Alyce Spotted Bear and Walter Soboleff Commission on Native Children

August 20, 2021
Alaska Regional Hearing
Hybrid Hearings: Panel 4 – Systems Innovation and Best Practices in Native Communities

Recording:
https://commissiononnativechildren.org/media/video/panel-4-systems-innovations-and-best-practices-in-native-communities-recording-august-20-2021/

Commissioners Present In-person:
Gloria O'Neill (Chair); Dr. Tami DeCoteau (Vice-Chair); Melody Staebner; Carlyle Begay; and Donald Gray.

Commissioners Present Virtually:
Dr. Dolores (Dee) Subia BigFoot, Anita Fineday, and Dr. Leander R. McDonald.

Commissioners Absent:
Elizabeth Morris Jesse Delmar, and Stephanie Bryan.

Detailees, Staff, and Contractors:
Ronald Lessard, Department of Education
Eileen Garry, Department of Justice
Regina Gilbert, Department of the Interior
Tiffany Taylor, Department of the Interior
Lisa Rieger, Cook Inlet Tribal Council
Joshua Franks, Cook Inlet Tribal Council
Miriam Jorgensen, Native Nations Institute, University of Arizona
Kyra James, Native Nations Institute, University of Arizona
Stacy Leeds, Leeds Consulting
Briana Moseley, Kearns & West
Chelsea Cullen, Kearns & West
Caisey Hoffman, Kearns & West

Agenda: 4:30 pm – 6:00 PM AKT - Panel 4: Systems Innovations and Best Practices in Native Communities

[Transcript]

Chair O'Neill 0:00	Okay, so I'm very excited about this next panel, and it is all focused on systems innovations and best practices in Native communities. What I would like to do before we introduce our panelists, is have the Commission members introduce themselves so I will start with Commissioners who are in the room in Anchorage.

Commissioner Staebner 00:31	I am Commissioner Melody Staebner, and I'm from Fargo, North Dakota. I coordinate Indian Education in my school district, Fargo and West Fargo and I'm also enrolled in the Turtle Mountain Reservation. Thank you for coming.
Commissioner Gray 00:46	Good evening. Commissioner Gray or Don Gray and I am a shareholder descendant, Ukpeaġvik Inupiat Corporation and the co-chair for the Alaska regional meeting. So welcome. Thank you for being here tonight.
Vice-Chair DeCoteau 01:05	Good afternoon. My name is Tami DeCoteau. I am from the State of North Dakota where I practice as a licensed psychologist. I'm a member of the Arikara Tribe and a descendant of the Turtle Mountain Chippewa and I serve as the vice chair to the Commission.
Commissioner Begay 01:21	Good afternoon or good evening depending on where you're at and what time zone, but my name is Carlyle Begay and I'm from the greatest State of Arizona and member of the Navajo Nation.
Chair O'Neill 01:36	Thank you, Commissioner Fineday.
Commissioner Fineday 01:46	Thank you, and welcome to this hearing. Thank you so much for spending your time with us. For me, it's this evening. My name is Anita Fineday and I'm in Minnesota, and I'm a member of the White Earth Tribe in Northwest Minnesota. I've worked with Casey Family Programs and I'm in charge of the Indian Child Welfare team at Casey. Thank you.
Chair O'Neill 02:15	Dr. McDonald.
Commissioner McDonald 02:19	Good evening, everybody. My name is Russ McDonald. I'm president for United Tribes Technical College located in Bismarck, North Dakota. I'm an enrolled member of the Spirit Lake Dakota Nation and proud descendant of the Sahnish, Hidatsa, and Hunkpapa peoples. Really look forward to your presentation this evening. Thank you.
Chair O'Neill 02:40	Thank you, Dr. BigFoot.
Commissioner BigFoot 02:44	Hello, and good evening. It's evening time here. We're getting a sunset. So, I'm in Oklahoma. I'm Dee BigFoot. And I am of Caddo Nation of Oklahoma. And I am on faculty at the University of Oklahoma Health Sciences Center, which is in Oklahoma City. And I run the Indian Country Child Trauma Center. So, it was wonderful to hear people talk about trauma-informed care and trauma principles in terms of treatment that are, throughout this week. And I also run the SAMHSA (Substance Abuse and Mental Health Services Administration) funded Suicide Prevention Resource Center. So, thank you for being here with us.

Chair O'Neill 03:32	Thank you. And again, my name is Gloria O'Neill and I have the privilege and honor to serve as the Chair of the Commission along with my role, my everyday role at Cook Inlet Tribal Council as President and CEO. So, without further ado, we're gonna go ahead and get started because it's Friday at 4:30 and we're still going. We'll note that for the next Commission in person hearing, okay. What I'd like to do is just take a few moments and allow each of our panelists to introduce yourself, who you are and, in your role,, and then we will start with Jessica. It's very exciting. As I read your bio, Jessica, I'm really looking forward to what you have to say so we'll have the panelists introduce themselves and then let's turn it to Jessica.
Dr. Jessica Ullrich 04:31	Hello, [native language] I am Jessica Saniguq Ullrich in Inupiaq in the University of Alaska Anchorage in the School of Social Work and I'm a descendant of the Native Village of Wales. I'm a tribal member of Nome Eskimo Community. And I know Gloria O'Neill's daughter. I know Anita Fineday, Dee BigFoot is why I got my PhD. So, I am so excited to be here with all of you today and I am passionate about promoting the well-being of our children because I feel like when we do that, and we have healthy children will have healthy families, communities, the earth and future generations. So excited to be here and to share a little bit about what I've been learning through my research on indigenous connectedness. Thank you.
Chair O'Neill 05:21	Thank you. Holly.
Holly Morales 05:26	Can you hear me okay?
Chair O'Neill 05:28	We can hear you.
Holly Morales 05:29	Oh, wonderful. Hello everyone. I am Holly Morales. I work here at Cook Inlet Tribal Council (CITC). Thank you for having me today. I have been with CITC for about 24 years. I love it here obviously. And I am a Yup'ik tribal member from Stebbins, Alaska, but I was born and raised here in Anchorage. I do have a blended background. My mom is from actually from Boston, Massachusetts, with Irish descent. And she met my father in the village as a VISTA (Volunteers in Service to America) volunteer nurse. And so, I have the privilege of coming out of that beautiful relationship. So, thank you for being, for allowing me to be here and look forward to hearing everybody's testimony.
Chair O'Neill 06:19	Thank you, Dr. Eby.
Dr. Doug Eby 06:24	Hi, Doug Eby, been a real pleasure to be allowed to work in support of Alaska Native people for the last 31 years. Catherine Gottlieb, the previous C.E.O. at SCF (Southcentral Foundation), and I met each other 28 years ago, and she allowed me to have a role to play in the system. So I'm a physician and public health stuff and lots of other certificates that don't really matter. I've been raised by three children

and corrected by a wife. And by many women who lead tribal organizations I work in support of, including one Gloria O'Neal, few other people, Lisa Wade was here earlier, another one of the powerful women I strive to be worthy of. So, it's always fine when I talk about things that the people that need input are the medical people, the institutional people, the policy people, and the elected officials. And the people who are community-based, like every single person on this Commission, generally know already a lot about what works and doesn't work way more than the supposed system professional. So, I look forward to interacting and hearing your questions and so forth.

