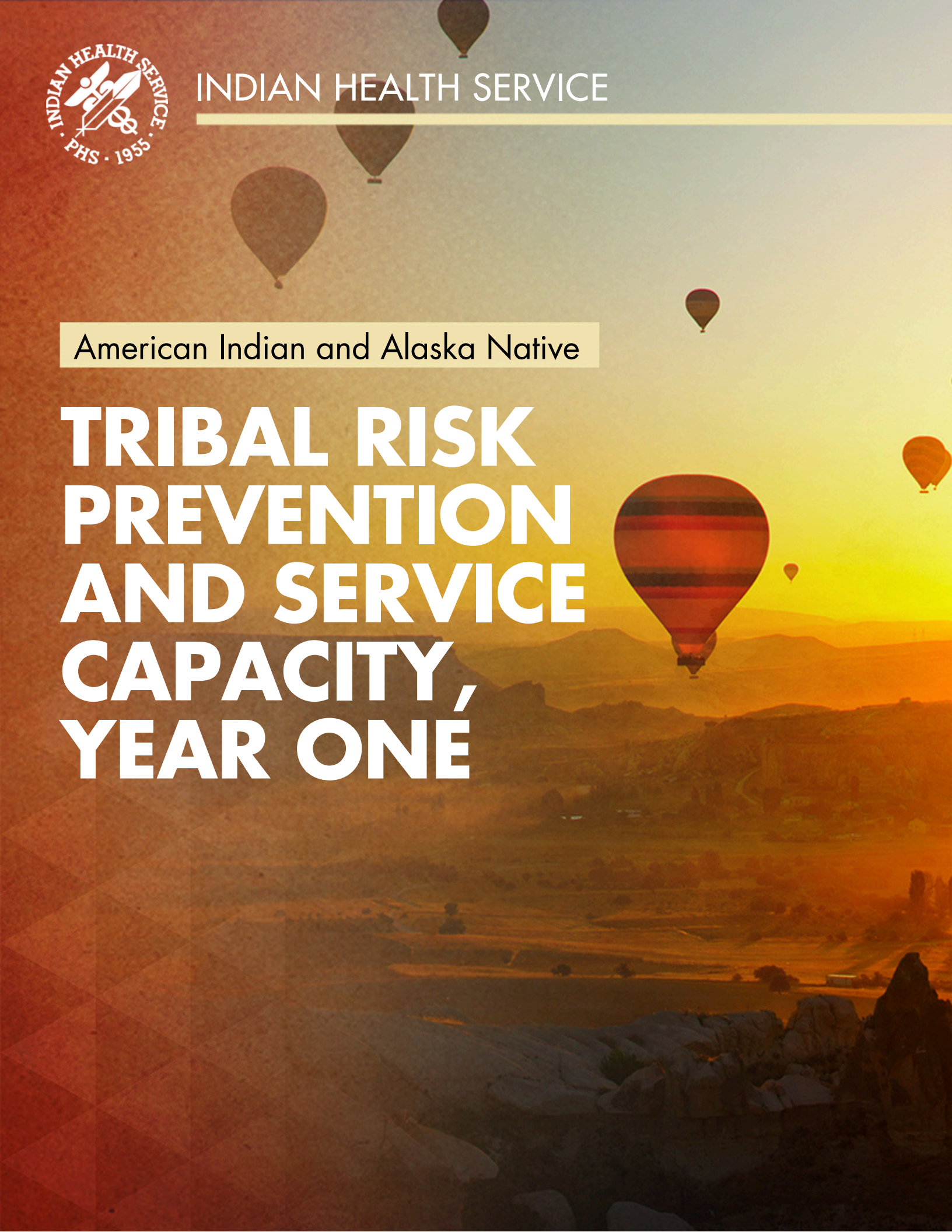

INDIAN HEALTH SERVICE

American Indian and Alaska Native

TRIBAL RISK PREVENTION AND SERVICE CAPACITY, YEAR ONE

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
OFFICE OF CLINICAL AND PREVENTIVE SERVICES

Tribal Behavioral Health Service Capacity Development, Year One

Authors: Paschane DM, Solimon AD, Espinoza J

Year: 2024

Source: Indian Health Service, U.S. Department of Health and Human Services

Author note: Paschane performed the analyses and wrote the manuscript. Solimon and Espinoza aided in interpretation of analyses. All authors discussed the results and commented on the manuscript.

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Executive Summary

Through partnerships with Tribes and Tribal organizations, IHS supports initiatives to help mitigate behavioral risks in Indian Country. In 2023, from May through October, 83 partners, with 113 projects, shared data on their needs and progress for developing behavioral health service capacity in their respective communities. The scope of the initiatives addressed the human risks associated with substance use disorders, domestic violence, and suicide. This report summarizes their progress as a cohort, and highlights successes that can inform future capacity-building partnerships. The analyses summarize progress in three objectives: First, building operational capacities to address workforce and measurement needs. Second, refining service protocols for effective community engagements and internal operations, noting any open requirements for technical and technological support. Third, assessing the service volume of clients and the progress with risk screenings and facilitating appropriate treatments. These basic records will support individual partners in their respective planning and refining of service capacities. The report identifies a few immediate needs and provides a general conclusion that IHS can better support Tribal partners in the field-testing of service protocol and the tools to reinforce improved protocols and other digital services. Through robust Tribal partner engagements during these initiatives, and consistent with Executive Order 14112 (December 2023), the IHS methods of managing these behavioral health initiatives increasingly supports Tribes' self-determination, with uniform data standards, low administrative burdens, and considerable autonomy in program operations and data attribution. To advance its support of Tribal partners, IHS is pursuing methods of specifying the risk burdens across communities, and planning standards of service capacities across Indian Country. These methods will help ensure that IHS programs are highly responsive to communities' specific service requirements.

Authors: Paschane DM, Solimon AD, Espinoza J

Year: 2024

Source: Indian Health Service, U.S. Department of Health and Human Services

Author note: Paschane performed the analyses and wrote the manuscript. Solimon and Espinoza aided in interpretation of analyses. All authors discussed the results and commented on the manuscript.

Introduction

The Indian Health Service (IHS) mission is to "raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level." The IHS fulfills this mission in three forms that serve American Indian and Alaska Native (AI/AN) persons:

1. Coordinates self-governed Tribal operations of health services.

2. Provides direct health services through federal sites.

3. Forms partnerships with Tribes, Urban Indian Organizations, and other AI/AN service systems to address critical gaps in services across Indian Country. The purpose of the partnerships is to address the (a) health service needs of overlooked subpopulations (e.g., youth, veterans, elderly), (b) critical gaps in the local continuums of services (e.g., detoxification, telehealth, aftercare), or (c) potentially overwhelming risk burdens (e.g., suicides, overdoses, violence).

This report describes the progress of one cohort of 83 partnerships with 113 projects, formed to address adult and youth service needs, with an emphasis on reducing risk burdens in four categories, and with respect to the discretion of Tribes in how they form and operate their service capacity development that is unique to their communities. Because IHS formed the partnerships through a grant mechanism, the report refers to the entities as grant-based partners throughout the report.

According to the IHS role in supporting the 113 projects, this report has four objectives in collecting, analyzing, and reporting data:

1. Comply with the Foundations for Evidence-Based Policymaking Act of 2018 and any other statues that apply to these data. IHS facilitates this compliance through an online inbound information portal, which enables secure, account-specific data records in a convenient digital format. See Appendix 1 for a template of the data collected through the inbound information portal.

2. Provide grant-based partners a record that summarizes their evidence of progress in forming their service capacity development and effects. The baseline *Year One* report describes the trends within the total cohort. The subsequent annual reports will describe changes year-over-year. Grant-based partners will receive their own project-specific year-over-year reports, with comparative analyses.

3. Provide grant-based partners administratively simple data collection and analyses that can support their future actions, such as pursuing needs-based funding, defining support requirements, and planning for digital tools.

4. Update the IHS strategies for advanced risk mitigation in Indian Country.

IHS Grant-Based Partners

The cohort of 83 grant-based partners operate 113 projects among the following four IHS programs:

1. Domestic Violence Prevention (DVP), 37 projects
2. DVP Forensic Healthcare (FHC), 4 projects
3. Substance Abuse Prevention, Treatment, and Aftercare (SAPTA), 36 projects
4. Suicide Prevention, Intervention, and Postvention (SPIP), 36 projects

In total, the four programs have a first year budget of $35,871,659. The project grant awards ranged from $200,000 to $400,000, with an average of $317,448.

The following table identifies the grant-based partners by the IHS Service Areas, and the count of their total grants among the four programs.

