the Chickasaw Nation
DEPARTMENT OF HEALTH

Division of Public Health

Community Health Improvement Plan

2024 - 2027



Chikasha saya. *I am Chickasaw.*

Our vision is to be a nation of successful and united people with a strong cultural identity.

The Chickasaw Nation

We are dedicated to our mission to enhance the overall quality of life of the Chickasaw people.

Core Values

THE CHICKASAW PEOPLE
Our focus and commitment is on the Chickasaw people and improving the quality of life of all Chickasaws. We are empowered and unified in purpose.

CULTURAL IDENTITY
We will preserve our cultural history and incorporate it into everything we do.

SERVANT LEADERSHIP
We are accountable to the Chickasaw Nation, and we put our people first.

SELFLESSNESS
We give of ourselves for the betterment of our people.

CAN DO ATTITUDE
We will work graciously with a Can Do attitude and a solution oriented philosophy by doing the right thing for the right reason.

PERSEVERANCE
We will never quit. We have a warrior tradition.

STEWARDSHIP
We will responsibly use the Chickasaw Nation's resources entrusted to us.

TRUST AND RESPECT
We trust one another and earn the trust of our citizens. We are caring and compassionate.

LOYALTY
We are committed to the Chickasaw Nation, its mission and its goals.

HONESTY AND INTEGRITY
We will do what we say and are honest and trustworthy. We uphold ethical standards and are accountable for our actions.

TEAMWORK
We work as a team with a strong work ethic toward solving the problems of the Chickasaw Nation.

The Chickasaw Nation acknowledges the Department of Health, Division of Public Health and the many departments for their leadership and contributions to creating this 2024-2027 Community Health Improvement Plan.

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From The Chickasaw Nation Secretary of Health

On behalf of the Chickasaw Nation Department of Health, I am pleased to present the 2024-2027 Chickasaw Nation Division of Public Health Community Health Improvement Plan.
It has been six years since we responded to a call for action to address and improve the health and well-being of the citizens of the Chickasaw Nation through the development and implementation of a Community Health Improvement Plan. Since the initial report issued in 2016, we have experienced substantial improvements in areas identified as the highest concerns impacting the overall health of the Chickasaw people. Response measures undertaken by the Chickasaw Nation, the Department of Health and the Division of Public Health during the COVID-19 pandemic demonstrated a new, high level of readiness and effectiveness in addressing emerging health threats. These efforts ensure the resilience of the Chickasaw community in the face of evolving public health challenges.

To further improve the quality of life of the First Americans we serve, we have implemented new clinics and expanded services. Examples of these initiatives include:

- Established the first youth and family wellness obesity clinic, “Empowered Living,” which provides the opportunity to place a strategic focus on reducing childhood obesity with successful results and outcomes.
- Decrease tobacco use among First Americans within the Chickasaw Nation from 28.7% in 2016 to 23.1% in 2021.
- Increased access to healthy and nutritious foods through the expansion of programs and services.
- Increased healthy activities and opportunities to exercise.
- Expansion of clinics and the new Inchokma Mobile Medical Unit improved access to care for many First Americans, advancing our goal of providing preventive, whole-person care toward living healthier, happier and longer lives.

The Chickasaw Nation remains committed to improving the overall quality of life of the Chickasaw people, as well as all who live within the Chickasaw Nation.



From The Chickasaw Nation Secretary of Health (cont.)

Over the next three years, we plan to:

- Further improve and expand access to care so all First Americans in our communities can receive high-quality health care regardless of where they live, learn, work, play, worship and age.
- Continue to increase access to healthy and nutritious foods.
- Provide additional opportunities for physical activity.
- Increase the number of preventive screenings, programs and treatments aimed at reducing the burden of chronic disease.
- Address mental health and substance misuse through innovative and collaborative public health and health care programs.

As you read through this report, I urge you all to find a place in your local community to connect and actively contribute to making a difference. I also encourage you to visit our website at ChickasawNationHealth.*net*, where you will find many opportunities, tools and information about creating a culture of health.

Thank you to our community partners for participating and providing valuable insights on how we can work collaboratively to improve health and well-being across the 13 counties within the Chickasaw Nation treaty territory. It is our hope that you find this community health improvement plan informative and valuable as we work together on identified issues, services, programs, campaigns and achievements impacting our communities.

Sincerely,

Charles Grim, DDS, MHSA
Secretary
Chickasaw Nation Department of Health



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Introduction

The Chickasaw Nation Department of Health (CNDH) plays a vital role in providing programs and services that promote and protect the health of Chickasaws, First Americans and other members of the community. One of CNDH's strategic priorities is to seek public health accreditation. The CNDH Division of Public Health (DPH) ensures that this goal is achieved. DPH is dedicated to enhancing and safeguarding the Chickasaw community's holistic well-being, vitality and safety. Through this commitment, DPH actively pursues disease prevention and takes decisive action to respond to a spectrum of health-related challenges and events, demonstrating a capacity to navigate complex health landscapes. As exemplified by their proactive measures during the COVID-19 pandemic, DPH showcases a high level of readiness and effectiveness in addressing emerging health threats and ensuring the resilience of the Chickasaw community in the face of evolving public health challenges.

The Chickasaw Nation DPH recognizes the importance of obtaining accreditation from the Public Health Accreditation Board (PHAB) as a testament to their unwavering commitment to excellence and community well-being. Accreditation by PHAB signifies a gold standard in public health practices and operations, validating the department's dedication to meeting rigorous national standards. By seeking this accreditation, the Chickasaw Nation DPH aims to not only elevate its own operational standards but also to enhance the trust and confidence of the Chickasaw community and stakeholders. PHAB accreditation serves as a tangible acknowledgment of the department's effectiveness, accountability and capacity to provide high-quality programs and services. Furthermore, this accreditation aligns with the department's overarching goal of continuous improvement. It ensures that it remains at the forefront of best practices in public health, thereby fortifying its position as a reliable and cutting-edge resource for the health and well-being of the Chickasaw community and beyond.
In line with this commitment to excellence, the Chickasaw Nation DPH's pursuit of accreditation underscores its dedication to meeting the specific requirements set forth by PHAB for developing and implementing a robust Community Health Improvement Plan (CHIP). This strategic alignment ensures that the department not only attains accreditation but also adheres to comprehensive standards that promote community health and well-being through a targeted and effective improvement plan.

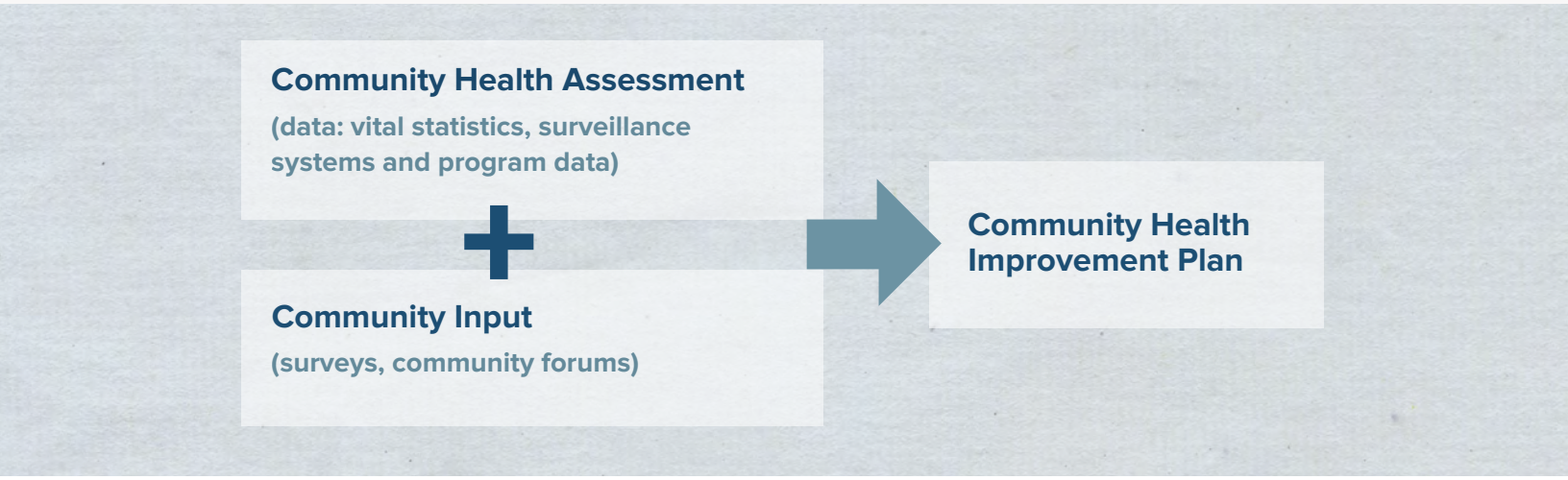


Introduction (cont.)

What Is a Community Health Improvement Plan?

A Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) are foundational components of public health accreditation. Together, the CHA and CHIP represent an overall health improvement planning process, along with the DPH's strategic plan. The CHA identifies critical health needs and priorities through systematic, comprehensive data collection and analysis, while the CHIP is a long-term, organized effort to address public health problems based on the results of CHA findings.

This CHIP is an action-oriented plan that outlines the priority health issues or concerns for a defined community and how they will be addressed. It is designed to be a broad, strategic framework for community health that can be modified as conditions, resources and external environmental factors change. Yet, the plan also includes specific, measurable objectives and strategies advancing and improve the health of the community. It is developed and written to engage multiple perspectives so all community groups and sectors can unite to improve the health and quality of life for those who live, work, learn and play in the communities within the 13 counties of the Chickasaw Nation.



Compliance with PHAB's accreditation standards and measures promotes accountability and demonstrates a commitment to promote, protect and improve the health of Chickasaw Nation communities. Accreditation supports activities that align with the Essential Public Health Services framework to address a range of core public health programs, including health education, health promotion, chronic disease prevention, maternal and child health, injury prevention, emergency preparedness, vital records and health statistics and management and administration.

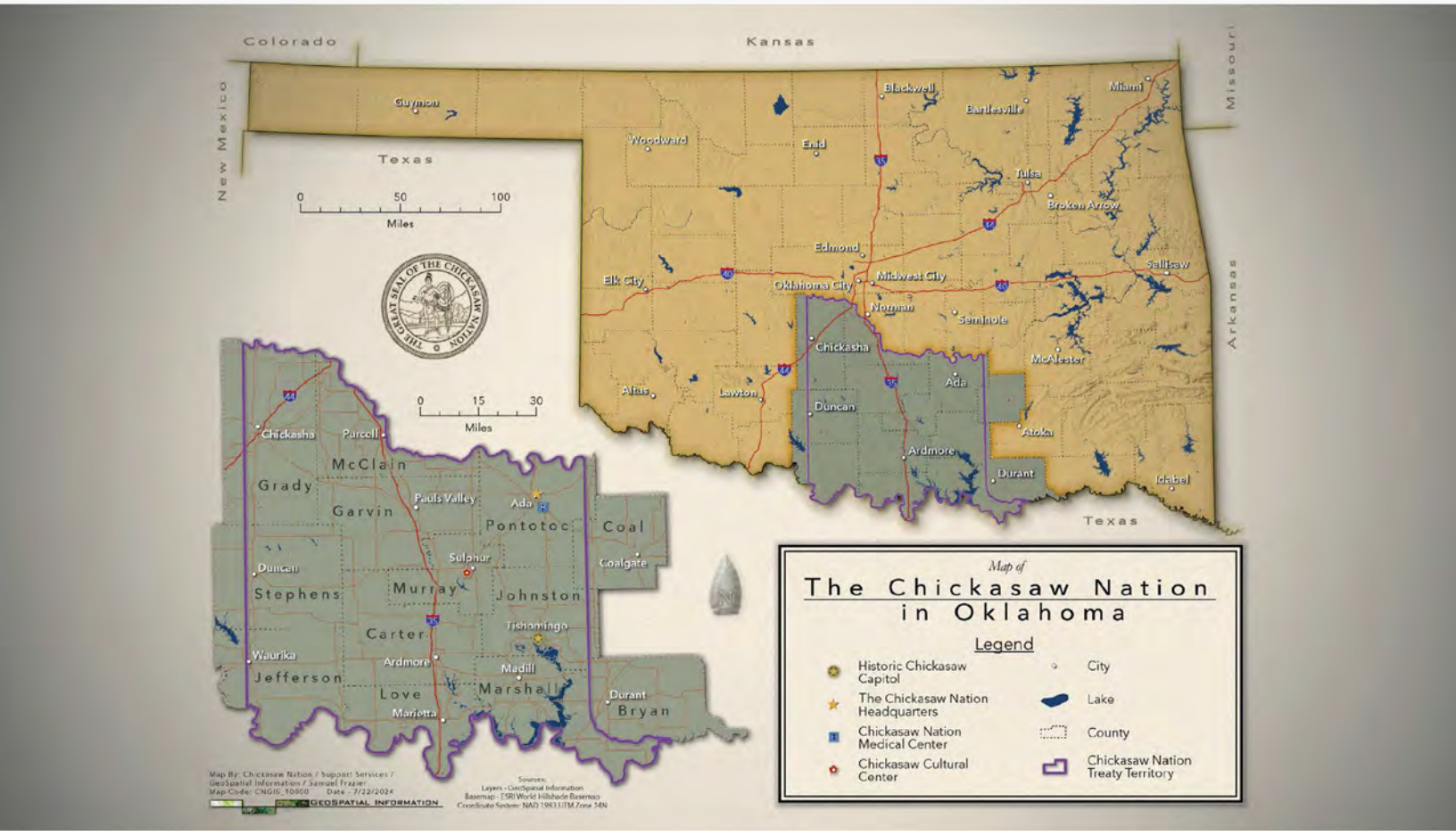
2024-2027 Community Health Improvement Plan

This section describes how the 2024-2027 CHIP was developed, how the priority areas were identified and selected based on data from the Community Health Assessment (CHA) and other data sources, who was involved in the process, how the plan will be implemented and includes a discussion on the social determinants of health. The final section outlines in narrative form the background and needs data for each priority area of the CHIP and in table format the CHIP goals, objectives, performance measures and activities.

Our Community

Through collaborative partnerships, the Chickasaw Nation Department of Health and DPH are committed to providing quality public health services to First Americans residing in the 13-county Chickasaw Nation. Our community consists of First Americans (the preferred term in the Chickasaw Nation for Indigenous people), Chickasaw Nation employees and non-First American Oklahomans residing in the Chickasaw Nation treaty territory, interacting together in collaborative relationships and partnerships.

Therefore, the term 'community' as defined in this plan is inclusive of the 363,993 Oklahomans living within the Chickasaw Nation treaty territory, which is predominantly rural. Approximately 28,311 identify as First American alone and an additional approximately 28,005 identify as First American in combination with another race.[1]



Map 2: Chickasaw Nation treaty territory

1. U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates

2024-2027 Community Health Improvement Plan (cont.)

DPH staff utilized the Mobilizing for Action through Planning and Partnerships (MAPP) model to conduct the CHA and to inform this plan. MAPP is a community-driven strategic planning process for assessing and improving community health. The MAPP model is comprised of a seven-step process with four individual assessments to answer the following:

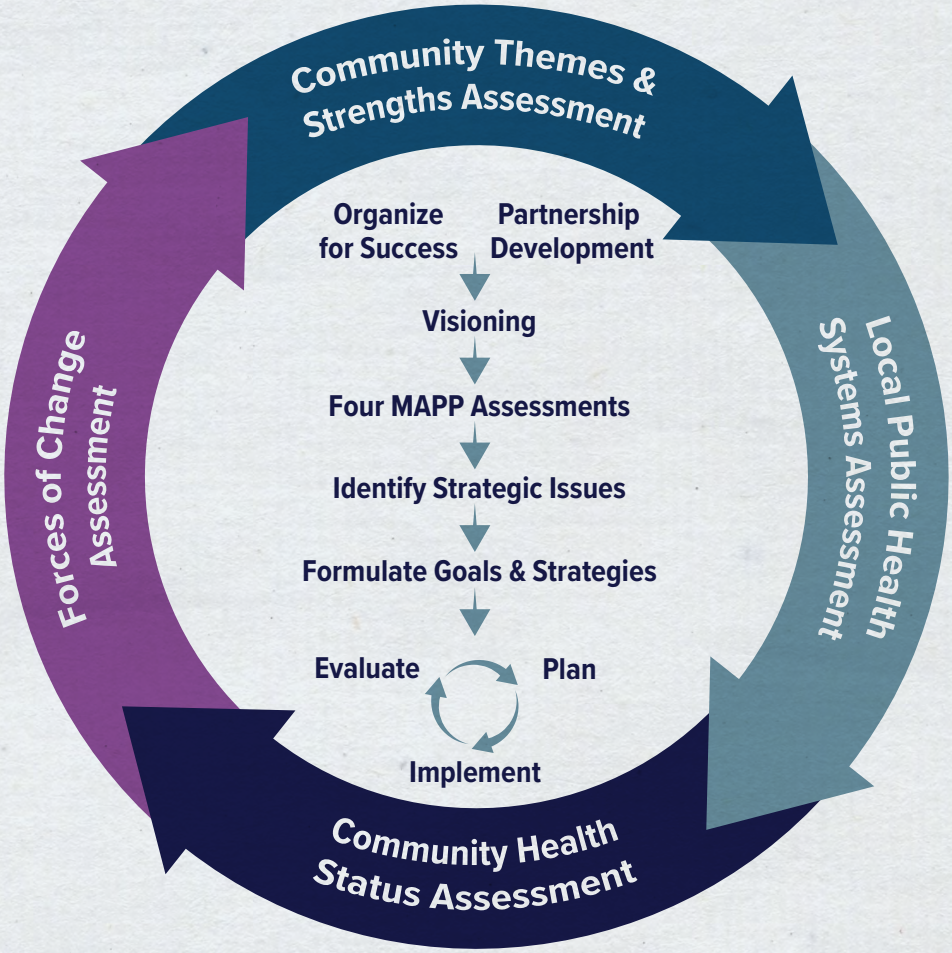
Community Themes and Strengths Assessment
"What is important to our community?" and "How is quality of life perceived in our community?"