Chair O'Neill 07:42 — Thank you, Dr. Eby. Deb.

Deborah Northburg — Push, how's that. Thank you for allowing me to be here and to share comments and learn from others. I'm Deb Northburg and I serve as a Senior Director of Child and Family Services at Cook Inlet Tribal Council. I've been with CITC almost 19 years, and in the human services field about 30 years. Most of my experience, nearly all, is around child welfare, family preservation, and my family is from the northwest part of Montana, near the Blackfeet reservation.

Chair O'Neill 08:33 — Great, thank you, Deb. Well, I think what we're going to do is as, as we kick this off, is Jessica, we're going to start with you because I'm really excited to hear what you have to say on your research.

I. Panelist: Dr. Jessica Saniguq Ullrich, Author of the Indigenous Connectedness Framework

Dr. Jessica Ullrich 08:48 — All right, thank you so much. And I did provide some written testimony, I hope you received, that provides a little bit of a summary regarding the Indigenous Connectedness Framework, but I, through my dissertation process, I interviewed 25 Alaskan Native Knowledge Bearers who represented foster care alumni, relative caregivers and foster parents. And I was hoping to learn from them what they believed promoted child well-being and how they conceptualized it and what those important relationships were, that they felt were needed for children to have in order to be healthy and well, and I learned a lot. One thing that was unexpected was the amount of information that came forward about some of the traumas and challenges that occurred for them, or that they witnessed in the children that they cared for. And I felt like one of the processes of engaging in Indigenous storytelling methods is that we step back, and we think about what is it that we need to learn. And one of those things that I felt like was important for everyone to learn from the Knowledge Bearers was the importance of acknowledging the trauma and the challenges and for us to talk about it. And that's, I can submit a PowerPoint with some of the quotes from the Knowledge Bearers that kind of hits on some of these lessons learned. But that acknowledgement was a big update on this framework. And that is represented in some words in the red in that visual, the circle visual, that I hope you have before you. And all of those different traumas and challenges

were spoken about at some point in some of the stories that were shared about their life experience. Another lesson learned was the importance of relational continuity. And that meant that we really think about child welfare through the lens of a child's eyes. And Child Welfare very much is embedded in a system of child removal yet, that's one of the primary interventions or occurrences in child protection services, and child removal, the big “A-ha” for me was through a child's lens, they're removed not only from their parents, they see it as their siblings are removed from them, their extended family members, their grandparents, their neighbors, their school, their teachers, their friends, their neighborhoods, their, the places where they feel familiar and comfortable. And they're removed from their culture in terms of being connected with people that teach that to them, that teach them about their spirituality and who they are and where they come from. And so that continuity was a message that came through loud and clear as we're this system, the way that it's set up right now is not doing a good job at ensuring relational continuity from that perspective. And from a caregiver perspective, it is difficult and challenging to have children who they may have provided love to for two years, then move and, and change placements. And there is a lot of grief expressed about some of that. So, I just have a deeper empathy and understanding from these various perspectives. And I feel like one of the messages I hope this Commission gets is the importance of listening to people with lived experience. So that to me is one of the most important things in terms of really getting at systems change, and coming up with solutions to improve services, is to listen to people with lived experience.

But this third lesson that was learned was, kind of coming back to this element of helping children know who they are and where they come from. And I feel like this framework is providing a roadmap. When we know who we are, and where we come from, that is our superpower. That is where all of this colonial trauma and harm and all of these false beliefs and social constructs that are put out there and lies that our children are told about who they are, that falls away, it sheds off. And it's sort of like knowing who you are, where you come from at the core, is it when you're grounded in that and you're connected with who you are, that's what helps us come back into right relationship, and that's the relational healing. That's the way that we achieve success in terms of ending the relational wounding that trauma caused in supporting relational healing, by engaging in the cultural activities and in the things that our elders have been telling us to do, to know who we are, where we come from, for generations. And I feel like we're at a very important point in time, especially with what's coming up around boarding schools and the intergenerational grief that is surfacing around that, it's time to stop the removal of our children. And I feel like we have a lot of ideas and practices out there that we're, we're trying to get implemented. But if we aren't grounded in an Indigenous worldview in our Indigenous theories, and our Indigenous knowledge and values, we're not going to see the success that we would hope to see, such as the Indian Child Welfare Act. This policy was passed. I feel like it very much is congruent with this Indigenous connectedness framework, but when it's embedded in a system that continues to operate in colonial ways of viewing things, like thinking of only the parent child dyad, rather than all of these relationships that children need, that

	we're not going to see that this policy be successful. We need the system to change the way that the work is being done, we need a huge paradigm shift to happen, we need to come back to being relational, we need this policy that was created for our children to end the ongoing removal of our children, we need this policy to apply to all and it does. I feel like this framework applies to all children. It's what it means to be a real human being, and we want our children to do that we want all of us to know who we are at the core, we want all of us to come back in right relationship with each other to end the oppressions and hierarchies and thinking about things in an individual way. Hence, the reason why COVID is such a mess right now, we have a lot of shifting to do in the way that we believe we should show up in the world. So, I have more to say, but I'll stop with that and, and I'll share as much info and resources and articles that, that this Commission might need. I really care about the work that you're doing. I love our children too. And if I can be of any more support or help to your efforts in any way, I'm happy to be available for that.
Chair O'Neill 17:07	Thank you, Jessica, I could listen to you for an hour. I'm so proud of you and the work that you're doing and how important it is and how it's gonna impact all the work that we do. I'm just so very proud of you. I'd like to just pause and ask if there are any Commissioners that might have a comment or question of Jessica. Yes, Commissioner Fineday.
Commissioner Fineday 17:39	Thank you. Hi, Jessica. So great to see you. I just want to, maybe, paraphrase what you're saying. I think I understand what you're saying. And, I believe that the child welfare system is moving in this direction of we shouldn't be removing children. So that's the bottom line, right?
Jessica Ullrich 18:11	Yes, I agree. That is the direction it's moving in. And I think there are some hiccups that are coming forward through like the Family First Prevention Services Act and the difficulty at obtaining those funds due to this requirement for evidence-based practices to be implemented. And I feel like we have evidence-based practices such as the AVCP (Association of Village Council Presidents) Healthy Families program and Child Free [Native language], I'm not Yupik, I don't say that but very clearly, but it just makes me think about what is the measure of our success? And does it always have to be quantifiable through statistics, or can we listen to the lived experience and that be enough? And that be what is our evidence that something is successful, if we have people that share how this program helped them heal if we share, have them share how their relationships have improved, or how they felt more connected with who they are, where they come from, like those to me are just as important to ask and to build as evidence as, as the numbers and the outcomes, and those sorts of things are still important as well. But I keep saying in all the spaces that I can that we also need to listen, we need to hear the stories we need to think about how we measure success in, in other ways.
Commissioner Fineday 19:51	Thank you for that.