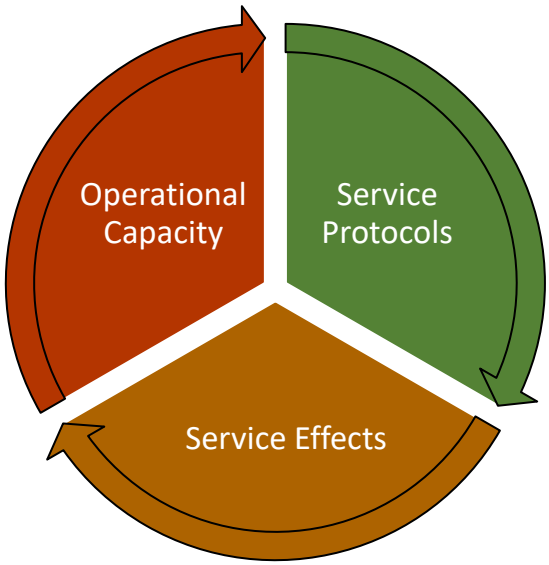
Grant-Based Partners by IHS Service Areas	Count of Grants
Alaska (14 Grant-Based Partners)	**20**
Alaska Native Justice Center, Inc.	1
Alaska Native Tribal Health Consortium	2
Aleut Community of Saint Paul Island	1
Aleutian Pribilof Islands Association, Inc.	1
Cook Inlet Tribal Council, Inc.	1
Dena' Nena' Henash (Tanana Chiefs Conference)	1
Fairbanks Native Association	2
Kenaitze Indian Tribe	1
Kodiak Area Native Association	3
Maniilaq Association	1
Norton Sound Health Corporation	1
Southcentral Foundation	2
Southeast Alaska Regional Health Consortium	2
Wrangell Cooperative Association	1
Albuquerque (17 Grant-Based Partners)	**11**
Eight Northern Indian Pueblos Council, Inc.	2
Five Sandoval Indian Pueblos, Inc.	3
Mescalero Apache Tribe	2
Pueblo of Acoma	1
Pueblo of Taos	1
Ute Mountain Ute Tribe	2
Bemidji (6 Grant-Based Partners)	**6**

Bay Mills Indian Community	1
Keweenaw Bay Indian Community	1
Little Traverse Bay Bands of Odawa Indians	1
Mille Lacs Band of Ojibwe	1
Minnesota Chippewa Tribe - White Earth Band	1
Pokagon Band Of Potawatomi	1
Billings (3 Grant-Based Partners)	**4**
Confederated Salish And Kootenai Tribes	1
Fort Peck Assiniboine & Sioux Tribes	2
Rocky Mountain Tribal Leaders Council	1
California (6 Grant-Based Partners)	**9**
California Rural Indian Health Board, Inc.	2
Feather River Tribal Health, Inc.	1
Hopland Band of Pomo Indians	1
Indian Health Council, Inc.	2
Toiyabe Indian Health Project, Inc.	1
Tuolumne Me-Wuk Tribal Council	1
Two Feathers Native American Family Services	1
Great Plains (4 Grant-Based Partners)	**9**
Great Plains Tribal Leaders Health Board	3
Ponca Tribe Of Nebraska	2
Santee Sioux Tribe of Nebraska	2
Sisseton-Wahpeton Oyate	2
Nashville (5 Grant-Based Partners)	**5**
Houlton Band of Maliseet Indians	1
Mississippi Band of Choctaw Indians	1
Saint Regis Mohawk Tribe	1
Tunica-Biloxi Tribe of Louisiana	1
Cherokee Indian Hospital Authority	1
Navajo (1 Grant-Based Partner)	**1**
Fort Defiance Indian Hospital Board, Inc.	1
Oklahoma City (12 Grant-Based Partners)	**16**
Cherokee Nation	2
Chickasaw Nation	1
Choctaw Nation of Oklahoma	2
Citizen Potawatomi Nation	1
Comanche Nation	2
Kickapoo Tribe of Oklahoma	1
Modoc Nation	3
Muscogee Creek Nation	1
Osage Nation	1

Pawnee Tribe of Oklahoma	1
Ponca Tribe of Oklahoma	1
Phoenix (2 Grant-Based Partners)	**2**
Hualapai Tribal Council	1
Reno-Sparks Indian Colony	1
Portland (6 Grant-Based Partners)	**6**
Benewah Medical Center	1
Cowlitz Indian Tribe	1
Puyallup Tribe of Indians	1
Quileute Tribe of the Quileute Reservation	1
Spokane Tribe of The Spokane Reservation	1
Squaxin Island Tribe	1
Tucson (1 Grant-Based Partner)	**1**
Pascua Yaqui Tribe	1
Urban (16 Grant-Based Partners)	**23**
All Nations Health Center, Inc.	1
American Indian Association of Tucson Inc.	2
American Indian Health Service of Chicago	1
Bakersfield American Indian Health Project	2
Central Oklahoma American Indian Health Council, Inc.	2
First Nations Community Health Source, Inc.	1
Fresno American Indian Health Project	2
Gerald L. Ignace Indian Health Center, Inc.	2
Indian Health Board of Minneapolis, Inc.	1
Indian Health Care Resource Center of Tulsa, Inc.	1
Indian Health Center of Santa Clara Valley	1
Native American Rehabilitation Association Inc.	1
Native Health	2
Phoenix Indian Center, Inc.	1
San Diego American Indian Health Center	1
South Dakota Urban Indian Health, Inc.	1
United American Indian Involvement, Inc.	1
Total of 83 Partners	**113 Projects**

Organization of Analyses

The analyses reported herein primarily focus on the domains of ***operational capacity***, ***service protocols***, and ***service effects***. These three domains tend to support each other in terms of improving services in response to local client needs. The report's analyses represent a subset of potential health policy and service analyses. See Appendix 2 for a description of the broader scope of potential analyses.



Operational capacity: The scope of operational capacity includes the acquisition of leaders, staff, volunteers, and partnering organizations, and investments in those persons through training, incentives, and service resources and tools. These are the most common expenses of a project, and require project specific plans to address the appropriate levels of investments to achieve the desired service capacity in each community.

Service protocols: The service protocols represent the formal commitments for taking actions, in terms of understating the local and individual needs, applying limited resources, and monitoring the effects of such actions. Because psychological and behavioral risk mitigation is complex and straining on a health system and its staff, the service protocols help guarantee that the services approximate ideal actions, given clients' unique circumstances. Analyses of service protocols helps affirm the fidelity of the actions, given the risk of errors during complex events.

Service effects: Ultimately, the service effects represent the value and impacts of the operational capacity and service protocols when applied to clients and a community. Service effects typically describe how many persons the project was able to engage, screen for recent and persistent risks, assess for resources to mitigate their risks, and provide precise and therapeutically effective services through the project, within the local continuum of services.

Year One Analyses of Projects

The first year of the grant-based projects started on May 1, 2022 (FHC started April 1, 2022). The annual reporting on the 113 projects began May 31, 2023, with the last responses received by IHS in August 2023. Throughout the project operations, IHS area project officers engage with the grant-based partners to monitor progress within their early service capacity development goals, and provide technical assistance when requested.

With regard to territory, travel distance, and Tribal membership, each grant-based partner identified their unique service catchment area and describe the AI/AN population contained therein. Across all programs, the total estimated population is 1.53 million, with 360,000 (31%) under the age of 25. Grant-based partners also estimated their general behavioral health service capacity gaps within the catchment areas. The total estimated persons affect by service gaps includes 180,105 adults (age over 24) and 14,500 youth (age under 25) who lack access to outpatient services, and 893 adults and 436 youth who lack access to inpatient services.

Operational Capacity

During the first year, grant-based partners made significant progress in developing their operational capacity. An effective method of building operational capacity is to engage in strategic planning through planning committees, policy committees, or community assessment committees. Across the cohort, partners trained 1,595 persons on issues of community assessments and planning (average of 14.1 per project). IHS anticipates that each of the 83 grant-based partners has a unique approach to strategic planning within their communities. As requested by grant-based partners, IHS area project officers can provide support and guidance in these processes.

Community Workforce Development

Critical to operational capacity is the means of recruiting and training the paid staff and a volunteer workforce within the community. Among the 113 projects, 68 (60%) achieved or exceeded their staff hiring goals within the first year. The total achievement was 96% of planned staffing, but taking into account staff losses, the net staffing was 88% across the total cohort. Projects identified a wide variety of factors affecting staffing, with the most notable pertaining to recruiting qualified AI/AN persons from beyond the local labor market and completing work clearances within a reasonable period.

In order to support volunteer participation from the local communities, 40 (35%) projects planned to use set-aside funds to help encourage volunteering, including funds to cover volunteers' expenses, offer stipends, and provide training and transportation. Among those projects applying their budget to support volunteers, the average proportion of the total budget was 16.5%.

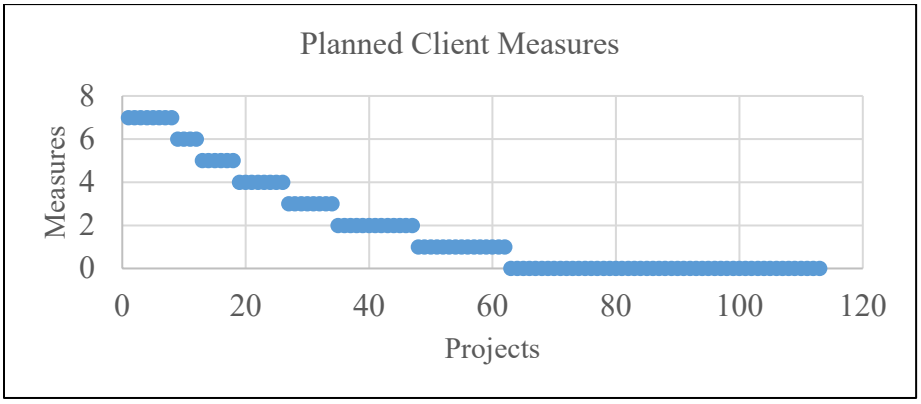
In total, the count of persons trained across the four programs was notable. The count of trainees who learned about key issues included 112,285 on referral methods, 13,468 on suicide risk and response, 12,339 on substance use disorders, 2,641 on overdose reversals, and 834 on suicide

risk screening. Other training foci addressed a variety of issues regarding safety, health, and grief. In total, the volume of trainees learning key issues was 157,007 (possible duplicated individuals). Of those trainees-by-issues volume, 7,497 of those were age 17 or younger, and 3,347 were ages 18 to 24. The total youth volume was 10,844.

