REPORT

# Community Health Representatives Policy Summit II

*"Gaining Momentum through Policy Action"*

- » Sept 29 - 30, 2016
- » Twin Arrows Casino Resort, Flagstaff, AZ

# ACKNOWLEDGEMENTS

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# EXECUTIVE SUMMARY

The **Community Health Representatives (CHR) Policy Summit II** was held on September 29-30, 2016 in Twin Arrows, Arizona on the Navajo Reservation. The Summit 1) provided updates on state and federal policy being considered for the CHR and Community Health Worker (CHW) workforce, 2) highlighted and shared best practices and innovative Tribal CHR program efforts, and 3) promoted CHR advocacy and determined next steps to advance the CHR workforce.

Roundtable discussions provided valuable feedback and recommendations in three key areas.

**1. Voluntary Certification –** Overwhelmingly, the CHRs support certification of the CHW workforce and viewed it as a means to accomplish a number of objectives: standardizing and legitimizing the workforce; establishing reimbursement through Medicaid; differentiating between other workforces; and potentially increasing CHR salaries. CHRs also favored identifying core competencies and standardizing the training. They also wanted the certification process to consider grandfathering CHRs who have had years of experience and for the certification to be recognized across state lines.

**2. Workforce Identity and Development –** CHRs identified many roles that they perform including bridging the gap between patients and the health/social service system, providing health education and advocating for their patients and community. They possess unique qualities that set them apart from other professionals: the ability to speak local indigenous languages; possessing knowledge of their clients' cultures and religions - this facilitates a trusting relationship. Lastly, CHRs expressed that they are undervalued in the health care system, thus may be underutilized and inadequately compensated.

**3. Vision for Healthy Communities –** CHRs indicated that better use of laptops and electronic health records could aid in their work. Basic needs such as improved office space and transportation were also cited. Factors that distract CHRs from their vision include duties and time management overload, lack of support and integration, inadequate program funding and leadership involvement, and high poverty. Successful strategies identified included cross-sector collaboration, specialized training, and CHR forums.

In addition, a CHR Workforce Assessment was administered during the Summit (below are highlights).

- 87% of respondents agreed/strongly agreed that the American Public Health Association (APHA) CHW Section definition of a CHW represented the definition of the CHR workforce.
- CHRs mostly agreed with the C3 Project 10 Core CHW Roles.
- Training needs varied but indicated interest in the areas of heart disease and stroke, chronic disease self-management, diabetes and behavioral health.
- 68% of CHRs agreed/strongly agreed with the Arizona's Voluntary CHW Certification process
- 58% of CHRs were likely to become certified, and 32% were unsure.

CHRs identified the following next steps to move forward CHR policy initiatives.

- Increasing awareness and advocacy at the tribal, state, and national level of the CHR field and promoting collaboration with other agencies at the tribal, state, and national level.
- Exploring mechanisms for CHR certification and better understanding of the Indian Health Service Community Health Aide Program (CHAP).
- Promoting increased opportunities for CHRs to build their skillset, share resources, collaborate, and network with other CHR programs.
- Assessing a Return on Investment (ROI) analysis on CHR services within primary care.

# INTRODUCTION

On September 29-30, 2016, the "Community Health Representatives (CHR) Policy Summit II: Gaining Momentum through Policy Action" was held at the Twin Arrows Casino Resort on the Navajo Nation. Policy Summit II brought together CHRs, tribal leaders, tribal health advocates, Indian health officials and other stakeholders to further engage and discuss policy opportunities to strengthen the CHR workforce in Arizona. Over 70 CHRs and CHR Supervisors representing 14 tribes attended (see Appendix A: List of Summit Participants). The objectives of the Summit II were to:

1. Provide updates on state and federal policy being considered for the CHR workforce,
2. Highlight and share best practices of innovative Tribal CHR programs,
3. Promote and share strategies of CHR advocacy, and
4. Determine next steps to continue to advance the CHR workforce.

Summit II allowed Tribal CHR stakeholders to continue discussions that had occurred during the first CHR policy summit that was held last year on September 1, 2015. The CHR Policy Summits were inspired by existing policy efforts focused on sustaining the broader CHW workforce throughout the state of Arizona and the need to engage Tribes in the decision making process. Multiple partners have leveraged their resources and knowledge to plan and conduct the CHR Policy Summits (see Appendix B: List of Planning Committee Members).

**Impact of CHRs**

In the US, health disparities are not decreasing. Socioeconomic, environmental and cultural barriers continue to impede access to equitable care and add to rising health care costs for minority and low-income populations. Generally, the CHR/W workforce is effective in improving health outcomes, health care cost savings and overall health care quality and access and health promotion. However, the workforce in general is not fully recognized as a profession, and thus CHR/Ws, lack the sustained financial support needed to impact marginalized, at-risk or unreached populations experiencing deep inequalities in morbidity and mortality, especially those indigenous communities served by CHRs throughout Arizona.

## PURPOSE OF REPORT

1. Document the proceedings of Summit II
2. Provide recommendations that were developed during Summit II
3. Provide results of the World Café Roundtable Discussions
4. Provide results of the CHR Workforce Assessment

It is highly encouraged to share this report along with its recommendations with other Indian health stakeholders. You may find this report and all presentation slides at the Arizona Advisory Council on Health Care website: https://acoihc.az.gov/reports and https://acoihc.az.gov/health-care-initiatives, respectively.

The CHR/W workforce is unique from other health professions in the following ways:

» Relationship and trust-building – to identify specific needs of clients
» Communication – especially continuity and clarity, between provider and patient
» Focus on social determinants of health – conditions in which people are born, grow, work, live, and age

# BACKGROUND

**History of the CHR Workforce**

In 1967 funding was made available from the Office of Economic Opportunity to create a Community Health Aide Program (CHAP). The IHS recognized this as an opportunity to train Community Health Aides in Alaska tribal villages and requested some of these funds. During this time the CHR model was being created. By 1972 all the CHR program funds were transferred to the IHS and they contracted these funds to Tribes to further develop the CHR roles and functions. The CHR program has always been a tribally run program.

Today, with over 1,400 CHRs nationally, these frontline public health workers provide services in more than 250 federally recognized tribes. In Arizona, all 21 Tribes have CHRs providing services. A CHR builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy. This trusting relationship enables CHRs to serve as a liaison between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHRs were the first community based paraprofessionals in the US performing this kind of work.

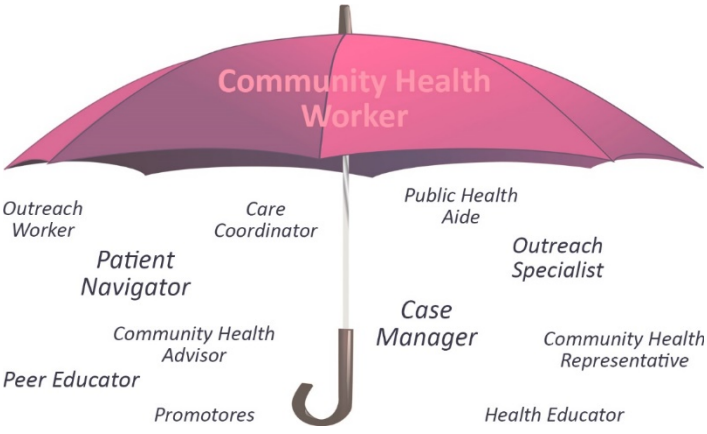
**Workforce Definitions**

**Community Health Representative (CHR):** A CHR is a trained, medically guided tribal or community-based health care provider specific to the Indian Health Service (IHS) or tribal health programs. "They are members of the community, who serve as advocates, are familiar with the dialects and the unique cultural aspects of their patient's lives, and know specific tribal health care needs. CHRs have contributed to lowering mortality rates through providing education and reducing tribal health expenses" (IHS, 2016).

**Community Health Worker (CHW):** A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery (APHA, 2016).

**The Evolving Workforce**

Over time, more and more CHR type paraprofessionals became integrated in communities nationwide. Their goals and work were similar but called themselves by different titles such as Promotoras, Community Health Workers, Peer Advocates, etc. Then, in 2010, the U.S. Department of Labor formally recognized this nationwide workforce under the title of Community Health Workers.




**Voluntary Certification of CHRs**

Although CHRs have been an integral part of the tribal/IHS system since the late 1960's, there is no formal certification process in place. Likewise, CHWs in Arizona do not have a formal certification process either. Therefore, many states have begun to adopt core competencies, a scope of work, and the necessary training needed for the CHW workforce. This process serves to standardize the workforce and put in place a certification pathway for all CHWs. These developments have tremendous

implications for how the CHW and the CHR workforce will continue to evolve, particularly with regard to the creation of statewide training and credentialing standards.

For Tribes, in June 2016,an additional pathway for certification occurred when the IHS issued a policy statement that would extend the CHAP to Tribes in Arizona. This program has been operating in the Alaska Native Villages for many years and has proven very successful. The policy would allow 4 different workforces: Community Health Aides, Dental Health Aides, Behavioral Health Aides, and CHRs to be certified under the CHAP through the IHS. When the CHAP is implemented, CHRs in Arizona could have multiple certification opportunities whether thought the state(s) or by the IHS.

**Financing and Reimbursement of the CHR Workforce**

The funds provided by IHS to support CHR Programs are a critical funding stream that has allowed Tribes to create innovative and responsive programs specific to their communities. Although continuous funding is available through the IHS, CHR Programs must advocate each year to remain in the IHS budget and for budget increases. With the national economic downturn, CHR Programs have received budget reductions and have had to supplement their budgets with other sources such as Tribal funds, grants, etc. or face reduction in CHR programming and services.

In 2010 the Patient Protection and Affordable Care Act (ACA) included CHWs as distinct members of the health care team. Then in July 2014, the Centers for Medicare & Medicaid Services (CMS) issued new guidance that allowed for reimbursement of preventive services offered by unlicensed professionals such as CHWs, if state Medicaid programs opt in. The ACA has spurred reforms in health care in the United States to incentivize the shift toward a value-based reimbursement structure that requires evidence of favorable outcomes among the patient population. The ACA has provided an opportunity to expand payment methods and focus on value and quality of care which may constitute a landmark in the movement to integrate CHRs and CHWs within the mainstreams of health care, public health, and social services.

