2017 National Exemplary Awards for
Innovative Substance Abuse Prevention Programs, Practices and Policies
APPLICATION COVER SHEET
(INCLUDE WITH APPLICATION)

1. Has this intervention been submitted for an Exemplary Award in previous years? [Circle one]

Yes (No)

2. What is the primary target for this program, practice or policy? [Circle one]

Individual School-Based Family/Parent Peer/Group

Workplace (Environmental/Community-Based) (Other)

If Other, explain: _____

1) Underage drinking among 12-20 yr old Native youth
2) Non-medical use of Rx drugs 12-25 yr old Native youth

PROGRAM INFORMATION

Program Name The Oklahoma SPF-PFS Intertribal Consortium Initiative

Agency Southern Plains Tribal Health Board

Contact Person Melanie Johnson Email mjohnson@spthb.org

Address 9705 N. Broadway Extension, Suite 150

Oklahoma City, OK 73114

Phone 405-416-3938 Fax 405-840-7052

I have reviewed the information contained in this application and certify that it is accurate, to the best of my knowledge.

Melanie Johnson May 5, 2017

Program Director Signature Date

NOMINATING AGENCY/ORGANIZATION INFORMATION

Agency/Organization OK DEPT MENTAL HEALTH & SUB ABUSE SERVICES

Contact Person JESSICA HAWKINS Email jhawkins@odmhsas.org

Address 2000 N. CLASSEN

OKLAHOMA CITY OK

Phone 405 248 9270 Fax

I have reviewed the information contained in this application and certify that it is accurate, to the best of my knowledge.

JHawkins 5/4/17

Nominating Agency Signature Date

Abstract: The Oklahoma Intertribal Consortium

The Oklahoma Intertribal Consortium (OIC) is a collaborative substance abuse prevention effort between four federally recognized American Indian Tribes in Central and Southwest Oklahoma and one of the national Tribal Epidemiology Centers (TEC). This initiative seeks to demonstrate that Tribes can successfully work together, under the structured guidance of a Native Managing Entity, to reduce underage drinking and prescription drug abuse and reduce substance abuse disparities among Natives.

The OIC Tribal Partners are the Absentee Shawnee Tribe, Cheyenne and Arapaho Tribes, Chickasaw Nation, and the Comanche Nation. Each of the Tribes operates within a multi-county Tribal Jurisdiction and each has Tribal government that has supported the OIC from its creation in 2010. The Managing Entity is the Oklahoma Area Tribal Epidemiology Center located in the Southern Plains Tribal Health Board, a not for profit organization that serves 42 federally recognized tribes in Kansas, Oklahoma and Texas, as well as four Urban Indian Health Clinics.

Our consortium came together in response to growing concerns about substance use among our Native people and the lack of an organized response (or service infrastructure) to save youth from a lifetime of substance use and hopelessness. Our goals were simple: obtain federal funding to identify the underlying causes of Native substance use and organize to deliver culturally appropriate evidence based prevention services to Native youth age 12-25 within our Tribal Jurisdictions. To complete this mission we adopted the Strategic Prevention Framework, a five step planning methodology that objectively assesses needs and resources and works to build capacity and implement programs that will be evaluated, and if successful, replicated.

Population within our four Tribal Jurisdictions who are Native alone, or in combination with one or more races, but self identify as Native totals approximately 102,000 individuals. Our target within that number is the subset of youth and young adults age 12 to 25. We serve all Native youth regardless of Tribal Affiliation. Our population tends to be economically disadvantaged and has high health disparities as well as behavioral health disparities.

Over the past seven years we have developed an intertribal substance abuse prevention system that has succeeded attracting large numbers of Native youth to our programs and to our social media sites. We are active in the schools and in our communities. We have developed administrative tools to keep our programs on track and in compliance with federal funding guidelines while promoting positive Native social norms. Regarding alcohol and prescription drug misuse, our internal evaluations show both behaviors to have substantially decreased among 343 Native youth tested from 2014 to 2015. Objective measurement of our progress from the Oklahoma Prevention Needs Assessment survey also shows reductions in both these drug categories within our Tribal Jurisdictions. We are especially pleased that drug use disparities with the Non Native population have also been reduced and in some Tribal Jurisdictions, Native youth drug use is lower than Non Native.

The OIC model of collaboration between Tribes and epidemiologists at the Managing Entity works well and has resulted in positive behavior change about substance use among large numbers of Native youth. The work of the OIC has been recognized by our funding agency, the Substance Abuse and Mental Health Services Administration and was visited by the US Surgeon General in 2016.

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A. Philosophy (10 points)

Q-1. The rationale for the OIC is simple: American Indian/Alaska Natives comprise about 5.2 million individuals[1] in our nation and have some of the highest behavioral health disparities of any race[2]. As a result of this fact, when the Substance Abuse and Mental Health Services Administration (SAMHSA) implemented the Strategic Prevention Framework, State Incentive Grant program in 2009, the agency recognized that American Indians[3] were a special population in need of Tribal Incentive Grants (TIG) to build behavioral health capacity and infrastructure in Native communities. The OIC follows the Strategic Prevention Framework and the Public Health Approach to substance abuse prevention.