Operational Capacity Strategies	Totals	Project Reference Points
Staff, planned hires	358	Average: 3.2
Staff, completed hires	343	Achieved 96% of planned
Staff, turnovers	44	Retained a net staffing of 88%
Staff, projects without hires	12	Critical deficit of 26 staff
Volunteers, planned	250	Average: 2.2
Volunteers, licensed providers	110	Average: 0.9
Volunteers, Tribal elders	66	Average: 0.7
Volunteers, congregational	36	Average: 0.3
Training events, general community	982	Average: 8.7
Training events, licensed providers	257	Average: 2.3
Training events, congregational	48	Average: 0.4
Training, trainees-by-issues, adults	146,163	Average: 1,293.5
Training, trainees-by-issues, youth	10,844	Average: 96.0

Planned Client Measures

In support of initial operational capacity development, IHS asked grant-based partners about their planned measurement practices for each project. A total of 62 (55%) projects have active plans to manage key client measures, including psychological changes (30; attitudes, decisions, or behaviors), spiritual engagements (35), long-term impacts (33), travel distances (36), access to treatment (40), communication methods (32), and service satisfaction (42). The following graphic illustrates the frequency of projects along the progress of pursuing nine client measures.



Service Protocols

Essentially, service protocols are formal written designs for operations, which identify the expected workflows, staff specializations, tools, and rules that pertain to services. There are three major categories of service protocols. One category is *community engagement protocols*, which

is how the service entity connects with and interacts with the community and other service entities in the local continuum of services and regional and national networks. A second and most common category is *internal operations protocols*, which are necessary records to inform service capacity development, service quality improvement, and service performance analyses among variable cases and workflows. The third category is *digital service protocols*, which guide tool prototyping, enable collections of technology requirements, and organize investment justifications for innovations.

Community Engagement Protocols

Service partner agreements (e.g., memorandums of agreement) can be critical for the success of projects, as there is often a required interdependency among service entities. Examples include agreements addressing the cost and coordination of referral management, differentiated services, and emergency services. Within the first year, the total agreements achieved among all 113 projects was 45% of those planned.

Community teaming can help build towards reliable agreements, and foster a continuum of services that sustain risk mitigation and healing. The 113 projects formed a variety of strategic community service teams, with the greatest number of members joining to address cultural promotion (565), followed by team members addressing youth outreach (509), crises response (340), school coordination (164), transportation (87), medically-assisted treatment (81) shelter (46), spiritual health (39), legal counseling (36), medical forensics (15), and research (10).

Across projects, 352 youth participated in youth advisory councils. The largest youth councils, ranging from 20 to 65 members, were among Cherokee Nation (OK), Comanche Nation (OK), Phoenix Indian Center, Inc. (AZ), Pueblo of Acoma (NM), Pueblo of Taos (NM), and Two Feathers Native American Family Services (CA). The success of youth engagement is a central focus in these grant-based partnerships.

The 99 projects that used media outreach mechanisms primarily relied on low-cost sources, such as local radio, billboards, and social media. Twenty-three projects made investments into customized media deliverables, with the Alaska Service Area accounting for 93% of such media deliverables, an expected observation due to the distance factors that affect engagement.

Community Engagement Protocols	**Totals**	**Project Reference Points**
Service partner agreements, planned	493	Average: 4.3
Service partner agreements, signed	221	Achieved 45% of planned
Strategic service team members	1,892	Average: 16.7
Youth advisory councils	34	Average membership: 10.4
Media outreach mechanisms	358	Average: 3.3 (108 projects)

Internal Operations Protocols

Of the 113 projects, 96 (85%) worked on improving internal operations protocols in the first year. IHS provided project respondents with a list of seventeen typical protocols, which are in classes of ten staff goals and seven client goals. The following are internal operations protocols

for staff goals, and the count of projects that worked on them in order of frequency: Prevention services (73), referral processes (73), screening methods (63), intake processes (61), data collection methods (55), aftercare support methods (40), case monitoring methods (40), communication reinforcement methods (40), care transfer methods (29), and long-term recovery methods (16). The following are internal operations protocols for client goals: Cultural inclusion methods (60), client therapeutic engagement (34), family integration methods (27), coaching methods (19), employability integration methods (10), congregation-based recovery methods (2), and spiritual inclusion methods (0).

Five grant-based partners stand out for leading service protocol designs for improving internal operations. Each of these partners worked on twice as many designs than the average count: Cowlitz Indian Tribe (WA), Five Sandoval Indian Pueblos Inc. (NM), Native Health (AZ), Tunica-Biloxi Tribe of Louisiana (LA), and Ute Mountain Ute Tribe (CO).

Internal Operations Protocols	**Totals**	**Project Reference Points**
Service designs, 10 staff foci	473	Average: 5.1 (93 projects)
Service designs, 7 client foci	152	Average: 2.2 (70 projects)
Service designs, 17 total	625	Average: 6.5 (96 projects)

A method that service entities can use to examine potential impact of their behavioral health services is to design and analyze client-centric protocols that promote self-efficacy through the development of helpful values and habits in clients. IHS assumes that where projects concentrate on the client-centric self-efficacy protocols they will continue to improve those services and their individual client effects. In the first year, among the 113 projects, 70 (62%) worked on improving client-centric self-efficacy protocols. IHS provided project respondents with a list of thirteen values development protocols and a list of thirteen habits development protocols that are often foundational to facilitating self-efficacy development in clients. Two grant-based partners stand out in addressing these protocols, as they both reported twice as many designs than the average count: American Indian Health Service of Chicago (IL) and Southcentral Foundation (AK).

Client-Centered Protocols	**Totals**	**Project Reference Points**
Internal 13 values development	574	Average: 8.7 (66 projects)
Internal 13 habits development	290	Average: 4.7 (62 projects)
Internal 26 self-efficacy development	864	Average: 12.3 (70 projects)

IHS provided project respondents with a list of twelve technical and possible digital design topics to identify which were currently relevant to their set of protocol analyses. These data help inform the grant-based partners and IHS on where there may be a need for future training or technical assistance in protocol development. The following table organizes the count of projects who noted the twelve topics (described below) by their IHS Service Areas.

Service Areas	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**	***Total***
Alaska	5	5	10	3	4	4	4	5	3	2	9	2	56
Albuquerque	6	7	9	1	0	1	1	6	3	1	4	3	42
Bemidji	1	2	2	1	0	0	2	2	0	1	2	1	14

Billings	0	0	0	0	0	0	0	0	0	0	0	0	0
California	1	1	3	2	1	2	1	1	1	1	2	2	18
Great Plains	0	2	5	4	3	2	2	2	3	3	4	1	31
Nashville	2	3	3	2	2	0	2	2	2	2	4	3	27
Navajo	0	0	0	0	0	0	0	0	0	0	0	0	0
Oklahoma	4	5	5	4	5	1	3	5	3	2	6	1	44
Phoenix	0	0	0	0	0	0	0	0	0	0	0	0	0
Portland	0	0	0	0	0	0	0	0	0	0	0	0	0
Tucson	0	1	0	0	0	1	0	0	1	1	0	0	4
Urban	6	10	12	3	2	4	2	6	9	4	10	2	70
Total	25	36	49	20	17	15	17	29	25	17	41	15	306

A. Validating Protocol Efficacy
B. Integrating Client Assessments
C. Integrating Cultural Reinforcement
D. Integrating Spiritual or Faith Reinforcement
E. Aligning Tribal Oversight
F. Involving Volunteers
G. Involving Clients as Volunteers
H. Pre-Approving Protocol Variability
I. Client Self-Administration Services
J. Parent or Caregiver Service Administration
K. Virtual Engagement
L. Preventing Risk to Client Safety or Self-efficacy

Digital Service Protocols

Digital service protocols are essential in managing accuracy and cost-effectives in health services, achieving precision services for clients, training staff prudently, and monitoring risks and risk mitigation actions among health systems and clients. As noted above, digital service protocols are tools for prototyping better services, outlining technology requirements, and justifying innovation investment.

IHS asked grant-based partners to identify where they may need technology-based improvements, thus a need for analyses that specify digital service protocols and any subsequent data integration and infrastructural sustainment. The total needs identified among 88 projects indicated 766 required digital service protocol analyses (average 8.7 needs per project). Ideally, IHS will coordinate these analyses in alignment with the Health IT Modernization Program.

Digital Service Protocol Requirements	**Count of Projects**
Managing Referral Process	46
Client Case Management	45
Organizing Strategic Planning	41
Assessing Clients' Satisfaction	40
Assessing Clients' Needs	38
Assessing Attitudinal and Behavioral Changes	38
Coordinating Partnerships Engagements	36
Organizing Protocols Designs and Uses	35
Managing Personnel Training	35
Aftercare and Recovery Monitoring	35
Cultural Inclusion Media	34

Client Treatment Engagement	33
Client Self-Care Online Tools	33
Monitoring Organizational Capacity	32
Tracking Priority Monitoring Conditions	29
Assessing Trainees' Learning	28
Emergency Communication Systems	26
Family and Care Giver Case Management	25
Family Integration Media	23
Vetting and Managing Volunteers	22
Creating Protocol or Legal Records	20
Collecting Forensic Data	19
Coaching and Counseling Online Access	19
Client Employability Development	17
Client Communication Call Centers	17
Total	766

Service Effects

Service effects help provide evidence that the funding was appropriately applied to clients within the plans of the community. The process of service development can have a generalized positive effect on communities, especially when the implementation of the local plans leads to trustworthy and reliable service protocols. One of the early signs of successful Tribal service capacity development is in processing of priority outputs, such as cultural and spiritual engagements, and performing screenings for risks and then making referrals for appropriate services.

Accurately measuring behavioral health service outputs is difficult because there is not an effective benchmark for most communities. Rarely does a community know its total population that is at-risk in their feasible service catchment area. Alternatively, service entities will record the percent of clients that they engaged, the proportion they screened for risks, the proportion they provided services to if they screened positive for a risk, and the proportion they treated or referred for risk-mitigation or treatment services. IHS does not assume that all grant-based partners have effective data recording systems for capturing these types of data.