Forces of Change Assessment
"What are the forces (e.g., trends, factors, or events), that are, or will, influence the community's health and quality of life, and the tribal public health system?"

Community Health Status Assessment
"What are the health concerns in a community?" "Why do health issues exist?" and "What factors contribute to poor health outcomes?"

Tribal Public Health System Assessment
"What are the components, activities, competencies and capacities of our tribal public health system?" and "How are the essential services being provided to our community?"

Figure 2: Mobilizing for Action Through Planning and Partnerships



Mobilizing for Action through Planning and Partnerships (MAPP) process was a joint project of the nonprofit National Association of County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC) in 2001.

2024-2027 Community Health Improvement Plan (cont.)

The synergy between the Community Themes and Strengths (CT&S) assessment, Forces of Change (FOC) assessment, Community Health Status Assessment (CHSA) and Tribal Public Health System Assessment within the MAPP process creates a powerful framework for understanding and enhancing community health. The CT&S assessment uncovers the intrinsic strengths and resources within a community, fostering a foundation for positive growth. Simultaneously, the FOC assessment illuminates external factors that may impact the community, prompting proactive measures to navigate changes effectively. These insights from CT&S and FOC assessments inform the CHSA, providing a comprehensive understanding of the community's health status, prevalent disparities and prioritized health concerns. Integrating cultural considerations, the Tribal Public Health System Assessment ensures that planning and interventions are tailored to the unique attributes of tribal communities. Together, these assessments form a cohesive narrative, guiding stakeholders to develop targeted strategies leveraging community strengths, address challenges and promote health equity. This holistic approach reinforces the MAPP process's commitment to responsive and inclusive public health planning, ensuring the well-being of diverse populations.

Outcomes from these four assessments were analyzed and used to inform the overall health improvement planning process, including the DPH Strategic Plan. Outcomes from the Community Themes and Strengths and Forces of Change Assessments are summarized in the following section. Outcomes from the Community Health Status are summarized in the DPH CHA, and Tribal Public Health Systems Assessments were utilized to inform the DPH Strategic Plan.



2024-2027 Community Health Improvement Plan (cont.)

Community Engagement and Assessment

MAPP begins with active community engagement, involving diverse stakeholders such as residents, community organizations, health care providers and government agencies. Comprehensive assessments, including the Community Themes and Strengths (CT&S), Forces of Change (FOC), Community Health Status Assessment (CHSA) and Tribal Public Health System Assessment, provide a thorough understanding of community dynamics, strengths, challenges and health needs.

DPH engaged the community and stakeholders in the Community Themes and Strengths and Forces of Change Assessments described in the previous section. Community input was sought through a health survey conducted among those who live, work or spend time in Chickasaw Nation's jurisdiction. The purpose of the survey was to better understand public perceptions of a range of health issues. Respondents were 178 (62%) First American (First American and Alaskan Native), followed by 99 (35%) White or Caucasian.[2] The survey asked respondents about critical social, economic and health concerns, access to services and experiences with the public health and health care system. The top social and environmental concerns affecting respondents, their families and social circles are found in Tables 1 and 2.

Table 1: Top Health Concerns Identified as Affecting Survey Respondents, Families or Close Social Circle

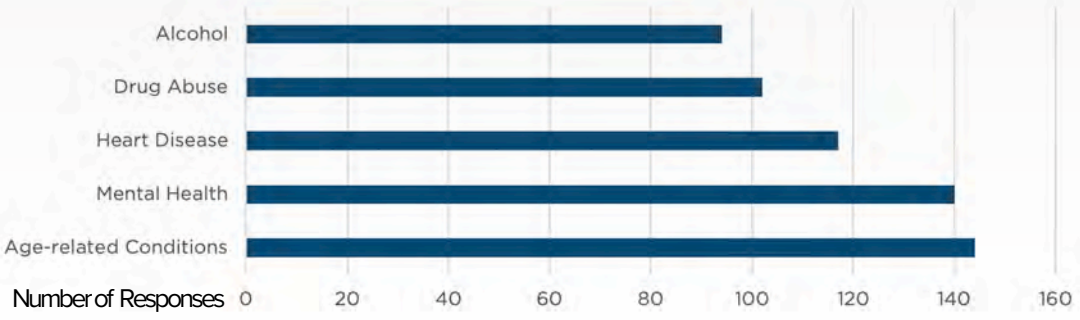
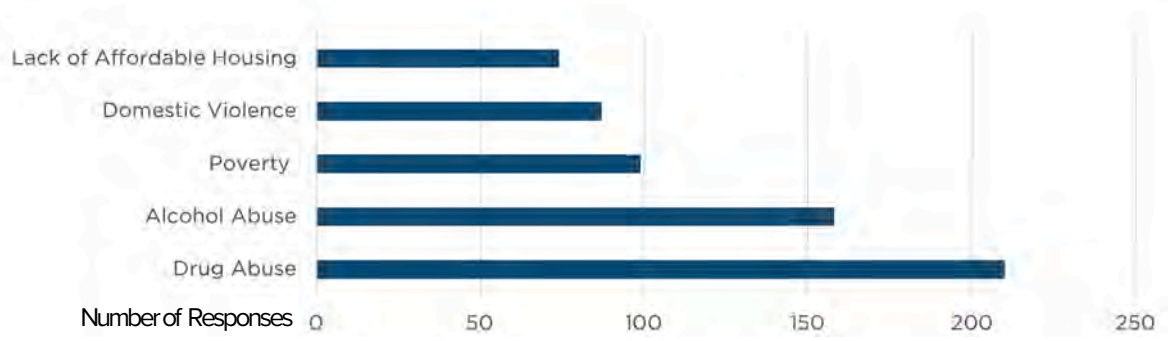


Table 2: Top Social Concerns Identified as Affecting Survey Respondents



2. Chickasaw Nation, Community Health Survey 2019

2024-2027 Community Health Improvement Plan (cont.)

Forces of Change: Data Analysis and Synthesis

In the Forces of Change section of the MAPP (Mobilizing for Action through Planning and Partnerships) process, communities identify and analyze the external factors and trends that influence health outcomes and community well-being. These forces can include social, economic, environmental, political and technological factors, among others. By examining these forces, communities gain insight into emerging issues, opportunities and challenges impacting public health priorities and strategies.

Through collaborative engagement with stakeholders and data-driven analysis, communities can anticipate and adapt to changes effectively, ensuring their health planning efforts remain relevant, responsive and proactive. Ultimately, the Forces of Change section empowers communities to navigate complex dynamics and leverage opportunities for promoting health equity and resilience.

The collected data from assessments were analyzed and synthesized to identify patterns, trends and priority health issues. Stakeholders collaborated to interpret findings, ensuring a shared understanding of the community's health status and determinants.

DPH stakeholders participated in a facilitated consensus-building process used to generate answers to the following question: "What is occurring or might occur affecting the health of our community or local public health system?" Participants brainstormed trends, factors and events, organizing them into common themes and providing an overarching 'force' for each of the category columns. The following are examples of trends, forces and events:

- Trends: Rising rates of chronic diseases such as diabetes and obesity, changes in mental health status or increasing life expectancy.
- Factors: Aging population, increasing diversity or changes in household composition
- Events: One-time occurrences, such as a hospital closure, a natural disaster or the passage of new legislation.



2024-2027 Community Health Improvement Plan (cont.)

After the consensus workshop, participants were asked to answer the second assessment question: "What specific threats or opportunities are generated by these occurrences?" Participants generated threats and opportunities for all the ideas within the following force of change categories:

Public Health Information	
Threats Posed	**Opportunities Created**
• Low health literacy • Difficult to reach isolated communities • Inaccurate and unreliable information about communicable diseases • Dependence on social media for health information • People not receiving the information and/or education necessary to respond to health threats	• Increase communication between Chickasaw Nation departments • Utilize Chickasaw Nation social media sites (Facebook, Twitter, Instagram, etc.) • Utilize messaging avenues (CNTV, Holisso Newsletter, Chickasaw Times) • Increase research by CDC into specific areas • Public Health nursing programs (health fairs, Caring Van, etc.) • Expand reach of health education programs/ services • Provide reliable, up-to-date, accurate information

Access to Care	
Threats Posed	**Opportunities Created**
• Health literacy • Lack of providers • Long driving distance to hospitals/clinics • Loss of marketplace insurers under ACA • Limited transportation options to health facilities available for those living in poverty, rural areas and/or with disabilities	• Virtual visits • Telemedicine • Mobile medical units • Section 1115 waiver • Public Health nursing programs (Caring Van) • Increase response to state sponsored waivers on how they provide Medicaid programs • Transportation department drives patients to and from appointments

2024-2027 Community Health Improvement Plan (cont.)

Health Behaviors	
Threats Posed	**Opportunities Created**
• Advertising • Convenience • Cadillac Tax • Drug/Alcohol abuse • Unsafe neighborhoods • Compliance with doctor's orders • Built environment inhibits physical activity • Lack of access to grocery stores and fresh, healthy food • Survival mode (e.g. eat fast food or nothing at all)	• Individual Development Plans • Employee wellness program • Chickasaw Travel Stop healthy sections • Inspire children to create a better future for themselves • Health behavior-focused education (cooking classes, recipes, workout routines) • Implement evidence-based programs to inspire health behavior changes



Community Health Status Assessment: Framework of Analysis

The MAPP Community Health Status Assessment (CHSA) is a systematic process involving gathering, analyzing and interpreting data to understand the current health status and factors influencing health within a community. This assessment typically includes a comprehensive review of demographic data, health indicators, social determinants of health, environmental factors and health-related resources. By conducting the CHSA, communities can identify priority health issues, assess health disparities and understand the underlying factors contributing to health outcomes. The findings from the CHSA inform the development of strategic plans and interventions aimed at addressing community health needs and improving population health outcomes. Ultimately, the CHSA serves as a foundational step in the MAPP process, providing essential data and insights to guide community health planning and action.

To identify the issues holding the greatest priority for the community, the indicator results were evaluated within the County Health Rankings Model framework created by the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation. The framework emphasizes factors helping improve the overall health of a community. This model is comprised of three major components:

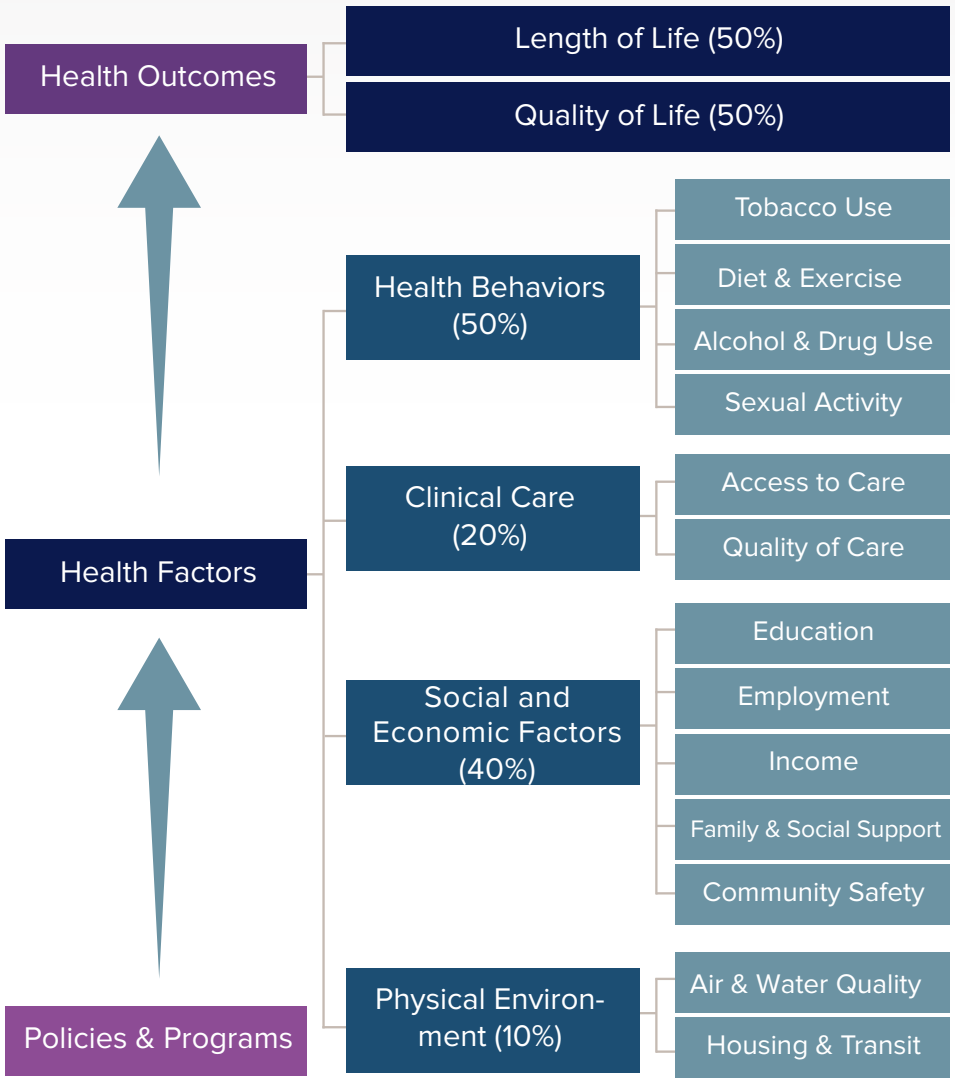
Health Outcomes

This component evaluates the health of a community as measured by two types of outcomes: how long people live (Mortality/Length of Life) and how healthy people are when they are alive (Morbidity/ Quality of Life).

Health Factors

Factors that influence the health of a community include the activities and behaviors of individuals (Health Behaviors), availability and quality of health care services (Clinical Care), the socioeconomic environment people live and work in (Social and Economic Factors) and the attributes and physical conditions in which we live (Physical Environment). Although an individual's biology and genetics play a role in determining health, the community cannot reliably or directly influence or modify these conditions, so these factors are not included in the model. These factors are built on the social determinants of health (SDOH) concept.

Figure 3. County Health Rankings Model



Community Health Status Assessment: Framework of Analysis (cont.)

Programs and Policies

Policies and programs at the local, state and federal levels have the potential to impact the health of a population, e.g., smoke-free policies or public funding for vaccines. As illustrated, policies and programs influence health factors, which in turn impact the health outcomes of a community. Health outcomes are improved when policies and programs are in place to correct negative health factors and strengthen positive health factors.

Health Equity Lens

The health equity lens is a comprehensive and inclusive approach seeking to analyze and address health issues by considering and mitigating disparities, ensuring fair and just opportunities for everyone to attain their highest level of health. In other words, the health equity lens is like putting on glasses helping us see and fix health problems in a way that is fair for everyone, ensuring everyone has a chance to be as healthy as possible.

Understanding the disproportionate impact of social determinants of health on underserved populations is crucial. Health equity is defined as all people having "the opportunity to 'attain their full health potential' and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance." A robust assessment of the larger social and economic factors affecting a community (e.g., housing, employment status, the built environment, etc.) should capture the disparities and inequities existing for traditionally underserved groups. According to Healthy People 2030, a science-based platform that provides 10-year national objectives for improving the health of all Americans, achieving health equity requires focused efforts at the societal level to address avoidable inequalities, especially among those who have experienced socioeconomic disadvantage or historical injustices.

Employing a health equity lens underscores the importance of tailoring interventions to address the unique challenges faced by underserved communities. By focusing on targeted strategies that account for social determinants, such as cultural nuances, historical contexts and systemic barriers, health initiatives become more effective in mitigating disparities. Recognizing health outcomes are intricately linked to social and economic conditions, the comprehensive assessment and planning process aims to empower communities and foster resilience in the face of health challenges.

Collaborative efforts with community stakeholders play a pivotal role in promoting health equity. Engaging community members in the decision-making process ensuring interventions are contextually relevant and sustainable. This participatory approach not only fosters a sense of ownership and trust but also enables the identification of community strengths leveraged for positive health outcomes. Through ongoing dialogue and partnerships, communities can collectively work toward removing barriers to health equity and building a foundation for long-term well-being.

Guided by a health equity lens, the community health assessment and improvement planning process ensured data encompassed various social and economic indicators, specifically for populations such as First Americans, the elderly and children. This approach aligns with the commitment to addressing disparities and fostering a more inclusive and equitable health care system.

Health Priority Setting

Through facilitated discussions and consensus-building activities, stakeholders prioritized the health issues identified during the assessments. Criteria for prioritization included the severity of the health problem, potential for intervention impact, community interest and readiness and available resources.