Chair O'Neill 19:55	Thank you. Commissioner BigFoot.
Commissioner BigFoot 20:01	Jessica, thank you. That was, that was important knowledge, the things you say about Knowledge Bearers. And I think we need to, I think your words are just absolutely amazing. I think we need to offer new definitions for things. And, like, child well-being. And, you know, definitely, I think we've always challenged the definition of families. So, I would like to challenge you to come up with some, some of these new definitions, I think you have it there. Because I think your child welfare, the Children's Bureau, the, you know, other child welfare organizations need to be challenged by their, the definitions that they have come up with. And I think we're being, becoming more aware of that relational aspects. And you know, Jerry Krause was one of the first that came up with it. And so being able to write this in and get it on paper, and I think, you know, one of the things we have to challenge is just because it's written down, doesn't make it true. But certainly, the literature has tilted in that way. So, congratulations, I think we all have much to be proud of, in terms of your work. And I look forward to, so, are you publishing this? That's my question.
Dr. Jessica Ullrich 21:35	Yes, I am publishing and co-authoring, and I have a dissertation published and I'm trying to put out more manageable pieces for people to digest rather than 100-page dissertation. So, I am working on getting more materials out there. And I'm also presenting in numerous venues, including the Kempe Center through a webinar next month. So, I'm reaching out, and I'm accepting invitations, if there are other platforms that I can disseminate this knowledge, I'm doing my best to share it.
Commissioner BigFoot 22:13	Thank you very much. Really wonderful.
Chair O'Neill 22:17	Great. Commissioner Gray.
Commissioner Gray 22:21	I am honored to have read some of the experts of your dissertation. And I am also excited to see that you're here today and could listen to you for hours as well. On one of the underlying themes, I think that I continue to hear is, it's more than just it's time to stop the removal of our children. I hear it's time to give our children their childhood back. Again, thank you for being here tonight.
Dr. Jessica Ullrich 23:00	Yes, thank you. And I really feel like we need to create better services that do not compound trauma for children, they've already been through enough. We don't need to add to that through the implementation of removal or these sorts of things that, that make it even more difficult sometimes and confusing for children. And that's part of what I was hearing from many foster care alumni that I spoke with, that we need a different system, we need a different way of doing this. They share the same goal, all the Knowledge Bearers expressed to me their desire for us to have better outcomes for children. So, it's time, and I keep saying to everyone that

it's time because all the right people that are meant to do this work to bring forth the healing efforts are here. And I feel like our future generations must have something to do with that, like they were doing this work for them. We're breaking cycles, we're making these shifts so that when they bring their gifts to the world, they're using them and not having to expend all this energy on healing from trauma that many of us have had to do. I'm excited about that. And I, I just put in the chat. I shared a PowerPoint that I gave to the Alaska Blanket Exercise facilitators, they kind of addressed history and resilience in those things. And I just wanted to also include that in terms of you having access to some of the quotes from the Knowledge Bearers. So that's why I do this work. I'm listening and I hope to continue sharing. Thank you.

Chair O'Neill 24:52 — Thank you. Yes, Commissioner DeCoteau.

Vice-Chair DeCoteau 24:55 — Yes, thank you Madam Chair. I have always said and continue to believe that our indigenous relatives have the wisdom to identify their problem and their solution. And your work is a perfect example of that. And how these participants identified their needs, is really excellent and I think can be used widely across Indian country. So, thank you for your work.

Chair O'Neill 25:24 — Yeah. Okay, thank you, Jessica, I hope you, you stay with us throughout the duration of the panel. Now I'm going to turn it over to Dr. Doug Eby.

II. Panelists: Dr. Doug Eby, Vice President of Medical Services, Southcentral Foundation

Dr. Doug Eby 25:37 — Wow, you're making me follow Jessica. That was great, Jessica. And I just feel that huge amount of resonance with the relational continuity lived experience. The comments about truth coming from the people themselves. It's something that's taken us a very long time to try to get our medical people to understand that's all true. So, we, you know, I work in a medical system, that's sort of where the practices and innovation and so forth that I want to speak to come from. They gave, I sent out talking points. So, there's two pages of what I'm going to say, in writing that you all have. And then I understand other people have talked about our New Generations Project and some other things. So, I just put some materials, more concrete materials from some of that work in and I think it's online on PDFs for other people to get to. So, I'm going to try not to repeat a lot of what's been said by other people over the last few days.

But the point I want to say perhaps over again, I'm not sure, but one of the things we've learned that when it comes to children, it's almost entirely about what I call the nest where they are created and incubated and birthed and supported in their early childhood, and not the child themselves. And so, all the programs that are aimed at like, you know, fixing the child, to us are sort of missing, there is work to be done there directly with children. But most of the work needs to be done on

what I would call the nest, the family, the community, the people who surround the child as it's being created, and then growing. And it's especially true in early childhood, and early childhood sets the stage for everything else throughout the entire rest of life. So, tied to that is stuff that's already also been said that there's also about issues of pride, honor, dignity, and self-confidence. And if you look at statistics related to population health, all around the world, the number one correlate to health outcomes at millions of people, but at each individual level is self-confidence. Because it turns out the more you do to life, the better life goes and the more life does to you, the worse life goes. So that means our core business is really the business of raising self-confidence, and connecting to people around pride, honor, dignity and self-worth, which really means we need to do restoration of multi-generational cultural fabrics and strengths as our core work and everything else, diagnoses and pills and therapeutic interventions are pretty much secondary to that work. And that's very uncomfortable to medical professionals who populate our healthcare system. So, it's a continual business of education, reeducation and changing the mental constructs, biases, and prejudices of our medical staff. And by the way, the training you get in pharmacy school, nursing school, behavioral health, school, doctor school, whatever, is full of prejudices and biases, our healthcare systems built off of beliefs and constructs that are full of preconceptions, many of which are just completely wrong. And so, I think that Jessica spoke to the truth in the child welfare, foster care and so forth. But they're the same truths in any way, anywhere that humans relate to each other and are trying to get to healthy places.

So therefore, we've taken our medical system and over the last 25 years, tried to recreate it from a customer-owner relationship-based system. And so I'm just gonna hit a few things as it pertains to children and you've heard a couple of them I just want to run through the list and then I know there were some questions about measurements and data and so forth. I want to get to that also. So one of the things we've done is place family health and wellbeing and children health and wellbeing back in the context of the nest, the whole fabric of people that surround them. So almost all of our services are now provided in multigenerational whole family whole household environments, and then we pull the experts to them. So, our pediatricians and pediatric case managers and pediatric dieticians, and so forth, are in all ages clinics as child experts, helping everyone get the technical expertise they need as they wrestle, child, wrestle child issues in the fabric of the whole family, and the whole household and the whole community. And that's radically different than in the rest of society. And definitely it's taken us a very, very long time to get acceptance with that. We also put pregnancy back in that paradigm. So, all the midwives, we're very midwife centric, and all the midwives and all the lower to mid-risk pregnancy stuff is back in that whole family fabric and so forth. And I'm super excited at the Indigenous Birth Workers Group that's now doing work in our community, that's come up from the community, which is just doing fabulous things as well.