By creating TIG grants, SAMHSA recognized its responsibilities toward federally recognized Tribal Nations that is clearly stated in the Trust Relationship. The Trust Relationship, based on the analysis of over 400 treaties with Native Americans, recognizes the government's obligation, to protect Indian sovereignty and provide for Indian welfare in exchange for the many tracts of land taken from them through the years. In 1977, in what is perhaps the most comprehensive review of Tribal rights ever, the Senate American Indian Policy Review Commission produced a 600 page report[4] dealing with federal responsibilities and the legal status of Indian Nations. It states:

> *The purpose behind the trust doctrine is and always has been to ensure the survival and welfare of Indian tribes and people. This includes an obligation to provide those services required to protect and enhance tribal lands, resources, and self-government, and also includes those economic and social programs which are necessary to raise the standard of living and social well-being of the Indian people to a level comparable to the non-Indian society.* p. 130

The commission's report provided standing to federally recognized Tribes to apply for and receive federal funding for "social programs…..to raise the social well being of Indian people". Clearly social well being is closely tied to the reduction of substance abuse disorder among Native people.

SAMHSA funding to Tribal Nations however, has not always been available to Tribal Nations. While states have received steady Substance Abuse Prevention and Treatment Block Grant funds since 1992 that has allowed them to develop an evidence based knowledge and infrastructure base, Tribes have only recently had access to some discretionary funding such as the Tribal Incentive Grants. It is the hope of our consortium, by demonstrating innovative successful ways of working with Tribes, the federal government will provide the consistent funding stream needed for real progress in behavioral health in Indian Country.

Q-2: The OIC believes that Native people are most receptive to public health interventions that build upon the positive aspects of Native culture. Further, we believe that in addition to standard outcomes such as reduction of alcohol and prescription drug use, our Native cultural values, such as restoring balance; strengthening connections; creating a sense of hope; establishing self-esteem; and fostering healthy community norms should be a central part of our program. We serve Natives of all Tribal affiliation within our Tribal Partner's Tribal Jurisdictions and none of the findings detailed in this application should be attributed to a single Tribe.

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[1] *The American Indian and Alaska Native Population 2010*. US Census report, includes Indian alone and Indian in combination with one or more races

[2] *Mental Health Disparities: American Indian and Alaska Native* 2010, American Psychiatric Association, Office of Minority and National Affairs

[3] The terms American Indian/Alaska Native, American Indian, and Native are used interchangeably in this report

[4] The US Senate voted to make the Committee permanent on June 6, 1984

Q 3. The OIC seeks to reduce all alcohol or nonmedical use of prescription drugs by Native youth and young adults ages 12-25. We stress the dangers of high risk use of any substances even if legal. We consider it important to measure and report on both juvenile and adult arrests for alcohol or drug related crime. High risk use or illegal use of substances have been shown to produce adverse effects including death, arrest, loss of property, HIV aids and Hepatitis C, and mental illness. These messages are at the core of our program.

Useful Definitions of Terms Used in this Application:

Culture Classes: One important medium by which prevention messages are delivered to Native participants.
Managing Entity (ME): The Grantee of the Partnerships For Success Grant. Also known as: Southern Plains Tribal Health Board, Tribal Epidemiological Center. The Managing Entity is responsible for fiscal and administrative accountability and provides Technical Assistance and support to the four Tribal Partners
Mixed Communities: Today most Natives live in multi racial communities in Oklahoma within Tribal Jurisdictions
Tribal Jurisdiction: Usually a multi-county area identified and delineated by federally recognized American Indian tribes in Oklahoma. Contains Tribal capital and Tribal governance
Tribal Partners: Four Tribal Partners, each one a federally recognized Indian Tribe, joined the Managing Entity to form the Oklahoma Intertribal Consortium. The four Tribes are:

The Absentee Shawnee Tribe
The Cheyenne and Arapaho Tribes
The Chickasaw Nation,
The Comanche Nation

Tribal Specialist: Individual trained in substance abuse who has direct contact with target population. There is one from each of the Tribal Partners.

B. Needs Assessment (30 points)

Q 1. The increase in the quantity and quality of assessment data is perhaps one of the OIC's most significant achievements. The absence of data specific to our Tribal Jurisdictions in Phase 1 was the most significant barrier to assessment. Assessment is best viewed in two phases:
Phase 1 from 2010 to 2012 where the OIC staff and our Tribal Partners worked on acquiring assessment data to plan specific interventions and completing two documents required by SAMHSA, the Epidemiological Profile and the Strategic Plan:

1) Assessment data during this phase was heavily dependent upon qualitative information such as Key Informant interviews, and aggregated data about Natives at the state or national level. Both consumption and consequence data was analyzed
2) National and state assessment data for Natives was collected to support the Epidemiological Profile and the selection of our two priorities, underage drinking and nonmedical use of prescription drugs,
3) A Strategic Plan or roadmap to implement interventions that included a large section on culturally appropriate interventions and culturally relevant measures of progress,
4) Both Epi Profile and Strategic Profile were approved by SAMHSA in 2012

Phase 2 occurred from 2013 to the present and is marked by:

1. Innovative data mining of state sources of state data specific to our Tribal Jurisdictions,
2. In depth assessments through enhanced planning and participant surveys of our interventions,

3. Increased analysis of Tribal Jurisdiction specific data, the use of logic models, and continuous quality improvements at the Tribal Partner level
4. Ongoing process assessments through review of Tribal Partner's Action Plans