According to the 2021 Annual Report published by America's Health Rankings, United Health Foundation, Oklahoma ranks 44th in the nation in overall health outcomes. This low health ranking is consistent with previously published reports, indicating Oklahoma remains one of the states with the poorest health outcomes. The data indicates immediate actions must be taken to improve the overall health of our state, the communities in which we live, the Chickasaw Nation citizens and other First Americans to affect change and strengthen the health of our future generations. There are many challenges associated with social and structural determinants of health, unhealthy behaviors and traditions or inherited familial traits, which all must work to overcome; however, with challenges come opportunities. The Chickasaw Nation DPH CHIP not only identifies those challenges but also provides a roadmap with strategies, goals and objectives that will optimizing the state of public health across the Chickasaw Nation.

To drive health improvement and enhance the performance of the Chickasaw Nation's public health system, leadership across the Chickasaw Nation assembled a diverse group of partners from various organizations to create a practical roadmap that enables and informs meaningful action (a complete list of participants can be found in the appendix). This collaborative process was deployed to promote inclusion and foster shared ownership of an actionable plan, which included compiling an assessment of the Chickasaw Nation's community health, identifying priority health areas and defining goals and objectives for advancing the health of the Chickasaw Nation community.

The health issue prioritization process was completed in three steps:

Step 1:
Identifying potential health issues. Ascendant Healthcare Partners reviewed data collected in the Community Health Status Assessment to identify issues in which the Chickasaw Nation performed worse than the state of Oklahoma. Consideration was given to issues having a worsening trend, even if county performance was better than state.

Step 2:
Using results from other assessments to validate health issues revealed in step one.
The team used the other assessments to determine:

- Common issues across multiple assessments.
- Community attitudes toward the health issues.

This helped determine whether the community saw the issue as important.

Step 3:
Narrowing priorities by considering the following guiding questions:

- Are resources currently available within the community to address the issue?
- Are there opportunities to achieve collective impact through partnerships?

Health Priority Setting (cont.)

This prioritization process brought the 2024-2027 CHIP into being and will serve as a three-year blueprint to enhance the public's health. The responsibility to improve the health of the community does not, and should not, fall on the shoulders of one person, one community group or one organization. It will take a coordinated community effort across all sectors (education, health care, business, government, etc.) to improve the health of the Chickasaw Nation. Success depends on the ability to work collaboratively with an intersectional approach to address a selected priority area.

By actively involving stakeholders in every step of the process, the MAPP approach ensures health priorities are grounded in the community's unique context, fostering a sense of ownership and sustainability for the identified interventions. This collaborative and data-driven approach enhances the likelihood of achieving meaningful and lasting improvements in community health.



Understanding the Social Determinants of Health

In addition to our individual genetics and lifestyle choices, many factors have an influence on health, including the social determinants of health (SDOH), which are the conditions in the environments where we are born, live, learn, work, play, worship and age. These determinants are a broad range of personal, social, economic and environmental factors that affect health, well-being, functioning and quality-of-life outcomes. Risks can be grouped into five domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment and social and community context.

When the social determinants of health contribute to disparities and inequities within a population, the result is poorer health outcomes and increased rates of morbidity and mortality. Moreover, inadequate access to quality health care contributes to only 10% of poor health and premature deaths, while unhealthy behaviors account for 40% of illnesses and premature deaths in the United States.

When states such as Oklahoma, and especially our rural communities within the Chickasaw Nation treaty territory, exhibit a higher-than-average incidence of chronic diseases, disabilities and premature deaths, it is not surprising to learn our communities are challenged by limited access to nutritious food, lack of physical exercise, increased rate of tobacco use and excessive alcohol consumption.



Health Priorities

Social relationships, both quantity and quality, affect mental health, health behavior, physical health and mortality risk. Studies have shown social relationships have short and long-term effects on health, for better and for worse, and these effects emerge in childhood and cascade throughout life to foster cumulative advantages or disadvantages in health. How people interact with their social and physical surroundings is shaped by individual and socioeconomic characteristics such as gender, age, race or ethnicity, education level, income status, religious affiliation, housing situation and geographic location. Throughout life, everyone is exposed to social conditions promoting or undermine health, and over time, these exposures accumulate to create growing advantages or disadvantages for health in socially patterned ways.

To make a positive impact on these challenges and on the overall health status of individuals and communities, the Chickasaw Nation Community Health DPH Improvement Plan aims to address these issues at the population level. The ways in which the SDOH was considered in the planning are described throughout the plan.



Chronic Disease



Behavioral Health



Access to Care

With the priority health areas determined from survey feedback and data within the CHA, the CHIP Steering Committee (members can be found in the appendix below) created priority area taskforces. It charged them with identifying impact goals for each of the three priority health areas. Proposed goals were presented by task force chairs to the CHIP Steering Committee for approval. Once priority area goals were aligned, the task forces gathered to define specific, measurable, achievable, realistic, time-bound, inclusive and equitable (SMARTIE) objectives for each priority area's goal. After a series of meetings, the CHIP Steering Committee reached a consensus on goals and objectives for each priority area defining the path forward for enhancing the public health of the Chickasaw Nation.

Health Priorities (cont.)

Alignment with Tribal, National and State Priorities

Aligning health goals and objectives with state and national health goals strengthens partnerships, enhances resource allocation, improves data tracking and evaluation, increases policy influence and promotes health equity and collaboration. By working together toward shared objectives, the Chickasaw Nation can advance its mission of improving the health and well-being of its community members while contributing to broader efforts to improve public health outcomes regionally and nationally.

Aligning the health goals and objectives of the Chickasaw Nation with state and national health goals offers several benefits and opportunities for improving population health and well-being:

1. Consistency and Coordination:
Aligning health goals ensures efforts are coordinated and complementary across different levels of government and health care systems. By sharing common objectives, resources and strategies, the Chickasaw Nation can work collaboratively with state and national entities to address shared health priorities and maximize the impact of interventions.

2. Resource Leveraging:
Aligning with state and national health goals allows the Chickasaw Nation to leverage resources, funding opportunities and expertise available at these levels. By participating in statewide and national initiatives, the Chickasaw Nation can access funding streams, technical assistance and partnerships to support its health programs and initiatives, enhancing capacity and effectiveness.

3. Data Sharing and Benchmarking:
Aligning health goals facilitates data sharing and benchmarking with state and national entities, enabling the Chickasaw Nation to track progress, monitor health outcomes and evaluate the effectiveness of interventions. By using standardized metrics and indicators, the Chickasaw Nation can compare its performance against state and national averages, identify areas for improvement and implement evidence-based strategies to address disparities and gaps in health outcomes.

4. Policy Influence:
Aligning with state and national health goals increases the Chickasaw Nation's influence and visibility in shaping health policy and priorities at these levels. By advocating for policies supporting tribal health priorities and align with state and national objectives, the Chickasaw Nation can influence decision-making processes, promote health equity and address systemic barriers to health and well-being.

5. Health Equity and Collaboration:
Aligning health goals fosters a shared commitment to promoting health equity and collaboration across tribal, state and national boundaries. By working together to address common health challenges and disparities, the Chickasaw Nation, state agencies and federal entities can create more inclusive and responsive health systems prioritizing the needs of all populations, including tribal communities.

Health Priorities (cont.)

CNDH Strategic Plan

The Chickasaw Nation Department of Health's 10-year strategic plan is a visionary roadmap centering on enhancing the overall experience for both customers and employees, optimizing performance and efficiency, advancing technology systems and analytics, expanding services and ensuring the sustainable allocation of resources to achieve comprehensive and lasting improvements in health care delivery.

Healthy People 2030

Healthy People 2030 (HealthyPeople.gov/) is the nation's health improvement plan. It provides national objectives for improving the health of all Americans over 10 years. Healthy People 2030 uses dozens of data sources to set national targets and track progress toward achieving objectives.

Oklahoma State Health Improvement Plan

The Oklahoma State Health Improvement Plan (OHIP) (Oklahoma.gov/health/health-education/data-and-statistics/oklahoma-state-health-improvement-plan.html) is about the health of all Oklahomans. The OHIP flagship priorities include Tobacco Use, Obesity, Child Health and Behavioral Health.

Tribal Public Health System Assessment: Developing Goals and Objectives

The MAPP Tribal Public Health System Assessment is a systematic evaluation process aimed at understanding the structure, function and capacity of the public health system within tribal communities. This assessment typically involves gathering data on key components such as governance, infrastructure, workforce, financing and essential public health services. By conducting the Tribal Public Health System Assessment, tribal communities can identify strengths, gaps and areas for improvement within their public health systems. The findings from this assessment inform strategic planning efforts, resource allocation decisions and capacity-building initiatives to strengthen tribal public health infrastructure and enhance the delivery of public health services. Ultimately, the Tribal Public Health System Assessment is a critical step in the MAPP process, helping tribal communities to better understand and address the unique public health challenges and opportunities they face.

Once priorities were established, the stakeholders worked collaboratively to develop specific health goals and measurable objectives for addressing the identified issues. Goals and objectives are aligned with the community's strengths and resources to ensure realistic and achievable outcomes.

By leveraging insights gleaned from the Tribal Public Health System Assessment, the DPH aligned priorities with the pressing health needs identified within the Chickasaw Nation. For instance, data reveals elevated rates of chronic diseases like diabetes and heart disease, emphasizing the urgency of prevention and management efforts. Similarly, mental health and substance abuse challenges underscores the necessity of prioritizing behavioral health initiatives. Identifying barriers to accessing health care services highlights the need to focus on improving access to care through policy advocacy and service expansion. By strategically targeting these priority areas, the DPH aims to enhance health outcomes and promote well-being among Chickasaw Nation community members.

Priority Area 1: Chronic Disease

Chronic diseases and conditions include tobacco-related illnesses, such as heart disease, stroke, Type 2 diabetes and cancer. They are among the most common health problems affecting people of all ages, socioeconomic statuses and ethnicities. Risk factors, including lack of physical activity, poor nutrition, tobacco use, excessive alcohol use, the environment and social and economic, cause much of the illness, suffering and early death related to chronic diseases and conditions. Health improvement goals are centered around increasing cross-sector collaboration, early detection, disease management and reducing the burden of obesity.

CNDH uses ABLE measures to monitor continuous quality improvement goals and prevention. These ABLE measures, standing for Assess, Build, Learn and Engage, constitute a comprehensive framework in quality improvement within various industries, particularly health care. The first step, assess, involves systematically evaluating existing processes and outcomes to identify areas for improvement. This may include data analysis, performance metrics and feedback from stakeholders. The second step, build, focuses on developing and implementing targeted interventions based on the assessment findings. This phase emphasizes the creation of innovative solutions, the enhancement of existing processes and the integration of best practices to address identified gaps and inefficiencies. The learn phase encourages a culture of continuous improvement by analyzing the results of implemented changes, fostering a learning environment and adapting strategies as needed. Lastly, the engage phase emphasizes collaboration and communication among stakeholders, including health care providers, administrators and patients, to ensure sustained improvements and the alignment of efforts toward common quality goals. ABLE measures provide a structured and adaptable approach, fostering a cycle of improvement that enhances the overall quality and effectiveness of systems and services. These chronic disease measures were developed and derived with the use of the Able Health by Health Catalyst quality measures.[4]

Four overarching goals were created to address the significant health challenges facing the First American population within the Chickasaw Nation, with a particular focus on chronic diseases and obesity.

Goal 1:	Increase cross-sector collaboration for education, prevention, early detection, treatment and management of chronic diseases and conditions to improve health equity.
Goal 2:	Promote cross-sector collaboration to increase awareness and access to early detection screenings.
Goal 3:	Reduce the burden of chronic disease among the First American populations through practical, evidence-based treatment and/or disease management programs.
Goal 4:	Reduce the burden of obesity among First American populations within the Chickasaw Nation.

Priority Area 1: Chronic Disease (cont.)

Goal 1: Increase Cross-Sector Collaboration for Chronic Disease Management.
Chronic diseases such as diabetes, heart disease and cancer disproportionately affect First American communities, including the Chickasaw Nation. By fostering collaboration across sectors such as health care, education and community organizations, Goal 1 aims to improve health equity by ensuring that individuals receive comprehensive care and support for the prevention, early detection, treatment and management of chronic conditions.

Goal 2: Promote Early Detection Screenings.
Early detection screenings are critical for identifying chronic diseases in their early stages when interventions are most effective. Goal 2 seeks to increase awareness of the importance of early detection screenings and improve access to these screenings within the Chickasaw Nation community. By promoting cross-sector collaboration, this goal aims to remove barriers to screening services and ensure that individuals have timely access to preventive healthcare.

Goal 3: Reduce Burden of Chronic Disease Through Evidence-Based Treatment.
Chronic diseases impose a significant burden on the health and well-being of First American populations, leading to increased morbidity and mortality rates. Goal 3 focuses on reducing this burden by implementing practical, evidence-based treatment and disease management programs tailored to the needs of the Chickasaw Nation community. By leveraging proven interventions, this goal aims to improve health outcomes and enhance quality of life for individuals living with chronic conditions.

Goal 4: Reduce Burden of Obesity.
Obesity is a major risk factor for chronic diseases and other health problems, and it disproportionately affects First American populations. Goal 4 targets obesity specifically within the Chickasaw Nation community, aiming to reduce its prevalence and associated health risks through comprehensive strategies such as promoting healthy eating, increasing physical activity and addressing environmental factors that contribute to obesity. By prioritizing obesity prevention and intervention efforts, this goal seeks to improve overall health and well-being among Chickasaw Nation community members.

Overall, these goals were developed to address the complex interplay of factors contributing to chronic diseases and obesity within the Chickasaw Nation community, with a focus on promoting health equity, prevention, early detection, evidence-based treatment and management strategies.

Priority Area 1: Chronic Disease (cont.)

Goal 1: Cross-Sector Collaboration

The Chickasaw Nation offers a variety of programs and services, including nutrition, health and fitness and youth and family wellness clinics, and there are opportunities to collaborate across multiple Chickasaw Nation departments and programs to promote well-being in the community.

Goal 1 - Increase cross-sector collaboration for the education, prevention, early detection, treatment and management of chronic diseases and conditions to improve health equity among First Americans.
Performance Measures: *How We Will Know We are Making a Difference* **Short term:** Increase in the number of staff designated to support outreach activities during community events. **Long term:** Increase the proportion of, and participation in, proactive, public health programs and policies across the Chickasaw Nation.
Objectives:
CD 1.1 By 2027, increase the number of internal partners and community members to 350 annually who have received training on Adverse Childhood Experiences and Resiliency among children ages 0-8 years.
CD 1.2 By 2027, attend eight health fairs to provide informational/educational health materials annually including Head Start and the Elders Conference.
CD 1.3 By 2027, maintain five published communication pieces promoting the Oklahoma Tobacco Helpline annually.
CD 1.4 By 2027, provide five tobacco prevention trainings to grade-level schools and clinics annually.
CD 1.5 By 2027, increase the number of Chickasaw Nation facilities implementing a smoke-free policy by one.
CD 1.6 By 2027, increase the number of dietitians integrated in the pediatrics department to assist in the promotion of proactive strategies for chronic disease prevention.
CD 1.7 Increase the number of participants for each of the Chickasaw Nation 5K runs by 2% annually by 2027.
CD 1.8 By 2027, create a surveillance system to identify and track the social determinants of health of First Americans utilizing the Chickasaw Nation Health Care System.

DPH is committed to empowering tribal programs and community members through comprehensive training on adverse childhood experiences (ACEs). Recognizing the profound impact ACEs can have on well-being, DPH is dedicated to equipping individuals with the knowledge and skills to understand, prevent and address these experiences effectively. Through tailored programs, workshops and accessible resources, DPH aims to foster a community-wide understanding of ACEs, providing practical tools to mitigate their effects and create a supportive environment. By prioritizing education and awareness in CD 1.1, DPH strives to enhance resilience within the community, ultimately contributing to the overall health and well-being of Chickasaw individuals and families.

Priority Area 1: Chronic Disease (cont.)

DPH is poised to make a meaningful impact on community health by actively engaging in health education initiatives at events such as Head Start Health Fairs and the Elders Conference. Leveraging its expertise, DPH envisions creating interactive and tailored health education programs catering to the unique needs of both young children participating in Head Start Health Fairs and the elderly community attending the Elders Conference. Through engaging presentations, workshops and resource distribution, DPH aims to disseminate valuable information on topics ranging from preventive care to nutrition, fostering a culture of well-informed health decisions. By actively participating in these community events, with CD 1.2 DPH seeks to empower individuals of all ages with the knowledge and tools to make informed choices, promoting a healthier and more resilient Chickasaw community.

Disseminating information about the Oklahoma Tobacco Helpline through various communication channels plays a pivotal role in benefiting the community served by DPH. By publishing communication pieces, DPH ensures that crucial details about the Oklahoma Tobacco Helpline are readily accessible to community members. This information is a beacon for individuals seeking support to quit tobacco use, providing them with a vital resource to initiate positive lifestyle changes. The communication pieces serve as educational tools, raising awareness about the harmful effects of tobacco and connecting community members with the necessary assistance to overcome addiction. Ultimately, by facilitating easy access to the Oklahoma Tobacco Helpline, DPH contributes to fostering a healthier and tobacco-free community, promoting overall well-being and reducing the prevalence of tobacco-related health issues within the Chickasaw Nation with CD 1.3.