We have agreed upon a single parenting structure, infrastructure, and then a single parenting curriculum, and have now taught that to hundreds and hundreds of our staff so that when you interact with us, you get consistent parenting support and

advice. No matter where you go, we employ 2,600 people that Consortium, our sister company employs 3,000. The idea is that you should get consistent advice that comes from values and known ways, traditional knowledge of what makes it healthy Alaska Native family. So, we're, we've committed massive resources to doing that. We're in the process of deploying parenting partners to every single household that has the Miracle of New Life occurring, and then staying in that relationship for multiple years. So complete redefinition of where and how we do prenatal, birthing, first several years of life, and all built around traditional ways of knowing what health and healthy families and so forth look like, bolstered by the science behind the infant and early childhood mental health stuff that's known as well.

We, I think you've heard before also about the Family Wellness Warriors work. And that's the same thing, right? It's getting at the nest. Family Wellness Warriors isn't looking for people where sexual violence happened yesterday. They're looking for families, where it's being passed down generation-to-generation and working with the multi-generational fabric to break those cycles and relearn new patterns. So, all of this is not a reaction in the crisis of the moment, but rebuilding the fabric of the home, the multiple generations, and the nest, because that's what gets you ultimately healthy children, not, quote, fixing the children, which is unfortunately the medical model.

We also though are committed to Centers of Excellence for, for children that have super complicated things. So, we've just deployed at whole population scale, pretty close now to supporting the entire State of Alaska, what's called CFDS, Child and Family Developmental Services. These are all the children who have particularly complex challenges already and ahead of them, and bringing together all the different disciplines and again in a family and whole person because, it's, it used to be fragmented between the schools between OCS (Office of Children's Services), between multiple different places, we've pulled it all together now under a tribal umbrella. So, Center of Excellence around children with deep, lifelong challenges, and again, built upon a nest or a family type of approach. And then the other one I just want to mention, is trying to be present when horrible acts of violence do occur. So, there's this program called Alaska Cares, that is operated by Providence, but we try to have a person present for every Alaskan Native person, every Alaskan Native family that ever has to go through that experience, so that we're there in relationship and trust, and then can build the bridge back to building positivity out of what otherwise is a horribly traumatic experience. So those are all listed in the talking points, there are 1-2-3-4-5-6-7 sort of programs of particular innovation, impacted are very different than the usual medical model. Part of our obsession is to always deploy at scale so we don't end up with little niche projects that only a few people get to do, which unfortunately, is extremely common. And instead, we try to do things that hundreds and 1,000s every single thing that we do at scale so every Alaskan Native person, family child, that might benefit from any of this can, can get to it with relatively immediate access.

And then just because I know questions were asked previously around the New Generations work, which I'm, I waited 10 years to be able to launch this sucker and launched it two years ago just super excited about what it's already doing. But in terms of measurement and evaluation, we have three different categories. We measure things related to children and family, measure things related to parents, and measure things related to staff. So, for example, staff, we've already surveyed hundreds and hundreds of our staff and things like whether they have sufficient knowledge of infant and early childhood, actual knowledge to be an expert to the community, what services they know about, what programs they know to refer to and so forth. And what's startling is 98% say it's super important to know all this in their job. These are all primary care people. It's super important, including, by the way, we have, like 57 behaviorists embedded in primary care. So, it's behaviorists and pharmacists and dieticians and primary care people, 98% say it's super important to know all this, but only 11 to 15% strongly agreed that they could do this well. And anywhere from depending on the question, 35% to 60%, said they could not with confidence do this at present. So, we hope that gets to, you know, somewhere between 95 and 100% by the time we get through this project. So that's one huge set of measures we think is extremely important.

With parents, we have two fundamental questions, “I have the tools to remain present and responsive for my child even when struggling,” and the other is, “I know where to get help as a parent or caregiver in times of difficulty.” And then underneath that there's a whole bunch of other self-reported questions about ability to cope with challenging systems, about their technical knowledge of infant and early childhood mental health, things about the five protective factors that we've incorporated into our parenting processes. And then in our general surveys to everyone, we’ll also track the cohort of people who self-identify as parents. And there's things in there about, get the resources, I need to make my own health decisions, to take control of my own health destiny, and my culture’s respected or not respected in the process. And then around children themselves. We're going to track the amount of medical diagnoses that we're looking for. So, things like developmental delays, and all the different ways people get labeled, which are generally actually unhelpful and problematic. So that is part of the problem is the terminology, putting someone in a box. So, for example, in our neurodevelopmental clinic, we're trying to get away from people being referred to ever, ever, ever, or even categorized by a diagnosis, it sits in the background for funding reasons, but it's not up front and how we communicate with children or family, they just have challenges, and we identify the actual challenges and address them. So, people are increasingly not labeled, for example, Fetal Alcohol affected, because that's actually somewhat of a pejorative term in our society. So, a lot of work around language and labeling and so forth. But we'll track those things because if we're really good at this, we should be picking up challenges at younger and younger ages, where interventions with family and environment can make a massive difference in their entire life trajectory. So, we'll track all of that. In the background. We'll track what are called ASQ scores, which are developmental scores, we’ll track those at every single age along the way.

Oh, and then we're gonna have some fun with a few things to just see what we find, like, how many children reach the age of five without a single cavity? How many whole mouth restorations do we do for people who have lost a lot of teeth as children? School readiness, so school readiness, at both age three and age five, and those that are connected to Early Head Start and Head Start, but also connected to our New Generations program. There's a lot of stuff collected already in Head Start and Early Head Start, we need parental permission to get access, but as long as people give us permission, we can get access. So, we think I have a pretty wide array of both clinical scores but also self-reported scores and parent and staff ability to feel fully knowledgeable about what it takes to be a good nest and supporter to children. And I, as, as Gloria knows, I can go on for hours and hours, I get worked up.

Chair O'Neill 39:38 — That was really good. I'm here. We have a lot of questions. So, do you mind if we pause there, and I asked Commissioners for questions?

Dr. Doug Eby 39:45 — I think that's fine, but I don't want to shortchange anybody else.

Chair O'Neill 39:48 — We have some time. So, we'll pause for questions. Commissioners, do you have questions? Commissioner Gray.