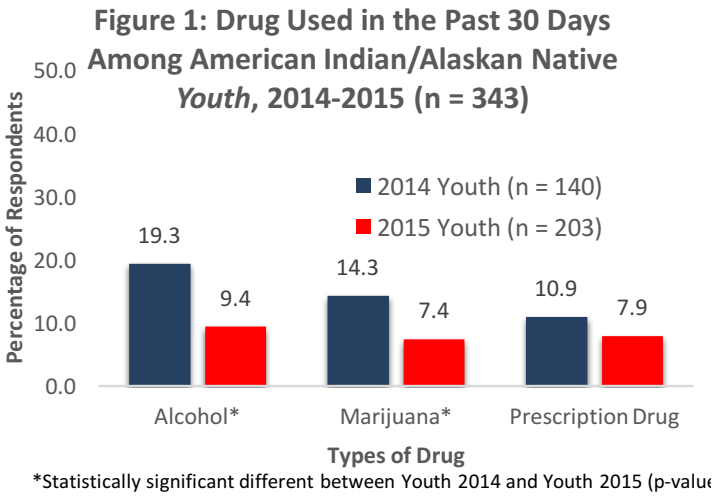
The most significant achievement during Phase 2 has been the acquisition of data from the Oklahoma Prevention Needs Assessment school student survey. These data provide us large samples of Native youth's responses (over 600 per Tribal Jurisdiction) and include data about consumption by grade and gender as well risk and protective factor information. Table 1 below, compares examples of the types of assessment data available now and at he beginning of the project. The OPNA analysis supported our original choice of underage drinking and nonmedical use of prescription as being the top data driven priorities. Recent analysis of these data allowed accurate measurement of racial disparities. Further analysis showed that at all grade levels Native youth scored higher than Non Natives in most risk factors and lower in most protective factors commonly associated with substance use

Table 1: Assessment in early and late phases of the program

Phase 1 assessment variables	Phase 2 Assessment variables
National rates of Native substance use NSDUH	OPNA Tribal Jurisdiction alcohol prevalence
State aggregate BRFSS data about Native drug use	OPNA Tribal Jurisdiction nonmedical use Rx drugs
State Native Adult Binge Drinking (BRFSS)	In house 25 question survey of prevalence
National (NVSS) and state (OK2share) chronic liver disease mortality	Drug and alcohol related crime consequences by Tribal Jurisdiction
State and National Opioid Deaths	Culture Class Survey results
Key Informant surveys to determine drug priorities	Environmental survey on most popular media

Q-2. Prior to obtaining the OPNA data listed in Table 1,Phase 2 the Managing Entity enlisted the Tribal Partners in conducting a short (25 question) survey one year apart of Native OIC program participants. Analysis of the 25 question survey from 345 Native youth from one of our culturally appropriate program shown on Figure 1 right shows marked reduction in all of the drug categories measured. The data for this program was drawn from the IAMNDN (pronounced I Am Indian) program in the Commanche Tribal Jurisdiction.

Other types of OIC analysis conducted included analysis of the Environmental Survey, a community survey to assess the types of media most used by Natives and the Notebook survey to assess Native youth's retention of prevention information printed on their school notebooks.



Q 3. All four Tribal Partners in the OIC complete yearly Action Plans that reflect needs assessment information from the OPNA and support the accomplishment of CSAP grant requirements. At the present time these are the requirements and research base associated with the Partnerships For Success grant. The Action Plans are collaboratively developed by OIC staff from the Tribal Epidemiology Center and Tribal

Partner's Prevention Specialist. Each Action Plan is tailored to impact either underage drinking or nonmedical use of prescription drugs by youth and young adults 12-25. Action plans provide:

- Accountability by setting due dates and person responsible as well as progress notes
- Specificity by identifying Action Steps and resources needed for completion of interventions
- Logic modeling to identify relationships related to drug use and risk factors
- Outcome driven process: short and long term outcomes that move each Tribal Partner closer to their goals are clearly defined

All Action Plan entries can be directly related to one or both of our project goals and any interventions proposed by our Tribal Partners must be shown to be in support of the Action Plan, Grant Requirements, or the OIC Strategic Plan before receiving full approval by the Managing Entity (the Southern Plains Tribal Health Board, Tribal Epidemiological Center).

Q 4. Key informant interviews were critical in the development of the Epi Profile and the Strategic Plan that identified the two OIC areas of focus: underage drinking and nonmedical use of prescription drugs. Later, focus groups of Natives suggested that youth were very much in need of activities that supported their Native culture and were drug free. In the past two years, two of our Tribal Partners have active youth coalitions and youth plan and implement prevention oriented activities such as Tipi building, media camp, culture and language classes and other activities. Native youth and young adults (our target population) provide feedback to their Tribal Specialist who in turn relays this information to the Managing Entity. This involvement has succeeded in adjusting survey language that was ambiguous in developing new prevention activities. All four Tribal Partners have media campaigns and social media web sites, mostly through Facebook and Instagram. Feedback from social media is constant and monitored by all four Tribal Partners.

C. Population(s) Served (20 points)

Q 1. Our target population is Native youth and young adults 12-25 years of age. Most if not all the target youth do the same things and like the same things as every other youth across the nation, ranging from social media usage to similar music and clothing. There is however one thing that separates these young Native individuals from others, their "cultural identity" as Natives. This is something that makes them different in a positive way. Natives feel that staying connected to their cultural roots and values allows them to have a solid foundation on which to build protective factors such as family attachment, sense of belonging, self-identity, esteem, attachment to their community, and many others. It is this distinct identity symbol that can also bring negative connotations from some people who do not accept our values.