The Chickasaw Nation has actively taken steps to help reduce the burdens and instances of chronic diseases on Chickasaw citizens and First Americans; the Diabetes Care Center, the addition of the Looapilå hypertension clinic and messaging campaigns to increase the number of screenings amongst those in our community. The DPH's own health promotion efforts around spreading awareness and providing free 5K runs are a few examples of the many programs offered to increase healthy behaviors and lower instances of chronic disease in our community.

Closing prevention care gaps is a critical objective within health care systems, aiming to ensure that individuals receive timely and comprehensive preventive care to maintain and improve their overall health. One key strategy involves leveraging technology to enhance communication and coordination among health care providers, allowing for the seamless sharing of patient information across different points of care. Electronic health records (EHRs) play a pivotal role in this process, enabling health care teams to access a patient's complete medical history, track preventive care recommendations and send timely reminders for upcoming screenings or vaccinations. CNDH plans to implement a more robust EHR by 2026. By leveraging technology to bridge communication gaps, health care providers can proactively address preventive care needs and engage patients in their own health management.

Education and community outreach are essential components of closing prevention care gaps. CNDH plans to implement more targeted campaigns to raise awareness about the importance of preventive care and the specific screenings or vaccinations recommended for different age groups and risk profiles. Community health fairs, informational sessions and partnerships with local organizations can help disseminate crucial information and encourage individuals to take an active role in their preventive health care. By fostering a culture of health literacy and community engagement, health care providers can empower individuals to prioritize and pursue preventive care, ultimately contributing to the reduction of gaps in preventative services.

Priority Area 1: Chronic Disease (cont.)

Furthermore, data analytics and population health management strategies that are critical components of the new EHR will play a crucial role in identifying and addressing prevention care gaps at a broader scale. Analyzing health data will allow CNDH to pinpoint trends, disparities and areas with lower adherence to preventive care guidelines. Armed with this information, health care providers can implement targeted interventions, outreach programs and resource allocation strategies to address specific needs within the community and reduce systemic barriers to preventive care. By embracing a data-driven approach, we can tailor efforts to the unique needs of our patient population, ultimately leading to more effective prevention and improved health outcomes.

Goal 2: Early Detection

"Cancer is the second leading cause of death in the U.S., but many kinds of cancer can be prevented or detected early. Leading risk factors for preventable cancers are smoking, getting too much ultraviolet (UV) radiation from the sun or tanning beds, being overweight or obese and consuming too much alcohol."[3] Smoking cigarettes is linked to 80-90% of lung cancer deaths in the U.S.[4] The four most diagnosed cancers in the U.S. are breast, prostate, lung and bronchus and colorectal. The all-cancer age-adjusted death rate across the U.S. is 171.2 per 100,000, but men are nearly 30% more likely to die from cancer than women.[5] Oklahoma AI/ANs experience the second highest age-adjusted death rate due to cancer among all racial groups. The age-adjusted death rate for Oklahoma AI/ANs is 191 per 100,000, which is 8% higher than the overall death rate.[6]

Goal 2 - Promote cross-sector collaboration to increase awareness and access to early detection screenings.
Performance Measures: *How We Will Know We are Making a Difference* **Short term:** Increase awareness of the importance of health screenings to the community. **Long term:** Increase in the number of colorectal, prostate and breast cancer screenings among adults 45 and older.
Objectives:
CD 2.1 By 2027, increase number of eligible patients screened for colorectal cancer by 25% annually.
CD 2.2 By 2027, increase number of eligible patients screened for prostate cancer by 10% annually
CD 2.3 By 2027, increase number of eligible patients screened for breast cancer by 15% annually.

A health care organization can implement a comprehensive approach to decrease cholesterol, blood pressure and glucose levels while improving dental care through proactive screenings and preventive measures. First and foremost, regular health screenings are crucial in identifying individuals at risk for cardiovascular issues and diabetes. Health fairs and community outreach programs can be organized to provide accessible screenings for cholesterol levels, blood pressure and glucose monitoring. These screenings serve as early detection tools, enabling health care providers to intervene promptly with lifestyle modifications, medication management and patient education.

3 Centers for Disease Control and Prevention (CDC). National Center for Chronic Disease Prevention and Health Promotion. July 2022. Chronic Disease Fact Sheets: Cancer.
4 Centers for Disease Control and Prevention (CDC). Division of Cancer Prevention and Control. October 2022.Lung Cancer: What Are the Risk Factors for Lung Cancer.
5 National Institute of Health. National Cancer Institute. March 29, 2017. Risk Factors for Cancer
6 Chickasaw Nation. GPRA. 2010-2021 Active Patient with Diabetes Diagnosis.

Priority Area 1: Chronic Disease (cont.)

The Chickasaw Nation is taking steps to improve dental care in its community by incorporating it into health care initiatives at health events and pediatric clinics. In addition to traditional health care screenings, dental care is being integrated to recognize the interconnectedness of oral health and overall well-being. Dental screenings, preventive services such as cleanings and fluoride treatments and education on the importance of oral hygiene and regular dental check-ups are being provided during these events, promoting awareness and encouraging individuals to prioritize their dental health. The Chickasaw Nation has also created new dental positions in each pediatric clinic to provide preventive fluoride varnish and referral services to dentists, further emphasizing the importance of dental care in the community.

To sustain long-term improvements, CNDH has leveraged technology to streamline the management of patient data and facilitate continuity of care. CNDH's new electronic medical record allows for efficient tracking of screening results, follow-up appointments and personalized care plans. Automated reminders can be set up to prompt individuals for regular health check-ups and screenings, ensuring that they stay engaged in their preventive care journey. By employing a coordinated and technology-driven strategy, this will allow CNDH to make significant strides in reducing cholesterol, blood pressure and glucose levels, while concurrently enhancing dental care and fostering a culture of proactive health management within the community.

Goal 2 aims to promote cross-sector collaboration to increase awareness and access to early detection screenings, including screenings for breast cancer, colorectal cancer, cholesterol, blood pressure, glucose and dental health. By emphasizing the importance of proactive health screenings, this goal seeks to empower individuals to take control of their health and detect potential health issues early, when they are most treatable.

The performance measures outlined for Goal 2 provide a framework for assessing the effectiveness of initiatives aimed at increasing awareness and access to screenings within the Chickasaw Nation community. In the short term, an increase in awareness of the importance of health screenings to the community indicates progress in educating individuals about the benefits of early detection and preventive care. This heightened awareness can lead to increased engagement in screening programs and improved health-seeking behaviors among community members.

In the long term, the goal is to achieve a measurable increase in the number of colorectal, prostate and breast cancer screenings among adults ages 45 and older. By tracking screening rates over time, the Chickasaw Nation can assess the impact of its initiatives on increasing access to screenings and improving early detection of cancer and other health conditions. This data-driven approach allows for ongoing evaluation and refinement of screening programs to maximize their effectiveness and reach.

Additionally, the objectives outlined for Goal 2 provide specific targets and milestones to guide the implementation and evaluation of screening initiatives. Objective CD 2.1 focuses on increasing the number of eligible patients screened for colorectal cancer by 25% annually, highlighting the importance of early detection in preventing colorectal cancer mortality. Similarly, objectives CD 2.2 and CD 2.3 target prostate and breast cancer screenings, respectively, aiming to increase screening rates among eligible patients by 10% and 15% annually by 2027.

Overall, Goal 2 and its associated performance measures and objectives demonstrate the Chickasaw Nation's commitment to promoting early detection and preventive care through collaborative efforts aimed at increasing awareness and access to screenings. By prioritizing proactive health screenings, the Chickasaw Nation aims to improve health outcomes, reduce disparities in cancer detection and treatment and enhance the overall well-being of its community members.

Priority Area 1: Chronic Disease (cont.)

Goal 3: Disease Management

The Chickasaw Nation is a leading health care provider in south-central Oklahoma, with three outpatient clinics and one outpatient/inpatient health care facility, providing primary and specialty care services to Chickasaw Nation citizens and other First Americans. Although CNDH provides health care services to many individuals and families who live in rural or even remote areas and communities, barriers often exist limiting some individuals' and families' ability to obtain health care. These barriers include lack of adequate transportation, lack of ability to take paid time off from work, low confidence in their ability to communicate with or understand their health care provider, low trust they can use services without compromising confidentiality or privacy, or uncertainty about the quality of care they will receive.[7]

Over the past five years, significant progress has been made to address identified or potential gaps within the health system that impact access to care. Access to health care means individuals have equitable and timely use of services and programs to achieve the best possible health outcomes. Access to care impacts the overall quality of life, including physical, social and mental health status, prevention of disease, detection, diagnosis and management of illness, avoiding preventable deaths and increased life expectancy.

Goal 3 Management - Reduce the burden of chronic disease among the First American populations through practical, evidence-based treatment and/or disease management programs.
Performance Measures: *How We Will Know We are Making a Difference* **Short term:** Increase in the number of new internal and external partners for the Remote Patient Hypertension Monitoring Pilot Program. **Long term:** Improved outcomes related to the Remote Patient Hypertension Monitoring Pilot Program initiatives through Evaluation and Data Monitoring Tools.
Objectives:
CD 3.1 Increase enrollment in the Remote Patient Hypertension Monitoring Pilot Program by 50% by 2025.
CD 3.2 CNDH Diabetes LifeRx Program will maintain recognition from the CDC Diabetes Prevention Recognition Program for conducting the National DDP Lifestyle Change Program.

Services and programs were expanded in the following clinical areas to maximize our ability to provide the care, management and services community members need most. These include: the addition of the Family Medicine Residency Clinic, the Inchokma Mobile Medical Unit, the Medication Assisted Treatment clinic, pediatric care added at all Chickasaw Nation satellite clinics, expansion of dental and vision services, adding telehealth services, an expanded state-of-the-art pharmacy facility at CNMC, the Looapilå clinical pharmacist integrated clinic and a Durable Medical Equipment store. The Chickasaw Nation is also in the process of planning for a large, new pediatric clinic in Ada as well as a second, larger, full-service hospital with outpatient clinics and public health facilities in Newcastle, Oklahoma, at the northern region of the Chickasaw Nation treaty territory, located just outside of the largest metro area in Oklahoma.

7 Chickasaw Nation Division of Public Health. 2024 Chickasaw Nation Community Health Assessment.

Priority Area 1: Chronic Disease (cont.)

The Chickasaw Nation is dedicated to ensuring all Chickasaw and First American citizens have access to comprehensive, high quality health care and will continue expanding the capability and capacity of all clinical services and programs to meet the needs of patients and improve health outcomes.

Goal 3 focuses on reducing the burden of chronic disease among First American populations by implementing practical, evidence-based treatment and disease management programs. This goal aims to improve health outcomes and enhance the quality of life for individuals living with chronic conditions within the Chickasaw Nation community. By implementing targeted interventions and strategies, Goal 3 seeks to address the root causes of chronic diseases, such as diabetes and hypertension and empower individuals to manage their health effectively.

The performance measures outlined for Goal 3 provide a framework for assessing the effectiveness of the initiatives and programs implemented to achieve this goal. In the short term, an increase in the number of new internal and external partners for the Remote Patient Hypertension Monitoring Pilot Program indicates progress in expanding access to innovative health care services. This pilot program aims to utilize technology for remote monitoring of blood pressure levels, allowing for timely intervention and personalized care for individuals with hypertension.

In the long term, improved outcomes related to the Remote Patient Hypertension Monitoring Pilot Program initiatives through evaluation and data monitoring tools demonstrate the success of the program in achieving its objectives. By tracking key metrics such as blood pressure control rates, medication adherence and patient satisfaction, the Chickasaw Nation can assess the impact of the program on improving health outcomes and reducing the burden of hypertension within the community.

Additionally, the objectives outlined for Goal 3 provide specific targets and milestones to guide the implementation and evaluation of the initiatives. Objective CD 3.1 aims to increase enrollment in the Remote Patient Hypertension Monitoring Pilot Program by 50% by 2025, indicating a commitment to expanding access to innovative health care services and improving disease management among individuals with hypertension. Objective CD 3.2 focuses on maintaining recognition from the Centers for Disease Control and Prevention Diabetes Prevention (CDC) Recognition Program for the Chickasaw Nation Diabetes LifeRx Program, highlighting the importance of evidence-based lifestyle interventions in preventing and managing diabetes within the community.

Overall, Goal 3 and its associated performance measures and objectives demonstrate the Chickasaw Nation's dedication to reducing the burden of chronic disease and improving health outcomes through innovative, evidence-based interventions and programs tailored to the needs of First American populations. By focusing on prevention, treatment and disease management, the Chickasaw Nation aims to enhance the overall health and well-being of its community members and reduce disparities in chronic disease outcomes.

Priority Area 1: Chronic Disease (cont.)

Goal 4: Reduce the Burden of Obesity

Obesity places children and adolescents at risk for developing health and obesity-related conditions such as high blood pressure, high cholesterol, Type 2 diabetes, breathing problems including asthma, sleep apnea and joint problems. These health conditions which are generally associated with adulthood. The CDC defines obesity as a body mass index (BMI) at or above the 95th percentile in their "BMI for age growth charts."

Approximately 1 million adults in Oklahoma are obese.[8] Among First American populations, the number is even greater. Obesity is a common risk factor among the leading causes of death and illnesses within the Chickasaw Nation population.[9] The likelihood of being overweight or obese in our population greatly increases with age. Over 80% of the First American population in the Chickasaw Nation are overweight or obese by the time they are 35-44 years of age.[10] Although obesity is a major issue within the First American population, it is also a problem within all races living in Oklahoma. In the Chickasaw Nation epidemiological data that includes, not only Chickasaws, but any First American who receive care at CNDH facilities, more than 53% of the American Indian adult population are obese.[11] Jefferson County reported the highest prevalence of obesity with more than 43 percent of all residents being obese.[12] Chickasaw Nation First American's who are overweight or obese is 71.6%,[13] and over 13% have been told they have diabetes.[14] Studies have shown that individuals who experience ACEs, such as abuse, neglect or household dysfunction, are at a higher risk for developing obesity and related health conditions later in life. This, coupled with limited access to healthy foods and safe places to exercise in rural areas, has contributed to the growing trend of obesity among the First American population in Oklahoma. It is important to address these underlying factors in order to improve the health outcomes of this population.

Childhood Obesity

Childhood obesity is occurring at an alarming rate throughout the United States and within the Chickasaw Nation treaty territory. According to the CDC, 12.7% of 2-5 years old are obese. In the Chickasaw Nation, almost 17% of First American children (mix of tribes) age 2-5 years are obese.[15] Due to the complexities associated with childhood obesity, a holistic approach is vital to effectively address it. The holistic approach to health and well-being is common in many First American cultures including Chickasaw culture.

Within the Chickasaw Nation childhood obesity is being addressed at many levels including providing comprehensive prenatal care, implementing a new maternal, infant and early childhood home visitation program, positive youth development trainings and support for parents, teachers and care givers of children 0-8 years via the Hofanti Chokma program, and comprehensive treatment of First American children age 2-18 years experiencing obesity through the Empowered Living youth and family wellness program. While each of the previously mentioned programs and services implement evidence based and informed strategies, they also incorporate cultural components aimed at increasing protective factors such as cultural connectedness, reducing adverse childhood experiences (ACEs) and instilling resiliency to improve health outcomes throughout their lifespan.

8 Oklahoma State Department of Health (OSDH). 2022. Health for a Lifetime: Oklahoma Obesity Prevention Plan. Sari Horwitz, Debbie Cenziper. "As Opioids Flooded Tribal Lands across the U.S., Overdose Deaths Skyrocketed." The Washington Post, 29 June 2020.
9 Chickasaw Nation. GPRA. 2010-2021 Active Patient BMI.
10 Chickasaw Nation. GPRA. 2021
11 University of Wisconsin Population Health Institute. County Health Rankings Oklahoma State Report 2021.
12 U.S. Census Bureau, 2016-2021 American Community Survey 5-Year Estimates
13 Chickasaw Nation. GPRA. 2010-2021 Active Patient with Diabetes Diagnosis.
14 Centers for Disease Control and Prevention (CDC). Childhood Obesity Facts. https://www.cdc.gov/obesity/data/childhood.html
15 Oklahoma State Department of Health (OSDH). 2022. Health for a Lifetime: Oklahoma Obesity Prevention Plan.

Priority Area 1: Chronic Disease (cont.)

Goal 4 - Reduce the burden of obesity within the First American Population within the Chickasaw Nation.
Performance Measures: *How We Will Know We are Making a Difference* **Short term:** Increase clinical time for children enrolled in Empowered Living. **Long term:** Decrease the percentage of childhood obesity.
Objectives:
CD 4.1 Expand the access of care for children who have obesity to the specialized services of the Empowered Living clinic at CNMC to 50% by 2027.
CD 4.2 Expand the access of care for children who have obesity to the specialized services of the Empowered Living clinic at Ardmore Satellite clinic to 25% by 2027.
CD 5.1 Through 2027 Enroll 400 1st through 3rd grade students, annually, into the Eagle Adventure program to encourage healthy eating among students and their families.

The establishment of a youth and family wellness clinic, “Empowered Living,” located at the Ardmore Health Clinic and later expanded to the Chickasaw Nation Medical Center’s (CNMC) pediatric clinic in Ada, was designed to offer children, adolescents and teens (ages 2-18) with a BMI greater than or equal to the 85th percentile with personalized and specialized services and resources to assist them in achieving healthy lifestyle goals. Through a dedicated, inter-disciplinary team of health professionals, participants in the program are provided education, guidance and support. All members of the family are encouraged to engage in healthy choices and activities supporting the individual's journey and contributing to the development of a healthier lifestyle for the entire family that can be sustained for many years to come.