Earlier this year the Arizona Health Care Cost Containment System (AHCCCS) through its 1115 Demonstration Waiver proposed to offer services that support an Indian Health Medical Home Program – Primary Care Case Management, 24-hour call line, diabetes education and care coordination – to its acute care Fee For Service Population. The Indian Health Medical Home Program includes the focus on patient-and family-centered care through health care teams of which CHRs can play an impactful role. Scientific evidence has demonstrated that CHWs, including CHRs are integral contributors in collaborative health care teams focused on providing comprehensive care. Utilizing their unique position, skills, and training, CHRs have shown to improve patient outcomes and reduce system costs for health care by assisting community members in avoiding unnecessary hospitalization and other forms of expensive acute care.

CHRs are increasingly recognized for their value in improving the efficacy of care and contributing to the provision of high quality and coordinated care. Well-functioning multidisciplinary care teams that include a CHW/CHR have been identified as contributing to the efficacy of Patient-Centered Medical Homes, similar to that of the Indian Health Medical Home, Accountable Care Organizations, and Community Health Teams. CHRs are well positioned to support these new models of care entities and effectively meet health reform mandates for prevention, education and coordination of care.

**Timeline of CHR Involvement and Events**

Since February 2015, partnering organizations have joined efforts to leverage resources, share knowledge, and understand similarities and difference of the CHW and CHR workforces in Arizona. Below is a timeline of how these partnerships were forged and the progress that has been made.

- **February 2015:** The Arizona Health Education Center awarded the University of Arizona, Arizona Prevention Research Center (APRC) and the Center for American Indian Resilience (CAIR) funds to create dialogue around specific opportunities for CHR workforce sustainability including training, career progression and reimbursement.
- **March – April 2015:** Listening sessions were held with various CHR Programs throughout the state. Through these meetings, the need and desire for CHRs to have a platform to share experiences, resources and opportunities for advancement became apparent.
- **May 2015:** Collaborations on statewide CHW workforce issues emerged among members of the APRC, CAIR, the Arizona Advisory Council on Indian Health Care, the Inter Tribal Council of Arizona, Inc. and the Navajo Nation CHR Program. It was through these partnerships and recognizing the important issues and opportunities facing CHR programs that the initial CHR Policy Summit originated.
- **September 1, 2015:** The first CHR Policy Summit, "Community Health Representative Policy Summit: Certification, Reimbursement and Sustainability for Healthy Communities" was held at the Little America Hotel in Flagstaff, Arizona. Approximately 65 CHRs and CHR Supervisors attended, representing 15 of the 22 Tribes in Arizona. It was during this gathering that the CHR Movement was borne with the goal of further informing and advocating for CHRs on policy initiatives that would further elevate the workforce.

- **October 2015 – February 2016:** Three meetings took place to continue to inform Tribes of the evolving CHW/CHR policy initiatives and to further build relationships.
- **May 2016:** Planning began to conduct Policy Summit II.
- **June 2016:** The IHS issued a Tribal Consultation letter on a draft policy statement that would extend the CHAP to Tribes in Arizona. This program has been operating in the Alaska Native Villages for many years and has proven very successful. This policy would allow 4 different workforces: Community Health Aides, Dental Health Aides, Behavioral Health Aides, and CHRs to be certified under this program through the IHS.
- **August 30, 2016:** The Arizona Community Health Outreach Worker Association (AzCHOW) submitted a Sunrise application to the Speaker of the House and President of the Senate requesting voluntary certification and standardization of practice of CHW: http://www.azleg.gov/alispdfs/sunrise/AzCHOW%20Sunrise%20FR-signed-2.pdf
- **September 29-30, 2016:** The second CHR Policy Summit, "CHR Policy Summit II: Gaining Momentum through Policy Action" was held at the Twin Arrows Casino on the Navajo Nation.

# PROCEEDINGS: DAY 1 (THURS, SEPT 29)

**Welcome**

*- Mae-Gilene Begay, CHR Director, Navajo Nation*

Ms. Begay welcomed the Summit attendees and introduced Susie Wauneka, Winslow CHR Supervisor, Navajo Nation who provided a blessing. Everyone in attendance introduced themselves to the group.

**Opening Remarks**

*- Brooke Bender, CHR Director, Hualapai Tribe*

Mr. Bender began his opening remarks by highlighting one of the Summit's primary objectives: to move the reimbursement and voluntary certification process forward. Brook commented on the diverse roles of a CHR, including: social worker, health educator, care coordinator, and counselor, among many others. He urged CHRs to take pride in the vital role they play in their communities. However, he noted that this internal awareness was not enough to advance the CHR field toward broader recognition and, ultimately, reimbursement. Reimbursement would allow for the expansion of services, broader reach, and long-deserved recognition for the CHRs. To move the process forward, Mr. Bender emphasized the crucial need for tribal buy-in of the CHR movement advocacy and policy efforts such as the Sunrise Application that describes what a CHW is and their roles. Lastly, Mr. Bender stated that the Hualapai Tribe had passed a tribal resolution in support of the CHR Movement and that more tribal resolutions are needed.

## CALL TO ACTION

- » CHRs should utilize the resources provided, such as the tribal resolution template, to advocate for tribal council and leadership support of the CHR Movement and the Sunrise application.
- » CHRs should use specific examples in translating what reimbursement could mean for communities such as CHRs could receive specialized training based on community needs. For example, nurses can be hired to train CHRs in wound care or other community-specific needs

**Background and Overview of Summit**

*- Kim Russell, Executive Director, Arizona Advisory Council on Indian Health Care*

Ms. Russell explained how the CHR Movement has evolved since its creation in 2015. Ms. Russell gave a summary of the first CHR Summit that occurred in September 2015, and the recommendations that were identified. Lastly, she informed the audience of the Summit II objectives.

**Keynote Address: Expanding Opportunities for Community Health Representatives**

*- Donald Warne, MD, MPH, Chair of the Department of Public Health, North Dakota State University*

Dr. Warne provided the keynote address on the pivotal role that CHRs play in tribal communities and the potential impact of expanding CHR services. Dr. Warne discussed the relationship between American Indian health and social determinants. Specifically, 70% of a population's health is determined by non-clinical community determinants, such as socioeconomic status and environmental influences. Since health is largely an environmental issue, there are tremendous opportunities for CHR/Ws to influence population health through "upstream", preventative approaches.

Dr. Warne highlighted options for policymakers to incorporate CHRs into state health care systems, thus, increasing cost savings to the state. Among the highest priorities was the need to explore CHR expansion opportunities within the ACA, which is the largest Medicaid expansion affecting Indian health. Under the ACA, Medicaid will now reimburse for preventive services recommended by licensed providers and provided, at state option, by non-licensed providers. This amendment means that Managed Care Organizations now have the ability to reimburse and, with a State Plan Amendment, CHRs fall into this reimbursable category.

**Definition**

**Social Determinants of Health:** The conditions in which people are born, grow, live, work and age. The social determinants (e.g. education, housing, employment status) of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries (WHO, CDC, 2016).


Dr. Warne shared lessons learned from advocacy efforts to pass North Dakota Senate Bill 2321, which would have established CHRs as a billable provider type, formalized a certification process, and established a Medicaid billing process. Further, he commented that the current status of the CHW workforce is an issue of social justice and human rights. Lastly, Dr. Warne stated that CHRs are an effective mechanism of improving health outcomes but, as a nation, we have not yet pursued pathways to make this workforce financially sustainable. In doing so, populations suffer because our system has not prioritized CHW work.

**Questions & Answers**

Q **How is a "licensed provider" defined?**
A CMS defers to the states to establish the definition within their statutes. There is a potential for advocacy and coordination with the legislature and Medicaid to update this definition.

Q **North Dakota legislation indicates that a CHW must work under supervision of a licensed provider. How that would work in Arizona considering that CHRs are supervised by CHR Supervisors and other professionals that do not meet that requirement?**
A Programs can have a Medical or Clinical Director fill that role within the program. With an increased funding stream from reimbursement, a Public Health Nurse (PHN) can also be hired to fill that licensed provider role.

Q **What are your thoughts on the CHAP model being utilized in Alaska Native communities?**
A CHA programs in Alaska are outstanding in that they are able to provide more services to remote communities. They also expand on the behavioral health, mental health, and oral health components. Alaska is one of many other templates that the CHR movement can draw upon.

Q **How can the CHR certification be compatible with the billing process considering that some CHR programs are under IHS and other are not? Their certification processes will likely be different.**
A If IHS and PL-638 organizations are working within the same community and it has been an ongoing challenge to "break down barriers" between the two systems. It is important to look at places where this collaboration has been done effectively, such as Alaska and individual tribes. Look to tribes that have more local control and collaboration for guidance.

**General Comments**

- It is important to consider that turnover of staff plays a large factor in collaboration. [CHR Supervisors] are constantly educating new staff on CHR roles and challenges.
- There are limitations to existing CHR funding that affects staff morale and retention. Namely, existing funds may not be used for celebrations such as birthdays, work anniversaries, and retirement dinners. Increased reimbursement may allow supervisors to recognize their staff, which will increase morale, retention, and overall job satisfaction.
- The burden of getting reimbursed and becoming certified is not solely on the CHWs. They should have the support of everyone in the "health arena". The Navajo Nation has 14 preventive health programs; each with their own grant funding that could potentially support this movement. Every tribe should approach their policymakers about the CHR movement.

## RECOMMENDATIONS

- Collaborate with the State (AHCCCS) to develop and submit State Plan Amendments allowing for CHR reimbursement
  - CMS allows for a non-licensed provider to provide billable services if a licensed provider is overseeing the process
- Further explore and establish CHR training and certification standards
  - Learn from states, such as Minnesota, that have succeeded in developing laws to bill for CHR services
  - Create reciprocity between IHS and state certification standards
- Bring together existing efforts into a unified national movement to expand the role of CHRs in AI/AN populations
- Stress the distinguishing factors between CHRs and health professionals, namely, their deep understanding of the community and culture, as well as the significant cost savings to the healthcare system.
- Include Public Health Nurses (PHN) in the process. PHNs awareness is important in "closing the gap" between the two professions and should be a priority.