It was found through focus group facilitation that some target youth are tired of being looked at and stereotyped as being the substance abuser, being told they won't amount to anything, and basically looked down upon. Despite these feelings of inferiority, there is a resiliency factor, and that is to be Native American. Tapping in to that factor is what some of the OIC member tribe's prevention programs has done. Through culture classes these programs have focused on their Native Youth, and they have invested all their efforts in providing opportunities to embrace their culture, and build upon that resiliency to keep them away from alcohol and prescription drugs. Due to socio-economic pressure, maintaining cultural identity can be costly. The OIC cultural programs have helped to fill the gap for those seeking to feel a sense of belonging. Table 1 below provides demographics of our target populations.

Q 2. Initially recruitment began with meetings and focus groups among Tribal members. These meetings were held to bring key stakeholders to the table and discuss what was going on in the community and how to address the target population of Native youth. Once those meetings began to generate ideas and strategies, next came the focus groups to bring the target population together to hear directly from them about what they wanted and needed. After the focus groups convened, each of the OIC member tribes began to create and establish their prevention programs. Through these programs they utilized social media, created eye catching graphics, engaged in multiple pro-social activities, and created youth councils.

Table 2: Native target population 18-25

Tribal Jurisdiction	<18	18-25	**Total**
Jurisdiction 1	8,308	2887	11195
Jurisdiction2	9,010	1867	10877
Jurisdiction3	4,398	763	5161
Jurisdiction4	6,092	1690	7782

It is a very difficult task to not only bring youth to the table when it comes to prevention efforts, but also to keep them coming back. A popular prevention activity, as well as a retention achievement, was the creation of the cultural classes. These classes not only gave prevention messaging and information but also gave the youth a sense of belonging. They could connect with other youth that were like them and, they learned more about their cultural past and the prevention activities kept them coming back. Two cultural programs deserve mention: the IAMNDN (pronounced I Am Indian) program which was effective in bringing youth in to the decision-making process. IAMNDN youth are involved in selecting what culture classes they would like to implement as well as being featured on prevention information posters. These posters include images of the youth along with positive messaging that give the youth a sense of pride and show the youth as positive role models for others to see. The other program is the Tradition Not Addiction program in which culture classes are also being implemented both as an after-school activity as well as a larger community intervention. Both programs use similar strategies and both have seen tremendous retention rates with youth returning to culture classes and other cultural events. These youth also want to be featured within positive prevention media.

Q 3. Most of the staff working in the OIC know the cultural patterns of the target populations because they are a part of the Native American population themselves and have grown up knowing the culture surrounding the population. The staff that aren't Native American seek guidance and input from other Native staff/co-workers, elders, oversight committees, youth councils, and community members. Knowing the cultural significance of this target population is very important. We have learned that rushing into program implementation or even planning without the proper steps and protocols can be chaotic. The OIC's Native American Substance Abuse Prevention Services Training Native SAPST filled a gap to weave the SPF methodology into tribal protocols. The results: relationships have been strengthened with our target population. The OIC staff does a tremendous job at this and ensures that the best interests of the Native youth that are being served are put first.

Q 4. The staff that comprise the OIC are themselves familiar with the cultural dynamics of the target population. Our staff is continually seeking input from elders, councils, co-workers, and youth that will allow the proper steps to be taken to ensure cultural competence. In addition, OIC staff have worked with the CAPT to host trainings that are applicable to our Native staff; training such as, historical trauma, tribal best practices, and coaching for success. OIC staff proactively seek out those key Tribal members who can assist us with behavioral change with our target population.

OIC staffs constantly ask the question: What is this doing for Native Americans? Can we do more? The answer is yes, we can always do more, there is never a day that goes by that our staff doesn't continue

to work on improving prevention programs, data, relationships, and advocating for the inclusion of our young people to be recognized as the next generation of leaders who will continue with their traditional ways. It is important those who came before us not be forgotten, as our ancestors gave up so much that they might continue to live a life free of substance abuse.

D. Building Capacity (30 points)

Q-1. Our program was first funded under the Strategic Prevention Framework, State Incentive Grant (SPF SIG) program which included applications for Tribal Incentive Grants in 2009. Our Tribal Incentive Grant was funded to create substance abuse capacity and infrastructure at the Tribal level.

Unlike states who have received Substance Abuse block grant funding since 1992, the OIC had no federal or state funding for training, services or program development for either treatment or prevention. Prior to the OIC there was no Tribal Prevention Strategy in any of our four Tribal Jurisdictions or at the Managing Entity. One of our Tribal Partners (Cheyenne and Arapaho Tribes) had a Native Connections Suicide Prevention grant (2010-2015) that was administered by that Tribe's Treatment Center but it had no substance abuse prevention component. There were no staff with prevention experience either at the Managing Entity (Tribal Epidemiological Center) or at any of the four Tribal Partners who were tasked with the field portion of the OIC's work.

