and patients, focusing on hypertension patients. Thus far, CHWs have been calling patients to create relationships and to follow up and address patient questions and needs. The CHWs also work with the NACA healthcare providers for a provider referral. Their Honoring the Gift of Heart Health class has been offered to patients and community members that were recruited by the CHWs. During Year 3, there were three cohorts of the healthy heart class.
- **Three Affiliated Tribes** focused on developing culturally-relevant materials to link clinical and community resources for this strategy. Four culturally-relevant Cardiovascular Disease (CVD) and Hypertension Prevention videos were developed and are now available on their websites and social media platforms. One of the cardiovascular disease and hypertension prevention videos was promoted through a YouTube advertisement, which attained 25,000 views in Year 3. Additionally, an eBook, Keeping Your Heart Healthy, was developed as a culturally-relevant resource for health care providers to use as an education tool with community members.

Challenges and Barriers for Strategy 4

- COVID-19 continued to have a large effect on Strategy 4 implementation. Recipients reported that CHRs were reassigned during the first part of Year 3 to address COVID-19 priorities. For some, Community Health Workers (CHWs) and CHRs were not allowed to do blood pressure screenings due to COVID restrictions or patients were declining CHR home visits due to COVID concerns.
- As with all strategies, high staff turnover delayed progress in Strategy 4. To implement activities within this strategy, programs had to spend a considerable amount of time getting CHWs through the hiring process to complete onboarding and the required staff trainings.
- Recipients also reported funding restrictions as a barrier for this strategy. Implementation was delayed because programs needed to purchase blood pressure monitors, which were not covered by GHWIC funding. Alternative funding was necessary in order to purchase monitors for community participants.

> *"We're not allowed to buy food but we want to teach people about traditional food and what it tastes like and they're not going to go out and buy it on their own. We can, you know what I mean? Because their food dollar is limited already and you're not going to spend it on something you're unfamiliar with or you don't know how to prepare, or you don't have a recipe for. So I think having access to be able to buy traditional foods would be huge."*
>
> – GHWIC RECIPIENT

Figure 27: Heart Health Craft Night (Qawalangin Tribe of Unalaska)

The Role of C2 Recipients: Supporting GHWIC Implementation

In addition to providing regional support to Tribes, urban Indian organizations (UIOs), and Tribal organizations, the 11 C2 recipients provided support to 95 GHWIC subawardees (refer to Appendix A: GHWIC Year 3 Subawardees) to implement GHWIC strategies in Year 3.

Year 3 Summary of C2 Activities:

101	2144	716	91
			
In-person and virtual training events conducted	**Training participants reached**	**Technical assistance requests fulfilled**	**Community partnerships established**

Increasing capacity for chronic disease prevention and management

C2 recipients increased the infrastructure and local capacity to prevent and control chronic disease in a variety of ways, addressing the needs and strengths of their partners and subawards during Year 3 of GHWIC. The C2 recipients offered trainings and webinars, fulfilled technical assistance requests, conducted virtual and in-person site visits, supported communication strategies, and monitored performance measure growth in the communities they serve.

Success Stories in Building Infrastructure and Chronic Disease Capacity:

- **Great Plains Tribal Leaders Health Board** provided culturally relevant technical assistance (TA), training, and resources to their subawardees in Year 3. They offered 73 instances of support in the form of TA/consultation, support meetings, and educational training sessions/workshops across all strategies of GHWIC. They reached over 1,438 people through this support.
- **Alaska Native Tribal Health Consortium's** Wellness Strategies for Health (WSH) reported success with their approach of having the WSH Communication Specialist work closely with each of their subaward partner sites to create individual communication plans that included at least one communications activity tied to a strategy in their work plans. Through this work, subawardees identified a primary and sometimes a secondary audience, created a culturally attuned message, and chose appropriate and attainable channels in their regions.
- **Albuquerque Area Indian Health Board** supported their staff to attend professional development trainings in Year 3 to improve advanced public health competencies and increase their capacity to assist Tribal chronic disease prevention and management efforts. Trainings and conferences attended included evaluation focused trainings, tobacco related webinars, various heart disease related webinars, conferences, technical skills trainings, leadership skills, presentation skills, and creative arts trainings.

Figure 28: Wellness Strategies for Health (Alaska Native Tribal Health Consortium)

Increasing the number of Tribes, Villages, and UIOs health programs' progress in achieving C1 outcomes

C2 recipients provided funds to a total of 95 subawardees to implement activities across all four GHWIC strategies in Year 3. With the support from C2 recipients, GHWIC subawardees worked on PSE activities, supported breastfeeding mothers, conducted nutrition and exercise events, worked on commercial-tobacco policies, increased CCL for all four GHWIC strategies, and enrolled patients into tobacco cessation, DPP, and self-management programs.

Success Stories in Health Program Progress in Achieving C1 outcomes:

- **California Rural Indian Health Board, Inc.** supported their 15 subawardees to implement unique culturally-driven chronic disease prevention programs within the four defined CDC strategies in more than 48 Tribal communities. The activities included the development of community gardens, national toolkits, distribution of healthy food, physical activity and nutritional courses, healthy food policies, fitness classes, wellness campaigns, traditional medicine/cultural sessions, a community greenhouse, educational/healthy cooking videos, tobacco cessation and referrals, diabetes prevention classes, and diabetes and blood pressure management courses.
- **Urban Indian Health Institute** worked with six subawardees through their Community Grants Program to implement GHWIC strategies to achieve C1 outcomes. All subawardees shared how reclaiming traditional practices and reconnecting with culture was core to their chronic disease management and prevention strategies. During their subawardee events and activities, they heard about the many ways in which grantees center culture throughout programming. As a result, community members responded enthusiastically to grantees' culturally attuned programming.