**National Community Health Worker Initiatives**

**Session A: Overview of the Indian Health Service Community Health Aide Program Policy**

- *Michelle Castagne, Congressional Relations Manager, National Indian Health Board*

This session described the rising demand for quality health care, and how communities are increasingly looking for innovative approaches to health service delivery. The CHAP originated in the Alaska Native Villages and has been successfully operating since the 1950's.

In 2010, through the Indian Health Care Improvement Act, Congress authorized the creation of a national federal CHAP that can be implemented in the Tribes of the lower 48 states. The IHS is currently exploring necessary steps to implement the national federal CHAP which includes the creation of a national certification board. Benefits of the CHAP expansion include: 1) increased routine, preventative, and emergent care provided in rural communities, 2) culturally competent, patient-centered, quality care provided, 3) continuity of care is established, and 4) increased cost savings to the health system.

## RECOMMENDATIONS

- Tribes should further research and discuss whether their communities could benefit from having Community Health Aides/Practitioners.
- Utilize the National Indian Health Board (NIHB) template letters in formally supporting CHAP expansion. More detailed updates are available at: http://nihb.org/docs/08032016/IHS_DTLL_08032016.pdf

The CHAP includes four distinct workforces; 1) CHRs, 2) community health aides, 3) behavioral health aides, and 4) dental health aides. There are currently more than 1,400 CHRs serving Indian communities that could potentially receive their certification through the IHS.

**Session B: Updates on National CHW/CHR Association Organizations**

*- Mae-Gilene Begay, CHR Director, Navajo Nation*

This session summarized the APHA CHW Section that convenes in-person at the annual APHA conference and also has a broader network of opportunities, such as webinars, listservs, and policy forums. Ms. Begay highlighted how CHRs can be a part of this national platform and provide input from a grassroots level and she urged CHRs to join the APHA CHW Section. For more information please visit: https://www.apha.org/apha-communities/member-sections/community-health-workers

**Update on Arizona's CHW Voluntary Certification Process**

*- Samantha Sabo, MPH, PhD, Assistant Professor, Mel and Enid Zuckerman College of Public Health, University of Arizona*

*- Yanitza Soto, CHW Program Manager, Arizona Department of Health Services*

This session provided an update on Arizona's proposed CHW certification process and an overview of the current CHW policy initiatives occurring in Arizona. Although CHRs are recognized by the IHS and have been allocated resources annually since 1968, there is no formal process in place to provide certification of the CHR workforce. In Arizona, non-tribal CHWs are not fully recognized as a paraprofessional workforce and are not certified as a workforce either. All CHWs and CHRs lack the sustained financial support required to meet the demand for this workforce.

**Arizona CHW Facts**

- There are over approximately 1,000 CHWs employed in Arizona.
- Almost one third (30%) are CHRs.
- The CHW workforce predominantly consists of women (95%).

In order to standardize the CHW workforce's definition, competencies, scope of work and training, several states have moved to certify the CHW workforce. In August 2016, the Arizona Community Health Outreach Worker Association (AzCHOW), the state-wide association of CHWs, proposed a pathway to voluntary certification for the CHW workforce in Arizona. Voluntary certification is not intended to regulate CHWs or to limit who works as a CHW. However, it does place limits on who can call themselves a certified CHW. Certification is not licensing.

Since March 2013, there have been 14 CHW/R stakeholder meetings. The goals of the stakeholder meetings are to create mechanisms for the recognition and sustainability of the CHW/R workforce in the state of Arizona. Below is a timeline that shows the progress made in Arizona towards voluntary CHW workforce certification.

Lastly, the pathways to CHW certification were discussed. The first pathway to voluntary CHW Certification is to standardize the competencies and scope of practice of the CHW workforce and establish professional recognition and career development for CHWs. The second pathway to voluntary certification is the Sunrise application (currently in process), which is a mechanism for health profession and non-health profession to request regulation and expansion of the scope of practice from the Arizona state legislature.

A draft flowchart was shared that demonstrated how Arizona envisioned voluntary certification for CHWs. Three main partner agencies will carry out the process and include AzCHOW, the University of Arizona Prevention Research Center, and the ADHS CHR Program (See Appendix C: Arizona's Certification Process.)

## TIMELINE

- **2013: Year of Awareness Raising**
  - Creation of AzCHOW
  - Sustainability and financing models identified
  - Lessons learned from other states and nationally
  - Role of state health department in supporting CHWS
- **2014: Year of Consensus Building**
  - Development of definition and scope of practice of CHWs
  - Establishment of a CHW manager position at the Arizona Department of Health Services (ADHS)
- **2015: Year of Assessment and Adoption**
  - Assessments of CHW/R workforce, health care providers and systems (health plans, IHS, and Tribal 638 facilities)
  - Discussion and listening sessions on CHW/R skills and competencies, and scope of practice
- **2016: Year of Advocacy and Policy**
  - Development of Voluntary Certification Process
  - Submission of Sunrise Application: http://www.azleg.gov/alispdfs/sunrise/AzCHOW%20Sunrise%20FR-signed-2.pdf

## Questions & Answers

Q **Would there be reciprocity of the IHS curriculum in CHR certification?**
A CHW Certification is not a license and although there is no rationale for reciprocity between states or tribes, this issue should be decided by the CHW Certification Board made up of 51% CHW/Rs.

Q **What is being proposed in the state of Arizona for the IHS curriculum? How is this being considered (Navajo participant question)?**
A The Navajo Nation is a sovereign nation; therefore Navajo Nation could develop their own CHR certification. Questions about how the state certification could impact the Navajo Nation certification, if they decide to do their own certification, are still unanswered.

**Luncheon Speaker:**
**"Across the National Landscape – CHW Certification & Training Perspectives"**
**-** Mr. Carl Rush, APHA CHW Section Adviser

Mr. Rush emphasized the importance of people who are doing the work to be represented at a national level. Mr. Rush highlighted the advancement toward a national organization of CHWs, Centers for Disease Control national policy study on CHW certification, endorsement of CHW participation in team-based care by national groups, CHW Core Consensus (C3) Project, and the proposed IHS guidelines on the expansion of the CHAP model and CHR qualifications.

## RECOMMENDATIONS

» Draft a brief description of CHRs to educate federal agencies and other national groups
» Learn more about the CHW Core Consensus (C3) Project: The C3 Project offers recommendations for national consideration related to CHW core roles (scope of practice), core skills, and core qualities (skills and qualities are collectively defined as competencies). The full report is available at: http://files.ctctcdn.com/a907c850501/1c1289f0-88cc-49c3-a238-66def942c147.pdf

**Tribal Panel: Tribal CHR Program Highlights**

**Session A: Community Outreach and Patient Empowerment (COPE) Program**

- Krista Haven, Diabetes Improvement Specialist, Navajo Area, Indian Health Service
- Miranda Williams, Diabetes Program Coordinator, Navajo Area, Indian Health Service
- Georgia Crawford, Fort Defiance CHR Supervisor, Navajo Nation

This session provided an overview of the COPE program and its collaboration with the Navajo Nation CHR program. The objectives of the COPE Program are: 1) to enhance the Navajo Nation CHR program by providing additional resources, training, and support; and 2) improve outcomes of individuals living with uncontrolled chronic conditions.

COPE CHR activities include providing increased health education and promotion training for CHRs, providing patient self-management teaching materials for CHRs to use in homes, and increasing linkages between clinic and community teams. The COPE program's accomplishments include: the implementation of electronic health record (EHR) access for CHRs, implementation of a healthy eating program in convenience stores, and participation in the CHR application for New Mexico CHW certification.

### Questions & Answers

Q **What was the timeline for implementing EHR access and, considering HIPAA, how was remote laptop access achieved?**
Q EHR access was a 3 year process and is still ongoing. COPE worked with IHS Internal Resource Management on resolving privacy issues related to laptop use.

Q **Is COPE open to sharing the EHR template with other service units?**
Q Yes, COPE is open to sharing templates with other IHS facilities that have EHR. Although COPE did not know how EHR access would work within PL-638 facilities since they use different EHR systems. It was recommended to contact the Clinical Application Coordinator to assess for compatibility.

**Session B - Oral Health Initiative on Hopi**

- Lori Joshweseoma, Director, Department of Health and Human Services, Hopi Tribe

This session provided an overview of the Hopi Tribe's 4 oral health care initiatives: 1) create a partnership with Hopi Head Start to initiate positive oral health habits early; 2) create a community oral health campaign; 3) establish a partnership with Northern Arizona University to increase healthy oral health habits among pregnant women; and 4) collaborate with Women, Infants, and Children (WIC) to increase oral health screenings among children.

**Questions & Answers**

Q **Have you incorporated a connection with a licensed dentist, in terms of CHRs providing a reimbursable service?**
A No, but that is a good recommendation and we will look into it.

**General Comments**

» Reminder: Oral health care (as a preventive service) falls under reimbursable services mentioned in CHAP presentation.

» It is good that the Summit saw what Alaska is doing; we need to work on bringing this to the "lower 48" states.

**Session C - White Mountain Apache Tribe CHR Program**

- The White Mountain Apache Tribe (WMAT) CHRs

This session provided an overview of their services provided and recent accomplishments. During the 2015 Diabetes Door-to-Door campaign, the CHRs visited over 3,000 homes, educated 1,447 families, and screened 881 individuals for diabetes. Of the 881 screened, 238 were referred to IHS for additional follow-up. They also highlighted the success of their Rocky Mountain Spotted Fever (RMSF) campaign. In this campaign, they visited over 4,500 homes and provided numerous trainings aimed at RMSF prevention and treatment. They also sponsored pesticide treatment clinics, provided tick collars, and coordinated an annual clinic.