While obesity continues to remain a major health concern among First Americans in the Chickasaw Nation, over the past six years, through the development and implementation of programs and services designed to improve health and wellness, we have been able to experience a slight decrease in the incidence of childhood obesity. This is a successful and positive trend we believe will continue in the years to come. These programs and services provide opportunities that facilitated progress toward the goal of reducing obesity, but for all age-groups within our First American population.

Goal 4 focuses on reducing the burden of obesity within the First American population within the Chickasaw Nation, aiming to improve the overall health and well-being of community members. By addressing obesity, this goal seeks to prevent chronic diseases, enhance quality of life and reduce health care costs associated with obesity-related conditions.

The performance measures outlined for Goal 4 provide a framework for assessing the effectiveness of initiatives aimed at reducing obesity within the Chickasaw Nation community. In the short term, an increase in clinical time for children enrolled in Empowered Living clinics indicates progress in expanding access to specialized obesity management services. By providing comprehensive care and support for children with obesity, these clinics help address the complex factors contributing to obesity and promote healthy lifestyle behaviors.

Priority Area 1: Chronic Disease (cont.)

In the long term, the goal is to achieve a measurable decrease in the percentage of childhood obesity within the Chickasaw Nation community. By tracking obesity rates over time, the Chickasaw Nation can assess the impact of its initiatives on improving health outcomes and reducing the prevalence of obesity among children. This data-driven approach allows for ongoing evaluation and refinement of obesity prevention and intervention programs to maximize their effectiveness and reach.

Additionally, the objectives outlined for Goal 4 provide specific targets and milestones to guide the implementation and evaluation of obesity reduction initiatives. Objectives CD 4.1 and CD 4.2 aim to expand access to specialized obesity management services at Empowered Living clinics, ensuring children with obesity have access to comprehensive care and support. Objective CD 5.1 targets obesity prevention among children by enrolling students into the Eagle Adventure program, which promotes healthy eating behaviors and active lifestyles among students and their families.

Overall, Goal 4 and its associated performance measures and objectives demonstrate the Chickasaw Nation's commitment to addressing obesity as a public health priority and improving health outcomes within the community. By prioritizing obesity prevention and intervention efforts, the Chickasaw Nation aims to reduce the burden of obesity, promote healthy behaviors and enhance the overall well-being of its population.



Priority Area 1: Chronic Disease (cont.)

Alignment with National and State Priorities

Healthy People 2030	Increase the proportion of adults who get screened for breast and colorectal cancer.
	Reduce the proportion of adults, children and adolescents with obesity.
	Improve cardiovascular health in adults.
	Reduce the number of diabetes cases diagnosed yearly.
	Increase the number of policies that prohibit smoking in worksites.
State OHIP 2020:	Reduce adult obesity prevalence from 32.5% in 2013 to 29.5% in 2020.
	Reduce adolescent smoking prevalence from 15.1% in 2013 to 10% in 2020 for high school-aged youth and from 4.8% in 2013 to 2% in 2020 for middle school-aged youth.
	Reduce adult smoking prevalence from 23.7% in 2013 to 18% in 2020.

Evidence-Based Practice Sources for Chronic Disease:

Hypertension: The Guide to Community Preventive Services: Heart Disease and Stroke Prevention: Interactive Digital Interventions for Blood Pressure Self-Management

Diabetes: Centers for Disease Control and Prevention: National Diabetes Prevention Program

Cancer: Centers for Disease Control and Prevention: Enhancing Use of Clinical Preventive Services Among Older Adults

Chronic Liver Disease and Cirrhosis - Substance Abuse and Mental Health Services Administration: Substance Abuse and Mental Health Services Administration's National Helpline

Obesity: U.S. Preventive Services Task Force: Obesity in Children and Adolescents: Screening

Priority Area 2: Behavioral Health

Behavioral health is a broad term that encompasses many complex and interrelated mental, psychological and physical systems. It can perhaps be more easily understood as the behaviors affecting physical and mental wellness, and good behavioral health results in a "state of mind characterized by emotional well-being, good behavioral adjustment, relative freedom from anxiety and disabling symptoms and a capacity to establish constructive relationships and cope with the ordinary demands and stress of life."[16] The behavioral health challenges faced by many First Americans living within the Chickasaw Nation treaty territory, as well across the state of Oklahoma and U.S, are influenced by a host of factors including genetics, family environment, discrimination, socioeconomic status, traumatic experiences, physical health and loneliness.[17] When communities are subjected to an increase in crime or drug use there is a negative impact to the overall behavioral health of its residents.

Therefore, health improvement goals begin with promoting children's development to protect mental health and extend to enhancing treatment access broadly and, more specifically, reducing opioid misuse and suicide deaths.

Goal 1:	Increase access to developmental resources and positive parenting support programs to reduce mental, emotional and behavioral health disorders in children within the Chickasaw Nation.
Goal 2:	Enhance access for mental, emotional and behavioral health disorders in children through improved screening and resource provision for parents and children within the Chickasaw Nation.
Goal 3:	Reduce opioid misuse and overdose deaths within the Chickasaw Nation.
Goal 4:	Expand youth mental health treatment opportunities within Chickasaw Nation.
Goal 5:	Reduce deaths by suicide within the First American population residing within the Chickasaw Nation.

The Chickasaw Nation recognizes the critical role behavioral health plays in an individual's overall health and well-being. Governor Anoatubby's mental wellness initiative, Chikasha Anokfilli (Thinking Chickasaw), was developed by the Chickasaw Nation to provide resources to support and promote mental wellness. Strategic planning efforts, dedicated staff time and newly acquired funding sources have all contributed to the development of a more comprehensive system of mental wellness care.

CNDH practices a holistic approach to health care. By combining primary care and behavioral health services, health care providers better understand the interconnected nature of physical and mental health. This integrated approach allows a more comprehensive assessment of a patient's overall health, leading to more accurate diagnoses and targeted interventions. Moreover, recent efforts also incorporate screening and supports for early childhood development to facilitate well-being at the youngest ages contributing to fewer mental health risks in the future.

Goals were created to address pressing mental health and substance use challenges within the Chickasaw Nation community, with a focus on prevention, early intervention, treatment and support. By prioritizing these areas, the Chickasaw Nation aims to improve mental health outcomes, enhance well-being and build a healthier and more resilient community for all.

16 American Psychological Association. APA dictionary of psychology.2022.
17 Office of the Surgeon General (US); Center for Mental Health Services (US); National Institute of Mental Health (US). Mental Health: Culture, Race and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2001 Aug. Chapter 4 Mental Health Care for American Indians and Alaska Natives.

Priority Area 2: Behavioral Health (cont.)

Goal 1: Increase Access to Developmental Resources and Parenting Support.
Mental, emotional and behavioral health disorders in children can have long-lasting effects on their well-being and future outcomes. Goal 1 aims to prevent and reduce these disorders by increasing access to developmental resources and positive parenting support programs. By providing families with the tools and resources they need to promote healthy development and resilience in children, this goal seeks to create a supportive environment that fosters mental and emotional well-being from an early age.

Goal 2: Improve Identification and Treatment of Mental Health Disorders.
Early identification and treatment of mental health disorders are essential for preventing long-term consequences and improving outcomes. Goal 2 focuses on improving identification and treatment of mental health disorders in both parents and children within the Chickasaw Nation health care system. By enhancing screening, assessment and intervention services, this goal aims to ensure individuals receive timely and appropriate care for mental health concerns, reducing the impact of these disorders on individuals, families and communities.

Goal 3: Reduce Opioid Misuse and Overdose Deaths.
Opioid misuse and overdose deaths have emerged as significant public health challenges across the nation, including within tribal communities. Goal 3 addresses this issue by focusing on reducing opioid misuse and overdose deaths within the Chickasaw Nation. By implementing strategies such as prevention education, access to treatment and recovery services and naloxone distribution programs, this goal aims to mitigate the impact of the opioid epidemic and prevent unnecessary deaths and harm associated with opioid use.

Goal 4: Expand Youth Mental Health Treatment Opportunities.
Access to mental health treatment services is essential for addressing the needs of youth experiencing mental health challenges. Goal 4 seeks to expand youth mental health treatment opportunities within the Chickasaw Nation, ensuring that young people have access to culturally appropriate and effective mental health services. By increasing availability and accessibility of treatment options, this goal aims to support the mental health and well-being of youth and reduce barriers to care.

Goal 5: Reduce Deaths by Suicide.
Suicide is a preventable tragedy affecting individuals, families and communities. Goal 5 focuses on reducing deaths by suicide within the First American population residing within the Chickasaw Nation. By implementing suicide prevention initiatives, increasing access to mental health services and promoting community support and resilience, this goal aims to prevent suicide and save lives. By addressing the underlying factors contributing to suicide risk and providing support to those in crisis, this goal seeks to create a culture of safety, hope and healing within the Chickasaw Nation community.

Priority Area 2: Behavioral Health (cont.)

Goal 1: Access to Resources and Support

Research indicates First American populations have disproportionately higher rates of behavioral health issues than any other racial or ethnic groups in the country, including substance abuse disorders (SUDs), post-traumatic stress disorder (PTSD), suicide and attachment disorders.[18] Many of these issues have been associated with generational historical traumas such as forced removal from original homelands and the institution of government and religious-operated boarding schools designed to intentionally separate First American children from their parents, spiritual practices and culture.[19]

Goal 1: Increase access to developmental resources and positive parenting support programs to reduce mental, emotional and behavioral health disorders in children within the Chickasaw Nation.
Performance Measures: *How We Will Know We are Making a Difference* **Short term:** Increase in the number of parents and caregivers engaged during community events. **Long term:** Increase in the proportion of parents trained in behavioral health youth programming.
Objectives:
BH 1.1 By 2027, increase the percentage of enrollments of parents or caregivers into HealthySteps Pediatric Program by 50 annually.
BH 1.2 Maintain the number of PAX Tools trainings to parents, caregivers, community members, Chickasaw Nation employees and partners annually through 2027.
BH 1.3 Increase the number of Chickasaw Nation Staff certified to deliver Youth Thrive Training from 0 to 2 staff members by October 2027.
BH 1.4 By 2027, increase Chickasaw Nation Children's Village student success support staff and house parents trained in Youth Thrive: Promotive and Protective Factors to Support Healthy Adolescent Development from 0 to 20.

A very successful merge of public health and direct care has been incorporating the HealthySteps program into pediatrics. The evidence-based program includes universal developmental screening, which plays a pivotal role in early identification and intervention for young children's developmental and behavioral concerns. The screening process assesses various aspects of a child's development, including physical, social and emotional well-being, as well as several aspects of the family's health-related social needs. Screening results are used to provide developmental guidance, parenting supports and resource referrals that match the identified need. By incorporating HealthySteps into pediatric care, health care professionals can identify potential issues early on, allowing timely interventions to positively impact a child's development. Early detection of developmental delays, behavioral challenges or social-emotional concerns provides an opportunity for health care providers to collaborate with families and implement targeted strategies and support services to address these issues effectively.

18 Ka'apu K, Burnette CE. A Culturally Informed Systematic Review of Mental Health Disparities Among Adult Indigenous Men and Women of the USA: What is known? Br J Soc Work. 2019 Jun;49(4):880-898.

19 Bear UR, Beals J, Kaufman CE, Manson SM; AI-SUPERPFP Team. Boarding School Attendance and Physical Health Status of Northern Plains Tribes. Appl Res Qual Life. 2018 Sep;13(3):633-645.

Priority Area 2: Behavioral Health (cont.)

Through the public health data project, CNDH was able to justify the need for early childhood developmental therapists in pediatrics. HealthySteps screening contributes to the overall well-being of children by promoting a family-centered approach to health care. The screening process involves engaging parents and caregivers in discussions about their child's development, allowing open communication and shared decision-making. This collaborative approach fosters a strong partnership between health care providers and families, empowering parents to participate actively in their child's health and development. By involving families in the screening process, HealthySteps identifies potential concerns and equips parents with the knowledge and resources needed to support their child's growth and address any challenges that may arise. Overall, HealthySteps in pediatrics underscores the importance of early intervention and family involvement in promoting young children's optimal development and health.

Goal 1 aims to reduce mental, emotional and behavioral health disorders in children within the Chickasaw Nation by increasing access to developmental resources and positive parenting support programs. The performance measures and objectives outlined for this goal provide a roadmap for achieving this objective and tracking progress over time.

In the short term, an increase in the number of parents and caregivers engaged during community events serves as an indicator of increased awareness and participation in programs and resources aimed at supporting children's mental health and well-being. By actively engaging parents and caregivers in community events, the Chickasaw Nation can disseminate information about available resources, promote positive parenting practices and foster a supportive community environment valuing and prioritizes children's mental health.

In the long term, an increase in the proportion of parents trained in behavioral health youth programming indicates progress in building parental capacity to support children's mental and emotional development. By providing training opportunities for parents and caregivers, such as the HealthySteps Pediatric Program and PAX Tools trainings, the Chickasaw Nation equips them with the knowledge and skills needed to promote positive mental health outcomes and prevent or address behavioral health disorders in children.

The objectives outlined for Goal 1 further support these efforts by establishing specific targets and milestones to guide implementation and evaluation. Objectives such as increasing enrollments in the HealthySteps Pediatric Program, maintaining PAX Tools trainings and certifying staff to deliver Youth Thrive Training demonstrate a commitment to expanding access to evidence-based parenting support programs and resources.

Overall, Goal 1 and its associated performance measures and objectives demonstrate the Chickasaw Nation's dedication to promoting children's mental health and well-being through targeted interventions and support for parents and caregivers. By increasing access to developmental resources and positive parenting support programs, the Chickasaw Nation aims to reduce the incidence of mental, emotional and behavioral health disorders in children and create a healthier and more resilient community for future generations.

Priority Area 2: Behavioral Health (cont.)

Goal 2: Early Identification

The Chickasaw Nation Pediatric Collaborative (CNPC) originated with funding under a Pediatric Mental Health Care Access grant from the Health Resources and Services Administration and the Maternal and Child Health Bureau. The grant's overall goal is to expand the primary care providers' knowledge and confidence in treating mental health concerns for child and adolescent patients and to minimize referring to specialty providers when possible. Under this program, pediatric medical and integrated behavioral health providers receive regular trainings relevant to managing pediatric mental health concerns in medical practice, as well as consultation access to specialists including a child and adolescent psychiatrist, a developmental behavioral pediatrician and a board-certified behavior analyst. Through a dedicated focus on serving youth with autism spectrum disorder, the CNPC also provides a unique parent consultation program to assist families virtually while families wait for acceptance at regional Applied Behavior Analysis treatment clinics. Over the next five years, the Chickasaw Nation looks to expand services and outreach even more through collaborative and evidence-informed and innovative tribal best practices to achieve mental and behavioral well-being. The CNDH has planned to construct a comprehensive developmental clinic that is set to open in 2027. The upcoming developmental clinic will offer therapy services for developmentally delayed children with a focus on early diagnosis and intervention. This will be a significant step forward in providing comprehensive care for children with developmental needs, as early intervention is crucial for better long-term outcomes. The Chickasaw Nation is committed to ensuring that children and families have access to the care and support they need and this clinic is just one of the many ways it is working toward achieving that goal.

Goal 2: Reduce mental, emotional and behavioral health disorders in children through improved identification and treatment of behavioral health and substance misuse disorders in parents and children within the Chickasaw Nation health care system.
Performance Measures: *How We Will Know We are Making a Difference* **Short term:** Increase the percentage of providers using the Survey of Well-being of Young Children (SWYC) screening tool during pediatric visits. **Long term:** Increase in the number of children and adults within the Chickasaw Nation health care system treated for behavioral health and substance misuse disorders.
Objectives:
BH 2.1 By 2027, SWYC screening tool implemented at 90% of all well-child visits ages 0-5 to increase the tracking of behavioral health disorders in children.
BH 2.2 By 2027, implement substance misuse surveillance system to identify substance misuse rates for the Chickasaw Children's Village and Marshall County.
BH 2.3 By 2025, train two prevention specialists to maintain Suicide Care Pathways registry.

Priority Area 2: Behavioral Health (cont.)

Goal 2 focuses on reducing mental, emotional and behavioral health disorders in children within the Chickasaw Nation by improving the identification and treatment of these disorders in both parents and children within the health care system. The performance measures and objectives outlined for this goal provide a framework for achieving this objective and monitoring progress over time.

In the short term, an increase in the percentage of providers using the Survey of Well-being of Young Children (SWYC) screening tool during pediatric visits serves as an indicator of improved identification of developmental concerns in children, family health related social needs and parent mental health or substance misuse concerns. By implementing the SWYC screening tool at pediatric visits, health care providers can systematically assess children's development and well-being, identify potential concerns early and initiate appropriate interventions or referrals. This is crucial for establishing and protecting the foundations of mental health at later ages.

In the long term, an increase in the number of children and adults within the Chickasaw Nation health care system treated for behavioral health and substance misuse disorders indicates progress in increasing access to care for individuals with mental health and substance use concerns. By implementing a substance misuse surveillance system and training prevention specialists to maintain a Suicide Care Pathways registry, the Chickasaw Nation enhances its capacity to identify and respond to acute behavioral health and substance misuse issues among children and adults.