Figure 29: Subawardee event for staff and community members (Urban Indian Health Institute)

Increasing the implementation of team-based systems of care to support prevention, self-management and control of diabetes, hypertension, high blood cholesterol, and obesity across their Area

C2 recipients advanced the implementation of team-based systems of care across their areas in Year 3 of GHWIC through developing partnerships, establishing community coalitions, building patient tracking and referral systems, and developing culturally-appropriate health education materials.

Success Stories for Increasing Team-based Systems of Care:

- **Northwest Portland Area Indian Health Board** successfully grew their Tribal food sovereignty initiative through the work of their Northwest Tribal Food Sovereignty Coalition (NTFSC). The NTFSC completed a series of training workshops and presentations to share knowledge and build capacity within the network. They also met several times to further develop action plans to address their strategic plan and policy platform, including a new calendar structure for social media. They saw additional growth through the expansion of community garden programs and integration of traditional foods with clinical approaches to chronic disease prevention.
- **Great Lakes Inter Tribal Council, Inc.** reported success in implementing team-based care for chronic disease prevention and management with two of their subawardee communities and shared positive outcomes. The clinic has been moving to a team-based care model with more integration between Community Health and the clinic, where there is now coordinated care between the Diabetes Educator, Wellness Advocate, and Registered Dietician (RD). Hypertension care coordination takes place between a Community Health Licensed Practical Nurse (LPN), RD, and community pharmacy. The chronic disease care team meets biweekly, and Bluetooth data and sharing of at-home blood pressure monitors is utilized in care coordination.

The Role of the C3 Recipient: Supporting the GHWIC Network

The Component 3 (C3) recipient, also known as ANTHC's CCG, continued to provide national support to the GHWIC Network implementing the four strategies by coordinating the GHWIC Community of Practice (CoP), collaborating with the CDC and Evaluation Advisory Group (EAG) on the GHWIC Evaluation process, disseminating GHWIC success stories and promising practices, and providing TA to the Network.

Figure 30: CCG staff (Alaska Native Tribal Health Consortium)

Year 3 Findings and Success Stories:

- **GHWIC CoPs and Webinars:** The CCG hosted 26 virtual CoP meetings and two webinars. Beginning in April, the CCG distributed surveys at the end of each meeting to identify areas of improvement and immediately implement changes.
- **Annual GHWIC Gathering:** The CCG hosted a virtual GHWIC Gathering where there were 253 participants, 41 presentations and 63 different presenters. Utilizing a new platform, Whova, 814 messages were exchanged among participants. Overall, interaction among attendees increased significantly compared to Year 2. The CCG distributed session surveys and a post-event survey to assess the types of sessions provided and the success of the overall event.
- **GHWIC Group on TEC Connect:** The CCG maintained the private GHWIC Group on TEC Connect for the GHWIC Network. The CCG provided one-on-one tutorials of TEC Connect, worked to update the GHWIC email and website directory, and rearranged documents and webinars to ease navigation for the GHWIC Network.
- **GHWIC Promising Practices:** The CCG identified, disseminated, and/or implemented a total of 62 promising practices, 377 success stories, 142 lessons learned, and 87 products/materials for the GHWIC Network. All categories except promising practices increased from Year 2.
- **EAG:** The CCG maintained the EAG and facilitated 12 virtual monthly meetings with the CDC and GHWIC recipients. An EAG feedback survey was disseminated to the group in June 2022. The CCG used these responses to facilitate a meeting with the EAG to improve the meeting topics and structure for Year 4.
- **Evaluation TA:** The CCG provided a total of 220 TA requests in Year 3. The TA were for a variety of topics, such as the Community of Practice (30), general communications needs (77), technology TA (34), which including TEC Connect navigation, and evaluation TA (79). Requests were answered via telephone, email, or Zoom meeting.
- **GHWIC Success Story Project:** In quarter 3, the CCG created a REDCap Tool for recipients to submit GHWIC success stories. These success stories are short narratives accompanied by a photo, video, or other multimedia product. In Year 3, the CCG collected 12 success stories through this tool. Another method of collecting success stories was through one-on-one interviews. The CCG collaborated with recipients to develop their program success stories. The CCG then disseminated the stories by posting them on the public facing website, GHWIC.org. In Year 3, six success stories were published on the website.