Commissioner Gray 39:58 — Thank you for that. When I, hear you talk about the family nest, what essentially I'm hearing is addressing the conditions that create wellness. And I'm really appreciative of that approach. And that, you know, it's not an issue that we can simply prescribe some medication to, you know, we actually had to adjust the levers and address the conditions that would create the wellness, the outcomes that we're looking for. So, in that, I think that you guys are doing some amazing, innovative work, and I'm excited to be a part of that journey and, and just see the outcome of some of that, I think that you have some amazing opportunities to track just a massive amount of data. And that the ANMC (Alaska Native Medical Center) is really in a unique perspective, or a unique place, that from birth to death. Everything happens there, you know, so you, whatever they, at some point, every asking Native is going to come through the doors at ANMC, and you have some amazing opportunities to capture data and actually be able to provide real input back into, what are the conditions that create wellness. Thank you.

Dr. Doug Eby 41:35 — Yeah, I think that last comment, I've always thought that IHS (Indian Health Service) and HRSA (Health Resources and Services Administration) and SAMSHA (Substance Abuse and Mental Health Services), ought to just throw money at us for learning reasons, because it's a closed if, especially if you look at the entire tribal health system as a whole from all the villages to the regions to ANMC. And almost all of us now are on a single medical record, almost all of us across the entire state. And the opportunity to learn from that is crazy, fantastic. And all these funders with tons of money to do health outcome evaluation ought to be throwing it at us because we are amazingly rich in opportunity to do that. And they don't, I don't get it.

Chair O'Neill — Other questions or comments? Dr. DeCoteau.

42:20

Vice-Chair DeCoteau 42:24

Thank you for your presentation. So, so interesting. I'm just sort of imagining unicorns for a second, imagining what it would take to overhaul our current tribal health care systems, Indian Health Care Services systems and implement this sort of philosophy. And I'm wondering if you have any thoughts about if we were to be able to do something like that? Where would we start in a system where there's probably going to be a lot of resistance? How do you get so many people on board in such, to hop on board with such a drastic paradigm shift? Even when we have the science and the evidence that it works? How do we do that?

Dr. Doug Eby 43:10

Yeah. So, some of you might know, we've won a lot of big national and international awards that aren't Native specific. And it's gotten us a lot of attention because we've actually produced a ton of, so despite people not pouring data into us for money, we produce a lot of outcomes data and our system, we prescribe way fewer medications, order way less labs and way less radiology, way less visits to specialists. And we benchmark to national databases all the time. And we're consistently in the top 25th percentile for health outcomes. And our diabetes control measures put us in the top 1% for the whole United States of America and so forth. And so people ask us that all the time, you know, what should we go home and do? And the tough, tough answer is that this, this is a fundamental reworking of the basic premises and prejudices that underlie the actual system. And so this is destabilizing to everybody with power in healthcare. It's destabilizing to every person who has been trained in a medical professional school. And all the people with power don't like us. So, you know, we order less meds, pharmaceutical companies don't like us. We order less labs and x-rays; we admit less people to the hospital. So pretty much in the national healthcare arena, international healthcare arena where we're the community, communities, regular people love us. And people that are in the public health love us. But the money-making medical machine people generally don't like us because there's less money to be made off of doing things the way we do it. In Indian Country, we've had tons and tons of Tribes and tribal organizations spend a lot of time with us. And there's really exciting stuff happening. I mean, there's like 25 places in Indian country doing fantastic work right now. At a whole system level, the East Band of Cherokee in North Carolina are phenomenal. In fact, they've gone way past, they took what we've done, and then they've, they've improved on it, we're now learning a ton from them. They're amazing and Casey Cooper who had heads that up is amazing, but the whole place there has just done a crazy amazing stuff. And because they're these bands on the East Coast, I think they get less play in Indian country than a lot of other places do but, and especially what they've done around behavioral health, end of life, and addictions, blows the doors off of almost anything else I've seen. So, there are people doing it, but it's very, very difficult. And there's not one or two things, the things we say in terms of one or two things is is, be customer-owners, people actually own their own health journey, and make us advisors to the customer-owner being in control, do everything based on messy human relationships. It's the same thing Jessica said a few minutes ago. It's all about influence and messy human relationships. And then you actually have to

fundamentally change the entire system and to constructs on which it's based, this is really difficult, difficult work. And we're far from perfect. I mean, those of you who live here and get services from us, I mean, we fail people every single day, we have so much more work to do.

In terms of child and adolescent work, I will also say I'm super excited about this early childhood stuff. And I think we've done really good stuff already there over the years and much better now. We have a massive Aging Well Initiative, working with elders and the whole business. So, from age 50 on up, but where a big hole is, is I would say we're average or below average in youth and adolescents and young adults. And some of the works we've done other places, some of the suicide work and other, other Tribes in Alaska. We're trying to learn from and there's a whole bunch about adolescence and youth that we just have a, it's not a strength of ours. We have so much yet to do.

Chair O'Neill 46:59 — Thank you. I have Commissioner Begay and then Commissioner Fineday.

Commissioner Begay 47:04 — Thank you, Madam Chairman. I think you point out a really good point in that integrated health care even at the pediatric level is just as important as we think about for adults and an ability to integrate both physical and behavioral health, mental health care together. And my question is, it's I'm sure you experienced many children who make it into a doctor's office are either not identified or having behavioral health or mental health care needs, is there's not really a model for screening those type of events. And largely because the systems that operate our healthcare system separate physical and behavioral healthcare into different systems. So, my question is, is this concept of integrated healthcare and especially for pediatric care, is there a training mechanism that you implement for pediatric care to identify and for your providers to identify behavioral health needs and referrals for that in the healthcare setting? Because I think that patients are told to contact a mental health care provider, it's probably very slim that they actually do that. But is there is there anything that you do at Southcentral that tries to prevent that or actually streamline that process? And then secondly, you had some, some recommendations about the, the payment methodology or the payment and policy level recommendations because I understand that's always been a struggle for bringing healthcare is the all-inclusive rate. And if a child comes in for a well visit, and perhaps referred to another service for behavioral healthcare, it's really hard to get reimbursement for both episodes of care. So any thoughts on, on how to be addressed that as well.

Dr. Doug Eby 49:08 — Yeah. So that's like an hour or two conversation just to answer those two questions. I am not good at making a short, but I'll try a couple of things. On the payment side, well, first of all, it may sound naive, but we tell all our staff never to worry about money. None of them are paid based on financial performance or RVUs (Relative Value Units), or any productivity measures, none, and we're very opposed to that everyone's told do the right thing. And here's how you're going to learn what the right thing is. We're going to reteach you what the right thing is, and then some of