The objectives outlined for Goal 2 further support these efforts by establishing specific targets and milestones to guide implementation and evaluation. Objectives such as implementing the SWYC screening tool at 90% of well-child visits for ages 0-5, establishing a substance misuse surveillance system and training prevention specialists demonstrate a commitment to improving identification and treatment of behavioral health and substance misuse disorders within the Chickasaw Nation health care system.

Overall, Goal 2 and its associated performance measures and objectives demonstrate the Chickasaw Nation's commitment to addressing mental health and substance use concerns among children and adults through proactive screening, early intervention and targeted treatment and support. By improving identification and treatment of these disorders within the health care system, the Chickasaw Nation aims to reduce the prevalence and impact of mental, emotional and behavioral health disorders, promoting overall health and well-being within the community.



Priority Area 2: Behavioral Health (cont.)

Goal 3: Reduce Opioid Misuse

A challenge faced by many communities, nationally and locally and as a result of the recent opioid crisis and compounded by the effects of the COVID-19 pandemic, was increased opioid misuse, overdose and death. Population-based data from the CDC indicates the opioid overdose mortality rate among all races, increased dramatically during the COVID-19 pandemic.[20] According to the Oklahoma State Department of Health, 43% of overdose deaths in Oklahoma involved an opioid.[21] Between 2016 and 2021, there were 491 drug overdose deaths in the Chickasaw Nation treaty territory; 38% of those were caused by prescription opioids. According to the CDC, Oklahoma had the fifth highest opioid prescription dispensing rate in the United States.[22] More than 3 million opioid prescriptions were filled in Oklahoma in 2022, which is roughly 76.95 opioid prescriptions per 100 people.[27] In 2022, approximately 311,038 opioid prescriptions were filled by all pharmacies (including private pharmacies) throughout the counties located within the Chickasaw Nation treaty territory, which is roughly 85.45 opioid prescriptions per 100 people.[23]

Chickasaw Nation prevention programs to reduce opioid misuse and tobacco use have been implemented and further expanded, including increasing access to life-saving tools such as naloxone for opioid overdose and supportive post-care and recovery services.

Goal 3: Reduce opioid misuse and overdose deaths within the Chickasaw Nation.
Performance Measures: *How We Will Know We are Making a Difference* **Short term:** Increase percentage in the uptake of naloxone kits throughout the Chickasaw Nation. **Long term:** Decrease in the percentage opioid deaths within the Chickasaw Nation.
Objectives:
BH 3.1 Increase the number of naloxone education encounters to Chickasaw Nation staff and community members by 2027.
BH 3.2 By 2025, Define Your Direction Opioid Awareness campaign will incorporate monthly message of where and how to access naloxone throughout the Chickasaw Nation.
BH 3.3 By 2027, CNDH Pharmacy in collaboration with Chickasaw Nation Tribal Opioid Response program will distribute 500 naloxone kits to Chickasaw Nation programs and to individuals at risk of an opioid overdose annually.
BH 3.4 By 2027, Chickasaw Nation will provide 1,000 medication lockboxes and/or lock bottles to community members at large.

20 Ghose, R., Forati, A. M., & Mantsch, J. R. (2022). Impact of the COVID-19 Pandemic on Opioid Overdose Deaths: a Spatiotemporal Analysis. Journal of urban health: bulletin of the New York Academy of Medicine, 99(2), 316–327.
21 Oklahoma State Department of Health, Injury Prevention Service
22 Oklahoma Bureau of Narcotics. Oklahoma Prescription Drug Monitoring Program (PMP). 2023
23 Oklahoma Bureau of Narcotics. Oklahoma Prescription Drug Monitoring Program (PMP). 2023

Priority Area 2: Behavioral Health (cont.)

Establishment of an Opioid Safety Committee is a strategic measure that CNDH has created to combat opioid misuse, a pervasive issue with serious public health implications. One key role of the committee is the development and implementation of comprehensive opioid prescribing guidelines within CNDH. By standardizing prescribing practices, the committee can help ensure opioids are prescribed judiciously and only when clinically necessary. These guidelines include dosage limitations, duration restrictions and thorough risk assessments to identify patients who may be more susceptible to opioid misuse. As a result, the committee's efforts contribute to a more cautious and evidence-based approach to opioid prescription, reducing the likelihood of misuse and addiction.

Another crucial function of the opioid safety committee is to enhance education and training for health care providers. By staying abreast of the latest evidence-based practices and guidelines, the committee facilitates ongoing education initiatives for clinicians. This includes training on alternative pain management strategies, recognizing signs of opioid misuse and promoting effective communication with patients about the risks and benefits of opioid therapy. Well-informed health care professionals are better equipped to make sound clinical decisions, fostering a culture of responsible opioid use and minimizing the potential for misuse within the health care system.

Furthermore, the opioid safety committee actively engages in monitoring and surveillance activities to identify and address patterns of opioid misuse. Through the implementation of prescription drug monitoring program (PDMP) and regular data analysis, the committee tracks prescribing trends, identifies outliers and intervenes when necessary. This proactive approach allows for early detection of potential issues, enabling timely intervention to prevent further escalation of opioid misuse. The committee's commitment to ongoing monitoring creates a system of accountability and continuous improvement, fostering a safer and more responsible approach to opioid prescribing.

Goal 3 aims to reduce opioid misuse and overdose deaths within the Chickasaw Nation by implementing strategies to increase naloxone uptake and distribution, as well as promoting opioid awareness and prevention efforts. The performance measures and objectives outlined for this goal provide a roadmap for achieving this objective and monitoring progress over time.



Priority Area 2: Behavioral Health (cont.)

In the short term, an increase in the percentage of naloxone kits distributed throughout the Chickasaw Nation serves as an indicator of improved access to naloxone, a life-saving medication used to reverse opioid overdoses. By increasing the uptake of naloxone kits among community members and health care providers, the Chickasaw Nation enhances its capacity to respond effectively to opioid-related emergencies and prevent overdose deaths. In the long term, a decrease in the percentage of opioid deaths within the Chickasaw Nation indicates progress in reducing the impact of opioid misuse and overdose on individuals and communities. By implementing comprehensive opioid awareness campaigns, distributing naloxone kits and providing medication lockboxes to community members, the Chickasaw Nation aims to prevent opioid-related deaths and promote safer opioid use practices.

The objectives outlined for Goal 3 further support these efforts by establishing specific targets and milestones to guide implementation and evaluation. Objectives such as increasing naloxone education encounters, incorporating naloxone access messages into opioid awareness campaigns and distributing naloxone kits and medication lockboxes demonstrate a commitment to expanding access to naloxone and promoting opioid harm reduction strategies.

Overall, Goal 3 and its associated performance measures and objectives demonstrate the Chickasaw Nation's commitment to addressing the opioid crisis and reducing the impact of opioid misuse and overdose within the community. By increasing naloxone distribution, promoting opioid awareness and providing resources for safer opioid storage and disposal, the Chickasaw Nation aims to save lives, prevent overdoses and improve the overall health and well-being of its population.



Priority Area 2: Behavioral Health (cont.)

Goal 4: Youth Services

The Chickasaw Nation has a strong commitment to the health and well-being of its youth. CNDH has planned a comprehensive expansion of pediatric services that will focus on delivering evidence-based, culturally competent, whole-person care. Services will focus on social determinants of health and trauma informed care. By providing this comprehensive care, the Chickasaw Nation aims to address the diverse needs of its youth and families. The expansion will include a developmental clinic with a dedicated focus on serving youth with autism spectrum disorder and an adolescent health clinic. The clinics will provide early detection and intervention for children with developmental delays or disabilities, as well as essential health services for teenagers, including reproductive health, mental health and substance misuse counseling. The Chickasaw Nation will also provide a unique parent consultation program to assist families virtually while families wait for acceptance at regional applied behavior analysis treatment clinics. The goal of this expansion is to ensure that children and families have access to the care and support they need to achieve optimal mental and behavioral well-being.

Overall, having these specialized clinics within a tribal health care setting can help improve access to care and outcomes for children and adolescents. By providing comprehensive, culturally sensitive care, these clinics can make a significant difference in the lives of First American children and families.

Goal 4: Expand youth mental health treatment opportunities within Chickasaw Nation.
Performance Measures: *How We Will Know We are Making a Difference* **Short term:** Increase in the number of professional partners within mental health services. **Long term:** Increase percentage of pediatric patients accessing care for complex mental health disorders.
Objectives:
BH 4.1 Provide four annual trainings for mental health treatment for autism and other developmental delays by 2027.
BH 4.2 Develop a network of professional partners from state, academic, clinical, community and tribal levels to increase pediatric mental health services by 2027.
BH 4.3 By 2027, develop an annual report on number of pediatric patients accessing care for complex mental health disorders provided by Pediatric Mental Health Care Access (PMHCA) program.

Goal 4 seeks to expand youth mental health treatment opportunities within the Chickasaw Nation by increasing access to professional partners and pediatric mental health services. The performance measures and objectives outlined for this goal provide a framework for achieving this objective and monitoring progress over time.

Priority Area 2: Behavioral Health (cont.)

In the short term, an increase in the number of professional partners within mental health services serves as an indicator of improved collaboration and resource-sharing among stakeholders involved in youth mental health care. By developing a network of professional partners from state, academic, clinical, community and tribal levels, the Chickasaw Nation enhances its capacity to deliver comprehensive and coordinated mental health services to youth.

In the long term, an increase in the percentage of pediatric patients accessing care for complex mental health disorders indicates progress in expanding access to specialized mental health treatment for youth within the Chickasaw Nation. By providing training opportunities for mental health treatment for autism and other developmental delays, the Chickasaw Nation equips health care providers with the skills and knowledge needed to effectively address the unique needs of pediatric patients with complex mental health disorders.

The objectives outlined for Goal 4 further support these efforts by establishing specific targets and milestones to guide implementation and evaluation. Objectives such as providing annual trainings for mental health treatment, developing a network of professional partners and producing annual reports on pediatric patients accessing care for complex mental health disorders demonstrate a commitment to expanding youth mental health treatment opportunities and improving outcomes for young people.

Overall, Goal 4 and its associated performance measures and objectives demonstrate the Chickasaw Nation's dedication to addressing the mental health needs of youth within the community. By expanding access to professional partners and pediatric mental health services, the Chickasaw Nation aims to enhance the quality, availability and effectiveness of mental health care for young people, promoting their overall health and well-being.



Priority Area 2: Behavioral Health (cont.)

Goal 5: Suicide Prevention

Communities face a variety of social, economic, and environmental challenges that can impact the health and well-being of residents. These challenges may include poverty, crime, substance use, and other factors that affect individuals, families, and the community as a whole. Oklahoma has the fifth highest prevalence of any mental illness in the United States, and the sixth highest prevalence of youth mental illness.[24] Research suggests that First American peoples suffer a disproportionate burden of mental health problems and disorders. 19.2% of First Americans in Oklahoma report frequent mental distress, compared with 15.6% in the state of Oklahoma and 12.9% nationally.[25]

First Americans also disproportionately die by suicide or have a family member or friend die by suicide compared to other racial groups. In 2018, the Oklahoma suicide rate for First Americans was 20.5 per 100,000 compared to the United States rate of 13.4. Suicide death rates amongst First Americans aged 15-24 years of age residing within the Chickasaw Nation was 22.4 compared to the national rate of 13.8 for the same age group.[26]

First American suicide prevention programs are of paramount importance due to the disproportionate rates of suicide within Indigenous communities and the critical need for culturally relevant support and intervention strategies. These programs serve as lifelines for Indigenous individuals facing mental health challenges, providing culturally sensitive resources, counseling and outreach efforts tailored to the unique cultural, historical and social contexts of First American communities. By addressing the underlying factors contributing to suicidal ideation and behavior, such as intergenerational trauma, historical injustices and socioeconomic disparities, these programs play a crucial role in promoting holistic well-being and resilience. Moreover, First American suicide prevention programs empower Indigenous communities to reclaim agency over their mental health outcomes, fostering a sense of cultural pride, solidarity and hope for future generations.

Goal 5: Reduce deaths by suicide within the First American population residing within the Chickasaw Nation.
Performance Measures: *How We Will Know We Are Making a Difference* **Short term:** Increase in the number of suicide prevention trainings provided throughout the Chickasaw Nation. **Long term:** Increase the number of employees and community members trained in identifying at risk individuals.
Objectives:
BH 5.1 By 2027, increase Chickasaw Nation trainers of suicide prevention trainings such as Applied Suicide Intervention Skills Training; Mental Health First Aid; safeTALK; A Gathering of Native Americans; Talk Saves Lives.
BH 5.2 By 2025, increase messaging using billboards to raise awareness of the suicide hotline number change to 988.

Goal five focuses on reducing deaths by suicide within the First American population residing within the Chickasaw Nation by implementing suicide prevention strategies and increasing awareness of available resources. The performance measures and objectives outlined for this goal provide a roadmap for achieving this objective and monitoring progress over time.

24 Mental Health America. The State of Mental Health in America Report. 2021.
25 United States Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Healthy People 2030, Social Determinants of health, 2022.
26 Oklahoma State Department of Health (OSDH); Vital Statistics. 2018.

Priority Area 2: Behavioral Health (cont.)

In the short term, an increase in the number of suicide prevention trainings provided throughout the Chickasaw Nation serves as an indicator of enhanced capacity to recognize and respond to suicide risk. By offering trainings such as Applied Suicide Intervention Skills Training (ASIST), Mental Health First Aid, safeTALK, A Gathering of Native Americans and Talk Saves Lives, the Chickasaw Nation equips employees and community members with the knowledge and skills needed to identify warning signs of suicide and intervene effectively.

In the long term, an increase in the number of employees and community members trained in identifying at-risk individuals indicates progress in building a network of support and intervention for those in crisis. By increasing awareness of available resources and providing training opportunities, the Chickasaw Nation empowers individuals to act and connect individuals in crisis with appropriate support services, reducing the likelihood of suicide deaths.

The objectives outlined for Goal 5 further support these efforts by establishing specific targets and milestones to guide implementation and evaluation. Objectives such as increasing the number of Chickasaw Nation trainers of suicide prevention trainings and using billboards to raise awareness of the suicide hotline number change to 988 demonstrate a commitment to expanding suicide prevention efforts and improving access to support services.

Overall, Goal 5 and its associated performance measures and objectives demonstrate the Chickasaw Nation's commitment to preventing suicide and promoting mental health and well-being within the community. By increasing awareness, providing training and promoting access to support services, the Chickasaw Nation aims to save lives and create a culture of support and resilience helping individuals in crisis find hope and healing.



Priority Area 2: Behavioral Health (cont.)

Behavioral Health: Alignment with National and State Priorities

Healthy People 2030	Increase the proportion of people with health insurance.
	Increase the proportion of children and adolescents with symptoms of trauma and serious emotional disturbance who get treatment.
	Reduce the proportion of people who misuse opioids.
	Reduce overdose deaths involving opioids.
	Reduce the suicide rate.
State OHIP 2020:	Reduce the prevalence of untreated mental illness from an 86% treatment gap to 76% in 2020.
	Reduce the prevalence of addiction disorders from 8.8% to 7.8% by 2020.
	Reduce suicide deaths from 22.8 per 100,000 in 2013 to 19.4 per 100,000 by 2020.

Evidence Based Practice Sources for Behavioral Health:
Substance Abuse and Mental Health Service Administration – NREPP (National Registry of Evidence Based Practices and Programs)

Suicide Prevention Resource Center Best Practices Registry



Priority Area 3: Access to Care

The basic definition of access to health care from the Institute of Medicine is 'the timely use of personal health services to achieve the best possible health outcomes'.[27] Equitable access to quality health care is essential to everyone's opportunity to achieve and maintain good health. First Americans have access to tribal health care facilities, which are crucial for providing preventive and primary care within Indigenous communities. However, accessing these services can present challenges due to barriers such as lack of transportation, limiting individuals' ability to reach health care facilities. Additionally, financial constraints and cultural considerations may further hinder access to preventive and primary care services. Furthermore, accessing specialty services poses additional difficulties, often requiring individuals to travel long distances to urban areas or specialized facilities, compounding the challenges faced by Indigenous peoples in obtaining comprehensive health care. Addressing these barriers necessitates holistic approaches prioritizing equitable access to quality health care services, including implementing telehealth initiatives, expanding community-based outreach programs and fostering partnerships between tribal health systems and external health care providers. These efforts are essential to ensure all First Americans have access to the preventive, primary and specialty care they need to maintain their health and well-being, regardless of the obstacles they may encounter.

Goal 1:	Increasing access in underserved areas by increasing the number of mobile medical clinics sent to these areas.
Goal 2:	Increase the number of eligible children and adults enrolled in SoonerCare and/or Medicare.
Goal 3:	Increase access to and expand pediatric services.
Goal 4:	Increase access to maternal, infant and early childhood home visitation services.
Goal 5:	Expand and improve access to quality health care services for First American residents living in the northern region of the Chickasaw Nation.

While access can often be challenging for many health care systems and organizations, the Chickasaw Nation has made substantial progress toward reducing barriers and improving access to high-quality health services and programs for all First Americans living within the Chickasaw Nation. The Chickasaw Nation Medical Center, located in Pontotoc County, is an expansive, state-of-the-art health care complex providing numerous services including an acute care hospital, emergency department and urgent care, behavioral health services, primary and specialty care clinics, disease specific clinics such as the diabetes care center and a full-service pharmacy. There are three satellite facilities strategically located throughout the Chickasaw Nation treaty territory offering outpatient pharmacy services, as well as primary care, pediatrics, dental, women's care, audiology and optometry services.