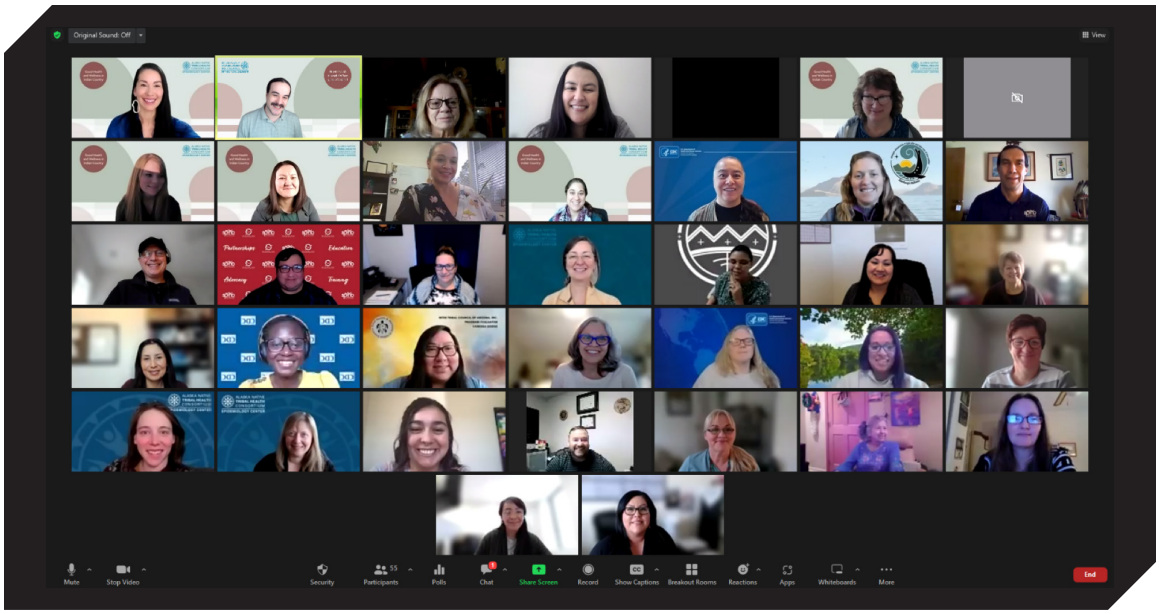


Figure 31: Community of Practice Meeting (Alaska Native Tribal Health Consortium)

Conclusion

Despite the challenges encountered, programs reported resilience and innovative planning to overcome barriers in Year 3. Recipients showed strength in their programs through their work in collaborative partnerships, capacity building, in-person programming, improving community clinical linkages (CCL) related activities, and sustainability planning. The Year 3 progress of recipients demonstrates substantial growth of GHWIC work compared to Year 1 (refer to Appendix D: Year 3 Performance Measure Results). Due to COVID-19, program implementation was slow to get started during the first two years of GHWIC, and in Year 3 programs experienced fuller implementation as momentum picked up with the lifting of pandemic restrictions, the return to in-person activities, and program adaptations and innovations.

GHWIC recipients had significant success in Year 3 implementing strategies to prevent and manage chronic illness through AIAN and urban Indian communities. In Year 3, GHWIC recipients and C2 subawardees succeeded in increasing the community members reached across all four GHWIC strategies: obesity prevention, commercial tobacco control and prevention, diabetes prevention, and heart disease and stroke prevention. In addition, C2 recipients and the C3 recipient achieved their objectives in improving GHWIC implementation and strengthening systems within Tribal and urban Indian organizations by providing training, technical assistance, and networking opportunities to their subawardees, partners, and network.

The focus of the GHWIC evaluation centers on improving the cultural relevance of programming, the evaluation findings, and Indigenous methodologies. The findings of this Year 3 report demonstrate progress made toward GHWIC short-term (1-3 years) and some intermediate (4-5 years) outcomes around policy systems and environmental changes (PSE) and CCL strategies and activities for GHWIC. Community-driven impacts will be identified and reported on by recipients in their final Year 5 evaluation reports due in 2024. The current national evaluation aims to inform future GHWIC programming beyond this and for improved long-term outcomes.

Appendix A: GHWIC Year 3 Subawardees by C2 organization

Alaska Native Tribal Health Consortium

- Aleutian Pribilof Islands Association
- Copper River Native Association
- Norton Sound Health Corporation
- Maniilaq Association
- Southeast Alaska Regional Health Corporation
- Tanana Chiefs Conference

Albuquerque Area Indian Health Board, Inc.

- Acoma Pueblo
- Cochiti Pueblo
- First Nations Community HealthSource
- Laguna Pueblo
- Nambe Pueblo
- Ohkay Owingeh
- Ramah Navajo
- San Felipe Pueblo
- Sandia Pueblo
- Santa Ana Pueblo
- Southern Ute
- Ute Mountain Ute

California Rural Indian Health Board, Inc.

- Bear River Band of the Rohnerville Rancheria
- Big Pine Paiute Tribe of the Owens Valley
- Bishop Paiute Tribe
- Bridgeport Indian Colony
- Cloverdale Rancheria of Pomo Indians of California
- Fort Independence Community of Paiutes of the Fort Independence Indian Reservation
- Greenville Rancheria Tribal Health Program
- Lake County Tribal Health Center
- Lone Pine Paiute-Shoshone Reservation
- Resighini Rancheria
- Riverside-San Bernadino County Indian Health, Inc.
- Sonoma County Indian Health Project, Inc.
- Toiyabe Indian Health Project, Inc.
- Torres Martinez Desert Cahuilla Indians
- United Indian Health Services, Inc.

Great Lakes Inter Tribal Council

- Bay Mills Indian Community
- Lac du Flambeau Band of Lake Superior Chippewa Indians
- Little Traverse Bay Bands of Odawa Indians
- Lower Sioux Indian Community
- Menominee Nation
- Native American Community Clinic
- White Earth Band of Chippewa Indians

Great Plains Tribal Chairmen's Health Board

- Missouri Breaks Industries Research Inc.
- Oyate Teca Project
- Santee Health & Wellness Center
- Sisseton Wahpeton Oyate Diabetes Center
- Special Diabetes Program for Indians (SDPI), Spirit Lake Tribe
- Winnebago Comprehensive Healthcare System

Inter Tribal Council of Arizona Inc.

