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Partnering for Success through Community Based Participatory Research In Indian Country

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Background

In May 2008, 5 organizations (Native American Cancer Research Corporation (NACR), Intertribal Council of Michigan, Inc. (ITCMI), Rapid City Regional Hospital (Walking Forward Program) (RCRH), Great Plains Tribal Chairmen's Health Board (GPTCHB) and Muscogee (Creek) Nation (MCN); (hereafter called "Partners" in this article)) initiated a partnership to implement a 5-year National Institutes of Health-funded study, called "Native Navigators and the Cancer Continuum (NNACC) [R24MD002811] (Figure 1). Results of NNACC are summarized in another article included in this issue of JCE. This article focuses partnership building which resulted in successful CBPR as well as the recruitment and

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engagement of community members and organizations throughout the NNACC education intervention.

Level 1 Partnerships: Development of Multi-State Inter-Tribal Partnerships

NACR staff had a long history of both NIH-supported CBPR (1989) and NIH-supported patient Navigation (1996) (frequently called, “lay health advisors” and “Native Sisters” in early years). Communities and organizations vary greatly in their abilities to collaborate effectively. For example, an early NACR study included a partnering organization led by an American Indian woman who would sabotage ongoing work so that she could come in to “rescue” the somewhat damaged project. Obviously, this was not a desirable characteristic for partners on any subsequent research. Thus, experience is a great teacher. NACR staff greatly valued Partners who were honest, innovative, proactive and dynamic. Each of the partners on this NNACC Team had collaborated with NACR on at least one previous program and each relationship started differently.

NACR and RCRH collaborated on patient navigation through the RCRH Walking Forward Program since 2002. Both organizations have subcontracts with one another for specific aspects of patient navigation within the Walking Forward intended populations (Rapid City, Rosebud and Pine Ridge Reservations).

NACR worked with GPTCHB on multiple projects. Again both organizations have subcontracted with the other group. For example GPTCHB NPCCCP subcontracted with NACR to conduct external evaluation, but similarly NACR subcontracted with GPTCHB for survivorship support education, cultural competency training and multiple other community education programs.

The relationship with ITCMI was initiated when Dr. Burhansstipanov heard Ms. Pingatore describe their Pink Shawl Program during the Mayo Clinic Spirit of EAGLES Triennial conference in 2002. Shortly following the conference both women mutually started the relationship through email. This led to collaborating on a CRC project and a NIH Small Business Innovative Research (SBIR) Study initiated by a mutual colleague. Similarly, NACR’s for-profit arm (Native American Cancer Initiatives, Inc. (NACI)) had a SBIR grant headed by Dr. Krebs and she too partnered with ITCMI for feasibility testing in diverse MI settings.

The relationship with MCN evolved from a personal friendship between Dr. Burhansstipanov and Ms. Isham. Ms. Isham had been closely involved with MCN annual Pink Parties to celebrate breast health and survivorship. She invited Dr. Burhansstipanov as a keynote plenary speaker multiple years. While attending the Pink Party, Dr. Burhansstipanov also met the nurse who later became the lead MCN Navigator.

Thus, these earlier interactions and networking opened the door to new possibilities and partnerships. NACR coordinated webinars with conference calls for all of the initial partners (ITCMI, RCRH, GPTCHB and NACR; MCN was added as a Supplement Site at the end of year 02 of the grant) to meet electronically and each shared their greatest cancer-related

issues and concerns. Gradually consensus evolved among the partners as to the 1st priorities for NNACC (patient navigation) and community education.

Budgeting within CBPR contributes to strong partnerships

True CBPR requires some budgetary equality for each Team member to be a decision maker. NACR was the recipient of the NIH grant with subcontracts to ITCMI, RCRH (which included a subcontract to GPTCHB) and later to MCN. About 20% of the budget went directly to NACR that had the responsibility for taking the leadership role on all communication, approvals and interactions with NIH. This also included the master IRB documents, protocols, and initial drafts of reports, scientific advancement summaries, and data analyses. The remaining monies (80%) was split equally among the 3 partners for the implementation and assessment of the NNACC education intervention. If it was less expensive for one Partner to purchase an item that all partners were going to use (Audience Response System equipment), one Partner would purchase the item and distribute to all others. MCN was added as a new site through NIMHD supplemental funding in 2010 and had additional funding to assist with late start-up to “catch up” to the other Partners. Budgets were transparent and all Partners knew they had equivalent amounts for the implementation of their local NNACC interventions.