**Questions & Answers**

Q **Have you applied for supplemental funding for your projects?**
A We applied for Housing and Urban Development (HUD) funds but we were not awarded. We rely on IHS emergency funds and are currently applying for a wildlife invasive species grant.

Q **Have you collaborated with Veterinarians? Are you receiving referrals from them?**
A No, we work with the University of Arizona rural veterinary services once per year but that is it.

**CHR World Café Roundtable Discussions**

A series of roundtable discussions were conducted that revolved around questions generated based on 2015 Summit feedback and by summit planning committee members.

Roundtable discussions provided valuable feedback and recommendations in three key areas. Please see Attachment A: World Café Roundtable Discussion on pages 25-28 for the full responses.

1. **Voluntary Certification** – Overwhelmingly, CHRs support Certification of the CHW workforce and saw it as a means to accomplish a number of objectives such as standardizing and legitimizing the paraprofession, establishing reimbursement through Medicaid, differentiating between other workforces, and potentially increasing salaries. CHRs also favored identifying core competencies and standardizing the training. They also wanted the state process to consider grandfathering CHRs who have had years of experience and for the certification to be recognized across state lines.

2. **Workforce Identity and Development** – CHRs identified many roles that they perform including bridging the gap between patients and the health/social service system, providing health education and advocating for their patients and community. They possess unique skills that set them apart from other professionals such as the ability to speak local indigenous languages and possessing knowledge of their clients' cultures and religions, which facilitate a trusting relationship. Lastly, CHRs expressed that they are undervalued in the health care system, are underutilized and inadequately compensated.
3. **Vision for Healthy Communities** – CHRs indicated that better use of laptops and electronic health records could aid in their work. Basic needs such as improved office space and transportation were also cited. Factors that distract CHRs from their vision: duties and time management overload; lack of support and integration; inadequate program funding and leadership involvement; and high poverty. Successful strategies identified included cross-sector collaboration, specialized training, and CHR forums.

# PROCEEDINGS: DAY 2 (FRI, SEPT 30)

**Concurrent Workshops**

**Workshop A: Prescription Drug Safety**

- Shelly Mowrey, Consultant, Arizona High Intensity Drug Trafficking Area (AzHIDTA)
- Anne Susan, Health Systems Coordinator, Inter Tribal Council of Arizona, Inc.

This session focused on prescription drug abuse and safety in tribal communities. When medication and/or prescription drugs are used incorrectly, it can lead to lifelong problems of substance abuse, addiction and even death. A person addicted to prescription drugs is 40 times more likely to become addicted to heroin. In addition, attendees received a training packet that included a PowerPoint, videos and materials to begin sharing this information within their communities.

**Workshop B: Comprehensive Approach to Good Health and Wellness in Indian Country**

- Madison Eve Fulton, Health Promotion Specialist, Inter Tribal Council of Arizona, Inc.
- Eric Hardy, Health Promotion Specialist, Inter Tribal Council of Arizona, Inc.
- Seth Pilsk, Botanist, Department of Forest Resources, San Carlos Apache Tribe
- Twila Cassadore, Cultural Projects Assistant, Department of Forest Resources, San Carlos Apache Tribe

This session discussed how the San Carlos Apache Tribe is exploring how a traditional Apache diet can be revitalized to combat modern chronic diseases. Their accomplishments include; development of a comprehensive database on the traditional Apache diet, interviewing hundreds of elders, and recreating pre-reservation menus. Current activities include: completing a nutritional analysis, developing calendars based on seasonal food availability, producing a recipe book, and developing a traditional Apache diet curriculum for various populations.

**Workshop C: Inner Journey: The Voice of a Sexual Violence Survivor**

- Caroline Antone, IMIG, LLC

This session focused on sexual violence from a survivor's perspective. The Survivor shared her experience with sexual violence. She disclosed her own thoughts, feelings (i.e. rage, confusion, conflicts, family dynamics, cultural beliefs, distorted thinking) to bring awareness to the survivor's perspective. The predator's manipulation, grooming and secrecy were also discussed. The purpose of the presentation was to help survivors of sexual violence by teaching attendees how to provide support to them.

**Workshop D: CHR Medicaid Reimbursement Policy Options**

- Alida Montiel, Health Systems Director, Inter Tribal Council of Arizona, Inc.
- Kim Russell, Executive Director, Arizona Advisory Council on Indian Health Care

This session focused on strategies of how the CHR workforce may be sustained and enhanced through a voluntary certification process. One aspect of certification is the envisioned reimbursement for preventive services CHRs provide to AHCCCS and KidsCare beneficiaries. The presenters discussed potential policy options to consider so that third party reimbursement may become possible.

**CHR Support: Advocate for your CHR Program!**

**Session A: CHR Advocacy Toolkit**

- Jennifer Richards, MPH, Mel and Enid Zuckerman College of Public Health, University of Arizona
- Jamie Wilson, MPH, Mel and Enid Zuckerman College of Public Health, University of Arizona

This session provided an overview of the CHR Advocacy Toolkit. The purpose of the toolkit is to provide templates that can be adapted to meet CHR needs in their efforts to change tribal, state and national policy. The toolkit includes templates of the following: 1) Policy Brief, 2) Letter to the Editor, 3) Elevator Speech, and 4) Tribal Resolution. The toolkit can be found at the AACOIHC website.

**Session B: Tribal Resolutions: How to Get it Done**

- Brooke Bender, CHR Director, Hualapai Tribe


During this session Mr. Bender shared his experience and success in passing a tribal resolution to recognize CHRs within the Hualapai tribe. He suggested CHRs attend community meetings to gain tribal support for the CHR movement. He explained that community buy-in is important in advocacy. Mr. Bender urged his peers to be proactive and advocate for their programs at the tribal and state levels.

**Session C: Leveraging Networks and Advocating for CHRs**

- Mae-Gilene Begay, CHR Director, Navajo Nation

This session provided a reminder to CHR Programs of the value of partnering with local community colleges and universities to advance training and implementation of programming. She also encouraged CHRs to become involved in local, state and national professional networks such as AzCHOW, the CHR Movement and the APHA CHW Section.

**Summary and Call to Action**

- Michael, Allison, Native American Liaison, Arizona Department of Health Services

Mr. Allison summarized the common themes that were voiced over the past day and half of the Summit II which were: 1) support for continued collaboration with the state CHW certification initiative, 2) support for continuation of the Summit Gathering, and 3) the need for additional CHR resources and support.

Michael summarized next steps which included: 1) a need to better understand the business model for CHR Programs for Medicaid reimbursements and the IHS CHAP Program, 2) initiation of internal tribal conversations with other tribal programs and committees to educate them on CHR programs and CHW voluntary certification initiatives, 3) seek tribal council resolutions in support of the CHR Programs, 4) become more involved with state and national level CHW conversations including participating in state legislative hearings on the CHW Sunrise Application, 5) explore public health training, and align CHW Core Competencies with the IHS CHR training and 6) explore the applicability of the tribal 100% Federal Medical Assistance Percentage (FMAP) for billing of services.

**Closing Remarks**

- Alfred Lomahquahu, Vice-Chairman, Hopi Tribe provided the closing remarks and expressed the need for Tribes to work closely with the State to move forward voluntary certification for CHRs. Vice-Chairman Lomaquahu expressed his gratitude for all the work that CHRs do in tribal communities.

# NEXT STEPS AND RECOMMENDATIONS

Attendees reflected on summit findings, presentations, and discussions to brainstorm next steps for the CHR movement. The following 5 key themes were identified.

**1. Awareness**

Summit attendees emphasized the need for increased awareness of CHRs at the community, tribal, state, and national level. The purpose of increased awareness is to promote cross-departmental collaboration, recognize CHRs role within tribal health care systems, and to garner support for certification and reimbursement of CHR services.

To increase awareness at the **tribal level**, proposed next steps include:

- Initiate, participate, and offer the CHR perspective in conversations with tribal departments, programs, and supervisors,
- Share information with health committees about CHW certification issues,
- "Break down silos" by improving communication and collaboration between CHRs and other tribal departments.

To increase awareness at the **state and national level**, proposed next steps include:

- CHR representation in state and national level conversations.
  - Be "in tune" to issues and "assertive" in advocacy
- Initiate and host an informational CHW/CHR meeting with leadership, including: IHS Area Office leadership, tribal "638," and health boards

**2. Advocacy**

Summit attendees expressed the need for CHR advocacy from the grassroots level to the national level by CHR staff. To mobilize and advocate, CHRs recognize that it is important for them to have the skills and tools to advocate on their own behalf. Therefore, advancing advocacy efforts was a huge priority for CHRs.

To increase advocacy at the **tribal level**, proposed next steps include:

- Develop a business model for CHR Programs. Staff from tribal programs should work on the "business side" of advocacy at the tribal, state and national level to develop a viable business model,
- Share personal testimonies and stories about the vast duties and challenges of CHRs. Highlight compassion and other CHR characteristics in advocacy efforts,
- Leverage support from tribal programs and leaders, both internally and externally, in recognition of the CHR workforce,
- Prepare and submit tribal resolutions that recognize and support CHRs in the healthcare system, and
- Develop strategies and tools to promote the CHR workforce identity, impact and cost savings

To leverage support from **state policymakers**, proposed next steps include:

- Be informed and proactive about CHW and CHR initiatives at the state level

- » Become familiar with the Sunrise application and process in Arizona
- » Attend and participate in legislative hearings on Sunrise application on behalf of your tribe to provide tribal input

To increase advocacy at the **national level**, proposed next steps include:

- » Be informed about CHW initiatives at the national level
- » Get involved in national CHW webinars, phone calls and meetings

**3. Voluntary Certification**

Another theme focused on formalizing a voluntary certification process for CHRs. Proposed next steps include:

- » Align CHW Core Competencies with IHS CHR training
- » Streamline avenues for CHR training and certification
- » Hold a CHR RPMS data workshop to improve CHRs skill at RPMS data entry, thus increasing justification for CHR certification
    - › Identify reimbursement codes, rates, and preventive services for CHR activities
- » Add documentation as a CHR role (i.e. PCC, RPMS, activities)
- » Increase understanding of the Community Health Aide Program (CHAP)
    - › Provide input and shape the CHAP
    - › Understand the CHAP business model

**4. Professional Development**

Professional development is a vital pathway relating to both voluntary certification and reimbursement of services. Proposed next steps include:

- » Explore avenues of public health training certification. The example highlighted was the partnership between Diné College, the University of Arizona (UA), College of Public Health, and Navajo CHR Program. Navajo CHRs earn a UA public health certificate by completing Diné College public health courses.
- » Increase shared resources among CHR programs. Many CHR programs are interested in diverse training opportunities, including grant writing and data entry.
- » Continue Annual CHR Summit and promote other forums for CHRs to collaborate.