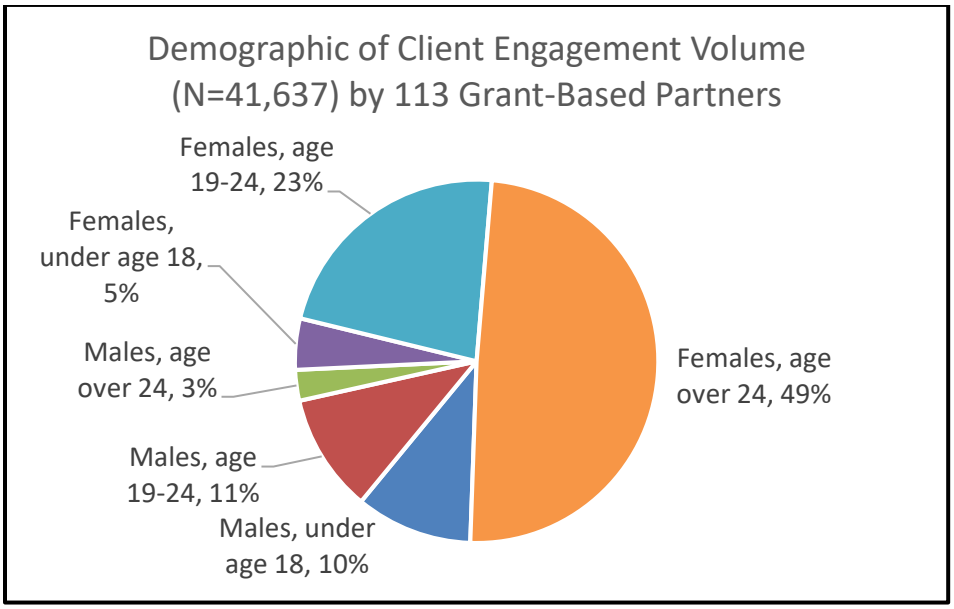
Client Engagement Volume

The following table summarizes the demographics of the total volume of client engagements, which is fostered through various clinical and community protocols, media, and events. For many reasons, a project can engage (serve) the same person multiple times in a year. Engagements are events where individual screenings for specific risks are possible, even if the client refused the screening. Grant-based partners reported demographic data inconsistently, as

57 (50%) of the projects did not identify those served; rather, they provided only the total of client engagements[1].

Client Engagement Volume	Totals	Project Reference Points
Total, under age 19	6,233	Average: 49.8 (45 projects)
Males, under age 19	*4,334*	*70%*
Females, under age 19	*1,899*	*30%*
Total, age 19-24	13,774	Average: 270.1 (51 projects)
Males, age 19-24	*4,391*	*32%*
Females, age 19-24	*9,383*	*68%*
Total, age over 24	21,630	Average: 424.1 (51 projects)
Males, age over 24	*1,139*	*5%*
Females, age over 24	*20,491*	*95%*
Total reported by demographics	41,637	Average: 743.5 (56 projects)

According to the projects that reported their client engagement data, the largest group of clients were female adults, who accounted for nearly half (49%) of all engagements. Youth, including adolescents and young adults, accounted for 48% of all engagements. Engagement with adult males (over age 24) was less than 3%.



Due to the unique developmental and legal risks that accompany adolescents, their risk is of particular concern to Tribes, IHS, and other federal agencies, in terms of the youths' stability of residence, schooling, and safety. The Year One cohort of projects achieved a volume of 6,233 youth (<19 years old) encounters, which is 15% of total reported with demographic data.

[1] The reported total population of 67,857 engaged (reported by 83 projects) does not match the total of the demographic subgroups. The difference is 26,220 persons (39%), reported in the total, but not accounted for demographically.

The most successful site for sustaining the volume of youth encounters is a SPIP project operated by the Reno-Sparks Indian Colony (RSIC) of Nevada. Although RSIC youth membership is very small (estimated as 142, 18% of 790), they fostered 2,607 youth encounters over the year, 42% of all youth encounters for this cohort. The RSIC services are robust in their scope, well known among the region's Tribal communities, and open to all AI/AN persons. The success of RSIC provides for an opportunity to examine the array of risk burdens that may go unexamined in Indian Country. The Reno-Sparks location is the regional hub to 26 surrounding rural Tribes and Tribes in neighboring states. It is also the westbound transportation hub for national trucking of goods, from Canada and Mexico ports. The combination of undetected movements of AI/AN youth in the region, the potential mobility of illegal activity and exposure to youth perpetrators, and the cross-sector information requirements (e.g., justice, education, health) poses a context for crises that may not be addressed through the current scope of IHS programming.

Risk Screening

Risk screening is a critical service protocol that occurs between client engagement and treatment services. Grant-based partners provide aggregated data, so there are limitations on examining the individual-level relationships between those engaged, screened, and treated, and their sustained outcomes. The following table summarizes the output of risk screening.

Risk Screening	Totals	Project Reference Points
Alcohol use disorder	40,777	Average: 1,132.7 (36 projects)
Any substance use, using SBIRT	2,759	Average: 153.3 (18 projects)
Opioid use disorder	10,329	Average: 382.6 (27 projects)
Suicide risk	62,749	Average: 1,494.0 (42 projects)
Victim of assault, non-sexual	6,116	Average: 291.2 (21 projects)
Victim of sexual assault	5,986	Average: 285.0 (21 projects)

In total, 59 projects reported the completion of 128,716 screenings for substance misuses and victims of violence or self-injury. The average count of all types of screenings per project was 2,110. Three projects accounted for 43% of all total screenings: Central Oklahoma American Indian Health Council, Inc. (OK), Indian Health Center of Santa Clara Valley (CA), and Indian Health Council, Inc. (CA).

It is important to note that all 113 projects can contribute to any of the risk screening types, regardless of the IHS program designs. As examples, 9 projects outside of the DVP or FHC programs screened for victims of assault, 17 projects outside of the SAPTA program screened for substance use disorders, and 25 projects outside of the SPIP program screened for suicide risk. These actions demonstrate that the discretion of Tribes to lead a broader scope of screening has made a notable contribution to the total screening services in Indian Country.

Identified Victim Cases

Through effective screening, 22 projects identified 20,466 cases of violence. Due to the aggregated, project-level data reporting, the case data can include an individual victim more than once because of crime categories, such as domestic violence and strangulation, or due to multiple

incidents of violence on a single person in the same year. Eighteen projects across the four programs reported 1,120 (average 62.2) violence-specific service referrals made to victims (DVP 79%, FHC 10%, SPIP 8% SAPTA 3%). Two DVP projects accounted for 74% of all reported cases. The total referrals reported for victims were 1,120, which is only 5.5% of the total cases.

Victim Cases	Totals	Project Reference Points
Violence, domestic	10,997	Average: 523.7 (21 projects)
Violence, other not specified	1,134	Average: 103.1 (11 projects)
Violence, non-sexual assault	23	Average: 5.8 (4 projects)
Human trafficking	2,640	Average: 293.3 (9 projects)
Sexual abuse	3,004	Average: 158.1 (19 projects)
Strangulation	2,668	Average: 381.1 (7 projects)

Identified Substance Use Disorders

Grant-based partners were able to identify persons with substance use disorders through effective client engagements and screening protocols, enabling referral cases and access to treatment for such disorders. Among those who reported, 38 projects made 9,301 referrals for cases requiring treatment because of an identified substance use disorder (SUD).

SUD Treatment Referral Cases	Totals	Project Reference Points
Alcohol use disorder	4,324	Average: 127.2 (34 projects)
Methamphetamine use disorder	659	Average: 36.6 (18 projects)
Opioid use disorder	1,686	Average: 73.3 (23 projects)
Other drug use disorder	1,746	Average: 67.2 (26 projects)
Medially assisted treatment (MAT)	886	Average: 63.3 (14 projects)

Identifying Psychological Distress

Psychological distress is associated with victims of crime and those with substance use disorders, and may be the primary risk of concern in persons who are suicidal or considering self-harm. In addition to the victim and SUD referrals, 34 projects made 8,962 referrals specifically for psychological distress. IHS assumes the referrals are unique to the needs of each AI/AN person.

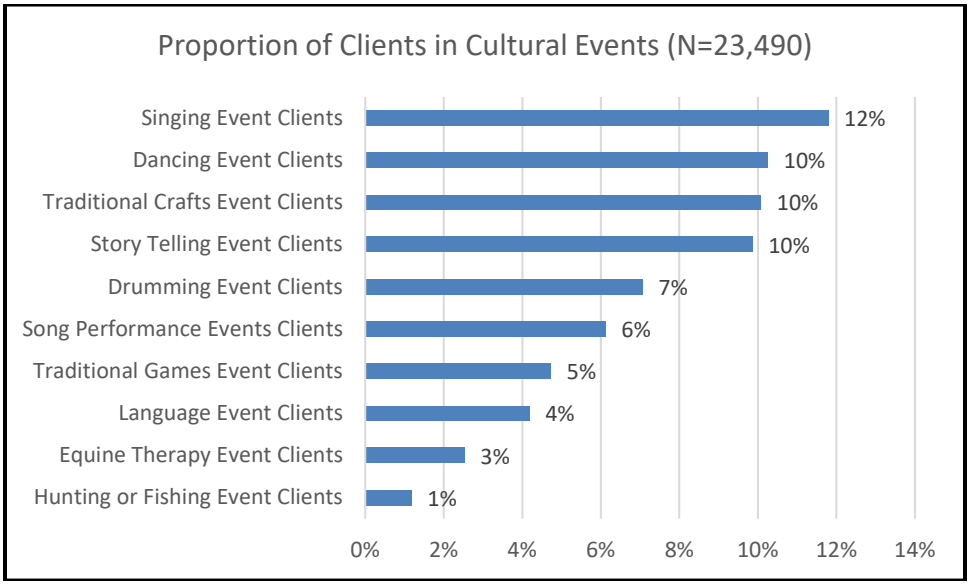
Distress Referral Cases	Totals	Project Reference Points
Mental health crisis	8,470	Average: 264.7 (32 projects)
Self-harm or suicidal	492	Average: 21.4 (23 projects)

Treating Psychological Distress

Grant-based partners utilized a variety of sources for treating psychological distress, depending on the needs of the individual, service protocols, and local service entities. The most common therapies relied on medical models of one-on-one therapy, with a majority, 48% of cases, served through motivational interviewing, followed by cognitive behavioral therapy (27%), dialectical behavioral therapy (7%), attachment-based family therapy (6%), and motivational enhancement therapy (5%).