Partners increasing the visibility of Navigators through the workshops

Although NACR had been conducting patient navigation grants since 1996, it lacked visibility throughout the very mobile Denver AI community. To address this weakness, the NNACC Administrative Team suggested the Navigators assume the lead role as faculty or facilitators for the workshop series. The process of having the Navigators take leadership roles was very challenging [1] and required a significant learning curve. At most sites, the Navigators were initially partially supported in their new leadership roles by inviting guest speakers or having staff members help teach specific workshop topics. Eventually the Navigators assumed the lead as workshop facilitators/faculty. This role was paramount in increasing the visibility of the Navigators throughout the respective communities.

Partners collaboration creating or revising workshop topics for inclusion in the workshop series

As the potential topics for the workshop series were discussed, each team member identified and shared their personal expertise. All administrative team leaders had some background in breast health, but other areas emerged. For example, one person had a background in and commitment to addressing the relationship between environmental contaminants and tobacco and cancer. A Navigator had a deep interest in human papillomavirus, survivorship, and support for caregivers of cancer patients. Others had interests in cancer staging, treatments, and quality of life. Walking Forward had a basic cancer education module and GPTCHB had a comprehensive Cancer 101 curriculum that included many of the topics of interest for implementation within the workshop series. NACR had validated cancer education curricula for most of the proposed workshop topics as well. Each team member took the lead for a specific curriculum topic and prepared and shared the module with the rest of the team. Everyone helped edit the content, interactive activities, and knowledge items specific to each workshop topic. During face-to-face meetings, the lead developer

would present the modules and help others learn how to answer questions. The number of face-to-face meetings that were held was insufficient; however, the Navigators' dedication and passion compensated for this weakness and enabled each team member to attain competence in teaching the modules.

On site meetings held in each Partners' location

Although each team member is proficient in the use of communication technology, face-to-face interactions were key to establishing strong working relationships with other tribal and clinic leaders prior to creating the grant. While visiting one another's locations, project team leaders identified significant issues and gaps in AI community needs and challenges for cancer services. Webinars were insufficient to actually experiencing the highways, roads, and terrain in each setting; the walks into clinical settings; the crowded conditions and long waiting times; and the intensity of the community demand for more cancer education and timely access to services. Through these and several other interactions, each organization described both CBPR and patient navigation as a priority for their respective communities. These interactions provided the basis for the NNACC grant and its partnerships.

Level 2: Formation of Local Partnerships

Each Partner had local leadership roles in selecting the Memoranda of Agreement (MOA) American Indian organizations with whom they would partner (local community partners are called "MOAs" in this paper). The MOAs had specific duties, including recruitment of participants to the NNACC project, coordinating a baseline Family Fun Event that promoted the upcoming workshop series to the communities and invited all to take part. The MOAs also coordinated the 24-hours of education workshops and tracked the audience response system keypads for all participants (i.e., a participant was supposed to use the same keypad for each subsequent workshop s/he attended). The MOAs also coordinated and implemented a follow-up Family Fun Event 3 to 6 months following the completion of the workshop series. The purpose of this gathering was to share study findings with the local community and workshop attendees. They also helped disseminate findings from the study to their local communities. Each MOA received a small fee to carry out these and other tasks. Table 1 summarizes each organization, the population served by that organization, the MOA community partners and total number of unduplicated participants.

NOTE: Many community members attended multiple workshop topics within the 24-hour series and are called "duplicate participants". "Unduplicated" counts a participant once, regardless of how many workshop topics they attended.

Native American Cancer Research (NACR)

NACR has worked in the Denver metropolitan community since 1999, providing support to AI cancer survivors, educating the community about cancer, and partnering with other organizations to sponsor health fairs, pow wows, and other social events to highlight and promote healthy lifestyles and early detection screening. NACR sponsors a cancer support group and navigates cancer patients. All of these activities have led to the community having

a trusting relationship with NACR. This relationship provided the groundwork for this project and enabled NACR to reach a broad representation of AIs in Denver.

The AI population in Denver is primarily from the Northern and Southern Plains and the Southwest. Some members of the Native community are third generation transplants from the reservation, others are new to the city, and almost half travel back and forth between the city and Reservation every year or two. The poverty rate of the population served by NACR is approximately 40%, and uninsured/underinsured rates are similarly high (Personal communication Linda Burhansstipanov). The Indian Health Service (IHS) partially supports Denver Indian Health and Family Services (DIHFS), which offers programs for diabetes, substance abuse, and mental health, many education programs and some limited medical services (they are not yet a full functioning clinic). Most AIs in the Denver area rely on NACR to help them access cancer screening and care at various local hospitals and cancer centers. Because of the trust NACR has developed with the AI population in Denver, the NNACC Navigators continue to receive requests for help by AIs seeking cancer screening or support with diagnosis, although the project has officially ended.