The creation of prevention capacity which now exists in the OIC is certainly one of its most important achievements. The OIC prioritizes staff development and each of its four Tribal Jurisdictions has a Prevention Specialist who is required to enroll in the states Prevention Credentialing process. To increase our capacity and efficiency, the OIC has developed several important tools including:

- Yearly Action Plans that are reviewed quarterly
- The use of Logic Models for planning all interventions
- Automated spending rate monthly reports
- Monthly reports and Monthly Data Addendum reports that mirror federal requirements
- Templates for prevention contracts, project budgets and budget narratives
- One on One Technical Assistance to the Tribal Partners

Q 2. The OIC is very much involved in collaborations, both at the Managing Entity (ME) level and at the Tribal Jurisdiction level. At the ME level we have active collaborations with:

- The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS),
- The Oklahoma Department of Health (ODH),
- The Oklahoma Bureau of Investigation (OBI),
- The Oklahoma Office of Juvenile Affairs, (OJA)
- The Southwest Center for the Application of Prevention Technologies (SW CAPT),
- The Cherokee Nation health care system

ODMHSAS is our most important collaborator and OIC sits in all meetings of the state's Evidence Based Practices Workgroup (EBPW) and the State and Tribal Epidemiological Outcomes Workgroup (STEOW). ODMHSAS and Cherokee Nation Behavioral Health work with OIC on the use of prescription drug data from the state's Prescription Monitoring Program. The CAPT provides OIC specialized trainings and consultation about best practices. Crime arrest consequence data is provided by the OBI and the OJA. .

At the Tribal Jurisdiction Level, there are four Tribal Partners each with their own network of partners and collaborators. They include the ODMHSAS Regional Representatives that work in their respective

areas, private prevention and substance abuse treatment providers such as Gateway Community Services, their respective Regional Epidemiological Outcomes Workgroups (REOW's) and Native and Non Native substance abuse coalitions. Two of our Tribal Partners have active OIC youth coalitions and one adult anti-drug coalition. The IAMNDN adult coalition meets monthly to gain input from the community sectors on how to better implement prevention activities. Collaboration efforts are also forged and planned at these monthly meetings. The Cheyenne and Arapaho are in the planning stages of creating their own Tradition Not Addiction adult coalition. To our knowledge the IAMNDN adult coalition is the only Native American coalition in the area. The Tribal Partners are active collaborators and report on these efforts monthly. The OIC considers its collaborations at all levels as a force multiplier.

A 3. The OIC is active in outreach throughout the 15-county catchment area that comprises its four Tribal Jurisdictions. Through our collaborations, we learn of events where we can set up information booths, participate in workgroups and present to local groups. The IAMNDN program partners with their local Bureau of Indian Education Johnson-O'Malley Program, on notebook distribution and various other activities such as, culture, language, academics, and dropout prevention. In addition, another Tribal Partner, the Cheyenne & Arapaho Tribes, have both radio and Television stations which reach area Natives. Each Tribal Partner maintains a prevention website which promotes their programs and activities. Facebook, Twitter and Instagram are successfully spreading prevention messages. Town Hall meetings were hosted by IAMNDN and Southern Plains Tribal Health Board to create outreach and stimulate discussion. Two tribal partner programs, IAMNDN and Tradition Not Addiction have also created youth choir and powwow groups which travel throughout the state performing cultural activities and promoting their prevention programs.

IAMNDN and Tradition Not Addiction participate in various powwow's during the year, especially during the summer months when Tribes are most active. In addition, both support 5k runs and other health and wellness events. We provide a Quarterly OIC newsletter and each Tribal Partner has a monthly newsletter.

Q 4. There is grassroots participation in each of the four Tribal Jurisdictions. Two of the four hold culture classes throughout the year where prevention messages are interspersed with cultural activities for Native youth such as drum making, manufacture of regalia, beading, Native language classes and language competitions. Another Tribal Partner provides prevention input into existing culture classes. Participation in culture classes is high for both adults and youth. Although culture classes target Native youth, some adults participate since they often provide transportation needed for youth to attend. Culture classes follow a predetermined schedule; use evidence based prevention messages and are repeated in cycles during the year.

Community service, especially outreach to Tribal elders, is another popular form of grassroots participation. Native cultures respect elders and Native youth are happy to serve them with outreach activities. Hymn singing in Native languages and food donations as well as visits to elder care centers are popular during the holidays. All youth participating receive prevention information.
Two of our Tribal Partners have active youth coalitions. One has a very active youth led coalition that has been active for several years. That coalition plans and participates in powwows and attends state conferences such as the popular United National Indian Tribal Youth conference. No drug or alcohol use is tolerated and older youth mentor younger or new participants.

Other Innovations and capacity building activities. One of our Tribal Partners has sponsored Naloxone training for 13 police, tribal and first responder agency and at least one young mother's life has been saved to date by reversal of her opioid overdose by Naloxone. The Managing Entity hires a prevention

subject matter expert who has worked in the field for 21 years. Tribal Partners receive Technical Assistance whenever they request it. The OIC has a Continuous Quality Improvement process where the Project Epidemiologist and the Project Evaluator meet at least twice yearly with Tribal Partners to review survey results and work jointly on logic models.

The OIC and its Tribal Partners have been widely recognized and presented at numerous conferences including: once at the American Public Health Conference, the American Indian Education Association, CADCA Prevention Day, OKTEC Tribal Public Health Conference, National Drop-Out Prevention Conference, National Rx Drug Abuse and Heroin Summit, and many more.