us will lose sleep over the money. And I think that's extremely important. And, but some of us do lose sleep over the money and we're quite financially sophisticated behind the scenes but our staff are not, on purpose. We don't want to ever to become that way. The way we can get paid. I think that's a whole big, huge conversation. I was just chatting with Gloria just before we started, I mean, so we get paid by everybody, we're paid by the VA (Veteran Affairs), by HRSA (Health Resources and Services Administration), for community health centers, by disability people, but directly by employers, we're a private company, we collect money from everybody we can find, pay us to do anything. And we fight, if they're not paying us, like the VA was a massive fight, we finally won, and they pay us now. And so daily rates great, but we also get paid a ton of other ways. And like for a lot of this child and adolescent stuff, I think we should not rely on the all-inclusive daily rate to pay for it, we should get other ways. So, we get like, we have a huge program called new TTA-CCBHC (National Training and Technical Assistance Center for Certified Community Behavioral Health Clinic Expansion Grants) and it's, it comes through SAMSHA. It's a five-year grant. But it keeps getting renewed every five years, as long as we don't screw it up through HRSA and Community Health Center money, there's all these add-ons for mental health, behavioral health, substance abuse, and it's the same sort of thing. It's a multiyear grant, and then you reapply again and get more years after that. We all know this is special diabetes money in Indian Health Service. And so, I think there's, I know that Val Davidson said, you know, let's put everything in the compact, we can put in the compact. And that's, of course, the best money is the compact money. But payers and government officials don't just want to say, here's money, we trust you, they want to put lots of strings on it. So, if this, let's play that game, but let's make sure that it's not just a five-year grant and goes away, let's make sure it's a targeted grant for the purpose of like, we would like these parent partners, for example, to be paid. And so, we'd like to use the new TTA-CCBHC model, which is a block grant, every five years renewed as long as we produce the outcomes that they expect us to produce. So, I think we should play every financial game that there is, and get money through every single channel we can possibly get money from. And I mean, that's what I've watched Native corporations in Alaska do is we just tap every revenue stream we possibly can and we bend it to our will. And we go fight with people if the requirements are obnoxious. And usually if you go high enough, you'll find real, some real high official who says, oh, yeah, you're meeting the requirements of the money. So, tell the lower down technical person approve it. But you have to not stop at the lower down person who says, you know, I read the fine print and you're not complying. So, I, by the way, I love doing battle with payers and policy people in granters. Because it's great fun, you can shame them big time because they're supposed to do this good stuff that they're in the way of doing. And I find shame and guilt works great with those people. So, I'm not into shame and guilt for our customer-owners, but I am for grantors and payers. Your first part, I already lost.

Chair O'Neill 52:59 — Yeah. Well, there's another Commissioner who has a question here before we move to Deb, and then Holly. So that's Commissioner Fineday.

Commissioner Fineday 53:09

Thank you. I'm taking notes about shame and guilt. I'm, just one really quick question. One of the things that I really dislike about all of these systems, medical, child welfare, education. Who else? Juvenile justice, they never talk to each other. They have the same child in all of these systems. And they never talked to each other about how they could all be working together to improve the well-being of this child. Does your system solve that issue?

Dr. Doug Eby 53:48

Oh, I don't know. Gloria, how we doing together? So, I think that it was a thing. I mean, I love working for Alaska Native people. First of all, Alaska Native people. Anytime they see an opportunity to control their own destiny, they say yes, surely we can't screw it up any worse than those crazy other people who are doing it to us. I love that attitude. I've worked with different colonized Indigenous groups all over the world. And there's a huge difference between folks who want to grab hold and control their own destiny and those who say, you know, once there's enough money, we'll take it over. I just love that give it to us. Surely, we can do better attitude. So, I think that goes a long, long ways towards a lot of the success. It's happened in Alaska. And then people like Gloria and the various leaders I've worked for over the years have all just said we need to not be competing with each other. We need to coordinate about money and services and all of that kind of stuff. So, we're not perfect, but I think we do better than average. You know, I've done a lot of work with Maori and South Pacific Islanders and our [Native word], as some people call it, New Zealand and they have this syndrome, last car in the driveway syndrome. And it's what you're talking about the same family has eight different case managers, and whoever was the last car in the driveway is who they heard last. And that's a huge, huge problem. And we ought not do that to people. So, I don't know that we've completely solved it. But just like everything else, it's, it's relationships. And if there's other people having cars in the same driveway, we need to build relationships and talk to each other. And I think the tribal leaders in the family of tribal groups that I work in support of have done pretty well at that. And then also, I give a lot of credit to things like the Rasmuson Foundation, which has been a powerful force for convening people around common problem solving. So, around people experiencing homelessness and substance abuse and alcohol. The Rasmuson Foundation has done a fabulous job of getting a lot of us to the table who otherwise aren't at the same table, that, that convening thing. And I think that's where government comes into, we should not let government off the hook. The, one of the primary roles of government is to convene other people. And again, I find shame and guilt and harassment actually works often well to make government convene people. I love going to battle and I recognize like, previous CEO, Catherine, I would, Catherine love doing battle too. And there were lots of times where, you know, I'd step back and she'd go to battle as a tribal leader, but there's times where she would send me as a white male doctor, like to the CDC and Washington DC, we lost some grants, and she said, Doug, get on a plane. I said, "No, Catherine, you're passionate, you'll do great, says now, the white male doctor needs to go, kick some white male doctor butt so go do it." And, you know, there's times and places for different faces to different entities, and we should never back off. Yeah, that's gonna be if people deserve way more than they've got. And until such time as they get everything they deserve, we should fight like hell.

Chair O'Neill 56:57 — Yeah. Well, I think that the last few days, the Commissioners that are visiting us here probably can see that we have a lot of trust-based relationship. When we walk into the rooms of partners at Southcentral Foundation, or with Val Davidson and her team, with our panelists, that there's just a lot of connectivity and spirit in how we see one another, and that we all have the same common goal. You know, we're not perfect for messy human beings, as Doug said, but we do pretty well. We do pretty well.

Dr. Doug Eby 57:37 — On relationships. In fact, I noticed Gloria, that the CEOs of the nonprofits are together right now. And you're here. So ...

Chair O'Neill 57:43 — I know well, not all of them. Actually, unfortunately, the majority of our, had to stay back to work. So, I'd like to go to Deb Northburg. Next. And Deb, why don't you tell us a little bit about yourself and your work at CITC (Cook Inlet Tribal Council)? Sure.

III. Panelists: Deb Northburg, Director of the Child and Family Services at Cook Inlet Tribal Council

Deborah Northburg 58:02 — My background, as I said, is, is mostly in child welfare and family preservation. I was a home basically, preservation therapist for many, many years. So that's my lens and perspective. And our Child and Family Services department offers an array of services from prevention to family preservation, family reunification. And our primary partner is, has been, over the years the State Child Protection Services System. And, we acknowledge that the State Child Protection Services System is well designed to externally manage safety of children through removal, but really not designed to provide the support that enables the behavior change of parents and family members that can keep children safe and well and connected to their family and the community. And so our work together over the many, many years that we've been partnering has focused on a couple of key areas and that is how we work together and how do we decide what success is. We have demonstrated improved access, improved services, by report of families through one key strategy that is colocation. CITC co-located an equality liaison way back in 1998 at the local child protection services office, and for the purpose of really being a point of contact and a person that parents could develop a relationship, with and feel comfortable going into the building and getting the information that they need. And we have replicated that strategy, recognizing that, as Doug said, and Jessica said, really, the process of healing and behavior change is, happens in relationship. Oftentimes harm happens in relationship, well so does healing. And the OCS system does not have the flexibility, the staff capacity, or the systems that function well enough for their social workers to develop relationships with families. And so families really rely on organizations like CITC, and others in the community to support moving forward and reunifying with their children. So, we've replicated the practice of colocation in other areas. Where recently, we have co located a domestic violence advocate from our local shelter, on site at CITC. Again, trying to develop an opportunity for ease of access, and for parents and participants to get

the services that they need in the place that they're most likely to be and feel most comfortable. And we've had some great success in that area.