In the Denver metropolitan area, NACR partnered with organizations that provided services to different segments of the AI community, and had little overlap in the populations served. Denver Indian Health and Family Services provided 2 series of 24-hours of workshops in 2009 and 2011 as did Denver Indian Family Resource Center in 2011 and 2012. Southwest Improvement Center was the MOA in 2009 and Colorado Coalition for the Homeless was the MOA in 2010. Table 2 summarizes the description of each MOA and years it provided the NNACC MOA roles. A total of 491 “unduplicated” community members participated in the project at this site.

Inter-Tribal Council of Michigan, Inc. (ITCMI)

ITCMI is a private nonprofit agency with 501C (3) status. Founded in 1966, the ITCMI serves as a consortium of the 12 federally recognized tribes in Michigan; its mission is to help promote the health, well-being, and quality of life of Indian people in Michigan. Several of the tribal members of the consortium provide clinical services. The ITCMI consists of 6 departments: Health Education and Chronic Disease, Maternal and Child Health, Behavioral Health, Economic Development, Early Childhood Education/Head Start, and Environmental Services. The ITCMI maintains effective working relationships and partnerships with the State Health Department and is an active member of the Michigan Cancer Consortium. These partnerships provide for added resource development, coalition building and linkages to cancer early detection and treatment programs across the state.

ITCMI worked with 2 tribal communities in Michigan, the Sault Ste. Marie Tribe of Chippewa Indians in the isolated rural area of Michigan’s Upper Peninsula (Sault Saint Marie) and the Saginaw Chippewa Indian Tribe in the rural region of the Central Lower Peninsula (Mount Pleasant). The 2 sites have a combined membership of over 30,000 and cover 9 counties designated as Health Professional Shortage Areas serving low socioeconomic populations [3]. According to the Michigan Department of Community Health Office of Minority Health’s report, for AIs compared to whites, the inequity gap increased for median household income, high school drop-out rate, infant mortality and

mortality from heart disease [6]. Each site operates a Tribal (IHS) ambulatory care clinic and community health department. Each site also collaborates with the local health department's Breast and Cervical Cancer Control Program, providing most screening services on-site. The Sault Tribe operates a radiology/mammography department on-site within the Sault Ste. Marie IHS Clinic, while the Saginaw Chippewa Tribe refers radiology/mammography services out to the local hospital. Additional cancer testing, diagnosis, and treatment services are provided by local hospitals or regional specialty care facilities. The travel distance required to receive services, and the long harsh winter driving conditions that can last for up to nine months, present many challenges to this low income population's ability to access health care.

NNACC staff at each Michigan site met with key staff and tribal leaders to discuss local implementation and the choice of community-based partners as a host agency or department to deliver their services. The Sault Tribe chose to educate their Elders, as they are considered the root of many tribal families. Elders convey knowledge within their families and the broader community and are respected sources for culture and information. An agreement was made with the Elder Services Department to serve as host organization and services were delivered in collaboration with the Elder meal program. This arrangement was highly successful as determined by the quantitative and qualitative outcomes. In comparison, the Saginaw Chippewa Tribe chose to work within their Community Health Center a place often used for community gatherings and education. They reached members of all ages and also had positive outcomes.

The NNACC program was implemented in an effective manner with attention to tribal culture and traditions, which allowed ITCMI to build respect and trust among local AI organizations that functioned as host organizations. This relationship is evident in that the Navigators were welcomed additions to the tribal clinic and community health staff and were invited to participate in planning and implementation of other health promotion and disease prevention projects and programs. The host sites were very pleased to participate in the project and served as common and trusted sites for new programs to build relationships and reach a large portion of the community. Recruitment averaged 35 participants per site per 12-week session. Challenges included finding a time frame to suit the needs of the target population, i.e., day, evening, and weekends. With the guidance and expertise of the host organization, the ITCMI team was able to reach elders, parents, and members of the broader community. A total of 182 "unduplicated" community members participated in the project at this site. NOTE: Due to conditions beyond ITCMI NNACC staff control, data were lost from both settings, one due to computer IT accidentally reformatting the hard drive of the laptop and the other due to the Navigator's home being robbed and the laptop was stolen. Thus, ITCMI likely reached double the number reported according to the Navigator's anecdotal notes and reports, but the data could not be confirmed.