Strategic Planning (30 points)

Q 1. The OIC has two goals: the reduction of underage drinking and the reduction of the nonmedical use of prescription drugs by Native youth and young adults 12-25 years of age. In the Assessment Section of this application we described how OIC Assessment can be divided into two phases. In the early years of our program we completed a formal Strategic Plan which was reviewed and approved by CSAP. That plan affirmed our priorities, outlined our goals, and introduced the importance of Native culture in any efforts to impact behavior change. That plan was approved by SAMHSA and its broad strokes remain in place, especially the plans emphasis on culturally appropriate programs and the establishment of intermediate outcomes that have cultural importance.

At this time we are funded by the Partnerships For Success SAMHSA grant. In our funded application we proposed six objectives which we are working to achieve:

1. Revitalize the Tribal Epidemiology Outcomes Workgroup (TEOW) to include gatekeepers of relevant data, establish data sharing agreements, collect data regarding Native disparities and expand the TEOW's charge,
2. Work with community law enforcement agencies in our Four Tribal Jurisdictions to enforce underage sales of alcohol laws as well as Oklahoma's Social Hosting Law,
3. Work with existing anti drug coalitions or create new coalitions of young adults within our institutions of higher learning,
4. Obtain feedback from the ODMHSAS Evidence Based Practices Workgroup,
5. Implement and evaluate cultural adaptations to substance abuse prevention interventions,
6. Focus on non medical use of prescription drugs for adolescents and young adults 12 to 25 years of age.

Q 2. Again, our most important needs assessment document is the OPNA (student school drug survey) and it allows us to measure all of the goals and many of the objectives listed in the Strategic Plan. For example, it provides consumption data that we use to measure progress in our two goals (reduction of underage drinking and reduction of non medical use of prescription drugs). We also use the OPNA to assess progress in our sixth objective, the need to focus on the nonmedical use of prescription drugs. The OPNA also provides information on where minors obtain alcohol and to what extent the social host is discouraging parents allowing their children to drink at home (social hosting) relevant to Objective 2.

At this time we are revitalizing our Tribal Epidemiological Outcomes Workgroup (Objective 1) and we have been successful in obtaining much needed data from TEOW members regarding our two PFS required consequence measures: youth alcohol and youth drug related arrests. Our Tribal

Partners have joined workgroups and coalitions in their respective districts and contribute to those bodies (Objective 3). All of our Tribal Partners have strong ties to law enforcement (Objective 2). One Tribal Partner, the Absentee Shawnee Tribe, has trained 12 law enforcement agencies in the use of the opioid reversing drug Naloxone and assisted another Tribal Partner, the Chickasaw Nation in their adoption of Naloxone for their Tribal police and first responders known as the Lighthorse Police. Managing Entity staff are regular members of the State Evidence Based Practices Workgroup (EBPW) and sit on EBPW workgroups (Objective 4). We are currently planning expansion of our programs into colleges and Universities where Natives attend (Objective 3).

Our most important planning tool to reach our Objectives is the Yearly Action Plan. The Yearly Action Plan is a planning vehicle that allows each Tribal Partner to follow the strategic plan but to adapt it to the individual Tribal Partners Tribal Jurisdiction's population, resources, tribal governance, and state of readiness. The Action Plan allows us to integrate epidemiological data as it becomes available without having to make major changes to the Strategic Plan.
Short term historical perspective is important here. After two years of Strategic Planning and at least six months review of the Strategic Plan by SAMHSA, Tribal Partners were anxious to do something in the field related to prevention. The Action Plan fitted those needs well. It allowed them to work on their goals in ways appropriate to their communities and got them started using prevention principles.
Q 3. . In our PFS application we committed to serving 1,000 Natives **during the five year span** of the grant. However, we are on track to greatly exceed that number and perhaps double it. Each year between our four partners who conduct multiple events and interventions we estimate that over 1,000 youth are reached each year. A conservative estimate of the number served is closer to 200 per year. Our programs have a wide reach through the Cheyenne and Arapaho Radio and TV stations, as well as the media campaigns supported in each Tribal Jurisdiction. Each Tribal Partner has a Facebook page and some are extremely active. Given additional time we could prepare a more accurate count.
Q 4. What mechanisms are in place to ensure long-term program sustainability? In their Action Plans, Tribal Partners are encouraged to plan for sustainability. Each Tribal Partner receives sustainability training in the Native SAPST training and all staff are required to attend. As previously stated, two of our Tribal Partners, Comanche Nation and the Cheyenne and Arapaho Tribes have made Tribal contributions of $38,000 and $50,000 respectively. It happens that these are the two Tribal Partners with the most active culture classes and it appears they are well on their way to sustainability.

Implementation (25 points)

Q 1. The OIC is an innovative program. Most innovations are of special significance to American Indian grantees but may have more general application as well. Examples are listed below.

Administrative Tools: *Use of a Managing Entity (ME) with epidemiological and administrative expertise*. When working with multiple sub grantees, it is important to have an experienced Managing Entity (ME). Our ME is the Southern Plains Tribal Health Board, Tribal Epidemiology Center[5] (SPTHB TEC). The SPTHB TEC has the specific tools (protocols, report formats, spending plans, budget requirements, and quality improvement mechanisms) to keep new programs moving quickly and efficiently. The ME also insures

[5] (https://www.facebook.com/spthb/?hc_ref=PAGES_TIMELINE&fref=nf

accountability by requiring sub-grantees complete grant requirements on a timely basis through contractual agreements and follow funding agency guidelines. The ME is able to plan for and avoid many challenges before they arise.