The other area we focused on is how we define success. And to Jessica's point earlier, there seems to be a real dearth of assessment tools or evidence about what really is success and what is the evidence of success from an indigenous lens. And so CITC, over a period of years, has engaged in a process of developing a twin assessment tool. That's a whole family tool. We call it the five factors. And the goal of the tool is to, is for participants, for our families to themselves tell us how they define success. And the way in which we developed it, over the many years, was doing literature reviews, consulting experts, but most importantly, consulting our stakeholders and families. So we went through an iterative process, over several revisions of this tool, getting feedback from our families, about really what it is that, how they define success. And we currently have implemented that five factors assessment across the organization. The great benefit of having a shared assessment tool that's used across the organization is that it really does bring people together around some shared goals, and recognizing that we each have individual participants, perhaps that we serve across the organization, but we share the responsibility for child's safety and family well-being. And the assessment is allowing us to develop some infrastructure around how we work better with people and collaborate around some shared goals. And it will inform how we ultimately collect data in the family information system that is currently under development. And so recognizing that sharing of data is really one key strategy to, to support the kind of collaboration that will make a change for parents and children.

Chair O'Neil 1:04:22 — Thank you. Questions or comments for Deborah? Questions or comments? Well, I just really appreciate you coming out and being here tonight. I know you have a full family. Not only being a leader within CITC but also a very busy mother as well. So, thank you for being here on your Friday. I think it would be good to ask Holly Morales to present next as it will show a continuum of how we work at CITC, Holly. Holly said that she's on mute. Can you unmute her, please?

Holly Morales 1:05:42 — Okay, can you hear me now?

Chair O'Neill 1:05:44 — Yeah, we can hear you.

IV. Panelist: Holly Morales, Senior Director in Employment and Training at Cook Inlet Tribal Council

Holly Morales 1:05:47 — Again, I'm Holly Morales. I'm the senior director in employment and training, which I failed to mention earlier here at Cook Inlet Tribal Council. One of the things I wanted to talk about today, which is near and dear to my heart, which is one of the tools that we use for our best practices and serving our families is Public Law 102-

477, which is the Indian Employment, Training and Related Services Act, which was amended in 2017. So, when that law was amended in 2017, it allowed us to integrate programs from 12, or four federal agencies to 12 federal agencies. And what mostly I'm talking about today is how at a program level of the program director, how it significantly impacts how we deliver services and serves families. The law allows us to have one report, one budget, and integrate funds under the programs that are employment and training services related. This is a crucial law for us in order to serve families. I love what Doug said earlier. If I could rename the law to grab and hold our own destiny, I think that this law allows us to do that. Some of the ways that we're able to do that, first, I want to mention the different agencies that are included in this law, which is Agriculture, Commerce, Education, Energy, Health and Human Services, Homeland Security, Housing and Urban Development, Labor, Transportation, Veterans Affairs, Bureau of Indian Affairs, and Justice. So, as you can see, that list is very long. And there's a lot of opportunities for us to integrate funds under one plan and one budget to serve families in unique ways for our individual Tribes. Because as most of you know, every family that walks in our door is unique and needs to be served in the way in which is best for their family. And that means that we need flexibility.

I'll just go over just a few things that we've done under this law. And this is just a small list. I know it's Friday at 5:39, so I'll go through this fairly quickly. We have a common intake. And that sounds easy. But we do intake with families to assess the services they need, and not just take their application, it's a matter of sitting down with them, talking to them about their family and figuring out what services they need to apply for. A lot of times they come into our door, not knowing what services we have. And it's usually a word of mouth. And so, they're like I want this program. But we sit down with them and make sure that they know that there's other services, so it gets them connected to services faster. Like Deb mentioned earlier, we're building a Family Information Services system, which will take, it will take a long time. But one of the first steps were one of the first departments that will allow us to, where participants can build their participant profile. And then we can screen them and help them to do that screening and connect them to services virtually. So not only will be able to connect with families, one-on-one, but we'll also be able to do that virtually, which is so important during times like this, during the pandemic and also for transportation issues. Another way that we're doing that is eligibility efficiency. We provide eligibility for multiple programs. So, when you're seeing somebody to determine eligibility, they're able to do determine eligibility for many programs that you could be eligible for. So, you're not having to retell your story over and over and fill out the same application over and over again, to access multiple services. You're doing it at one time. And one application sounds easy, but it took a lot of work to get there. And it's a huge benefit for families.

One of the things we're proud of is the efficiencies allow for innovation. One of the one of the departments that we have here that work in partnership and do receive 477 funding is they built a badge for our Fab Lab, which is teaching youth how to use our Fab Lab safely, and they can get this badge and earn the badge. That's recognized and built by CITC. We've added a Youth Services program to

employment and training. When we first started years ago, we had one youth case manager. Because of 477, an ability to decrease administrative costs and do services more effectively, we now have over six staff focus on employment education for our youth. That kind of growth and being able to leave the resources where the needs are is what makes 477 so important for us, we're able to add cultural and spiritual services to our participants. During the pandemic, like I mentioned before, we can shift resources where the needs are. In 2018, we had an earthquake, we have to be able to flex and be and do what we need to do to help families during those times of crisis. And now during the pandemic, 477 (allows us to be flexible and meet the families where their needs are. One of the other things that were we were able to do, being more efficient, is in partnership with Deb's program, we're able to add a service to our Tribal TANF (Temporary Assistance for Needy Families) program, which is the Welfare to Work program, where if a family unfortunately loses their children, we now offer post reunification cash assistance. Because usually if somebody is on welfare and they lose their children, the first thing they do is they lose the cash that helps support their family, which means they lose their housing, they lose transportation. And so, we added this service to make sure that we're meeting the needs of the family so that we can directly work in partnership with Deb's programs, and Child and Family Services for them to continue to research, receive services and not worry about where the cash is going to come from. As long as they are working towards reunification, we continue that service. Like I mentioned, we have the case management integration with Deb's program. Increases are successful outcomes. I could ramble off different numbers for you. But you can imagine by reducing administrative burden on these programs and be able to work across services, that increases the resources that go to the services that we provide to families. It increases coordination. As mentioned earlier, programs operating in silos, they don't they don't support coordination of services. And we've heard that from other presenters today. It doesn't just happen in the social service areas. It happens everywhere, 477, by sharing information, and providing more services that increases the collaboration. And really, the staff can work closely with the families in order to focus on addressing each unique needs of the youth. Last time I checked, there was about 76 Tribes across the United States that have a 477 plan, representing over 200 Tribes. And so, some of the successes and the little wins that we have I talked about, there's 200 more Tribes that have the same story. And so, I just wanted to share that recommendation, because I think that, like Doug mentioned earlier, having all of those strings attached, and it may be increased, or have having less strings attached to money that you receive, and having more trust in the people that know how to provide services to our families. I think we could do more. Thank you.