- Cocopah Indian Tribe
- Fort Mojave Indian Tribe
- Gila River Indian Community
- Pyramid Lake Paiute Tribe
- Quechan Tribe
- San Carlos Apache Tribe
- Shoshone-Paiute Tribes of Duck Valley Reservation
- Te-Moak Tribe of Western Shoshone
- Tonto Apache Tribe
- Ute Indian Tribe of Uintah and Ouray Reservation
- White Mountain Apache Tribe
- Yavapai-Apache Nation

Appendix A: GHWIC Year 3 Subawardees by C2 organization

Northwest Portland Area Indian Health Board

- Coeur d'Alene Tribe
- Confederated Tribes of Siletz Indians
- Coquille Indian Tribe
- Cowlitz Indian Tribe
- Jamestown S'Klallam Tribe
- Port Gamble S'Klallam Tribe
- Quinault Indian Nation
- Shoshone Bannock Tribe
- Swinomish Indian Tribal Community

Rocky Mountain Tribal Leaders Council

- Blackfeet Tribe
- Eastern Shoshone Tribe
- Fort Belknap Indian Community
- Little Shell Tribe
- Northern Arapaho Tribe
- Rocky Boy Tribe

Southern Plains Tribal Health Board Foundation

- Absentee Shawnee
- Cheyenne & Arapaho Tribes of Oklahoma
- Indian Health Care Resource Center of Tulsa
- Muskogee Creek Nation
- Native Youth Preventing Diabetes Coalition
- Prairie Band Potawatomi Nation
- Osage Nation
- Wichita & Affiliated Tribes of Oklahoma

United South and Eastern Tribes, Inc.

- Alabama Coushatta Tribe of Texas
- Eastern Band of Cherokee Indians
- Jena Band of Choctaw Indians
- Mohegan Tribe
- Penobscot Indian Nation
- Poarch Band of Creek Indians
- Seneca Nation of Indians
- Shinnecock Indian Nation

Urban Indian Health Institute

- American Indian Community House (AICH)
- Minneapolis American Indian Center (MAIC)
- Native American Health Center (NAHC)
- Native American Youth and Family Center (NAYA)
- Native Health
- Sacramento Native American Health Center (SNAHC)

Appendix B: GHWIC Program Logic Model

Inputs	Strategies & Activities	Short-term Outcomes (1-3 years)	Intermediate Outcomes (3-5 years)	Long-term Outcomes (5+ years)	Impacts
GHWIC C1 Recipients GHWIC C2 Recipients GHWIC Subawardees CCG TEC Connect GHWIC Recipient Partners GHWIC Program Partners CDC GHWIC 1903 Funding CDC Healthy Tribes Program CDC SMEs, Evaluators and POs	C1, Strategy 1: Implement ... PSE to prevent obesity. • Improve Tribal food and beverage programs and systems • Improve activity-friendly routes • ↑ continuity of care/community support for breastfeeding	↑ # of places: • Offering healthy foods and beverages... • Improving connectivity to places for physical activity... • Implementing culturally adapted ... strategies to promote and support breastfeeding.	↑ # of people that have access to places that sell or distribute healthy foods and beverages... ↑ # of people using safe and accessible places for physical activity. ↑ % improvement in the # of people using ... for physical activity. ↑ # of breastfeeding mothers who use community services that support breastfeeding. ↑ % improvement in the # of breastfeeding mothers who use community services that support breastfeeding.	↑ purchasing of healthier foods ↑ physical activity with an emphasis on walking ↑ breastfeeding ↓ prevalence of commercial tobacco use ↓ incidence of type 2 diabetes (T2D) ↓ prevalence of HBP	↓ chronic disease risks ↑ chronic disease protective factors Improved management of chronic diseases
	C1, Strategy 2: Implement ... PSE to prevent and control commercial tobacco use. • Implement commercial tobacco-free policies • Provide referrals to evidence-based ... cessation treatment	• ↑ # of practices and policies addressing protection from secondhand commercial tobacco smoke. • ↑ # of referrals to evidence-based ... cessation.	↑ # of that implement commercial tobacco-free policies. ↑ % improvement in the # of places that implement commercial tobacco-free policies. ↑ # of commercial tobacco-using patients who receive ... cessation interventions. ↑ % improvement in the # of commercial tobacco-using patients who receive ... cessation interventions.		
	C1, Strategy 3: Implement ... CCL to support T2D prevention. • Expand access to and reach of the National DPP • ↑ awareness of prediabetes • Support prediabetes screening, testing, and referrals to National DPP • Establish sustainable National DPPs • Develop culturally relevant approaches to ↑ National DPP participation and retention	• ↑ # of community members/health professionals educated about prediabetes and associated risk for T2D, heart attack, and stroke. • ↑ # of adult community members screened and tested for prediabetes and referred... • ↑ # of CDC-recognized type 2 DPPs/classes... • ↑ # of CDC-recognized DPPs/classes offering ... materials and approaches...	↑ # of community members at high risk for diabetes enrolled in CDC-recognized type 2 DPPs offered in AIAN communities.		
	C1, Strategy 4: Implement ... CCL to support heart disease and stroke prevention. • Engage CHR and other health paraprofessionals in chronic disease prevention/management • Expand referrals for those with high risk of HBP/HBC to ... programs • Implement team-based care in managing patients with or at risk for HBP/HBC.	• ↑ # of trained CHR who are equipped to deliver ... programs to support prevention, detection, and control of HBP/HBC. • ↑ # of patients with or at risk for HBP/HBC receiving team-based care. • ↑ # of ... materials and approaches to link ... resources and clinical services to support prevention, detection, and control of HBP/HBC.	↑ % of patients 18-85 years of age with diagnosed hypertension who have a BP >140/90. ↑ % of patients with total cholesterol at goal (LDL and HDL). ↑ # of patients with HBP/HBC engaged in self-management and treatment programs. ↑ % improvement in the # of patients with HBP/HBC engaged in self-management and treatment programs.		
	C2 • Expand the implementation of C1 strategies and activities. • Provide TA, training, and resources to support C1 strategies. • Develop multi-sector partnerships to support C1 strategies and activities. • Develop and implement tailored health communication/messaging C1 strategies.	• ↑ # of Area Tribes/Villages/UIOs implementing ... C1 strategies. • ↑ # of Area Tribes/Villages/UIOs engaged in active collaborations to ... C1 strategies. • ↑ # of communication messages disseminated...	↑ # of Area Tribes/Villages/UIOs implementing activities across all four C1 strategies (PSEs and CCLs).		