Psychological Treatment Cases	Totals	Project Reference Points
Therapy, medical models	6,840	Average: 228.0 (30 projects)
Therapy, chaplain or pastor	68	Average: 22.7 (3 projects)
Therapy, spiritual integrated counselor	185	Average: 18.5 (10 projects)
Therapy, twelve-step group	829	Average: 46.1 (18 projects)

Cultural events are effective ways to foster community reinforcement approaches to risk mitigation, and were common among a majority of the grant-based partners. Sixty-three (56%) of the projects integrated a variety of culturally formatted experiential therapeutic methods into the scope of risk mitigation and therapy. The total volume of clients that received culturally formatted experiential therapies was 23,490, where the same person may experience multiple cultural events. The largest proportion of the volume was 32%, labeled as unspecified events, with a few indications that these focused on traditional foods and medicines. The graphic below illustrates the proportional distribution of all specified culturally formatted experiential therapeutic methods. Next year data collection will ask about smudging and talking circles.



Service Outcomes

The ability to measure service outcomes in those persons who receive risk mitigation services is difficult in any context. It is especially difficult if the service entity is in the early phases of service capacity development, lacks digital service protocols, or is serving a highly mobile or dispersed population. Due to these structural limitations, the reporting of service outcomes may not represent the full status of risk mitigation in the represented communities.

Critical Service Milestones

Among possible service outcomes, measures of critical service milestones mark those events that inform the life-changing impacts of projects. These measures warrant the attention of the grant-based partners and IHS, in order to determine the progress of risk mitigation in local continuums

of services, given clients' experiences towards wellbeing and the progress of Tribal service capacity development.

Service Outcomes	Totals	Project Reference Points
Entered inpatient treatment	182	Average: 9.6 (19 projects)
Achieved sobriety	1,282	Average: 67.5 (19 projects)
Overdosed	55	Average: 7.9 (7 projects)
Cases reported for prosecution	8	Average: 2.0 (4 projects)

Note: The long-term outcome of these cases is unknown, as the data may not be readily available through projects' data management practices.

Client Measured Impacts

IHS provided an opportunity for projects to report their client service impact measures if they collected such data on individual persons. The reported client data are of measured changes in psychological and behavioral wellness, which can reinforce long-term risk-mitigation, healing, and recovery from injuries and substance use disorders. The grant-based partners who are leading a robust set of client-level measures include Mississippi Band of Choctaw Indians (MS), Southcentral Foundation (AK), and Two Feathers Native American Family Services (CA).

Client Impacts	Totals	Project Reference Points
Individual valuation of:		
Self	968	Average: 138.3 (7 projects)
Peers	72	Average: 10.3 (7 projects)
Family members	311	Average: 44.4 (7 projects)
Community members	63	Average: 9.0 (7 projects)
Tribe-specific culture	1,016	Average: 145.1 (7 projects)
Treatment services	84	Average: 12.0 (7 projects)
Spiritual/religious activities	280	Average: 46.7 (6 projects)
Traditional or cultural activities	425	Average: 60.7 (7 projects)
Affirmed commitment to:		
Protect own body	446	Average: 89.2 (5 projects)
Protect own mind	281	Average: 56.2 (5 projects)
Protect own soul, faith, spirit	0	(4 projects)
Change substance use influences	363	Average: 72.6 (5 projects)
Change substance use behavior	82	Average: 16.4 (5 projects)
Be accountable to others	662	Average: 165.5 (4 projects)
Complete treatment services	72	Average: 14.4 (5 projects)
Practice spiritual/religious activities	0	(4 projects)
Practice cultural activities	0	(4 projects)
Measured improvements in:		
Substance use	398	Average: 79.6 (5 projects)
Legal alternative activities	118	Average: 23.6 (5 projects)
Family-affirming activities	348	Average: 69.6 (5 projects)

Financial management activities	0	(4 projects)
Social network affiliations	0	(4 projects)
Culturally-affirming activities	480	Average: 80.0 (6 projects)
Community-affirming activities	398	Average: 79.6 (5 projects)
Spiritually-affirming activities	0	(4 projects)
Being accountable to others	0	(4 projects)
Employability attributes	118	Average: 23.6 (5 projects)

Conclusions

The full scope and scale of behavioral and psychological risk mitigation in Indian Country is complex. It includes a combination of regional service networks, agreements among available service specializations, recruitment and vetting of local personnel and volunteers, and precise attention to the changing, long-term whole-person burdens that affect individual AI/AN persons.

The Year One analysis of these 113 projects demonstrates a significant amount of work by the 83 grant-based partners, across the potential scope of service capacity development. While some projects are in the process of building initial capacity, others are well-established and refining protocols and measuring client-level outcomes. The data reported by grant-based partners have helped IHS recognize where partners may require additional support.

Over the course of these four programs, IHS will build a reliable set of composite metrics for indicating service capacities and effects in the local continuum of services, thus enable accurate support of risk-mitigation in dynamic contexts. An example of a composite metric is the level of support for spiritual health. An initial review of the data demonstrates that 81 (72%) projects made strong commitments to clients' spiritual health. Based on the composite metric, the notable leaders in fostering spiritual health include American Indian Health Service of Chicago (IL), Fairbanks Native Association (AK), Hopland Band of Pomo Indians (CA), Sisseton-Wahpeton Oyate (SD), and Ute Mountain Ute Tribe (CO). Their experiences offer other Tribes opportunities to explore potential best practices.

Overall, the progress of the Health IT Modernization project is likely to have impacts on the represented communities, in the form of (a) improving service protocols, (b) responding to clients, and (c) collection reliable data. As Tribes continue to explore their advantages in digital service protocols, the results from these projects will inform the total breadth and scope of innovations in Indian Country.

While working with Tribes, IHS Service Area leaders, and other federal agencies, IHS is examining how it can test protocol and prototype refinements, as they can inform operational data, digital health records, and future analyses of unmet community needs, such as addressing high burdens and urgent requirements for risk mitigations.

True to the its mission, this report expresses what IHS currently knows about the physical, mental, social, and spiritual health of AI/AN persons in 83 Native American communities.

Appendix 1: Inbound Information Portal Design

The portal design includes (a) software as a service low-code, HIPPA-compliant Caspio platform, (b) platform administrative support by the Albuquerque Area Southwest Tribal Epidemiology Center, (c) a data dictionary, (d) ticket request system for user support, (e) on-demand training videos for users, and (d) a progress report template.

Through grant-based partners, IHS area project officers, the portal ticket system, virtual office hours, site visits, event roundtables, and Tribal Epidemiology Centers (TECs), IHS collects feedback to make updates to the inbound information portal design. Unless there is maintenance to the portal, the individual accounts for annual reporting are open throughout the year. This allows for convenient recordkeeping, such as inputs regarding training events. The inbound information portal is at NDCSP (aastec.net)

The following progress report template includes 47 key questions, with 17 optional questions based on relevance to the project. The portal does not ask all 64 questions of every project, as their presentation to the respondent depends on the question relevance to the project and the Tribal choices to operate or report in specific areas.

IHS PROGRESS REPORT TEMPLATE INTRODUCTION

The purpose of the inbound information portal is to support IHS partners' project-level data storage for IHS to provide project specific and consolidated annual analytic reports. The portal operates as private, HIPPA-compliant accounts per Tribal partner.

A Tribal partner has discretion in how they assign project data to each account. This discretion supports their handling of multiple projects, multiple funding sources, and cases where the services they provide exceed their project budget (e.g., in-kind work). IHS encourages Tribal partners to report their accurate and complete data to create reliable evidence in support of local planning and future funding justifications.

Three Tribal sovereignty principles guide the design of the inbound information portal.

1. The Tribal partner owns their data in the accounts and any secondary data use besides IHS reporting is restricted, upon Tribal approval.
2. The data collection process is the minimal workflow to support year-over-year project analyses and comparative analyses for national program evaluations.
3. The data analyses and reports align with reliable methods of supporting project and program level evidence and planning through Tribes and federal agencies.

To support minimum data collection, the data fields offer places where users can decide if a set of data fields are applicable or not applicable to their project in that reporting year. The data entry controls allow the user to skip non-relevant inputs, with an official record that those data are not necessary for the reporting. Likewise, the data entry controls allow the user to make records for relevant activities that they did not initially plan for, such as screening for co-occurring risk conditions that were not specific to the program funding.

Some data fields include a set of possible check-box responses, such as types of activities. There is no expectation that all check-box responses are completed; only those that are relevant. If the user has a project-critical response to provide where there is no check-box, there are "other" fields for writing short descriptions for the missing response. If there is a check-box response that a user wants added to a data field, they can notify their area project officer who can determine if it is a common data requirement among other projects in the same program.

The minimal scope of data collection represents three general categories:

1. The progress of developing operational capacity in a community, such as staff hires, volunteers, local agreements, and training. Even if the attribution of these data exceed the budget of the project, the data can provide a reliable record for future budget plans.
2. The progress of establishing service protocols, to support clients' needs. Measuring how projects perform service quality improvements through protocols, and where specific tools may reinforce improved services, adds evidence to the work performed to support local clients as a whole.
3. The service effects in the community and among clients. This starts with the project's volume of client engagements, by their demographics, which are encounters with persons who are eligible for a risk screening, though they may refuse such screening. The possible subsequent service effects include the counts of:
    a. Risk screenings by types and their results
    b. Referrals to services
    c. Provision of services (may be specific to a program type)
    d. Critical service milestones (e.g., entering inpatient treatment)
    e. Client impacts (e.g., measured changes in attitudes or activities)

Because projects' operational capacity and service protocols, as well as technical data collection capability vary, IHS anticipates that each project is unique and will face local service capacity challenges because Tribal partners may not collect or have all of the service effects data.