Assessment: *Use of existing state student school drug survey data to work with racial minorities*. Most states in the United States have some type of student school survey where students are asked basic demographics including race. The OIC sought permission from the state SSA to contact the report writers for the Oklahoma Prevention Needs Assessment Survey and contracted with the report writers to produce reports that compared Native and Non Native drug use and risk and protective profiles. A similar approach may be useful to other Native grantees in need of American Indian data.

Capacity Building: *Native-specific Substance Abuse Prevention Services Training (SAPST)*. There are substantial differences between working with a state SSA and working with a Sovereign Tribal Nation. Tribal Nations require specific trainings that translate modern evidence based nomenclature to familiar terms. The OIC approached the Southwest Center for the Application of Prevention Technologies (SW CAPT) who convened a group of Native prevention subject matter experts, who coordinated a Native-specific SAPST. OIC also provides individualized technical assistance to the Tribal Partners

Evaluation: *Project Evaluator and staff Epidemiologist working together*. Because programs with Native participants will need cultural adaptations to increase participation and relevance, it is essential that adaptations are carefully made and an evaluation plan prepared prior to implementation. Our evaluator and epidemiologist both participate in the sub grantee yearly site visits and quality improvement trainings with the Tribal Partners. If other Tribes see successful stories they could learn from our experiences and use the tools we developed.

Financial Contributions: Two of our Tribal Partners have contributed substantial funding to augment OIC programs.

Implementation: *Formal trail run implementation plan exercises*. We have found value in requiring sub-grantees prepare an Implementation Plan on a fixed schedule in their grant award, say, before Year 3. Sub grantees are often so overwhelmed with perfecting the first three steps of the SPF that they delay moving to step 4, Implementation. The completion of a formal Implementation Plan (whether or not it turns out to be what is actually implemented) gives new organizations an opportunity to plan the entire implementation process on paper.

Planning: *Action Plans supplementing Strategic Plans. Continuous Quality Improvement sessions.* While formal Strategic Plans are a useful exercise to identify priorities, they are insufficient to drive additional day to day planning. The Action Plan format which the OIC has implemented (modified from the Drug Free Communities Program) is an excellent and necessary supplement to the Strategic Plan. OIC conducts a top to bottom review of such Action Plans at least twice a year. In addition, the OIC has an active continuous quality improvement process in which our epidemiologist and evaluator's conduct day long reviews of program progress with Tribal Partners to discuss evidence based and Tribal perspectives.

Time Management Planning: American Indian Tribes are sovereign nations and may require additional Tribal approvals and consultation. Funding agencies should be prepared to grant reasonable time extensions. Moreover, to make prevention viable to Native youth prevention practices should be presented so that they build pride in youths' First Nations heritage. This may take extra time, but will help insure that Tribal governance and families of target youth are on board with our prevention initiative. Native youth know they are different from the white population and that fact needs to be accepted, nurtured, and developed into positive social accomplishments.

Tribal Best Practices: All four of our Tribal Partners have conducted extensive research on Tribal Best Practice from evidence based sources such as NREPP. However, there were so few Tribal evidence based programs that it became clear we would have to either adapt an existing program or develop home grown Tribal best practices based on evidence based foundations. We have consulted with SAMHSA, and with our Project Evaluator and our Project Epidemiologists and are evaluating all our programs relative to the six Partnerships For Success outcome measures required by the PFS Grant.

Q 2. . We feel the distinguishing characteristic is our emphasis on cultural competence and Tribal Best Practices. Our four Tribal Partners work hard to assess Native youth's readiness and to use culture as prevention as well as state of the art social media and Tribal Best Practices to satisfy Native youth's needs for positive self identity. Two of our tribal partners have taken the appropriate steps to building their grass roots culture as prevention programs. The IAMNDN program and the Tradition Not Addiction program have been able to recruite, retain, and make a lasting impact on native youth in their communities. Using weekly and monthly culture classes, these two programs provide prevention messaging and education while instilling cultural knowledge and building resiliency factors in an individualized participation setting. The newley crowned IAMNDN princess Juliana Wahnee stated "Being a part of IAMNDN has provided me with many outlets. I have been exposed to the culture and language of my tribe, met and made friendships with other Native youth who share the same dreams in life as I do, and I've gained mentors who not only can teach me about our Native ways, but can also be a shoulder to cry on when I need it. Representing IAMNDN all over Oklahoma has given me so much happiness. The role has provided me with more confidence to be more involved in my school activities and has also given me friendships that will last a lifetime." Another youth participant, Brayden Halberg, says "IAMNDN has made a major impact on my personal life. I would not be the person I am today without the help of the advisors from IAMNDN. They have changed my whole outlook on life and it has made me a better person. Many of the culture classes held that I have partaken in has given me a healthy and cultural alternative then throwing my life away to drugs and alcohol." It is essential to recruit Native staff with a passion and heart for instilling not only cultural values, but having the want and yearning to put the youth first and advocate for those that get left out. We are fortunate to have such leaders who show kindness and good attitude.

The second distinguishing factor is the inclusion of our Managing Entity. Our ME has both epidemiological and administrative expertise as well as federal grant experience. Moreover, our ME is a Native organization and has long established relationships with both large and small Tribes.