Rapid City Regional Hospital's (RCRH) Walking Forward Program

The Walking Forward program is the partner from the RCRH. It established a presence on the Pine Ridge Reservation in 2002, has offered navigation assistance since its inception. Key components of Walking Forward include comprehensive patient navigation, community

and patient education, identification of barriers to cancer screening and early detection, and access to cancer clinical trials. As an example of the program's community focused work, several phase II cancer trials have been developed to help shorted treatment duration, as many patients live a median of 140 miles from the cancer center.

As of 2013, over 3,700 AIs participated in various Walking Forward research studies. Critical outcomes included the establishment of trust within tribal communities, identification of barriers to cancer screening, creation of a research infrastructure, higher completion rates and patient satisfaction for patients undergoing radiation treatments, enrollment of patients in phase II trials with excellent clinical outcomes, and the establishment of new research partners within South Dakota and nationally to address new research questions, with the ultimate goal of improving cancer cure rates. Recent analysis suggests that AI cancer patients with screening detectable cancers (cervical, prostate, colorectal, and breast cancer) are now presenting with earlier stages of disease and higher cure rates (Personal communication with Dan Petereit. Manuscript in preparation).

The Pine Ridge Indian Reservation, located in the southwest corner of South Dakota, covers approximately 500 square miles and is home to the Oglala Sioux Tribe. The terrain of this reservation is flat and desolate, and the weather can be harsh, with a lot of wind. One central hospital is located in the reservation town of Pine Ridge, and smaller clinics are located in reservation towns of Kyle and Wanblee. The average distance from Pine Ridge to Kyle is approximately 50 miles, and from Pine Ridge to Wanblee is approximately 80 miles. The IHS on the reservation is chronically underfunded and understaffed. Outside of medical personnel coming out to work off student loans, there is very little incentive to recruit and retain quality medical staff. The Pine Ridge Reservation has a population of approximately 36,000 and an unemployment rate of approximately 86%; the poverty rate is the second highest in the nation.4 Bringing an education program to this population to address cancer and other healthy lifestyle issues was a challenge.

In the first year of the NNACC project, RCRH collaborated with the Oglala Sioux Tribe Health Educator Coordinator for the workshop series. The Tribal Health Educator is a very strong, articulate, educated Lakota woman who is a fluent Lakota speaker, which gave the RCRH NNACC project another level of respect and legitimacy in a community that is often bombarded with outside programs. RCRH started the educational program in Kyle, South Dakota, at the College Center. Workshops were held during the evening and a meal was served, but attendance was low. In the second project year, workshops were held during the day at the Porcupine Health Clinic and a light snack was served. At times, the attendance was standing room only, with approximately 30 people per session. During the third project year, NNACC returned to Kyle but held the workshops during the day at the Kyle Cap Office (Community Building). The numbers increased to almost 40 people per session, with an average increase in knowledge pre-test to post-test of approximately 26%. Over the entire project period, a total of 487 "unduplicated" community members participated in the project at this site.

Great Plains Tribal Chairmen's Health Board (GPTCHB)

The GPTCHB NNACC was a subcontract of the RCRH site (i.e., RCRH provided 1 NNACC workshop series each year and GPTCHB provided 1 NNACC workshop series each year. GPTCHB worked with AIs in Rapid City, the largest city in South Dakota, with a population of approximately 70,000 people. AIs comprise about 14% of the city's population. There are 3 reservations relatively close to Rapid City: Pine Ridge (110 miles), Cheyenne River (170 miles), and Rosebud Sioux (180 miles). The poverty rate among American Indians residing in Rapid City is 51% [4]. Tribal and IHS facilities on the 3 reservations provide primary care services and limited specialty care. Sioux Sans IHS Hospital in Rapid City also provides full health care services to enrolled members of these 3 tribes and primary care services to AIs living in its coverage area. Although most cancer screening tests can be done at the Sioux San IHS facility, patients who need cancer diagnostic tests and treatment are referred to larger hospitals or specialists. In addition to the RCRH, many AI patients in Rapid City go out of state to get cancer treatment, including to the Mayo Clinic in Rochester, Minnesota, about 600 miles from Rapid City.

Prior to the implementation of the NNACC project, GPTCHB's Northern Plains Comprehensive Cancer Control Program had conducted a number of outreach activities, including establishing cancer support groups in Rapid City and surrounding communities. With the support of NNACC, 2 of the support groups developed mission statements and articles of incorporation, and are currently in the process of obtaining 501 C 3 status. The Comprehensive Cancer Control Program already had a trusting relationship with the community, and the relationship became even stronger through collaboration for the NNACC project.