**5. Reimbursement of Services**

The final theme focused on reimbursement of CHR services. One of the recommendations was to measure the return on investment (ROI) of CHR services through a partnership with the Navajo Community Outreach and Patient Empowerment (COPE) program. The Navajo COPE program began in 2009 and is a "collaboration with tribal leadership and IHS to address health disparities in Navajo Nation through community-based outreach and food security initiatives" (COPE). COPE was suggested as a potential partner due to their existing collaboration with Navajo CHRs and the infrastructure COPE and Navajo CHR Program has built to contribute to an ROI analysis.

# CHR WORKFORCE ASSESSMENT RESULTS

In 2015, the CHR Policy Summit Planning Committee developed a CHR Workforce Assessment to establish a baseline understanding of the CHW workforce in Arizona. The workforce assessment is an anonymous and voluntary survey completed by participants who attended the CHR Policy Summits. Survey participants included CHRs, CHR supervisors, and tribal health department directors. The survey asked participants about:

1. CHR functions, including scope of practice, role and responsibilities,
2. Current and desired workforce training,
3. Health and social issues of focus,
4. Opportunities and barriers to financing and sustaining the CHR workforce, and
5. Awareness of local, state and national policies related to the advancement of both the CHW and CHR workforce.

To provide perspective on the CHR workforce overtime, workforce assessment results from the 2015 and 2016 CHR Workforce Assessments are reported.

## I. Definition, Core Competencies and Roles

In an attempt to identify commonalities between the CHW and CHR workforces we asked CHR Policy Summit participant opinions about how they perceived the definition, role and scope of practice identified for the broader CHW workforce. A total of 35 people responded to the assessment.

**Definition**

**Community Health Worker:** A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison / link / intermediary between health / social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery (APHA, 2016)."

### a. Workforce Definition

A total of 87% of respondents agreed and strongly agreed that the APHA CHW Section definition of a CHW represented the definition of the CHR workforce. The APHA definition of a CHW is the umbrella job title recognized by the US Department of Labor.

### b. Core Roles and Competencies

In 2015, the CHW Common Core Consensus Project (C3) engaged in a national consensus building effort in the U.S. CHW field to produce recommendations for consideration and adoption on common elements of CHW Scope of Practice and Core Competencies. The C3 anticipates "these recommendations, building on foundational work in the field, will be useful in various settings including in the design of training curricula and CHW practice guidelines for use at the local, state, and national levels".

We asked CHRs to review the core roles identified through the C3 initiative and determine how much the CHR workforce engaged in the roles (Table 1). Findings suggest that respondents overwhelmingly agreed and strongly agreed that the CHR workforce engaged in each of the ten roles identified by the C3.

*Table 1. CHR Agreement with the C3 Project 10 Core CHW Roles **

| How much do you agree that CHRs engage in the following roles? | Agree/Strongly Agree | |
|---|---|---|
| | Percent | Total |
| 1. Cultural liaison among individuals, communities, and health and social service systems | 90% | 36 |
| 2. Provide culturally appropriate health education and information | 88% | 39 |
| 3. Care coordination, case management, and system navigation | 93% | 37 |
| 4. Provide coaching and social support | 93% | 37 |
| 5. Advocate for individuals and communities | 96% | 38 |
| 6. Build individual and community capacity | 82% | 32 |
| 7. Provide direct service | 95% | 38 |
| 8. Implement individual and community assessments | 83% | 33 |
| 9. Conduct outreach | 82% | 32 |
| 10. Participating in evaluation and research | 75% | 20 |

* CHW Roles were identified through the Community Health Worker Common Core Consensus Project (C3)

## II. Health and Social Areas of Focus and Desired Training

### a. Areas of Focus

In 2015 and in 2016 participating CHR programs identified screening and self-management of diabetes, prevention of chronic disease, elder health as among the top health and social areas of focus. In 2016, far less survey respondents reported working, across multiple disease areas which is indicated by the arrow and equal signs in the table below (Table 2).

*Table 2. Community Health Representative Health and Social Issue of Focus*

| What top issues do CHRs in your program currently work on? | 2015 | | 2016 | |
|---|---|---|---|---|
| | Total | Percent | Total | Percent |
| Diabetes (Screening and Self-management) | 28 | 88% | 35 | 88% |
| Prevention (Nutrition and/or Physical Activity) | 20 | 63% | 26 | 65% |
| Elder health | 22 | 69% | 26 | 65% |
| Chronic Disease Prevention | 24 | 75% | 23 | 57% |
| Injury Control | 16 | 50% | 19 | 48% |
| Environmental Health | 16 | 50% | 16 | 40% |
| Accessing Health Services | 11 | 34% | 12 | 30% |
| Cardio Vascular Disease (Screening and Management) | 13 | 41% | 9 | 23% |
| Cancer (Screening and Treatment) | 16 | 50% | 8 | 20% |
| Maternal and Child Health | 15 | 47% | 8 | 20% |
| Behavioral Health / Mental Health | 10 | 31% | 8 | 20% |
| Alcohol/Substance/Tobacco User | 11 | 34% | 8 | 20% |

| | | | | |
|---|---|---|---|---|
| Adolescent Health | 7 | 22% | 5 | 13% |
| Oral health | 4 | 13% | 4 | 10% |
| Sexual or Reproductive Health | 11 | 34% | 3 | 8% |
| Asthma | 6 | 19% | 3 | 8% |
| Tuberculosis - TB | 10 | 31% | 2 | 5% |
| Occupational Health | 5 | 16% | 1 | 3% |
| HIV / AIDS | 11 | 34% | 1 | 3% |
| **Total** | **32** | **100%** | **40** | **100%** |

[+] Respondents could choose more than one answer.

**b. Training Needs**

Training needs for CHRs varied. In 2016, more than half of participants identified need for training in heart disease and stroke, chronic disease self-management, diabetes and behavioral health. Overall in 2016, less respondents identified trainings in oral health, cancer, fall prevention, substance abuse, maternal and child health asthma and smoking cessation.

***Table 3. Community Health Representative Top Workforce Training Needs by Year***

| | 2015 | | 2016 | |
|---|---|---|---|---|
| **What are the top trainings you believe CHRs in your program could benefit from?** | **Total** | **Percent** | **Total** | **Percent** |
| Heart disease and stroke | 25 | 78% | 27 | 68% |
| Chronic disease self-management | 21 | 66% | 25 | 63% |
| Diabetes | 23 | 72% | 24 | 60% |
| Behavioral Health | 19 | 59% | 21 | 53% |
| Oral Health | 23 | 72% | 19 | 48% |
| Cancer | 22 | 69% | 19 | 48% |
| Falls prevention | 19 | 59% | 18 | 45% |
| Substance abuse | 18 | 56% | 16 | 40% |
| Maternal and child health | 16 | 50% | 9 | 23% |
| Asthma | 14 | 44% | 6 | 15% |
| Smoking cessation | 16 | 50% | 5 | 13% |
| HIV/AIDs | - | - | 5 | 13% |
| Behavioral/Lifestyle coaching | - | - | 1 | 3% |
| **Total** | **32** | | **40** | |

[+] Respondents could choose more than one answer.

## III. Voluntary Workforce Certification and Sustainability

***Table 4. Voluntary CHW Certification Requirements Proposed by the Arizona Community Health Outreach Workers Association (AzCHOW)***

1. 18 years or older and have a physical address in Arizona*
2. Documentation of 2500 hours of paid or volunteer CHW experience in the past two years
   **OR**
   Completion of an AzCHOW approved CHW training curriculum and 1000 hours of paid or volunteer CHW experience (may include internships).
3. Completion of AzCHOW training center CHW Core Competency Training/Assessment (4 hours).
4. Two professional letters documenting CHWs experience.
5. $100.00 certification fee (includes 4-hour CHW Professional Orientation and AzCHOW Membership).
6. Voluntary Certification requires renewal every 2 years ($50 fee for renewal). Eight hours of ongoing training per year must be documented for renewal.

### a. Requirements

We asked participants their opinion on the proposed Arizona voluntary certification requirements (Table 4).

- Among 35 respondents:
  - 68% (27) agreed and strongly agreed with the Arizona Voluntary CHW Certification
  - 21% (8) were unsure.
- Among the 32 respondents that answered the question, "How likely are you to become certified?", approximately:
  - 58% were likely,
  - 9% were unlikely and
  - 32% were unsure if they would become certified as a CHR.
- Among 28 respondents who responded to the question, "What would help you become certified as a CHR?":
  - 42% said they would become certified with or without any support and
  - 57% reported they would participant in voluntary certification only if their employer paid the certification fee.

### b. Community Health Aide Program

We asked participants about the CHAP which was presented to them earlier in the day. This new program of the IHS proposes a certification process for Community Health Aides, Behavioral Health Aides, Dental Health Aides and CHRs.

- Approximately, 68% (27) of respondents had never heard of the CHAP program, and
- 80% (32) of respondents would like to know more about the CHAP program.