Appendix C: GHWIC Evaluation Questions

Component 1

Strategy 1

- How have the number and percentage of AIAN people with access to places that sell or distribute healthy foods and beverages in the community been improved?
- How have the number and percentage of AIAN using safe places for physical activities across the life span been improved?
- How have the number and percentage of breastfeeding mothers who use community services that support breastfeeding been improved?

Strategy 2

- To what extent has the number and percentage of workplaces, restaurants, bars, casinos, schools, multi-unit housing, indoor and outdoor events, celebrations and gatherings that implement commercial tobacco-free policies increased?
- How have the number and percentage of commercial tobacco using patients who receive commercial tobacco cessation interventions been improved?

Strategy 3

- To what extent has the number of adults at high risk for diabetes participating in the National Diabetes Prevention Program been improved?

Strategy 4

- To what extent has the number and percentage of patients with high blood pressure or high blood cholesterol engaged in self-management and treatment programs improved?

Component 2

- How has the capacity for chronic disease prevention and management to support the prevention of obesity and diabetes, reduce commercial tobacco use, and control of hypertension or high blood cholesterol increased across the Area?
- To what extent has the number of Tribes/Villages/UIOs health programs' progress on achieving C1 outcomes increased?
- To what extent have team-based systems of care to support prevention, self-management and control of diabetes, hypertension, high blood cholesterol, and obesity been implemented across the Area? How has this increased over the period of performance?

Component 3

- To what extent have the GHWIC promising practices and success stories been disseminated and adapted over time among AIAN communities?
- To what extent has a plan for tracking and disseminating Network-related publications, presentations, products, and other materials been developed and implemented?
- To what extent has an evaluation plan, including evaluation products and a dissemination plan, to coordinate monitoring of Components 1, 2, 3 accomplishments in achieving the outcomes of the NOFO been developed and implemented?
- To what extent has a coordinated and collaborative Community of Practice focusing on chronic disease prevention, including oral health, to facilitate knowledge-sharing, problem-solving, and communication across the Network been developed and adapted over time among AIAN communities?

Appendix D: Year 3 Performance Measure Results

Component 1 (C1) Performance Measures
Strategy 1 – Nutrition, Physical Activity, Obesity
C1PM1: Number of people that have access to places that sell or distribute healthy and traditional foods and beverages in the community.
C1 recipients: **14,535**
C2 subawardees: **150,478**
Year 3 Cumulative Total: **165,013**
C1PM2: Percent improvement in the number of people that have access to places that sell or distribute health and traditional foods and beverages in the community.
Year 1 Baseline (C1 & C2 combined): 26,484
Year 3 Percent Improvement (C1 & C2 combined): **523%**
C1PM3: Number of people using safe and accessible places for physical activity.
C1 recipients: **69,985**
C2 subawardees: **49,413**
Year 3 Cumulative Total: **119,398**
C1PM4: Percent improvement in the number of people using safe and accessible places for physical activity.
Year 1 Baseline (C1 & C2 combined): 67,990
Year 3 Percent Improvement (C1 & C2 combined): **76%**
C1PM5: Number of breastfeeding mothers who use community services that support breastfeeding.
C1 recipients: **577**
C2 subawardees: **1,177**
Year 3 Cumulative Total: **1,754**
C1PM6: Percent improvement in the number of breastfeeding mothers who use community services that support breastfeeding.
Year 1 Baseline (C1 & C2 combined): 327
Year 3 Percent Improvement (C1 & C2 combined): **436%**
Strategy 2 - Tobacco
C1PM7: Number of workplaces, restaurants, bars, casinos, schools, multi-unit housing, indoor and outdoor events, celebrations and gatherings that adopted or enhanced commercial tobacco-free policies.
C1 recipients: **9**
C2 subawardees: **211**
Year 3 Cumulative Total: **220**