The expectation, at least for the first one or two years of projects, is that Tribal partners will report the data they can, based on the progress of operational capacity and service protocols. In order to highlight general project stories, Tribal partners are encouraged to prepare project narratives with their area project officers. The portal supports numeric data fields that are comparable year-over-year and between projects while project narratives support how projects have been executed and the magnitude of the project not detailed by numbers.

Based on the data that Tribal partners provide, IHS can produce consolidated annual analytic and descriptive reports, analytic reports specific to the project and reported through the private portal account, and program-level evaluations based on the analytic data and potential Tribal partner interviews.

SECTION 1 – BASELINE DESIGN AND BURDEN (collected ONCE)

What is the physical address of your entities' central operations?
_____Street
_____City _____State _____Zip code

Does your entity organize its project operations through any of these methods (choose all that apply)?
____ (Y/N) Our entity provides client, non-patient services (e.g., education, screenings, and referrals)
____ (Y/N) Our entity provides direct patient services (e.g., exams, treatments, counseling)
____ (Y/N) Our entity contracts out client, non-patient services (e.g., education, screenings, and referrals)
____ (Y/N) Our entity contracts out direct patient services (e.g., exams, treatments, counseling)

Note: Catchment areas are references to specific geographic boundaries that your administration uses to describe the places where the clients live, which you serve, with or without the funds of this project. These boundaries may be defined by travel distances, landscape barriers, or jurisdictional policies. The catchment area may cross administratively-defined lines, such as cities, counties, Tribal land, states, and IHS service areas. You may serve in multiple non-connected areas, due to a Tribal diaspora or migration.

Please describe your service catchment areas, in terms of what geographic boundaries you use, such as tribal land, counties, towns, travel distances, natural markers, landscapes, IHS service units, etc._____

Within your total catchment areas, describe NATIVE YOUTH (12-24 years old):
_____# Estimated Total Population
_____# Need in-patient behavioral health services, but NOT being met
_____# Need outpatient or ambulatory behavioral health services, but NOT being met

Within your total catchment areas, describe NATIVE ADULTS (25 years old and older):
_____# Estimated Total Population
_____# Need in-patient behavioral health services, but NOT being met
_____# Need outpatient or ambulatory behavioral health services, but NOT being met

SECTION 2 – OPERATIONAL CAPACITY

Note: Individual projects may not produce a strategic plan, policy plan, or asset map as they develop operational capacity, but they may rely on one from another source to operate. If your project formed committees for such purposes, please note them here. If your project relies on such items, note their status here.

_____(Y/N) Have you formed a **planning committee** (or team) to produce a strategic plan to address required community priorities, and resources, to strengthen operations and organizations for the project?

Regardless of who formed it, when was the last time your strategic plan was updated/completed?
_____Month _____Year

_____(Y/N) Have you formed a **policy committee** (or team) to produce a policy plan to govern protocols and network agreements to safeguard sufficient continuum of services?

Regardless of who formed it, when was the last time your policy plan was updated/completed?
_____Month _____Year

_____(Y/N) Have you formed a **community assessment committee** (or team) to produce an asset map that reveals strengths and weaknesses in the service workforce and service provisions, within the local continuum of services?

Regardless of who formed it, when was the last time your asset map was updated/completed?
_____Month _____Year

_____(Y/N) Did your project funds go directly to educating individuals in issues of community assessments and planning or policy?

(Previous "N" skips follow-up items)
How many individuals did you train in issues of community assessments and planning or policy (in at least one training event)? _____

COMMUNITY WORKFORCE DEVELOPMENT

Note: As an example of full time equivalent (FTE) responses, one full-time person is equal to 1.0 FTE, and a half time (50%) person is equal to 0.5 FTE, and a 10% time commitment is equal to 0.1 FTE. A combination of 2 full-time persons, and one half-time person would be 2.5 FTE. Volunteers include anyone who contributes work to the project, but is not a hired staff.

[Default 0] _____# How many full time equivalent (FTE) staff did you plan to hire and assign to your project for this past year? (Paid by the project budget, NOT in-kind from another source)

[Default 0] _____# How many of the planned FTE have you hired for the project, for this past year, even if they have left the project? (Paid by the project budget, NOT in-kind from another source)

[Default 0] _____# In this past year, of the FTE hired for the project, how many FTE have been lost due to staff turnover (rather than being fired)?

VOLUNTEERS

[Default 0] _____% What percentage of the planned budget was set-aside for volunteers for the past year (e.g., covering volunteers' expenses, offering stipends, and providing training or transportation)?

[Default 0] _____# How many full time equivalent (FTE) volunteers were planned for your project in the past year? (Including in-kind staff not paid for by the project)

[Default 0] _____# How many individual volunteers have you recruited for the project, in the past year? (Including in-kind staff not paid for by the project)

(Previous "0" skips follow-up items)
Given the recruitment of volunteers reported in the previous response, assign all of the individuals who are likely to participate as volunteers in the project according to their primary role (count each person only once, the data are totaled as a count of individuals):
[Default 0] _____# Licensed Medical Service Providers (may be in-kind staff, not clients)
[Default 0] _____# Licensed Behavioral/Mental Service Providers (may be in-kind staff, not clients)
[Default 0] _____# Non-Licensed in-kind Staff (not clients)
[Default 0] _____# Chaplain or equivalent Spiritual/Faith Leaders (not clients, not in-kind staff)
[Default 0] _____# Congregation-Based Volunteers (not clients, not in-kind staff)
[Default 0] _____# Tribal Elders (not clients, not in-kind staff)
[Default 0] _____# School Leaders (not clients, not in-kind staff)
[Default 0] _____# Law Enforcement, Detention, or Probation Officers (not clients, not in-kind staff)
[Default 0] _____# Child or Youth Protection Staff (not clients, not in-kind staff)
[Default 0] _____# Vocational or Housing Support Staff (not clients, not in-kind staff)
[Default 0] _____# Other professional or volunteer staff (not clients, not in-kind staff)

PERSONNEL TRAINING

[Default 0] _____# Number of licensed clinical provider training events funded by the project and facilitated in this reporting period?

[Default 0] _____# Number of congregation or faith-based (spiritual/faith partners) training events funded by the project and facilitated in this reporting period?

[Default 0] _____# Number of general community-based training events funded by the project and facilitated in this reporting period? (not designed for licensed clinical providers or congregation/faith specific)

[Default 0] _____# Number of adult (25 years old or older) trainees participating in training events funded by the project in this reporting period? (Can include duplicated counts of adults who you trained on more than one issue).

[Default 0] _____# Number of youth (younger than 25 years old) trainees participating in training events funded by the project in this reporting period? (Can include duplicated counts of youth who you trained on more than one issue).

(Previous "0" for both skips follow-up items)

Given the total volume of trainees (adults and youth) trained (sum of the two previous responses) how many were trained on the following issues: (not all training issues are expected, and they may be outside the program focus)
[Default 0] _____# Preventing, treating, and aftercare of Substance Use Disorders (SUDs)
[Default 0] _____# Safeguarding and properly disposing of controlled prescription medications
[Default 0] _____# Recognizing signs of opioid overdose and administering opioid overdose reversal drug, e.g., Naloxone (NARCAN)
[Default 0] _____# Preventing, intervening, post-intervention for suicide risk or events in adults
[Default 0] _____# Preventing, intervening, post-intervention for suicide risk or events in youth
[Default 0] _____# Methods and tools for screening for suicide
[Default 0] _____# Methods and tools for referral pathways and connections, such as those to clinics, chaplains, coaches, and others in the community
[Default 0] _____# Other issues not listed in the above categories.

PLANNED CLIENT MEASURES

In this reporting period, did your project plan to use the following client measures, even if you experienced challenges or barriers with any of these data collection activities:
____ (Y/N) Measures of Attitudinal Changes
____ (Y/N) Measures of Decision Changes
____ (Y/N) Measures of Behavior Changes
____ (Y/N) Client Need for Cultural or Spiritual/Faith Engagements
____ (Y/N) Measures of Client Impacts Months after Leaving the Project
____ (Y/N) Client Burden of Travel Distance or Isolation
____ (Y/N) Client Access to Treatments or Services
____ (Y/N) Client Need for Communication Methods (Infrastructure, Devices, or Mobile Applications)
____ (Y/N) Measures of Client Satisfaction with Project and Impacts

SECTION 3 – SERVICE PROTOCOLS

COMMUNITY ENGAGEMENT PROTOCOLS

Note: A service partner is another service entity that has an official agreement or plan to support the purposes of the project, but was not awarded the grant. The effort to form partnerships may be paid for by the budget.

[Default 0] _____# What is the planned count of service partner agreements (e.g., Memorandum of Understanding/Agreements) needed for the success of your project?

(Previous "0" skips follow-up item)
[Default 0] _____# How many of the planned service partner agreements have been established, to date?