# ATTACHMENT A: WORLD CAFÉ ROUNDTABLE DISCUSSIONS

**Cafe Topic 1: CHR Certification**

**A. *What does the ideal process for certification of the CHR workforce look like to you (feel free to describe what it should look like at the national IHS, tribal, or state)? What purpose should certification serve?***

CHRs identified the purpose of certification as a step towards reimbursement of their services through the Arizona Health Care Cost Containment System (AHCCCS) and to increase funding streams to their programs. CHRs also view certification as a means to increase funding for salary. Other identified purposes were: to garner CHR recognition; to narrow the focus of the CHR scope of work through standardized certification; to incorporate Certified Nursing Assistant (CNA) certification with CHR certification; to distinguish between CHR, CNA, and Public Health Nurses (PHN); to demonstrate that CHRs do more than translation and transport; to increase tribal pay for CHRs who obtain certification; to learn new skills and improve in their current position; and to identify basic standardized skills for all CHRs.

In terms of process, CHRs discussed the following:

- Certification Format: CHRs favored both an online and 10-day training format.
- Certification Design and Development Process: CHRs commented that there should be CHR and tribal input into certification development. They favored identifying core competencies and standardizing the training.
- "Grandfathering" process: CHRs discussed the importance of "grandfathering" in current CHRs as well as those with CNA certification.
- Partners to Engage: CHRs communicated that training should be established in partnership with tribal community colleges, tribes, and CHRs.
- Curriculum Content: CHRs favored hands-on clinical skills training, incorporation of existing IHS training topics, culturally-specific information for each tribe, basic language requirements, and basic anatomy and physiology.
- Reciprocity: CHRs commented on the importance of reciprocity with CHR certification. They would like the training standardized enough to be honored across state lines and within all tribal communities.

**B. How can CHR certification support the role of CHRs in their communities?**

CHRs discussed certification giving them the confidence to complete their work, enabling them to provide more extensive paraprofessional services that meet their community needs, helping to build trust in their community, and empowering community members to take control of their health.

## Café Topic 2: CHR Workforce Identity and Development

### A. What are the most important roles of a CHR?

CHRs identified several roles of a CHR they felt were most important in their scope of practice. Roles included bridging the gap between patients and the health/social service system, providing health education and advocating for their patients and community. When describing the gap between patients and health/social services, CHRs discussed their role as interpreters; ensuring cultural practices by providing proper communication and interpretation between their patients and providers. CHRs expressed that health promotion and disease prevention through education as an essential role for managing chronic diseases. Additionally, CHRs identified advocacy as an important role. CHRs see themselves as frontline workers and part of the community; they know what the needs of the community are, therefore, they are equipped to advocate on their behalf.

### B. What are the qualities that make CHRs unique and different from other health professionals?

CHRs described several qualities that make their profession unique and different from other health professionals. CHRs are culturally competent mediators, they know the language, culture and religion of their clients; this facilitates a trusting relationship between the CHR and their community. They described themselves as the "Jack of all Trades." CHRs facilitate not only health services, but other services like chopping wood for their elderly and disabled clients. Many CHRs see themselves as advocates for their clients. They connect their clients to resources they need, such as social services, food distribution, housing programs and other assistance programs. CHRs consider their passion to be a unique quality because it drives them to go above and beyond their duties to ensure their patients remain safe and in good health.

### C. If you could design your CHR Scope of Work, how would it look?

A majority of CHRs expressed that they are undervalued in the health care system, and thus are underutilized and inadequately compensated. CHRs saw value in changing the current salary of CHRs by increasing or implementing a pay scale for CHRs to match their vast skill sets and experiences. Ideally, CHRs would like to be sufficiently compensated for their skilled work. Further, CHRs felt that health professionals often overlook or they are not aware of their services. For this reason, CHRs would like to "make sure providers and other health professionals utilize CHRs to their fullest potential" by increasing teamwork and collaboration opportunities with nurses and other health professionals to provide the best care for their patients. Internally, CHRs discussed that they would appreciate more supportive leadership within their tribal programs to fulfill and/or expand their duties.

### D. In an ideal world, what would a career as a CHR look like? Where would it take you?

CHRs discussed several components of the ideal CHR career. The most popular factor to an ideal CHR career were opportunities for wage increases and promotions. CHRs felt that having tiered positions (entry level, intermediate, experienced and advanced levels) would improve their career. In addition, they stated compensation for overtime work should be provided and paid at the overtime pay rate.

Other components include providing opportunities to expand CHR skills through education and training. Many CHRs voiced their interest in continuing their education in the following degree programs: medical assistant (MA), degrees in public health: associates (AS), bachelors (BS), masters (MPH), and doctorate (PhD, DrPH); and degrees in nursing: certified nurse assistant (CNA), registered nurse (RN), and licensed practical nurse (LPN). In addition, administrative skills such as billing and coding were also mentioned.

**Café Topic 3: CHRs Vision for Healthy Communities**

**A. In an ideal world, what would support you as a CHR or as a CHR program to better address the health and social needs of the community?**

CHRs and CHR programs identified several mechanisms to better address the health and social needs of the community. Administration of the CHR program was considered an area needing improvement in terms of: 1) hiring more staff, 2) increasing salary (i.e. merit pay), 3) upgrading transportation, 4) improving office space, 5) updating training/education material and 6) updating office equipment (i.e. laptop, cell and internet service) to help support the CHR program. In addition, remote access to the electronic health records (EHR) and resource and patient management system (RPMS) would support CHRs in reporting their work in the field. Further, one electronic system would be ideal and eliminates the duplication of reporting. CHRs expressed that these areas need to be considered in order to better support their work. Providing health education utilizing traditional methods was also considered very important.

Other issues related to CHR support include improvement or development of better definition, scope of work, recognition, integration and valuing of CHRs. CHR programs believe this will strengthen the workforce and enable the third party reimbursement from Medicaid. In addition, the recognition and integration of CHRs into teams composed of many different types of health care professionals may foster a better relationship and health outcome for their clients.

Further, CHRs considered "eliminating silos" and establishing partnerships with other tribal programs/departments and healthcare professionals as a way to address the health and social needs of the community.

**B. What distracts you from this vision to strengthen communities as a CHR or a CHR program?**

CHR programs identified several factors that distracts CHRs from the vision to strengthen communities, which spanned the following levels:

- Duties and time management overload: CHRs discussed the issues of burning out from numerous assigned projects and reports that lead to less "community involvement" and work overload.
- Lack of support and integration: CHRs expressed that their work is devalued and unsupported within the healthcare system which has led to programs "working in silos." CHRs would like to be fully integrated into the health care provider models and to establish consistent collaboration with clinical care teams.
- Inadequate program funding and leadership involvement: CHRs voiced their concerns of the inadequate program funding, which includes low wages, no uniforms, no offices, poor technology and equipment (i.e. laptop, cell service, internet service). Some CHRs also mentioned low involvement of leadership that distracts them from the vision to strengthen communities.
- High poverty within the community: CHRs identified that poverty has contributed to poor health outcomes in many tribal communities. Some communities have few options for healthy food, CHRs believe this is a barrier for their clients.

**C. Can you share any strategies that have worked for you in your program and community?**

CHRs shared successful strategies that spanned the following categories:

- Cross-sector collaboration: CHRs discussed greater recruitment and participation, as well as cost reduction, when "piggybacking" on other department events (e.g. WMAT "hot topic" campaigns with other departments). Other examples of successful collaborations included: achieving broader departmental support and recognition through memorandums of understanding (MOU), CHR involvement in strategic planning and evaluation, recognition of common goals, and provision of support from various programs (i.e. treatment facilities, youth counseling, and workforce investment act).
- Specialized training: CHRs reported successful strategies pertaining to the pursuit of specialized training. For example, some CHR programs have been awarded grants for early childhood education (i.e. Family Spirit early childhood home visiting training through IHS, Hopi oral health initiative) or have obtained certifications in various specialized areas such as; emergency services or Rocky Mountain Spotted Fever prevention.
- CHR forums: Many CHRs favored opportunities to gather with other CHRs, both internally and with other tribes. The most highly favored events were CHR retreats and the annual CHR Policy Summit. Summits were believed to contribute to standardizing their scope of work, ensuring that CHRs are pursuing the same goals, encouraging intertribal collaboration, and providing professional development opportunities.

# ATTACHMENT B: WORLD CAFÉ ROUNDTABLE RESPONSES

**Café Topic 1: CHR Certification**

| Purpose | Process |
|---|---|
| Medicaid reimbursement | Online |
| funding to come back to your program | 10 day training |
| CHW recognition | Core competencies (Identify) |
| Deciding to focus on specific Scope of Practice, currently CHR scope is broad | Standard training |
| Incorporate CNA certification with CHR certification (one training) | Try to hire CNAs, Medical Assistants, Nursing Assistants |
| Medicaid reimbursement for CHR | Establish training at a tribal community college |
| To show that CHRs do more than translation/transport | Incorporating Indian Health System into the curriculum |
| Tribe pay for education/certification | clarify role of PHN vs. CHRs vs. CHAs |
| Learn new skills, improve in job | Basic Anatomy/Physiology |
| Tribes should have say in format/how to certify | Hands-on clinical hours |
| Have basic skills for CHR require for certification (standardized) | Increase salary (Highest # dots) |
| | Training covered by 3rd party |
| | Grandfather in current CHRs |
| | Confidence to complete work |
| | Build trust in the community |
| | Provide more extensive services that community needs (Paraprofessional services) |
| | Empower community members to take control of their health |
| | Cross state lines - general for all and specific for tribes (reciprocity NM/AZ) |
| | Culturally specific to each tribe |
| | Must have CHR input |
| | Grandfather in CNA certification |
| | Each tribe have way to honor other tribes' certifications |
| | Language requirements (testing for this) |