Appendix D: Year 3 Performance Measure Results

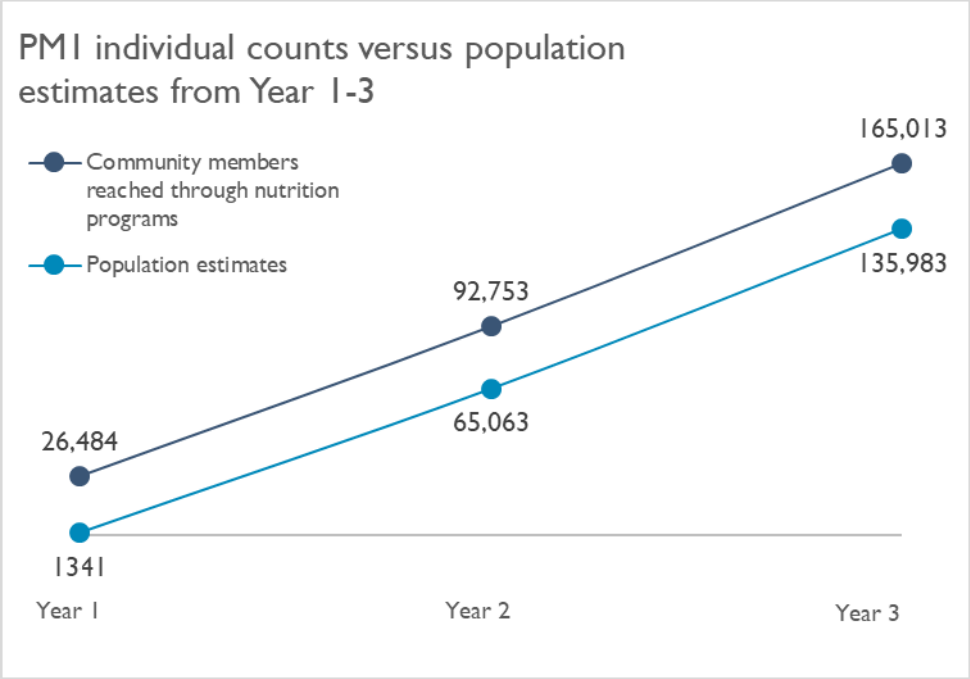
C1PM8: Percent improvement in number of workplaces, restaurants, bars, casinos, schools, multi-unit housing, indoor and outdoor events, celebrations and gatherings that adopted or enhanced commercial tobacco-free policies.
Year 1 Baseline (C1 & C2 combined): 54
Year 3 Percent Improvement (C1 & C2 combined): **307%**
C1PM9: Number of commercial tobacco-using patients who receive commercial tobacco cessation interventions.
C1 recipients: **4,793**
C2 subawardees: **3,453**
Year 3 Cumulative Total: **8,246**
C1PM10: Percent improvement in number of commercial tobacco-using patients who receive commercial tobacco cessation interventions.
Year 1 Baseline (C1 & C2 combined): 2,074
Year 3 Percent Improvement (C1 & C2 combined): **298%**
Strategy 3 - Diabetes
C1PM11: Number of community members at high risk for diabetes enrolled in CDC-recognized type 2 diabetes prevention programs offered in AIAN communities.
C1 recipients: **636**
C2 subawardees: **7,360**
Year 3 Cumulative Total: **7,996**
Strategy 4 – Stroke & Heart Disease
C1PM12: Number of patients with high blood pressure or high blood cholesterol engaged in self-management and treatment programs.
C1 recipients: **2,603**
C2 subawardees: **3,408**
Year 3 Cumulative Total: **6,011**
C1PM13: Percent improvement in number of patients with high blood pressure or high blood cholesterol engaged in self-management and treatment programs.
Year 1 Baseline (C1 & C2 combined): 1,335
Year 3 Percent Improvement (C1 & C2 combined): **350%**

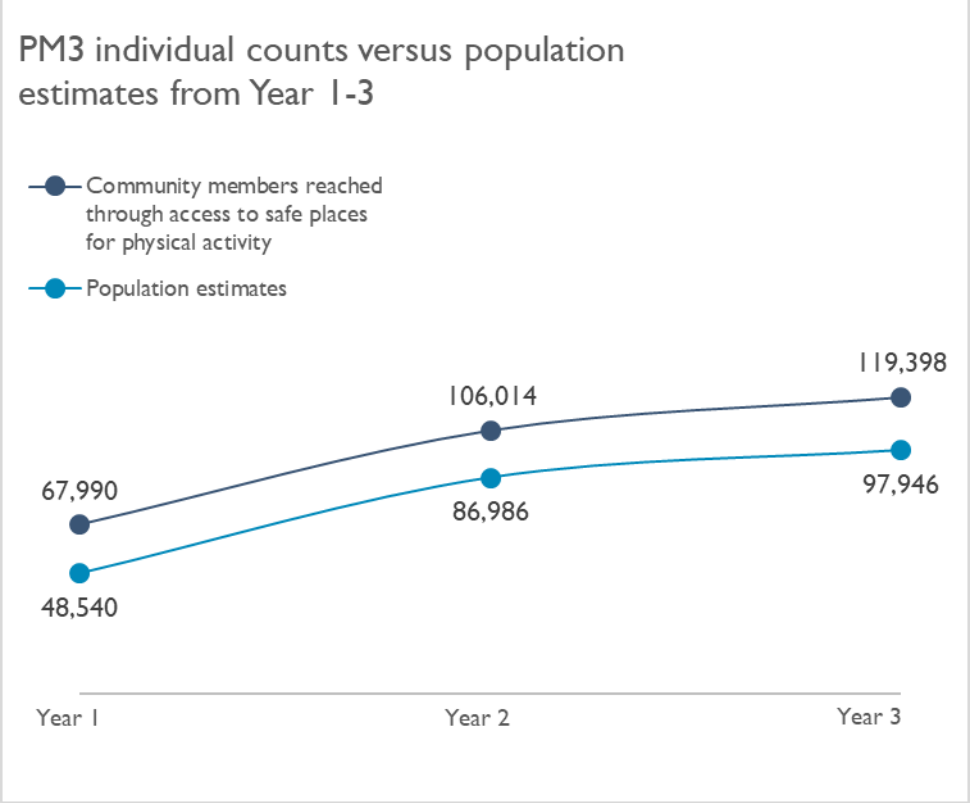
Appendix D: Year 3 Performance Measure Results