Increasing enrollment in Medicaid can significantly alleviate barriers to health care access for First Americans by expanding coverage and reducing financial barriers to care. Medicaid provides comprehensive health care benefits, including coverage for preventive services, primary care visits and specialty care, thereby ensuring individuals have access to a wide range of medical services without facing prohibitive out-of-pocket costs. Additionally, Medicaid expansion can support the sustainability of tribal health care facilities by providing crucial reimbursement for services rendered to Medicaid beneficiaries, allowing these facilities to continue providing high-quality care to their communities.

27 Institute of Medicine (US) Committee on Monitoring Access to Personal Health Care Services; Millman M, editor. Access to Health Care in America. Washington (DC): National Academies Press (US); 1993. Summary.

Priority Area 3: Access to Care (cont.)

With the implementation of home visitation services CNDH will enhance health care accessibility for individuals who face transportation challenges or other barriers to accessing traditional health care settings. The home visitation program brings health care services directly to individuals' homes, facilitating regular health screenings, preventive care interventions and chronic disease management in a familiar and comfortable environment. This approach can be particularly beneficial for elderly individuals, individuals with disabilities and families with young children who may face difficulties accessing health care due to mobility issues or caregiving responsibilities.

The Inchokma mobile medical unit is equipped with medical equipment and staffed by health care professionals bridging the gap in health care access for remote or underserved communities. The mobile unit travels to various regions, including rural areas, to provide essential medical services, preventive screenings, vaccinations and health education to individuals who may otherwise have limited access to health care facilities. The mobile unit offers flexibility and adaptability to meet the unique health care needs of the population while overcoming geographical barriers to care.

With the expansion of a larger health care facility in the northern region, CNDH will enhance health care accessibility by centralizing specialized services and resources within closer proximity to Indigenous communities in the region. By strategically locating the health care facility in an area with higher population densities and offering specialized services, individuals can access a broader range of medical specialties, advanced diagnostic services and treatment options without having to travel longer distances. The new facility will serve as a regional hub for health care delivery, complementing the services provided by the existing medical center and tribal health clinics and ensuring that individuals have access to comprehensive and coordinated care closer to home.

Overarching goals were created to address specific health care access challenges and disparities within the Chickasaw Nation community, with a focus on improving access to essential services, promoting health equity and enhancing health outcomes for individuals and families across the region. By prioritizing these goals, the Chickasaw Nation demonstrates its commitment to ensuring all members of the community have access to the health care services they need to live healthy, happy and fulfilling lives.



Priority Area 3: Access to Care (cont.)

Goal 1: Establish and Expand Services in Remote Areas.
Many remote areas and underserved communities within the Chickasaw Nation face significant barriers to accessing health care services, including geographic isolation and limited infrastructure. Goal 1 aims to address these disparities by increasing access to health care services in remote locations through the deployment of mobile medical clinics. By bringing essential medical care directly to these communities, the Chickasaw Nation seeks to improve health outcomes, reduce health care disparities and ensure all individuals have access to timely and appropriate medical care, regardless of their location.

Goal 2: Increase Enrollment in SoonerCare and/or Medicare.
Access to health insurance coverage is essential for ensuring individuals can afford and access necessary health care services. Goal two focuses on increasing the number of eligible children and adults enrolled in SoonerCare (Oklahoma's Medicaid program) and/or Medicare (federal health insurance program for individuals aged 65 and older and certain younger individuals with disabilities). By expanding enrollment in these programs, the Chickasaw Nation aims to improve financial access to health care services, reduce out-of-pocket costs for individuals and families and enhance health insurance coverage among vulnerable populations.

Goal 3: Increase Access to and Expand Pediatric Services.
Children have unique health care needs that require specialized services and resources. Goal three seeks to address gaps in pediatric health care services by increasing access to and expanding pediatric services within the Chickasaw Nation. By enhancing pediatric care offerings, including preventive care, screenings, immunizations and treatment services, the Chickasaw Nation aims to promote the health and well-being of children, improve health outcomes and support families in raising healthy and thriving children.

Goal 4: Increase Access to Maternal, Infant and Early Childhood Home Visitation Services.
Maternal and child health is a priority area for promoting healthy families and communities. Goal four focuses on increasing access to home visitation services for expectant mothers, infants and young children within the Chickasaw Nation. Home visitation programs provide valuable support, education and resources to families during pregnancy, infancy and early childhood, promoting maternal and child health, enhancing parenting skills and fostering healthy development. By expanding access to these services, the Chickasaw Nation aims to improve maternal and child health outcomes, reduce disparities and support families in providing nurturing and supportive environments for their children.

Goal 5: Expand and Improve Access to Quality Health care Services in Northern Region.
Geographic disparities in health care access can contribute to unequal health outcomes among different populations. Goal five addresses these disparities by focusing on expanding and improving access to quality health care services for First American residents living in the northern region of the Chickasaw Nation. By investing in health care infrastructure, facilities and resources in underserved areas, the Chickasaw Nation aims to reduce barriers to care, improve health outcomes and ensure all individuals have equitable access to high-quality health care services, regardless of where they live.

Priority Area 3: Access to Care (cont.)

Goal 1: Mobile Clinics in Remote Areas

The Inchokma mobile medical unit offers a wide range of health care services mirroring those available in a traditional primary care setting, making it a versatile and accessible option for delivering comprehensive medical care to underserved populations. Equipped with state-of-the-art medical equipment, skilled health care professionals and a variety of resources, the mobile unit is capable of providing most services typically found in a primary care setting.

1. Primary Care Services:
The mobile medical unit delivers primary care services such as routine check-ups, preventive screenings and health assessments. Patients can receive comprehensive physical examinations, including vital sign measurements, cardiovascular assessments and evaluations of overall health status.

2. Chronic Disease Management:
Patients with chronic conditions, such as diabetes, hypertension and asthma, can receive ongoing management and monitoring through the mobile unit. Health care providers offer medication management, disease education, lifestyle counseling and preventive interventions to optimize patients' health outcomes and quality of life.

3. Acute Care:
The mobile unit is equipped to provide acute care services for common illnesses and minor injuries. Patients can receive evaluation, diagnosis and treatment for acute medical concerns, such as infections, respiratory symptoms, musculoskeletal injuries and skin conditions, without the need for a traditional office visit.

4. Immunizations and Vaccinations:
The mobile unit offers immunizations and vaccinations to prevent infectious diseases and promote public health. Patients can receive routine vaccinations, flu shots, travel vaccines and other immunizations conveniently at community locations, increasing access to essential preventive services.

5. Diagnostic Testing:
The mobile unit is equipped with diagnostic testing capabilities to facilitate timely and accurate diagnosis of medical conditions. Patients can undergo a variety of diagnostic tests, including laboratory testing (e.g., blood tests, urine tests), point-of-care testing (e.g., rapid strep tests, glucose monitoring) and diagnostic imaging (e.g., X-rays, ultrasounds).

6. Health Education and Counseling:
The mobile unit provides health education, counseling and support services to empower patients in managing their health and making informed decisions. Health care professionals offer guidance on nutrition, exercise, smoking cessation, medication adherence, chronic disease self-management and other health-related topics to promote wellness and prevent disease.

7. Referrals and Coordination of Care:
The mobile unit facilitates referrals to specialty care providers and community resources as needed. Health care providers collaborate with local health care facilities, specialists, social services agencies and other organizations to ensure seamless continuity of care and address patients' diverse health and social needs.

Priority Area 3: Access to Care (cont.)

In summary, the mobile medical unit offers an array of health care services comparable to those available in a traditional primary care setting. By bringing health care directly to underserved communities, the mobile unit enhances access to high-quality care, promotes preventive health measures and improved health outcomes for individuals who may face barriers to accessing traditional health care services.

Goal 1: Establish and expand services in remote areas by increasing access in remote locations and other areas that are underserved by increasing the number of mobile medical clinics sent to these areas.
Performance Measures: *How We Will Know We Are Making a Difference* **Short term:** Increase in the number of elders receiving an annual wellness check/screening. **Long term:** Develop a policy or SOP for instituting annual wellness visits into the Inchokma Medical Unit or prevention clinic.
Objectives:
ALCC 1.1 Provide 100 mobile clinics per year until 2027.
ALCC 1.2 Increase the number of service locations provided by the Inchokma Medical Unit by 100% by 2027.

Receiving annual wellness checks and screenings, including the Medicare Annual Wellness Visit exam, offers significant benefits to elders by promoting proactive management of their health and well-being. These annual check-ups serve as important opportunities for elders to engage in preventive care and early detection of health issues, ultimately contributing to improved quality of life and longevity. Here are several key benefits:

1. Early Detection of Health Issues:
Annual wellness checks enable health care providers to identify potential health problems early on, before they escalate into more serious conditions. Through comprehensive screenings and assessments, providers can detect risk factors for chronic diseases, such as diabetes, hypertension and cardiovascular disease, allowing for timely intervention and management.

2. Customized Preventive Care Plan:
The Medicare Annual Wellness Visit exam allows elders to work with their health care providers to develop personalized preventive care plans tailored to their specific health needs and goals. Providers can assess elders' health risks, review medical history and discuss preventive measures, such as vaccinations, screenings and lifestyle modifications, to optimize their overall health and well-being.

3. Medication Review and Management:
Annual wellness checks provide an opportunity for elders to review their current medications with their health care providers, ensuring appropriate dosage, efficacy and safety. Providers can identify potential medication interactions, side effects, or unnecessary medications, optimizing medication regimens to minimize risks and improve adherence.

Priority Area 3: Access to Care (cont.)

4. Health Education and Counseling:
Elders can benefit from health education and counseling provided during annual wellness checks, empowering them to make informed decisions about their health and lifestyle choices. Providers can offer guidance on nutrition, physical activity, smoking cessation, fall prevention and other preventive measures, promoting healthy aging and disease prevention.

5. Coordination of Care:*
Annual wellness checks facilitate coordination of care among health care providers, ensuring seamless communication and collaboration in managing elders' health needs. Providers can address gaps in care, facilitate referrals to specialists or community resources and promote continuity of care to enhance elders' overall health outcomes.

6. Patient-Centered Approach:
The Medicare Annual Wellness Visit exam emphasizes a patient-centered approach to care, focusing on elders' individual health goals, preferences and values. Providers engage elders in shared decision-making, empowering them to actively participate in their health care decisions and treatment plans, fostering a sense of autonomy and empowerment.

Overall, receiving annual wellness checks and screenings, including the Medicare Annual Wellness Visit exam, is essential for elders to proactively manage their health, prevent disease and maintain optimal well-being as they age. These comprehensive assessments not only promote early detection and intervention but also support elders in achieving their health goals and living healthier, more fulfilling lives.



Priority Area 3: Access to Care (cont.)

Goal 1: Enrollment in SoonerCare and Medicaid

The CNDH provides health care to more than 300,000 First Americans through an integrated health system consisting of an acute care hospital with on-site primary care, specialty clinics and three satellite clinics providing adult and pediatric primary care. Despite the availability and supply of these services in relative proximity to many Chickasaw Nation citizens, there are other factors impedeing access, including reliable transportation, adequate insurance coverage for specialty care outside of the CNDH scope of services or even an individual's long-standing behavior or attitude toward health.

Cost can be a barrier to care even for those who have insurance. Those with private, non-group insurance were three times as likely as those with employer-sponsored insurance to face such cost.[28] Approximately 30% of First American adults receiving care at the Chickasaw Nation are not insured.[29] Uninsured children are a particularly vulnerable population.

Medicaid expansion has led to increased health care coverage for tribal members who may not have qualified for Medicaid before. This has improved access to essential health care services and has given CNDH a greater financial ability to support the health care infrastructure including preventive care, which is crucial for overall community health.

Goal: 2 Increase the number of eligible children and adults enrolled in SoonerCare and/or Medicare.
Performance Measures: *How We Will Know We Are Making a Difference* **Short term:** Increase in the number of adults reached during discussions of SoonerCare and/or Medicare at health fairs. **Long term:** Increase the proportion of adults who get recommended evidence-based preventive health care; and the proportion of adolescents who had a preventive health care visit in the past year.
Objectives:
ALCC 2.1 Develop a report that monitors the number of SoonerCare eligible First Americans within Chickasaw Nation applying for renewed coverage annually through 2027.
ALCC 2.2 Increase awareness of SoonerCare eligibility requirements for First American families and children by attending six youth health fairs annually through 2027.

Goal 2, which aims to increase the number of eligible children and adults enrolled in SoonerCare and/or Medicare, is vital for improving access to health care services and promoting health equity within the Chickasaw Nation community. The performance measures and objectives outlined for this goal provide a framework for tracking progress and evaluating the effectiveness of efforts to expand health insurance coverage.

28 Kaiser Family Foundation. Mapping Marketplace Foundation. 2018

29 U.S. Census Bureau, 2021 American Community Survey 1-Year Estimates. Health Insurance Coverage.

Priority Area 3: Access to Care (cont.)

In the short term, an increase in the number of adults reached during discussions of SoonerCare and/or Medicare at health fairs serves as an indicator of improved awareness and understanding of health insurance options among community members. By actively engaging with adults and providing information about SoonerCare and Medicare eligibility requirements, the Chickasaw Nation enhances its capacity to connect individuals with available health insurance resources and facilitate enrollment in these programs.

In the long term, an increase in the proportion of adults who receive recommended evidence-based preventive health care and adolescents who attend preventive health care visits reflects improved access to health care services and utilization of preventive care among enrolled individuals. By ensuring that more individuals have health insurance coverage through SoonerCare and Medicare, the Chickasaw Nation aims to facilitate access to preventive services, screenings, vaccinations and wellness checks, ultimately improving health outcomes and reducing the burden of preventable illnesses.

The objectives outlined for Goal 2 further support these efforts by establishing specific targets and actions to increase SoonerCare enrollment and raise awareness of eligibility requirements among First American families and children. By monitoring SoonerCare eligibility applications, attending youth health fairs and disseminating information about health insurance options, the Chickasaw Nation enhances its ability to reach and enroll eligible individuals, reducing barriers to health care access and promoting health insurance coverage among underserved populations.

Overall, Goal 2 and its associated performance measures and objectives demonstrate the Chickasaw Nation's commitment to expanding health insurance coverage and improving access to health care services for individuals and families within the community. By increasing SoonerCare and Medicare enrollment, the Chickasaw Nation aims to enhance financial access to health care, facilitate preventive care utilization and promote overall health and well-being among community members.



Priority Area 3: Access to Care (cont.)

Goal 3: Pediatric Services

The Chickasaw Nation is continuously expanding its programs and services to meet the health care needs of First Americans. To increase capacity and offer additional services to children and adolescents, plans are in place to relocate and expand the pediatric clinic, currently located within the Chickasaw Nation Medical Center, to its own dedicated facility on the Ada campus. The pediatric clinic will expand from 12,000 square feet to approximately 65,000 square feet and will be offering new services, such as a pediatric developmental clinic, expansion of general pediatrics and the Empowered Living pediatric wellness clinic. To further improve access to pediatric health care and preventive care, plans are being developed to build an expanded, multi-service health care facility for First American residents in Newcastle, Oklahoma, adjacent to the Oklahoma City metroplex. This facility will be one of the largest and most comprehensive tribal health care facilities in the country and will provide CNDH an opportunity to expand the public health/community health footprint in the northern region.

Goal: 3 Increase access to and expand pediatric services.
Performance Measures: *How We Will Know We Are Making a Difference* **Short term:** Increase clinical time for children enrolled in Empowered Living at CNMC and at Ardmore clinic. **Long term:** Expand comprehensive pediatric services throughout Chickasaw Nation.
Objectives:
ALCC 3.1 Establish a child development clinic aimed at evaluating and providing comprehensive treatment and for developmental disorders by 2027.
ALCC 3.2 Expand the access of care for children who have obesity to the specialized services of the Empowered Living clinic at CNMC to 50% by 2027.
ALCC 3.3 Expand the access of care for children who have obesity to the specialized services of the Empowered Living clinic at Ardmore satellite clinic to 25% by 2027.

Goal 3, which focuses on increasing access to and expanding pediatric services within the Chickasaw Nation, plays a critical role in promoting the health and well-being of children and families. The performance measures and objectives outlined for this goal provide a framework for monitoring progress and evaluating the impact of efforts to enhance pediatric health care services.

In the short term, an increase in clinical time for children enrolled in Empowered Living clinics at CNMC and Ardmore clinic reflects improved access to specialized pediatric care for children with complex health care needs. By allocating additional clinical time and resources to these clinics, the Chickasaw Nation aims to ensure children receive timely and comprehensive medical evaluations, treatments and interventions, enhancing their overall health outcomes and quality of life.

Priority Area 3: Access to Care (cont.)

In the long term, the expansion of comprehensive pediatric services throughout the Chickasaw Nation signifies a commitment to addressing the full spectrum of pediatric health care needs within the community. By establishing a child development clinic aimed at evaluating and treating developmental disorders, the Chickasaw Nation enhances its capacity to identify and address developmental delays and disabilities in children, promoting early intervention and optimal developmental outcomes.

The objectives outlined for Goal 3 further support these efforts by establishing specific targets and actions to expand access to specialized pediatric services, particularly for children with obesity. By increasing access to the Empowered Living clinic at CNMC and Ardmore satellite clinic for children with obesity, the Chickasaw Nation aims to address the complex health care needs of this population, provide comprehensive treatment and support services and improve health outcomes related to obesity and related conditions.