COMMUNITY TEAMING

Please indicate if your entity facilitated or formed any of these strategic service teams in support of your project in the last year: (may be formed by in-kind staff or paid for by another source than the project)
____ (Y/N) Youth advisory councils
____ (Y/N) Elder advisory councils
____ (Y/N) Multidisciplinary coordination groups
____ (Y/N) Advocacy or prevention groups
____ (Y/N) Crisis response teams
____ (Y/N) Legal consulting teams (e.g., Tribal, judicial)
____ (Y/N) School coordination teams
____ (Y/N) Academic or research teams

____ (Y/N) Cultural promotion teams (e.g., traditions, ceremonies)
____ (Y/N) Spiritual/Faith teams (e.g., chaplains, congregations)
____ (Y/N) Shelter coordination teams
____ (Y/N) Transportation coordination teams
____ (Y/N) Medical forensic teams (e.g., sexual assault)
____ (Y/N) Youth outreach teams
____ (Y/N) Medically-Assisted Treatment teams
____ (Y/N) 12-Step support groups

(Previous "Y" to any, use follow-up item)
[Default 0] _____# How many total persons participated in strategic service teams (or councils, groups) in the past year? (the same person may be counted more than once if they participated in more than one unique team—not meetings of the same teams)?

(Previous "Y" to youth advisory council, use follow-up item)
[Default 0] _____# How many youth participated in youth advisory councils in the past year? (the same youth may be counted more than once if they participated in more than one unique youth advisory councils—not meetings of the same councils)?

MEDIA OUTREACH

____ (Y/N) Did your project use any of these low-cost media campaign tools because they were available for local promotion: Social Media, Tribal Website, Podcasts, Good Health TV, or other in-kind media?

____ (Y/N) Did your project pay to produce any media ads (radio/TV/billboard)?

INTERNAL OPERATIONS PROTOCOLS

Note: Internal operations protocols are valuable, formal, explicit, written guides to events, actions, and decisions that identify how services will be performed. They usually require operational instructions and a collection of corresponding data on who is qualified or needed to be involved. This includes legal or pragmatic procedures to be follow, timing and duration of actions, physical conditions of the space required, why the protocol fits a particular client need, the tools and data to use, key decision points, and time-cost or cost of the work.

Of the protocols designed, refined, or under improvement, did they address any of these 10 specific internal operations protocols for staff goals?
____ (Y/N) Prevention Services (e.g., preventing substance use like vaping)
____ (Y/N) Referral Processes (e.g., increase confirmation of intakes)
____ (Y/N) Screening and Assessment Methods (e.g., using the ASQ short-form for suicide risk)
____ (Y/N) Intakes Processes
____ (Y/N) Data Collection Methods
____ (Y/N) Aftercare Support Methods
____ (Y/N) Case Monitoring Methods
____ (Y/N) Communication Reinforcement Methods (e.g., providing call lists)
____ (Y/N) Care Transfer Methods
____ (Y/N) Long-Term Recovery Methods

Of the protocols designed, refined, or under improvement, did they address any of these 7 specific internal operations protocols for client goals?
____ (Y/N) Cultural Inclusion Methods
____ (Y/N) Client Treatment Engagement Methods (e.g., promoting health and care-seeking)
____ (Y/N) Family Integration Methods
____ (Y/N) Coaching Methods (e.g., refining supportive volunteer tasks)

____ (Y/N) Employability Integration Methods
____ (Y/N) Congregation-Based Recovery Methods (e.g., 12-Step programs)
____ (Y/N) Spiritual Inclusion Methods

Of the protocols designed, refined, or under improvement, did they address any of these 13 client-centric value development protocols (promoting self-efficacy)?
____ (Y/N) Accepting forgiveness
____ (Y/N) Giving forgiveness
____ (Y/N) Generosity
____ (Y/N) Kindness
____ (Y/N) Patience
____ (Y/N) Humility
____ (Y/N) Love
____ (Y/N) Volunteerism
____ (Y/N) Sacrificing time and effort for others
____ (Y/N) Peace
____ (Y/N) Joy
____ (Y/N) Gratitude
____ (Y/N) Gentleness

Of the protocols designed, refined, or under improvement, did they address any of these 13 client-centric habit development protocols (promoting self-efficacy)?
____ (Y/N) Practicing solitude
____ (Y/N) Prayer
____ (Y/N) Worship
____ (Y/N) Journaling
____ (Y/N) Taking a period of rest
____ (Y/N) Charity
____ (Y/N) Sacred text reading
____ (Y/N) Meditation
____ (Y/N) Fasting
____ (Y/N) Simplicity of life
____ (Y/N) Confidential sharing or confession
____ (Y/N) Celebrating life and life events
____ (Y/N) Seeking guidance from elders

Of the protocols designed, refined, or under improvement, which of these 12 technical and possible digital design topics are explicitly addressed (topics may need future training or technical assistance to support protocol development):
____ (Y/N) Validating protocol efficacy
____ (Y/N) Integrating client assessments
____ (Y/N) Integrating cultural reinforcement
____ (Y/N) Integrating spiritual or faith reinforcement
____ (Y/N) Aligning tribal oversight
____ (Y/N) Involving volunteers
____ (Y/N) Involving clients as volunteers
____ (Y/N) Pre-approving protocol variability
____ (Y/N) Client self-administration services
____ (Y/N) Parent or caregiver service administration
____ (Y/N) Virtual engagement
____ (Y/N) Preventing risk to client safety or self-efficacy

(Previous "Y" to any, use follow-up item)

[Default 0] _____# Of all the previously identified protocols, how many were specific to services for Native Youth (12-24 years old)?

DIGITAL SERVICE PROTOCOLS

Has your entity determined that your project has a need for these technology-based improvements for collecting data or delivering services (may need analyses of digital service protocols, such as data integration or infrastructural sustainment):
____ (Y/N) Monitoring Organizational Capacity
____ (Y/N) Tracking Priority Monitoring Conditions
____ (Y/N) Organizing Strategic Planning
____ (Y/N) Coordinating Partnerships Engagements
____ (Y/N) Vetting and Managing Volunteers
____ (Y/N) Organizing Protocols Designs and Uses
____ (Y/N) Managing Personnel Training
____ (Y/N) Assessing Trainees' Learning
____ (Y/N) Client Case Management
____ (Y/N) Family and Care Giver Case Management
____ (Y/N) Assessing Clients' Needs
____ (Y/N) Assessing Clients' Satisfaction
____ (Y/N) Client Treatment Engagement
____ (Y/N) Client Employability Development
____ (Y/N) Aftercare and Recovery Monitoring
____ (Y/N) Emergency Communication Systems
____ (Y/N) Client Communication Call Centers
____ (Y/N) Client Self-Care Online Tools
____ (Y/N) Assessing Attitudinal and Behavioral Changes
____ (Y/N) Collecting Forensic Data
____ (Y/N) Creating Protocol or Legal Records
____ (Y/N) Managing Referral Process
____ (Y/N) Cultural Inclusion Media
____ (Y/N) Family Integration Media
____ (Y/N) Coaching and Counseling Online Access

SECTION 4 – SERVICE EFFECTS

CLIENT ENGAGEMENT VOLUME

Note: A project can engage (serve, see) the same person as a client multiple times in a year, thus you can count a person more than once when they are client engagements. Client engagements are encounters when the project can screen the client for risks, such as a private session, even though the client may refuse the screening during the encounter. Training is not a client engagement, as that is a process when the person is a trainee.

For this reporting period, Total Client Population Served through funding of this project:
[Default 0] _____# Count of male clients under the age of 19 years
[Default 0] _____# Count of male clients age 19 to 24 years
[Default 0] _____# Count of male clients age 25 or older
[Default 0] _____# Count of female clients under the age of 19 years
[Default 0] _____# Count of female clients age 19 to 24 years
[Default 0] _____# Count of female clients age 25 or older
[Default 0] _____# Total *(auto-generated sum of the above groups)*

For this reporting period, Total Client Population Achieved Sobriety:
[Default 0] _____# Count of male clients under the age of 19 years
[Default 0] _____# Count of male clients age 19 to 24 years
[Default 0] _____# Count of male clients age 25 or older
[Default 0] _____# Count of female clients under the age of 19 years
[Default 0] _____# Count of female clients age 19 to 24 years
[Default 0] _____# Count of female clients age 25 or older
[Default 0] _____# Total *(auto-generated sum of the above groups)*

For this reporting period, Total Client Population Entered In-Patient Treatment:
[Default 0] _____# Count of male clients under the age of 19 years
[Default 0] _____# Count of male clients age 19 to 24 years
[Default 0] _____# Count of male clients age 25 or older
[Default 0] _____# Count of female clients under the age of 19 years
[Default 0] _____# Count of female clients age 19 to 24 years
[Default 0] _____# Count of female clients age 25 or older
[Default 0] _____# Total *(auto-generated sum of the above groups)*

For this reporting period, Total Client Population Overdosed on Drugs or Alcohol:
[Default 0] _____# Count of male clients under the age of 19 years
[Default 0] _____# Count of male clients age 19 to 24 years
[Default 0] _____# Count of male clients age 25 or older
[Default 0] _____# Count of female clients under the age of 19 years
[Default 0] _____# Count of female clients age 19 to 24 years
[Default 0] _____# Count of female clients age 25 or older
[Default 0] _____# Total *(auto-generated sum of the above groups)*

RISK SCREENINGS

Note: The following items pertain to the risk screening performed for or by the project, though staff who work as in-kind to the project may perform the screening as part of a larger process that supports the project. It is at the discretion of the project to complete screening that is outside their program focus. If the project performs such screenings, you can reported them here.