Component 2 (C2) Performance Measures	
C2PM1: Number of Area Tribes/Villages/UIOs implementing activities across all four C1 strategies	
Component 2 Recipient	**Number of subawardees**
Alaska Native Tribal Health Consortium Inc.	**6**
Albuquerque Area Indian Health Board Inc.	**12**
California Rural Indian Health Board Inc.	**15**
Great Lakes Inter Tribal Council	**7**
Great Plains Tribal Chairmen's Health Board	**6**
Inter Tribal Council of Arizona Inc.	**12**
Northwest Portland Area Indian Health Board	**9**
Rocky Mountain Tribal Leaders Council	**6**
Southern Plains Tribal Health Board Foundation	**8**
United South and Eastern Tribes, Inc.	**8**
Urban Indian Health Institute	**6**
Total	**95**
Component 3 (C3) Performance Measures	
C3PM1: Number of GHWIC promising practices and success stories disseminated among AIAN communities.	
	72
C3PM2: Number of recipients submitting data to CDC to evaluate the national program in aggregate.	
	28
C3PM3: Number of promising practices, lessons learned, and success stories identified, shared and implemented over time.	
	581
Additional Metrics	
Total people reached across all GHWIC strategies	
	308,418
C1PM1: Percent of total people reached through Tribal food and beverage programs.	
	53.5%
C1PM3: Percent of total people reached through improved land use design.	
	38.7%
C1PM5: Percent of total people reached through breastfeeding support.	
	0.6%
C1PM9: Percent of total people reached through commercial tobacco cessation interventions.	
	2.7%
C1PM11: Percent of total people reached through diabetes prevention programs.	
	2.6%
C1PM12: Percent of total people reached through high blood pressure or high blood cholesterol self-management and treatment programs.	
	1.9%

Appendix D: Year 3 Performance Measure Results

Population estimates: For PM 1 and PM3, GHWIC recipients had the option to report population counts (versus individual counts) as their performance measure totals. For the graphs below, the dark blue line represents the total community reach for the PM, while the light blue line accounts for the amount within the total that was reported as a population estimate (versus an individual count).