**Café Topic 2: CHR Workforce Identity and Development**

| CHR Roles | CHR Qualities | Ideal SOW | CHR Career |
|---|---|---|---|
| Bridging gap between patient and providers; Interpreter | Advocate | Resourceful | Case Manager |
| Prevention; Promote wellness | Jack of all trades | Increase pay/wages (most dots) | MA/CNA/CHR do same work |
| Advocacy | Know language, culture, religion | Team with PCP Nurses | Having CHR tiers depending on skill |
| Education | Good listener; Reliable/dependable; Empathetic/Caring | Make sure providers utilize CHRs to their full potential | RN, LPN |
| Compassionate; open-minded | Bilingual | Chronic Disease Prevention | Advanced/more medical skills |
| Proactive | Chop/stack wood | Strong leadership values | More admin skills (billing and coding) |
| eyes/ears of community ("pulse of community") | Trusted community members; Confidante; Confidential advocate | Health screening | More money; Tiered levels based on skill; Overtime not comp time |
| Communication | Provide security | Oral health | First Responder |
| Front line | Focus on patient, not diagnosis; More time with clients | | Continue education in Public Health: AS, BS, MPH, PhP |
| Know client on personal level; Include family | Resilient | | Family Spirit |
| Home visits | Motivators | | BG certification |
| Detective | | | Promotion opportunities |

**Café Topic 3: CHRs Vision for Healthy Communities**

| What would support CHR? | Distractions from vision/program | Strategies that have worked |
|---|---|---|
| Hire more staff | Other duties as assigned (get taken away from community involvement) | Grants for special projects |
| Specific projects (specialize) | Politics | Early education (health sciences) |
| Training/education materials | Duplication of reporting | CHR retreat |
| IT equipment (laptop, cell service, Internet service) | Working in silos | CHR acknowledgement/recognition |
| Materials/Supplies | CHR burnout | Developing MOUs/MOAs with other departments |
| Teach in traditional methods | Lack of housing | Annual CHR meeting |
| Recognition by providers (physicians, PHN, RN, RD) for CHR role (better relationship) | Lack of funding | Great departmental support |
| Increased salary (merit pay) | Time management (not enough time) | Specialized training |
| Better vehicles | No money for CHR uniforms | Piggyback on other community events |
| Office space (improved) | Lack of technology (laptops, cell service, Internet service) | Develop common goals (standardizing) |
| Better support system from tribal leaders and HC professionals | Lack of equipment | CHR involvement in strategic planning and evaluation |
| Remote access to EHR and RPMS (one electronic system for both) | No offices for CHRs | Intertribal collaboration |

# APPENDIX A: LIST OF SUMMIT PARTICIPANTS

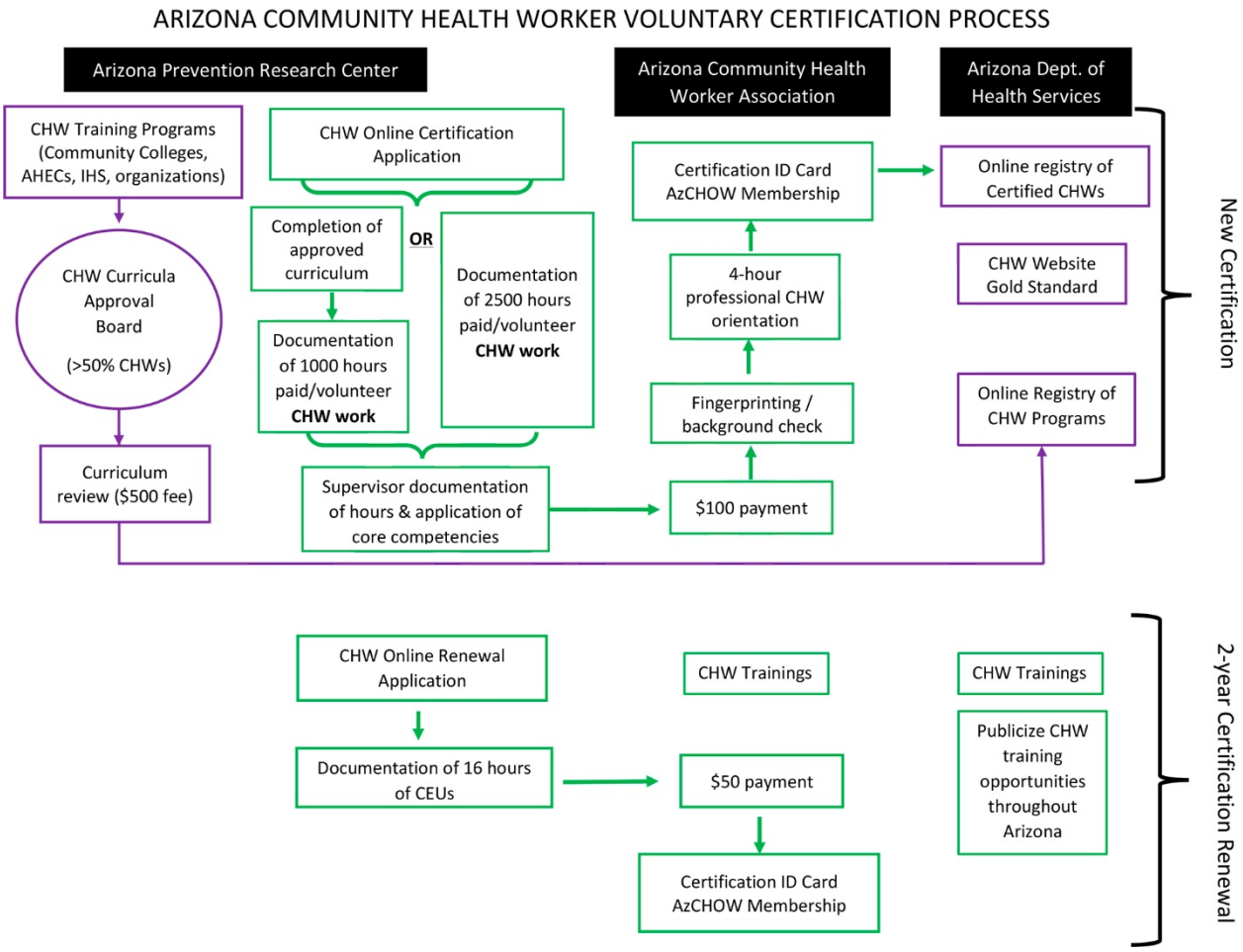
| | | |
|---|---|---|
| **Allison, Michael**<br>Arizona Department of Health Services | **Cosen, Robert**<br>White Mountain Apache Tribe | **Fulton, Madison Eve**<br>Inter Tribal Council of Arizona, Inc. |
| **Antone, Caroline**<br>Tohono O'odham Nation | **Crawford, Georgia**<br>Navajo Nation | **Gonzalez, Renee**<br>Yavapai Apache Nation |
| **Baldwin, Julie**<br>Center for Health Equity Research | **Dawdy, Suzzett**<br>Yavapai Apache Nation | **Greybull, Lynnette**<br>Standing Rock |
| **Barton, Sheila**<br>Navajo Nation | **Declay, Jeanette**<br>White Mountain Apache Tribe | **Hardy, Eric**<br>Inter Tribal Council of Arizona |
| **Barlese, Debra**<br>Pyramid Lake Paiute Tribe | **Descheenie, Eric**<br>Navajo Nation | **Harvey, Sherry**<br>White Mountain Apache Tribe |
| **Begay, Mae-Gilene**<br>Navajo Nation | **Dobervich, Gretchen**<br>North Dakota State University | **Haven, Krista**<br>Navajo Nation |
| **Bender, Brook**<br>Hualapai Tribe | **Eagle, Kelly**<br>Phoenix Area Indian Health Services | **Hill, Esther**<br>Colorado River Indian Community |
| **Bennett, Marianne**<br>Salt River Pima-Maricopa Indian Community | **Elwell, Kristan**<br>Center for Health Equity Research | **Hopper, Genevieve**<br>White Mountain Apache Tribe |
| **Brehmeyer, David**<br>Hualapai Tribe | **Enriquez, Lydia**<br>Arizona Advisory Council on Indian Health Care | **Housten, Ellen**<br>Pyramid Lake Paiute Tribe |
| **Brown, Nathaniel**<br>Navajo Nation | **Estrella, Jenniferlin**<br>Tohono O'odham Nation | **Ivans, Wayne**<br>White Mountain Apache Tribe |
| **Cassadore, Twila**<br>San Carlos Apache Tribe | **Ethelbah, Kathy**<br>White Mountain Apache Tribe | **Jean, Lisa**<br>Hopi Tribe |
| **Castagne, Michelle**<br>National Indian Health Board | **Flores, Lesa**<br>Colorado River Indian Tribes | **Johnson, Preeo**<br>White Mountain Apache Tribe |
| **Charley, Mabel**<br>Navajo Nation | **French, Luana**<br>Salt River Pima-Maricopa Indian Community | **Joshweseoma, Lorencita**<br>Hopi Tribe |
| **Lomaquahu, Alfred**<br>Hopi Tribe | **Nashio, JT**<br>White Mountain Apache Tribe | **Sixkiller, Krishna**<br>Ute Indian Tribe |
| **Lopez, Donnilla**<br>Tohono O'oodam Nation | **Nozie, Timmy**<br>White Mountain Apache Tribe | **Smith, Zena**<br>Navajo Nation |

| | | |
|---|---|---|
| **Manuel, Cynthia**<br>Tohono O'oodahm Nation | **Pilsk, Seth**<br>San Carlos Apache Tribe | **Sneezy Patsy**<br>San Carlos Apache Tribe |
| **Mattias, Eugenia**<br>Tohono O'oodam Nation | **Pine, Brenette**<br>Navajo Nation | **Soto ,Yanitza**<br>Arizona Department of Health Services |
| **Mix, Claradine**<br>Tohono O'odham Nation | **Riley, Millie**<br>White Mountain Apache Tribe | **Susan, Anne**<br>Inter Tribal Council of Arizona |
| **Montiel, Alida**<br>Inter Tribal Council of Arizona | **Row, Rebecca**<br>Gila River Health Care Corporation | **Tessay, Larrell**<br>White Mountain Apache Tribe |
| **Moore, Cassandra**<br>Hualapai Tribe | **Robinson, Deborah**<br>Salt River Pima-Maricopa Indian Community | **Thomas, Dora**<br>Pyramid Lake Paiute Tribe |
| **Mowrey, Shelly**<br>Arizona High Intensity Drug Trafficking Area | **Rush, Carl H.**<br>University of Texas Institute for Health Policy | **Thomas, Melinda**<br>Salt River Pima-Maricopa Indian Community |
| **Muneta, Anita**<br>Navajo Nation | **Rudolfo, Jessica**<br>White Mountain Apache Tribe | **Truax, Larue**<br>White Mountain Apache Tribe |
| **Nasafotie, Annalese**<br>Hopi Tribe | **Russell, Kim**<br>Arizona Advisory Council on Indian Health Care | **Warne, Donald**<br>North Dakota State University |
| **Nelson, Katherine**<br>Navajo Nation | **Samantha Sabo**<br>University of Arizona | **Wauneka, Susie**<br>Navajo Nation |
| **Nez, Victoria**<br>Navajo Nation | **Sangster, Deanna**<br>Native Health | **Williams, Miranda**<br>Navajo Nation |
| **Yazzie, Jeannette**<br>Navajo Nation | **Willson Jamie**<br>University of Arizona | |