What was the total count of completed screenings this reporting year for:
[Default 0] _____# Screenings specific to alcohol use disorder
[Default 0] _____# Screenings by the *Screening, Brief Intervention, and Referral to Treatment* (SBIRT)
[Default 0] _____# Screenings specific to suicide risk (e.g. ASQ)
[Default 0] _____# Screenings specific to drug use disorders
[Default 0] _____# Screenings specific to victim of non-sexual assaults
[Default 0] _____# Screenings specific to victim of sexual assaults

IDENTIFIED VICTIM CASES

How many cases of individuals did your project identify as victims of these crimes (whether they were screened or not):
[Default 0] _____# Domestic violence
[Default 0] _____# Other non-specific violence
[Default 0] _____# Other non-sexual assault
[Default 0] _____# Human trafficking
[Default 0] _____# Sexual abuse
[Default 0] _____# Strangulation

Of those total cases of victims of crimes recorded, and were provided referrals (or direct services), how many of the following subsequent actions were also completed (whether they were screened or not):
[Default 0] _____# Forensic Violence Medical Exam
[Default 0] _____# Forensic Sexual Assault Medical Exam
[Default 0] _____# Violence Police Interview
[Default 0] _____# Sexual Assault Police Interview
[Default 0] _____# Child Protection Agency Interview for Violence
[Default 0] _____# Child Protection Agency Interview for Sexual Assault
[Default 0] _____# Legal Assistance

IDENTIFIED SUBSTANCE USE DISORDERS

How many cases of individuals did your project identify for substance use disorders, and were provided referrals (or direct services) to start treatment services (whether they were screened or not):
[Default 0] _____# Alcohol use disorder
[Default 0] _____# Methamphetamines use disorder
[Default 0] _____# Opioid use disorder
[Default 0] _____# Other drug use disorder
[Default 0] _____# Medically-assisted treatment (MAT)

(If in a substance use disorder program, use follow-up item)
How many cases of individuals did your project record as receiving harm reduction services based on each of these methods:
[Default 0] _____# Syringe Exchanges or Service Projects
[Default 0] _____# Fentanyl Test Strips distribution
[Default 0] _____# Narcan distribution
[Default 0] _____# Other, not specified above

IDENTIFYING PSYCHOLOGICAL DISTRESS

How many cases of individuals did your project identify for psychological distress, and were provided referrals (or direct services) to start treatment services (whether they were screened or not):
[Default 0] _____# Treated for psychological recovery (for any cause)
[Default 0] _____# Risk of suicide

TREATING PSYCHOLOGICAL DISTRESS

Of those total cases of clients who required therapy services (for psychological distress or any form of recovery), and were provided referrals (or direct services) to start treatment services (whether they were screened or not), how many individuals started these treatment services by these primary methods:
[Default 0] _____# Attachment-Based Family Therapy (ABFT)
[Default 0] _____# Cognitive Behavioral Therapy (CBT)
[Default 0] _____# Dialectical Behavioral Therapy (DBT)
[Default 0] _____# Matrix Model (MM)
[Default 0] _____# Motivational Enhancement Therapy (MET)
[Default 0] _____# Motivational Interviewing (MI)
[Default 0] _____# Community Reinforcement Approach (CRA)
[Default 0] _____# Contingency Management (CM) / Contingency Management Titration (CMT)
[Default 0] _____# Other, not specified above

Of those total cases of clients who required spiritually integrated or informed therapy services (for psychological distress or any form of recovery), and were provided referrals (or direct services) to start treatment services

(whether they were screened or not), how many individuals started these treatment services by these primary methods:
[Default 0] _____# Therapy by chaplain or pastoral or equivalent spiritual leader
[Default 0] _____# Therapy by spiritual integrated counselor (not spiritual leader)
[Default 0] _____# Therapy by 12-step group

How many individuals received these cultural services (an individual can be counted more than once if they accessed more than one type of cultural event):
[Default 0] _____# Dancing
[Default 0] _____# Drumming
[Default 0] _____# Language
[Default 0] _____# Singing
[Default 0] _____# Songs
[Default 0] _____# Story Telling
[Default 0] _____# Traditional Crafts (e.g., beading, basket weaving, tool making, jewelry)
[Default 0] _____# Traditional Games
[Default 0] _____# Equine Therapy
[Default 0] _____# Hunting/Fishing
[Default 0] _____# Smudging
[Default 0] _____# Talking Circles
[Default 0] _____# Other, not specified above

SECTION 5 – SERVICE EFFECTS

CRITICAL SERVICE MILESTONES

Among persons your project engaged, how many cases of individuals can your project identify in terms of these service outcomes:
[Default 0] _____# Cases entered inpatient treatment
[Default 0] _____# Cases achieved sobriety
[Default 0] _____# Cases overdosed
[Default 0] _____# Cases reported for prosecution

CLIENT MEASURED IMPACTS

_____(Y/N) Did your project measure individual Attitudinal Changes (before, during, and after project services) among clients for this reporting period?

("No" skips follow-up items)
How many cases of individuals did your project assess and record as showing these improvements over the course of working with your project for this reporting period:
[Default 0] _____# Measured change in valuation of self
[Default 0] _____# Measured change in valuation of peers
[Default 0] _____# Measured change in valuation of family members
[Default 0] _____# Measured change in valuation of community members
[Default 0] _____# Measured change in valuation of tribe-specific culture
[Default 0] _____# Measured change in valuation of treatment services
[Default 0] _____# Measured change in valuation of spiritual/religious activities
[Default 0] _____# Measured change in valuation of traditional or cultural activities

_____(Y/N) Did your project measure individual Decision Changes (during and after project services) among clients for this reporting period?

("No" skips follow-up items)
How many cases of individuals did your project assess and record as showing these improvements over the course of working with your project:
[Default 0] _____# Affirmed commitment to protect own body
[Default 0] _____# Affirmed commitment to protect own mind
[Default 0] _____# Affirmed commitment to protect soul, faith, spirit
[Default 0] _____# Affirmed commitment to change substance use influences
[Default 0] _____# Affirmed commitment to change substance use behavior
[Default 0] _____# Affirmed commitment to be accountable to others
[Default 0] _____# Affirmed commitment to complete treatment services
[Default 0] _____# Affirmed commitment to practice spiritual/religious activities
[Default 0] _____# Affirmed commitment to traditional or cultural activities

_____(Y/N) Did your project measure individual Behavioral Changes (during and after project services) among clients for this reporting period?

("No" skips follow-up items)
How many cases of individuals did your project assess and record as showing these improvements over the course of working with your project:
[Default 0] _____# Measured improvements in substance abuse
[Default 0] _____# Measured improvements in legal alternative activities
[Default 0] _____# Measured improvements in family-affirming activities
[Default 0] _____# Measured improvements in financial management activities
[Default 0] _____# Measured improvements in social network affiliations
[Default 0] _____# Measured improvements in culturally-affirming activities
[Default 0] _____# Measured improvements in community-affirming activities
[Default 0] _____# Measured improvements in spiritually-affirming activities
[Default 0] _____# Measured improvements in time being accountable to others
[Default 0] _____# Measured improvements in employability attributes

Appendix 2: Progress Reporting in the Context of Health Policy and System Improvement

Due to the complexity of serving AI/AN persons across Indian Country, IHS performs health policy and systems analyses (HPSA) to enable advanced risk mitigation and quality improvement among existing health services. The HPSA is fitted to the national, regional, and local levels, with cooperation from Tribes and other federal and state agencies that affect Tribes and AI/AN persons.

As funding allows, IHS leads HPSA that focuses on psychological and behavioral risk conditions, and the formation and impact of risk mitigation among AI/AN persons. The scope of IHS work in HPSA is limited to formally established partnerships and specialized initiatives.

There are three main drivers for increasing HPSA and gathering useful evidence from its deliverables.

1. Tribes increasingly require evidence to support their negotiations in self-determination across sectors, including health services. The negotiations stem from statutes, namely the Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA).

2. The U.S. Congress has appropriated funding to IHS to enable its Health IT Modernization Program. The Program requires evidence in support of a wide-range of digital service protocol standards and improvements, including integration with future digital health record systems, dynamically linked among Tribes, IHS, and other services.

3. Both IHS and Tribes require HPSA that can provide evidence for the efficacy of service protocols and innovative tools, and their respective data integration. Such advancements are especially important in complex area of therapeutic engagement, self-managed services, co-managed services, coaching services, referral processes, emergency processes, and others that affect behaviors among potential and active clients.

The evidence summarized in this report provides a small portion of the necessary HPSA to support Indian Country. The final report will include program evaluation interviews, and the interview questions will develop through engagements with the 83 grant-based partners. The following are possible topics for the evaluation, where each topic can support exploring project challenges and future community requirements:

1. Community workforce staffing development
2. Community volunteer development
3. Data collection at the client level
4. Protocol development, analyses, and fidelity
5. Development of digital services
6. Referral operations and tracking of outcomes from referrals
7. Developing whole-person services, integrating physical, mental, spiritual, cultural needs
8. Service reimbursements
9. Sustaining service capacities

In order to preserve low-burden administration in a grant-based partnership, the scope of HSPR by IHS is very limited. As a comparison, a full analysis of contextualized service capacity development, in support of advanced risk mitigation, would include the following elements:

1. Analyses of the local catchment area of potential clients, given travel distances and the organization of service sites within the local continuum of services.

2. Analyses of the diseases, ailments, and risks that create burdens within the catchment area, as the likely requirements for services.

3. An inventory of the various operational capacities and their methods of building a fully trained workforce and community support system by specific service requirements.

4. Service protocol analyses that examine the breadth of protocols, and their respective scope, use, and effectiveness within the local continuum of services, given the service requirements.

5. Client effect analyses that determine the client-level experiences in terms of healing and wellness, risk mitigation, improvements in attitudes and behaviors, strengthening sense of coherence, safety, and strengthening of reliable coaching and employability relationships.

6. The testing and adoption of digital tools that enable self-services, co-managed services, remote services, and cross-sector services, while improving precision in clients' changes to risk, wellness, and resilience.

Presently, IHS does not perform full HSPA with Tribes to determine the progress of service capacity development. However, there are communities that may warrant such scope of HSPA, especially where there are unmitigated crises in the form of very high death rates or unprecedented risk of crimes or abductions.

Through appropriations and reports on preventing alcohol-related deaths (2017 to 2023), the U.S. Congress has set a precedent for the appropriateness of HSPA in Indian Country. The example is specific to the alcohol-related death rates in the region of Arizona and New Mexico.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