Throughout the project period, GPTCHB NNACC staff worked with 1 host organization, the Oglala Lakota College (OLC) Student Organization. OLC was established in 1971 by the Oglala Sioux Tribe. It was one of the first tribally controlled colleges in the United States. It is sanctioned by the tribe, and its governing body is made up of tribal members. OLC has 9 district college centers, an extension center in Rapid City, a college center on Cheyenne River Reservation, a nursing program, and a master's degree program. The tribe values and promotes Lakota traditions and way of life by incorporating Lakota language and cultural aspects in its curriculum, instruction, and community services. OLC hosts a variety of events, including athletic games and a Halloween party, and offers Lakota language classes. GPTCHB selected the OLC Student Organization because it is trusted by community members and the community has ownership of the college. The Student Organization is visible in the community because it hosts many community events. The Navigator who conducted educational activities for the NNACC project was accepted well by the community. This individual went back every week or so to present educational sessions, which helped to strengthen ties with workshop participants and the host organization. Over time, the community members felt more comfortable asking questions and seeking help from the Navigator. Due to this partnership and the commitment of the NNACC-OLC team, the participation rates doubled (up to 60 for some workshops), leading to moving the event to a larger community building to accommodate the increased number of participants. A total of 349 unduplicated community members participated in the project at this site.

Muscogee (Creek) Nation (MCN)

The MCN is situated in an11-county region south of Tulsa, Oklahoma and has 75,000 enrolled members. The MCN has entered into a compact with the IHS to provide comprehensive medical services to eligible AIs and Alaska Natives living within the established boundaries of the Nation. MCN's general health clinics offer some cancer screening services but no treatments. All cancer treatments are obtained through IHS Contract Health Services. About 21% of American Indians are below poverty level and all counties in the tribal jurisdiction are health professional shortage areas [5].

A community advisory board provided guidance for the project. The advisory board concurred with the recommendation to use community centers for the host organizations and as sites for the workshops. The MCN charters 26 community centers to operate in the central, north, southwest and southeast areas of the tribal boundaries. The MCN NNACC contracted with a community center in each area except for the central area, where an independent contractor was selected to assist with the first workshop series in the Okmulgee area due to time constraints. The Holdenville, Eufaula, and Sapulpa community centers hosted the workshop series. A Holdenville community member actively contacted the MCN NNACC staff to request to host the workshop in their community.

The MCN provided orientation as to assigning keypads, tracking participants, etc. Workshop participants were recruited through community meetings; tribal newspaper; and posting flyers in the community centers, clinics, churches, and other local organizations. The Navigator was interviewed on the tribal radio program prior to the first workshop series in the central area. There were 455 "unduplicated" persons in attendance at the 4 workshop series, which far exceeded the expected 135 unduplicated persons for this supplement site. The Okmulgee (central area) and Sapulpa (north area) workshops averaged 60 persons per session, with some sessions as high as 80. These 2 workshop series included several young participants as well as older participants. The Holdenville and Eufaula workshops averaged 35 persons, with most being elderly. Anecdotal reports from the sessions indicated that the groups sometimes seemed competitive in trying to improve their pre- and post-test scores over other communities. The sessions were informal and many participants enjoyed joking and visiting with others. The Holdenville participants seemed to treat the workshops like a class, and enjoyed making binders of the handouts. Going to the centers felt like going into someone's home, with the community members hosting the event.

Discussion

Researchers who use traditional research methodology frequently attempt to call such research "CBPR" which it is not unless there are true partnerships. They also express frustration with the long amount of time required to create strong, trusting community partnerships. NNACC documents that most of the Partners had previously collaborated in some fashion since 2002. Such long-term relationships evolved into strong trust and respect among all Partners. The time to develop such relationships is well worth the time and effort and provides a strong foundation for future collaboration and research funding.

1st level of partnerships

A genuine effort to build trust among the partners and communities was one of the keys to the project's success. Each site functioned proactively to tailor the standard intervention to their respective geographic and tribal communities. As a team, the partners all shared information and resources.