# APPENDIX B: LIST OF PLANNING COMMITTEE MEMBERS

| Name | Title | Tribe/Organization |
|---|---|---|
| Michael Allison | Native American Liaison | Arizona Department of Health Services |
| Mae-Gilene Begay | CHR Director | Navajo Nation – CHR Program |
| Brook Bender | CHR Program Manager | Hualapai Tribe - Health Education & Wellness |
| David Brehmeyer | Assistant Director | Hualapai Tribe - Health Education & Wellness |
| Kelly Eagle | PHN/CHR Consultant | Indian Health Service - Phoenix Area Office |
| Lydia Enriquez | Administrative Assistant | Arizona Advisory Council on Indian Health Care |
| Lorencita Joshweseoma | Director | Hopi Tribe - Department of Health and Human Services |
| Leah Meyers | Director | Rural Women's Health Network |
| Alida Montiel | Health Systems Director | Inter Tribal Council of Arizona, Inc. |
| Lorraine Ramirez | Coordinator | Rural Women's Health Network |
| Jennifer Richards | PhD Student/Consultant | University of Arizona – Mel and Enid Zuckerman College of Public Health |
| Kim Russell | Executive Director | Arizona Advisory Council on Indian Health Care |
| Samantha Sabo | Assistant Professor | University of Arizona – Mel and Enid Zuckerman College of Public Health |
| Yanitza Soto | CHW Program Manager | Arizona Department of Health Services |
| Jamie Wilson | PhD Student/Consultant | University of Arizona – Mel and Enid Zuckerman College of Public Health |

# APPENDIX C: ARIZONA'S CERTIFICATION PROCESS



# APPENDIX D: AGENDA

## DAY 1: THURSDAY, SEPTEMBER 29, 2016

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|---|---|
| **7:00am » 5:00pm** | **Conference Registration** |
| **7:00am » 8:00am** | **Continental Breakfast *(Provided)*** |
| **8:00am » 8:10am** | **Welcome** |
| **8:10am » 8:15am** | **Blessing**<br>→ Susie Wauneka, CHR Supervisor, Winslow Service Unit, Navajo Nation |
| **8:15am » 8:30am** | **Opening Remarks**<br>→ Brook Bender, CHR Program Manager, Hualapai Tribe |
| **8:30am » 8:45am** | **Introductions of Summit Participants** |
| **8:45am » 8:50am** | **Recognition of Planning Committee and Summit Sponsors/Partners** |
| **8:50am » 9:00am** | **Background and Overview of Summit**<br>→ Kim Russell, Executive Director, Arizona Advisory Council on Indian Health Care |
| **9:00am » 10:00am** | **Keynote: "Expanding Opportunities for Community Health Representatives"**<br>→ Donald Warne, MD, MPH, Chair, Department of Public Health, North Dakota State University |
| **10:00am » 10:15am** | **Break** |
| **10:15am » 11:15am** | **National Community Health Worker Initiatives**<br>Session A: Overview of the Indian Health Service Community Health Aide Program (CHAP) Policy<br>→ Michelle Castagne, Congressional Relations Manager, National Indian Health Board<br>Session B: Updates on National CHW/CHR Association Organizations<br>→ Mae-Gilene Begay, CHR Program Director, Navajo Nation |
| **11:15am » 12:00pm** | **Update on Arizona's CHW Voluntary Certification**<br>→ Flor Redondo, President, Arizona Community Health Outreach Worker Association<br>→ Samantha Sabo, PhD, Assistant Professor, University of Arizona<br>→ Yanitza Soto, Program Manager, Community Health Worker Program, Arizona |

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|---|---|
| **12:00pm » 1:00pm** | **Lunch Buffet *(Provided)***<br>Luncheon Speaker: "Across the National Landscape – CHW Certification & Training Perspectives"<br>→ Carl Rush, Project on CHW Policy and Project on CHW Policy & Practice, University of Texas Institute for Health Policy |
| **1:00pm » 2:30pm** | **Tribal Panel: Tribal CHR Program Highlights**<br>Session A: Community Outreach and Patient Empowerment (COPE) Program<br>→ Krista Haven, Diabetes Improvement Specialist, Navajo Area Indian Health Service<br>→ Georgia Crawford, CHR Supervisor, Fort Defiance<br>→ Miranda Williams, Diabetes Program Coordinator, Navajo Area Indian Health Service<br>Session B: Hopi Dental Grant<br>→ Lori Joshweseoma, Health Director, Hopi Tribe<br>Session C: White Mountain Apache Tribe CHR Program<br>→ White Mountain Apache Tribe CHR Staff |
| **2:30pm » 2:45pm** | **Break** |
| **2:45pm » 2:50pm** | **Overview of the CHR World Café Process**<br>→ Topic 1: Future Plans for CHR Certification<br>→ Topic 2: CHR Workforce Identity and Development<br>→ Topic 3: CHR Vision for Healthy Communities |
| **2:50pm » 3:50pm** | **Part 1: CHR World Cafe Group Discussions** |
| **3:50pm » 4:30pm** | **Part 2: CHR World Cafe Group Reflection** |
| **4:30pm » 5:00pm** | **Part 3: Group Report Out** |
| **5:00pm** | **End of Day One** |

## DAY 2: FRIDAY, SEPTEMBER 30, 2016

**7:30am » 8:30am** **Breakfast *(Provided)***

**8:30am » 10:00am** **Concurrent Workshops**

Session A: Prescription Drug Safety

*Workshop Description » There is an epidemic sweeping our American Indian and Alaska Native Tribal communities. Children, elders, friends and family members are addicted to or are dying from prescription drug abuse. While the medication is meant for healing, when used incorrectly, it can lead to lifelong problems of substance abuse, addiction and even death. Even more frightening is that a person addicted to prescription drugs is 40X more likely to become addicted to heroin. Inter Tribal Council of Arizona in partnership with AZ HIDTA developed a presentation on preventing prescription drug misuse and abuse. This research based program equips attendees with a training packet that includes a power point, videos and materials to take into your community to share with parents, youth, elders and tribal officials.*

→ Shelly Mowrey, Consultant, Arizona High Intensity Drug Trafficking Area (AzHIDTA)

→ Anne Susan, Health Systems Coordinator, Inter Tribal Council of Arizona, Inc.

Session B: Comprehensive Approach to Good Health and Wellness in Indian Country

*Workshop Description » For the past 25 years this project has been studying highly-detailed pre-Reservation Apache information about healthcare and education systems, and the underlying causes of chronic disease, substance abuse, suicide/attempted suicide/cutting, and sexual violence. Project staff is now working to bring this knowledge to bear on these issues in practical and meaningful ways. The Inter Tribal Council of Arizona, Inc. staff will also present on their project.*

→ Madison Eve Fulton, Health Promotion Specialist, Inter Tribal Council of Arizona, Inc.

→ Eric Hardy, Health Promotion Specialist, Inter Tribal Council of Arizona, Inc.

→ Seth Pilsk, Botanist, Department of Forest Resources, San Carlos Apache Tribe

→ Twila Cassadore, Cultural Projects Assistant, Department of Forest Resources, San Carlos Apache Tribe

Session C: Inner Journey: The Voice of a Sexual Violence Survivor

*Workshop Description » The Survivor opens herself up to help others who work, live or love sexual violence survivors so they can have an understanding of what might a survivor be going through. By disclosing her own thoughts of rage, confusion, conflicts, family dynamics, culture beliefs, distorted thinking as well as the predator's manipulation, grooming and secrecy she hopes that she can help the survivor's friend, family or staff learn how to support their person.*

→ Caroline Antone, I:MIG, LLC

Session D: CHR Medicaid Reimbursement Policy Options

*Workshop Description » Since 2015, Tribes in Arizona have come together to examine ways in which the CHR workforce may be sustained and enhanced through a voluntary certification process. One aspect of certification is the envisioned reimbursement for preventive services CHRs provide to AHCCCS and KidsCare beneficiaries. The presenters will*

*discuss potential policy options to consider so that third party reimbursement may become a reality.*

→ Alida Montiel, Health Systems Director, Inter Tribal Council of Arizona, Inc.

→ Kim Russell, Executive Director, Arizona Advisory Council on Indian Health Care

**10:00am » 10:15am** **Break**

**10:15am » 11:30am** **CHR Support: Advocate for your CHR Program!**

Session A: CHR Advocacy Toolkit

→ Jamie Wilson, DrPH Student, University of Arizona

Session B: Tribal Resolutions: How to Get it Done

→ Brook Bender, CHR Program Manager, Hualapai Nation

Session C: Leveraging Networks and Advocating for CHRs

→ Mae-Gilene Begay, CHR Program Director, Navajo Nation

**11:30am » 11:45am** **Summary and Call to Action**

→ Michael Allison, Native American Liaison, Arizona Department of Health Services

**11:45am » 12:00pm** **Closing Remarks**

→ Alida Montiel, Health Systems Director, Inter Tribal Council of Arizona, Inc.

**12:00pm » 12:05pm** **Closing Blessing**

→ Honorable Alfred Lomaquahu, Jr., Vice Chairman, Hopi Tribe

**12:05pm** **Summit Adjournment**