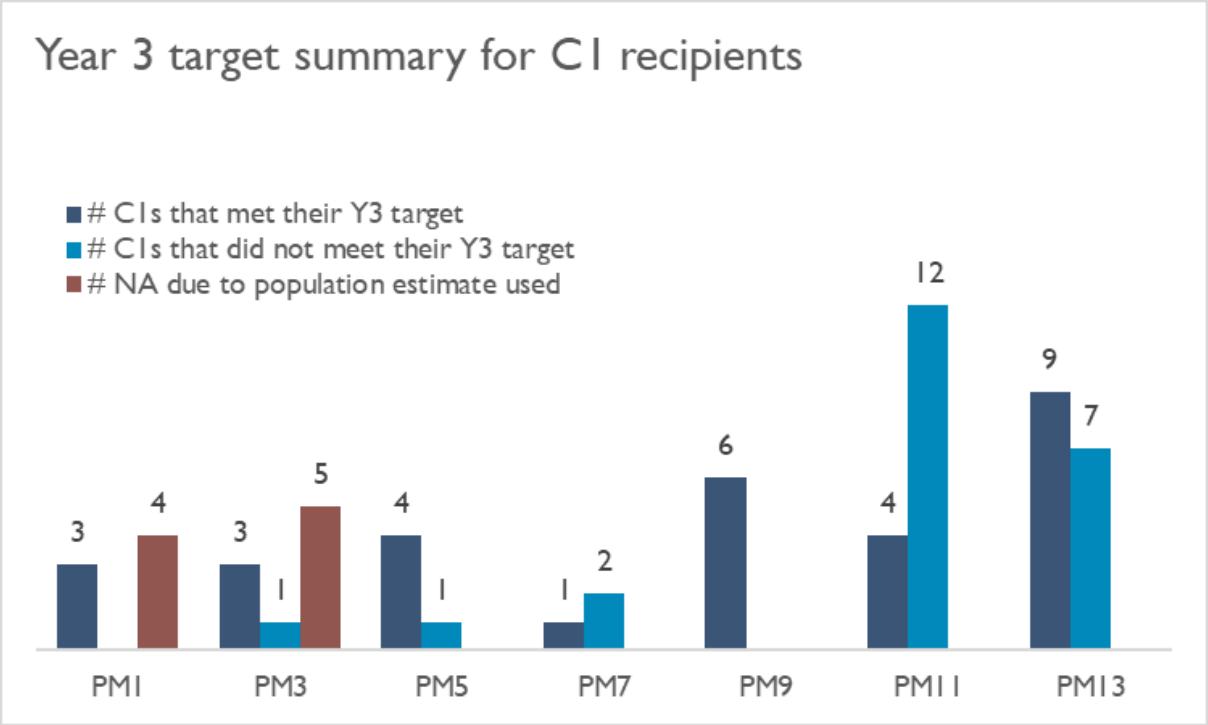


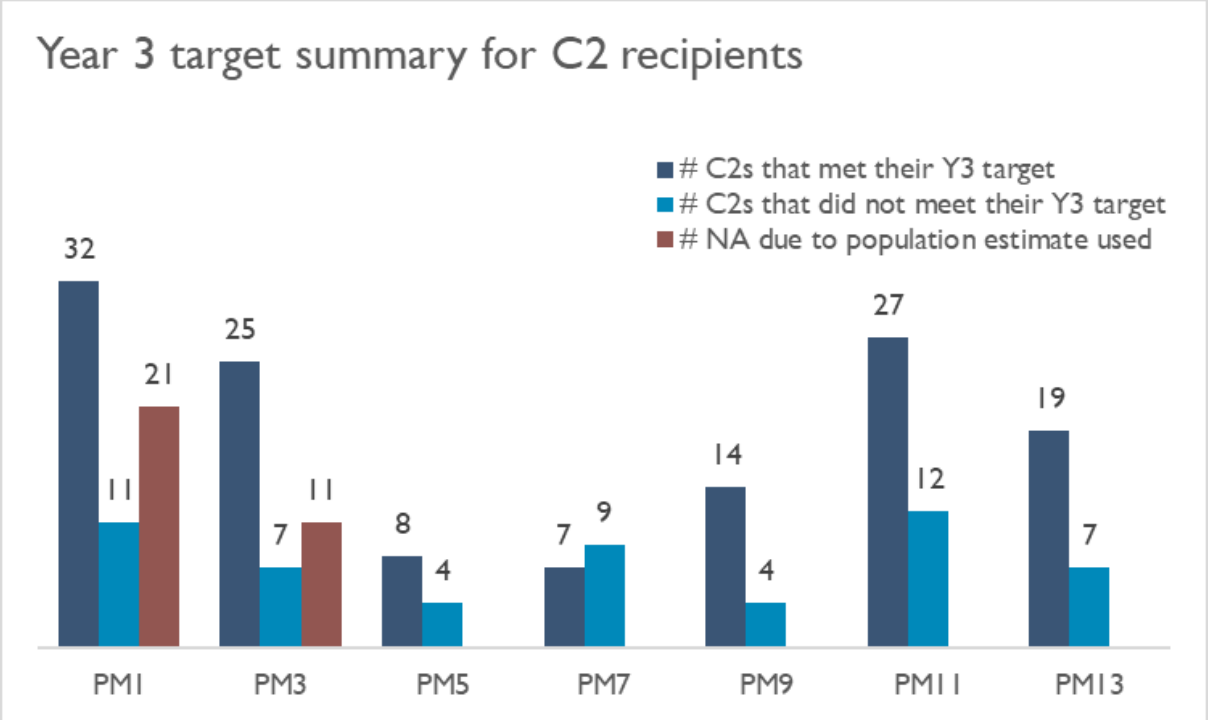


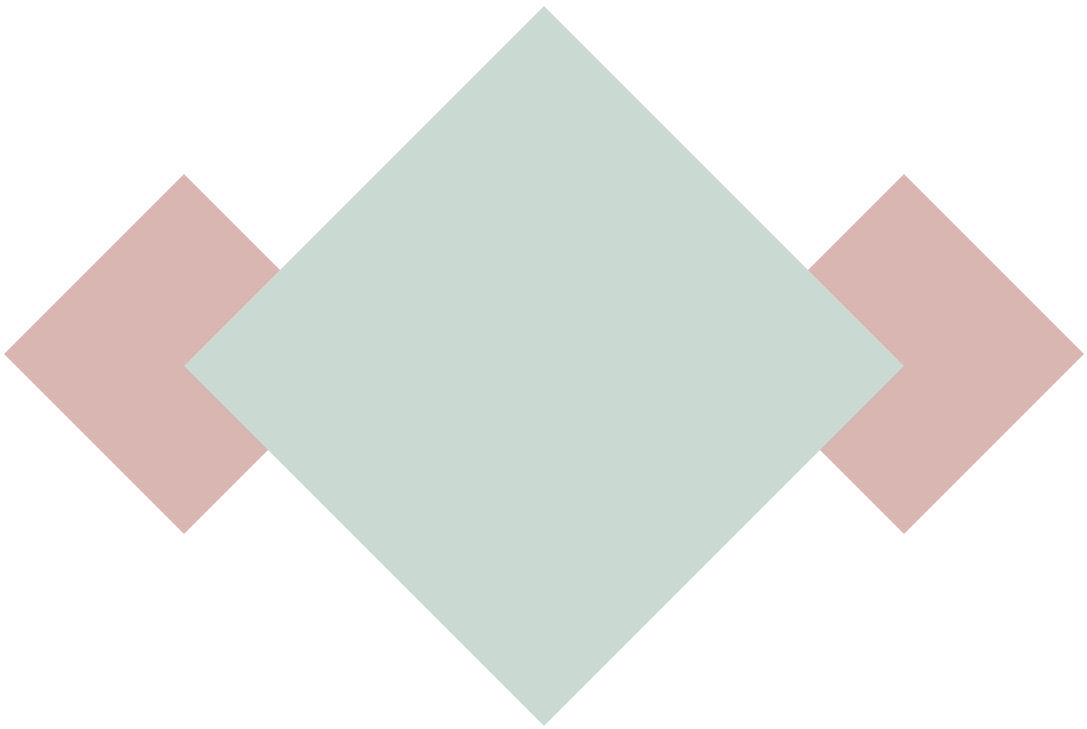
Appendix E: Year 3 Target Summary

The extent to which C1 recipients and C2 subawardees met their Year 3 targets				
	# recipients or subawardees implementing each activity	**# that met their Y3 target**	**# that did not meet their Y3 target**	**# NA due to population estimate used***
Strategy 1 Obesity Prevention				
Performance Measure 1: Nutrition				
C1	**7**	3	0	4
C2	**64**	32	11	21
Performance Measure 3: Physical Activity				
C1	**9**	3	1	5
C2	**43**	25	7	11
Performance Measure 5: Breastfeeding				
C1	**5**	4	1	0
C2	**12**	8	4	0
Strategy 2 Commercial Tobacco Prevention				
Performance Measure 7: Tobacco Policies				
C1	**3**	1	2	0
C2	**16**	7	9	0
Performance Measure 9: Cessation Treatment				
C1	**6**	6	0	0
C2	**18**	14	4	0
Strategy 3 Diabetes Prevention				
Performance Measure 11: NDPP Enrollment				
C1	**16**	4	12	0
C2	**39**	27	12	0
Strategy 4 Heart Disease and Stroke Prevention				
Performance Measure 13: Self-Management Programs				
C1	**16**	9	7	0
C2	**25**	19	7	0

Appendix E: Year 3 Target Summary







GOOD HEALTH AND WELLNESS
IN INDIAN COUNTRY

YEAR 3
Comprehensive Report

Measuring the Value and Impact of Good Health and Wellness in Indian Country (GHWIC)