Another key component that contributed to the successful collaboration among the partners was the transparency of the budget. Administrative tasks (such as IRB processes, communicating and reporting to NIH) were allocated 20% of the total budget. The remaining 80% was split equally among the partners for implementation of the NNACC intervention. This greatly contributes to all Partners taking on different roles and responsibilities, beginning with the writing and revisions to the grant, creating the education intervention, sharing individual strengths with other Partners and overall leadership decision-making roles. Similarly, that each partner hosted a NNACC meeting allowed others to learn and understand more about the host American Indian community, geography, transportation and clinical services. Such knowledge helped Partners provide proactive recommendations and guidance for coping with local challenges.

2nd level of partnerships

Each of the Partners used different strategies and characteristics to identify with whom they wished to collaborate for the local MOA American Indian organization. The MOAs had clearly defined roles and responsibilities that were common to all. However, each Partner selected a MOA for criteria specific to their respective sites. All MOAs were trusted and well-regarded organizations. Some were selected because of the American Indian populations they served (young adults, elders, homeless), others because they were held in regions that rarely were included in cancer education prior to NNACC (e.g., Porcupine, SD and Holdenville, OK). Local lead roles for such decisions was essential for this effective CBPR study.

Local MOA American Indian organizations played an important role in promoting the project and recruiting the participants. In addition, the Native Patient Navigators from local communities already were trusted by community members and were accepted and welcomed by the participants. Each Partner received requests from other American Indian organizations to be a MOA, but budget and protocol limitations preventing such expansion. However, these requests indicate the strong positive reactions by community members and organizations to increase cancer knowledge and healthy behaviors.

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Table 1

Summary of NNACC Partner sites

	Colorado	**Michigan**	**South Dakota**		**Oklahoma**
	NACR	**ITCMI**	**Walking Forward**	**GPTCHB**	**MCN**
Organization information	American Indian, community-based non-profit organization that works locally, regionally and nationally.	A private nonprofit agency that comprises a consortium of Michigan's 12 federally recognized tribes.	American Indian cancer navigation program based at Rapid City Regional Hospital in SD.	A private nonprofit agency that comprises tribal health board membership of 18 tribal leaders in ND, SD, NE, and IA.	Muscogee (Creek) Nation, a federally-recognized tribal nation based in OK
Population served for NNACC project	Urban American Indians in Denver, CO. The majority are from the Northern and Southern Plains and the Southwest.	2 settings: (1) The Sault Ste. Marie Tribe of Chippewa Indians in Michigan's Upper Peninsula and (2) The Saginaw Chippewa Indian Tribe in the Central Lower Peninsula (Mt. Pleasant).	Pine Ridge Reservation (Oglala Sioux Tribe) located in the remote southwest corner of South Dakota.	Urban American Indians in Rapid City, South Dakota. Many are from three nearest reservations (Pine Ridge, Cheyenne River, and Rosebud Sioux).	American Indians 11-county region south of Tulsa, Oklahoma in mixed urban and rural areas.
Frequency of MoA Partner	6 workshop series with 2 different partners each grant year	6 workshop series with the same 2 tribally operated programs	6 workshop series. RCRH implemented NNACC on Pine Ridge Reservation and GPTCHB was subcontracted to RCRH to implement NNACC in Rapid City. The Pine Ridge site used a different setting each year and GPTCHB worked with the same Tribal college organization every year		4 workshop series (MCN started 2 years later as supplement site=2 years for intervention) with 2 different partners each grant year
Community partners for NNACC project	**a.** Denver Indian Health and Family Services (twice) **b.** Denver Indian Family Resource Center (twice) **c.** Colorado Coalition for the Homeless **d.** Southwest Improvement Center	**a.** Elder Service Department and **b.** the Community Health Center.	**a.** College Center, Kyle, SD **b.** Porcupine Health Clinic **c.** Kyle Cap Office Community building.	**a.** Oglala Lakota College Student Organization.	**a.** Okmulgee, OK **b.** Sapulpa, OK **c.** Eufaula, OK **d.** Holdenville, OK
Total unduplicated number of participants	491	182	487	349	455

Table 2

Characteristics and years of NNACC MOA Partners in Denver

MOA	Brief Description of MOA	Years NNACC intervention
Denver Indian Health and Family Services	Partially funded by IHS for education programs and limited clinical services	2009 2011
Southwest Improvement Center (SWIC)	Improvement of affordable housing and living conditions; free meal programs; neighborhood clean-ups	2009
Colorado Coalition for the Homeless	Serves the majority of homeless American Indians living in Denver; education, job training, temporary housing support	2010
Denver Indian Family Resource Center	Provides strong family support program, training people in parenting skills, being a responsible and proactive single parents and several other home and family safety issues	2011 2012