Overall, Goal 3 and its associated performance measures and objectives demonstrate the Chickasaw Nation's commitment to prioritizing pediatric healthcare and ensuring children have access to high-quality, comprehensive services promoting their health, development and well-being. By expanding pediatric services and addressing the unique health care needs of children, the Chickasaw Nation aims to create a healthier future for the next generation and support families in raising thriving and resilient children.



Priority Area 3: Access to Care (cont.)

Goal 4: Maternal, Infant and Child Home Visitations

Growing evidence indicates adversity and toxic stress during childhood increases chronic physical and mental disease throughout life, making Adverse Childhood Experiences (ACEs) a significant public health concern. The increased occurrence of physical diseases and mental disorders appear to occur through alterations in molecular and epigenetic activity, which change the development and functioning of a child's neurological, immune and endocrine systems.[30]

The most recent estimates available for 2019-2020 show that 17.5% of Oklahoma children have experienced two or more ACEs from a list including: parental divorce or separation; living with someone with an alcohol or drug problem; experiencing or witnessing neighborhood violence; living with someone with mental illness or suicidality; witnessing domestic violence; having an incarcerated parent; experiencing discrimination due to race or ethnicity; and experiencing the death of a parent.[31] This can be compared with a national average of 14.8% of children experiencing two or more ACEs. Oklahoma has the 13th highest rate of ACEs for children from 0-17 among all 50 states.[32] At this time, there is not county level data on the rate of ACEs in Oklahoma.

Maternal, Infant and Early Childhood Home Visitation Programs (MIECHV) are designed to provide support and education to expectant parents, new mothers and families with young children. While the primary goal is to improve maternal and child health outcomes, these programs can also play a role in decreasing Adverse Childhood Experiences (ACEs) among infants and young children, as well as ameliorating negative impacts of ACEs parents experienced earlier in life. MIECHV programs contribute to reducing ACEs through:

1. Early Intervention and Support:
MIECHV programs often begin during pregnancy or shortly after childbirth, providing an early opportunity to identify and address potential stressors or challenges within the family. Early intervention can prevent or mitigate factors that may contribute to adverse experiences later.

2. Parenting Education and Skill Building:
Home visitation programs focus on educating parents on child development, parenting skills and creating a nurturing and supportive environment for the child. By enhancing parenting knowledge and skills, these programs empower parents to provide a stable and positive upbringing for their children.

3. Stress Reduction and Coping Strategies:
MIECHV programs often address parental stress and mental health, providing tools and strategies for stress reduction and coping. Supporting parents in managing stress can contribute to a more stable family environment, decreasing the risk of ACEs.

4. Promotion of Healthy Relationships:
Home visitors in MIECHV programs can help families build positive and supportive relationships. By fostering healthy parent-child relationships and promoting positive interactions within the family, these programs contribute to a protective environment buffering against adverse experiences.

30 Boullier, M., Blair, M. (2018). Adverse childhood experiences. Pediatrics and Child Health, 28(3), 132-137.
31 America's Health Rankings analysis of National Survey of Children's Health, U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau, MCHB, United Health Foundation, AmericasHealthRankings.org.
32 America's Health Rankings analysis of America's Health Rankings composite measure, United Health Foundation.

Priority Area 3: Access to Care (cont.)

5. Screening for Risk Factors:
MIECHV programs typically involve screening for risk factors that may contribute to ACEs, such as substance misuse, domestic violence or mental health issues. Identifying these risk factors early allows for targeted interventions and support.

6. Connecting Families to Resources:
Home visitors can help families access community resources and services, including mental health services, child care, housing assistance and substance misuse treatment. Addressing socioeconomic factors and connecting families to appropriate resources can reduce stressors that contribute to ACEs.

7. Promoting Child Well-Being:
MIECHV programs focus on the overall well-being of the child, including physical and mental health. By addressing health and developmental needs early, these programs contribute to a positive and nurturing environment that can prevent adverse experiences.

8. Building Resilience:
MIECHV programs aim to build parental and family resilience, which is a key factor in preventing the negative impact of stressors. Resilient families are better equipped to handle challenges and disruptions, reducing the likelihood of adverse childhood experiences.

Retrieved from https://mchb.hrsa.gov/programs-impact/maternal-infant-early-childhood-home-visiting-miechv-program

Goal: 4 Increase access to maternal, infant and early childhood home visitation services (MIECHV).

Performance Measures: *How We Will Know We Are Making a Difference*
Short term: Increase the percentage of staff trained in maternal, infant and early childhood home visitation services.
Long term: Decrease in the number of injuries reported in homes. Increase in the percentage of mothers who receive prenatal care. Increase in the percentage of infant immunizations.

Objectives:

ALCC 4.1 By 2027, develop a Chickasaw Nation maternal, infant and early childhood home visitation program incorporating evidence-based strategies and tribal best practices.

Goal 4, which aims to increase access to maternal, infant and early childhood home visitation services within the Chickasaw Nation, is designed to support the health and well-being of mothers, infants and young children during critical developmental stages. The performance measures and objectives outlined for this goal provide a framework for evaluating the impact of home visitation programs and monitoring progress toward improving maternal and child health outcomes.

Priority Area 3: Access to Care (cont.)

In the short term, an increase in the percentage of staff trained in maternal, infant and early childhood home visitation services reflects a commitment to building the capacity of health care providers and home visitors to deliver high-quality, evidence-based care to families. By investing in training and professional development opportunities for staff, the Chickasaw Nation aims to ensure home visitation services are delivered by knowledgeable and skilled professionals who can effectively support families in navigating the challenges of early parenthood and promoting optimal child development.

In the long term, the performance measures focus on key indicators of maternal and child health outcomes, including a decrease in the number of injuries reported in homes, an increase in the percentage of mothers who receive prenatal care and an increase in the percentage of infant immunizations. These indicators provide valuable insights into the effectiveness of home visitation programs in promoting safe and healthy home environments, improving access to prenatal care and enhancing vaccination rates among infants, all of which contribute to better maternal and child health outcomes.

The objectives outlined for Goal 4 further support these efforts by establishing specific targets and actions to develop a Chickasaw Nation maternal, infant and early childhood home visitation program that incorporates evidence-based strategies and tribal best practices. By designing and implementing a culturally relevant and effective home visitation program, the Chickasaw Nation aims to provide families with the support, education and resources they need to promote maternal and child health, foster positive parent-child relationships and ensure children have the best possible start in life.

Overall, Goal 4 and its associated performance measures and objectives demonstrate the Chickasaw Nation's commitment to supporting families during the critical early years of parenthood and promoting the health and well-being of mothers, infants and young children. By increasing access to home visitation services and focusing on key maternal and child health outcomes, the Chickasaw Nation aims to empower families to thrive and create a healthier future for generations to come.



Priority Area 3: Access to Care (cont.)

Goal 5: Access in the Northern Region

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life. Access to health care impacts overall physical, social and mental health status; prevention of disease and disability; preventable hospitalization; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

People with a consistent source of care have better health outcomes and fewer disparities and costs. Health Resources and Services Administration (HRSA) defines areas and populations as "Medically Underserved" based on four weighted variables: ratio of primary medical care physicians per 1,000 population; percentage of the population with incomes below the poverty level; infant mortality; and percentage of the population age 65 or over.[33] In the Chickasaw Nation treaty territory, the rate of physicians per 100,000 (41) is lower than the average physician rate in Oklahoma (61)(Table 16).[34]

The Chickasaw Nation's expanded health care facility in the northern section of the Chickasaw Nation treaty territory represents a significant stride toward enhancing the well-being of patients in the region. With state-of-the-art medical infrastructure and an expanded range of services, this facility is poised to provide comprehensive and accessible health care to the community. Patients will benefit from a broader spectrum of specialized medical care, including advanced diagnostics, specialized treatments and preventive services. The expansion reflects a commitment to meeting the diverse health care needs of the population, ensuring that individuals receive timely and high-quality care. Additionally, the facility is likely to foster a sense of community and support, as patients can access a range of health services in a centralized and modern setting. This development not only signifies an improvement in health care infrastructure but also underscores the Chickasaw Nation's dedication to promoting the health and well-being of Chickasaw and First American citizens.

Goal: 4 Expand and improve access to quality health care services for First American residents living in the northern region of the Chickasaw Nation.

Performance Measures: *How We Will Know We Are Making a Difference*
Short term: Determining new and expanded services for the Newcastle location.
Long term: Complete construction of the Newcastle hospital to expand access to care to more First Americans.

Objectives:

ALCC 5.1 Interview 100% of selected department staff to assist in the schematic design of the new medical facility in terms of character, materials, shape and organization of interior spaces and exterior appearances by 2025.

ALCC 5.2. By the end of 2025, complete 100% of the design, documentation and permitting stages to begin the final stage, construction of the new medical facility.

33 Clancy C, Munier W, Brady J, et al. 2012 National healthcare quality report. Rockville, MD: Agency for Healthcare Research and Quality (AHRQ); 2013
34 University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps 2021.CMS, National Provider Identification

Priority Area 3: Access to Care (cont.)

Goal 5 focuses on expanding and improving access to quality health care services for First American residents living in the northern region of the Chickasaw Nation, addressing disparities in health care access and ensuring all individuals have equitable access to essential medical care. The performance measures and objectives outlined for this goal provide a framework for assessing progress and evaluating the impact of efforts to enhance healthcare services in the northern region.

In the short term, the determination of new and expanded services for the Newcastle location reflects a commitment to identifying and addressing gaps in health care services within the northern region of the Chickasaw Nation. By conducting assessments and strategic planning efforts, the Chickasaw Nation aims to identify the specific health care needs of the community and develop plans to expand and improve services, accordingly, ensuring residents have access to a comprehensive range of medical services close to home.

In the long term, the completion of construction of the Newcastle hospital represents a significant milestone in efforts to expand access to care for First American residents in the northern region. By investing in the construction of a new medical facility, the Chickasaw Nation aims to increase capacity, improve infrastructure and enhance the quality of health care services available to residents, ultimately improving health outcomes and promoting wellness in the community.

The objectives outlined for Goal 5 further support these efforts by establishing specific targets and actions to involve staff in the design and planning of the new medical facility and ensure timely completion of the construction process. By engaging staff in the design process, the Chickasaw Nation aims to create a facility meeting the needs of both patients and health care providers, fostering a supportive and conducive environment for delivering high-quality care.

Overall, Goal 5 and its associated performance measures and objectives demonstrate the Chickasaw Nation's commitment to addressing health care disparities and promoting health equity for First American residents in the northern region. By expanding and improving access to quality health care services, the Chickasaw Nation aims to ensure all individuals can receive the care they need to live healthy, fulfilling lives, regardless of where they reside within the community.

Priority Area 3: Access to Care (cont.)

Alignment with National and State Priorities

Healthy People 2030	Increase the proportion of adolescents who had a preventive health care visit in the past year.
	Increase the proportion of people with health insurance; reduce the proportion of people who are underinsured.
	Increase the ability of primary care and behavioral health professionals to provide more high-quality care to patients who need it.
	Reduce the proportion of people who cannot get medical care when they need it.

Evidence Based Practice Sources for Access to Care:
Centers for Disease Control and Prevention: Enhancing Use of Clinical Preventive Services Among Older Adults



Conclusion: Transformation in Action

A community-centric approach to health in tribal communities offers numerous benefits, emphasizing collaboration and the sharing of resources. Tribal collaborations with state and federal entities can enhance the exchange of knowledge and resources, tailoring health care strategies to meet the community's unique needs and traditions. By incorporating cultural practices and leveraging the expertise of tribal health care practitioners, a holistic approach to health can be developed, promoting overall well-being and a stronger sense of cultural identity.

The co-location of clinical care and public health initiatives within tribal health systems streamlines service coordination, ensuring comprehensive care delivery and effectively addressing individual and population health needs. This integrated model fosters collaboration among health care providers, researchers and public health professionals, facilitating a holistic understanding of health within the community. By leveraging shared resources, expertise and data, clinical care and public health initiatives can identify emerging health trends, customize interventions and track outcomes over time. This collaborative approach enables proactive and preventative health care strategies, focusing on promoting wellness and addressing social, economic and environmental factors that influence health.

Furthermore, the integration of clinical care, public health initiatives and community health programs within tribal health systems enhances accessibility, cultural relevance and engagement with services for tribal members. By providing culturally competent care and tailored programs reflecting the community's unique needs and preferences, barriers to health care access are minimized, fostering trust in the health care system. This inclusive approach acknowledges the importance of cultural identity in promoting overall well-being and resilience among tribal populations. Leveraging modern health care resources and technology, this integration ensures the health care system is responsive to the holistic health needs of the community, addressing social determinants of health and promoting wellness through a combination of clinical interventions and community-based strategies.

State-level collaborations further amplify the impact of community-focused health initiatives. Partnerships between local health departments and community organizations can lead to more effective health education campaigns, preventive care programs and outreach efforts. By pooling resources and expertise, states can address public health challenges comprehensively, reaching diverse populations with targeted interventions. The exchange of best practices and data between tribal and state health agencies can enhance the overall health infrastructure, creating a seamless continuum of care benefiting individuals and families across the community.

Collaboration with federal partners and funding agencies becomes imperative for developing policies and initiatives addressing the unique health disparities within communities. Federal agencies can support community-driven health programs by providing funding, technical assistance and policy frameworks aligning with the specific needs of diverse populations. By fostering open communication channels and promoting mutual understanding, federal collaborations contribute to the creation of a more resilient and inclusive health care system benefiting communities at every level. Ultimately, a community-oriented approach to health, supported by tribal, state and federal collaborations, lays the foundation for a healthier, more interconnected society.

Conclusion: Transformation in Action (cont.)

The Chickasaw Nation Health Improvement Plan is designed to inspire the Chickasaw Nation and communities to work collaboratively together to help all First Americans and citizens to live healthier, happier and longer lives. While great strides have been made in recent years, challenges and opportunities remain. Integrating the input and findings derived from published health data, stakeholder and community engagement and evidence-based frameworks and practices, the 2024-2027 CHIP proposes new ways of interacting, new structures for communication and a renewed hope that progress on issues of mutual interest can be achieved through the Chickasaw Nation and its partnerships as well as individual residents' commitment and involvement.

All citizens, both First American and community citizens of the Chickasaw Nation treaty territory are asked to participate by creating a culture of health. Change begins when we adopt the recommended healthy lifestyle, the recommended health policies and engage everyone within our community.

Visit ChickasawNationHealth.net/Public-Health to explore Chickasaw Nation's health priorities and issues.

Implementation

As part of DPH's performance management system, taskforce members will be engaged to track, trend and report on the progress of the established measures over the course of this three-year plan through the Enterprise Service Management (ESM) system.

ESM is a holistic approach to managing an organization's services across departments, functions and business units. Unlike traditional models that focus on individual departmental needs, ESM seeks to optimize and streamline service delivery throughout the entire enterprise. It is often associated with adopting service management principles and practices across all departments. By breaking down silos and promoting cross-functional communication, CNDH can address complex challenges more effectively and leverage the expertise of various departments. Like the traditional Balanced Scorecard approach, ESM involves measuring and monitoring key performance indicators (KPIs) to assess the effectiveness of services across the organization. This data-driven approach helps in making informed decisions and continuous improvement.

This comprehensive strategy recognizes the interconnectedness of various services within the organization and aims to improve overall operational efficiency, agility and customer satisfaction. It aligns with the broader goal of adopting a more holistic and integrated approach to managing resources and services.

The ESM Balanced Scorecard software is pivotal in the collaboration between each taskforce and the Steering Committee for the 2024-2027 CHIP. The software efficiently tracks and shares progress toward goals, serving as a central hub for data input. Quarterly, the priority area for each taskforce discusses progress, addresses concerns and proposes actionable solutions or CHIP revisions utilizing data from ESM software in their meetings. Each taskforce recommends any necessary enhancements or changes to the Steering Committee, fostering a streamlined process of collective monitoring and continuous improvement. The Steering Committee, leveraging the insights from the ESM software, meets twice a year to monitor taskforce progress and review the plan, ensuring its ongoing relevance and effectiveness. Additionally, a new website has been developed to provide comprehensive information on the 2024-2027 CHIP, benefiting taskforce members, the Steering Committee and all residents of the Chickasaw Nation.

Conclusion: Transformation in Action (cont.)

Stakeholders

Rocco DiMambro	**Accreditation Coordinator**	Chickasaw Nation Division of Public Health
TBD	**TBD**	TBD
TBD	**TBD**	TBD
Sheryl Goodson, MBA, CMPE	**Executive Officer of Ambulatory and Public Health**	Chickasaw Nation Department of Health
TBD	**TBD**	TBD
TBD	**TBD**	TBD
TBD	**TBD**	TBD

CHIP Steering Community

Rocco DiMambro	Accreditation Coordinator
Miranda Willis-Webster, MPH	Epidemiologist Manager
Jeffrey Wells PT, DPT	Director of Public Health, Chronic Disease Chair
Misty Boyd, Ph.D.	Director of Community Health, Behavioral Health Chair
Heather Summers, RN, MSN	Population Health Manager, Access to and Linkage to Access to Care Chair
TBD	TBD
TBD	TBD
TBD	TBD
TBD	TBD
Sheryl Goodson, MBA, CMPE	Executive Officer Ambulatory and Public Health

Chickasaw Nation Department of Health Division of Public Health

Community Health Improvement Plan

2024-2027