Chair O'Neill 01:13:53

Thank you, Holly. And just to add to that, it's interesting that all of our organizations are really focused on some of the same themes, that is those deep and meaningful, long-term relationships that we create. Our innovation of how we organize our resources to support the whole person and the whole family. And that's what I'm really excited about as we, like Doug said, we have a lot of tools in our toolbox. We have various funding sources. Holly is one of those superstars that, she has led the, and helped, working across the nation and ensuring that the 477 law really

expanded and that we have great ability, we haven't even seen how we can implement the full extent of working with all of those agencies and departments that Holly described and how we bring that into one contract, we have one report, and it's all a comprehensive, multi perspective, multi-generational approach to serving our families. So that is what's really exciting. And as Holly said that there are a lot of innovation like 477 going on across the country in well over 200 Tribes. So I think this, the 477 (model is one that we really need to look at, and have as a recommendation in our report, as it is one of the most significant tools that Tribes have in ensuring flexibility with their funding and self-determination. So really meeting people where they are and responding to community need. So very, very exciting about where we are today. And I do know, I'm sorry, to Deb and Holly, that you our last presenters at 5:30. It's kind of tough, but I'm just gonna open it up and see if the Commissioners have any last questions or comments before we close the day.

V. Wrap Up

Commissioner Gray 1:16:13	Again, thank you guys, all of you guys for your time tonight on a Friday night. And I greatly appreciate your willingness to provide testimony. One of the real reoccurring themes that we've heard throughout the week is the, life is about relationships. And we all intuitively understand that. But I often wonder if maybe we not institutionalize that, and I can certainly appreciate Southcentral's attempt, not attempt but that they're actually doing and implementing an approach along those lines. When I think about the, the relationship between Tribes and Native corporations and the government, be at the state level, be it at the municipality level, be it at the federal level, I am hearing a reoccurring theme of the need for a centralization of relationships, and the implementation of some sort of, a way to measure and quantify the quality of that relationship, you know, that we put the onus on both entities that on an annual basis, semiannual basis, whatever it may be, that there is a measurement, where we are grading the quality of that relationship, and we're looking at various aspects and say, Okay, we need to invest some time and energy over here, and being able to ensure that those, those conversations are happening across the board. And thank you for your time today.
Chair O'Neill 1:18:10	Thank you. Commissioner Fineday.
Commissioner Fineday 1:18:16	Thank you so much. I want to thank you for taking the time out of your busy schedules to do these presentations for us. I think the things that you have talked about are really promising, and certainly fit the bill for innovation. And I'm really interested in hearing more. I liked the whole idea about the nest and 477 (sounds very promising for all of Indian country. I know there were a lot of Tribes involved, and it looks different in different places. So I'd be really interested in receiving more information about your 477 Program. Thank you again.

Chair O'Neill 1:19:07	Thank you. Dr. DeCoteau.
Vice-Chair DeCouteau 1:19:09	Thank you, Madam Chair. I just wanted to say thank you all for four really great and exciting presentations. I appreciate the work that you're all doing. And Dr. Eby, your presentation was probably the best example I've ever heard of how to make a person-centered, holistic healthcare system work in a capitalist society. Thank you.
Chair O'Neill 1:19:34	I better write that one down. Dr. McDonald.
Commissioner McDonald 1:19:40	Yeah, I'm jotting it down too. But I, yeah, me too. I just want to thank you for sharing. I really appreciate it and sticking with us this evening and it's 10 to nine over here in North Dakota. But I you know, one of the one of the things that I've heard in your presentations and also on the other presentations we heard today is that there's been a common theme. And then this theme is, this common theme is the spirituality piece. And even if it was, whether it was said or unsaid, I felt it was there. And I felt that maybe it was just from your personas, or how you were sharing, but it made me feel at home, in regard to, I think, in regard to what we need to do to go forward. And because we want people to, we need that piece, we need that spirituality piece, we need that cultural piece, that in regard to healing, and to help ourselves, help, in order for people to help themselves and to help ourselves. So, thank you. Thank you all for sharing.
Chair O'Neill 1:20:57	Dr. Eby.
Dr. Doug Eby 1:20:58	I'd like to say thank you to the Commission and the people on the Commission who put in massive hours into this effort. As a doctor, leader in a medical system. Back to the question of how do you change a system? The way it changes is for the people who own the system to take full ownership and change it. And like I said, we've done consulting now literally all over the world. And one of the single biggest problems is that people accept modern medicine and the medical model as truth. And it's not, it's a culturally based, full of biases, particular way of understanding wellness and illness, which then drives what the solutions are and where the money goes. And if that remains unchallenged, it won't change. And no matter where I go in the world, whether it's Europe, Southeast Asia, South Pacific, Indigenous, non-Indigenous, it's amazing that a lot of community-owned systems, like tribal organizations will take control of an organization, and they'll run the corporate office, and they'll run the finances, then they leave the medical paradigm to the medical professionals. And that's just wrong. Until the community owns what is illness, what is wellness? How do you get there? Where should you put your money to try to get there and make the medical people, technicians, who advise and follow, you won't get changed. So thank you for doing this. You all are the Commission. You're all American, Indian, Alaska Native people, you're putting the time and energy into this. And hopefully you're going to affect policy and payment methodology. But even more fundamentally, I think I would keep encouraging you

	to drive content, and philosophy and things like Jessica shared from her Ph.D. work and so forth, as fundamental truths around which money and operational structures ought to be driven. So, thank you for your efforts. I deeply appreciate it, there's not enough of that customer-ownership of the agenda of healthcare.
Chair O'Neill 1:23:12	Well, we may just bring you back for another panel. So stay tuned. Commissioner Staebner.
Commissioner Staeber 1:23:23	I just want to thank you all, for coming to present, I think we've learned a lot tonight. And I want to go back to something Jessica said, who they are and where they come from. If they have that, it's you mentioned, it's a superpower. And I think that's very powerful. I've seen a lot of kids getting taken out of the home, and they hunger for their culture and their language and want to know who they are. And I've heard a lot about traditional healing, and about how culture and language has purposely and intentionally been infused into a lot of programs here in Alaska. And I think that's very exciting. And, then the, the nest model. I think so often our parents don't have enough support and training. And sometimes they're told what they have to do, but they're not really guided and taught like how to how to parent or how to access resources for the whole family. So keep on doing the good work your doing and thank you for being here his evening.
Commissioner Gray	I know we got to go but Jessica I really needed you on the Tuesday panel, who you are and where you're from. Well stated. Thank you.

[END OF TRANSCRIPT]

[Transcript completed by Kearns & West]