OIC seeks to serve all Natives within each of our partners Tribal Jurisdictions. Unlike some Tribal grantees that focus only on members of a particular Tribe, we seek to serve all Native youth and young adults regardless of Tribal affiliation. By not reporting evaluation results by Tribe, we avoid unfairly stigmatizing any particular Tribe.

Q 3.. The OIC operates through yearly performance based prevention services contracts to the four federally recognized Tribes who do the work in the field. Each of the Tribes has the same deliverables based contract but implements the Deliverables in their own ways. New contracts are developed each year as the grant matures. Deliverables are monitored. Our sub grantees agree to target Native youth 12-25 and to work to reduce underage drinking and nonmedical use of prescription drugs. We encourage our Tribal Partners to adapt SAMHSA and CDC evidence based practices to Native populations. Each Tribal Partner operates in a multi county Tribal Jurisdiction that includes between 4,500 and 9,000 Native youth age 12-17.

Q 4. Activities are usually planned at the Tribal level by the Tribal Specialist and their local partners. Some of our Tribal partners are very youth driven and youth participate heavily; others rely more on media and agency partners to support activities. Volunteers are always welcome.

Q 5. There is no state substance abuse block grant or other state funding. The program is supported by discretionary grants from SAMHSA. Recently, two Tribal Governments have supplemented funding for OIC activities.

Q 6. Our Tribal Communities are relatively small compared to state SSA programs. Many Tribal members know each other or meet at yearly Powwows or festivals. Evan so, some of our activities have over 1,000 participants while other's like culture classes are much smaller say 10 to 40 individuals. We have been pleasantly surprised to witness our Native youth's results improving on the state school drug survey. Three out of four Tribal Jurisdictions have improved in 30 day alcohol use from 2014 to 2016 for 12th grade, and three out of four are below State Average monthly alcohol use. Similarly, three of four Tribal Jurisdictions had lower nonmedical use of prescription drugs for twelfth graders than from 2014 to 2016. One Jurisdiction was below State Average. Capacity at the ME is adequate, but it would be good to have funding for two full time staff (currently there is only one) for each Tribal Partner.

Q 7. There are approximately 102,000 individual Natives between all four Tribal Jurisdictions. We estimate that approximately 15% were impacted.

Q 8. Our experience is most applicable to programs serving American Indian Tribes or communities, however, the use of the statewide school survey can be utilized for grantees serving any racial minority population. The challenges in achieving positive results in American Indian communities should be helpful to anyone, anywhere, serving minority populations.

G. Evaluation (40 points)

Q 1. The OIC has had important impacts and outcomes in several domains. First, we will list impacts by domain then; we will focus on providing data relative to outcomes related to our two goals, reduction of underage drinking and reduction of nonmedical use of prescription drugs.

Federal Funding: We feel our OIC model that contains leadership by a Native Managing Entity, provides funding agencies a solution to working with multiple Tribes compared to grants to single Tribes. At this time, smaller poorer Tribes with little grant writing expertise receive fewer grants and services than large well financed Tribes. The experience at the Managing Entity at the OIC makes allowance for variation in Tribal governance and speed of decision making. While one Tribe may be considering an alternative, another Tribe may have found a way forward. Thus, there is always progress occurring somewhere in the collaborative and new strategies are being tested.

Capacity Building: Prevention initiatives are successful only to the extent that they are popular among the target population, offer effective solutions to community issues, and enjoy enough support to be sustainable. The OIC has trained 11 local Natives staff at our four Tribal Partners. Together, the Managing Entity and Tribal Partners have designed culturally appropriate prevention programs for Native youth that attract large numbers of youth. The OIC partners have made significant progress in our two priority drug areas.

Disparity reduction and Outcomes: American Indian populations have historically been a high disparity health population[6]. As measured by the Oklahoma Prevention Needs Assessment student school survey, the OIC has made great strides in disparity reduction in their Tribal Jurisdictions.

Tribal Governance Buy In: The original intent of the SAMHSA grants that funded the OIC had a foundational principles of creation of infrastructure and sustainability. We are pleased to report that in the past year the Tribal governments of two of our Tribal Partners have contributed $50,000 and $38,000 respectively to augment prevention programming by the OIC. In addition, all four Tribal Governments have been most supportive in providing in-kind services such as office space, a 10 passenger van, and in public announcements of support through their newsletters and other media outlets.

Reductions in underage drinking and nonmedical use of prescription drugs. Comparisons of pre and post OIC program implementation OPNA are very encouraging and show reductions in alcohol and nonmedical use of prescription drugs.

Table 4: OPNA Results of Native Students perception of harm binge drinking &nonmedical use of Rx, Native 10th grade students, 2014-2016

Area	Alcohol 2014	Alcohol 2016	Nonmedical Rx drugs 2014	Nonmedical Rx drugs 2016
Jurisdiction 1	79.7	87.1	83.9	78.0
Jurisdiction2	73.5	78.2	82.8	78.9
Jurisdiction3	78.2	78.0	81.8	83.8
Jurisdiction 4	80.6	81.2	77.7	81.1

Q 2. The OIC is currently in the midst of a five year prevention grant, the Partnerships For Success or PFS whose goals are identical to our two priorities, nonmedical use of prescription drugs and underage drinking. Two other PFS outcomes relate to youth attitudes that are known to be associated with drug use, perception of harm from binge drinking and perception of harm from the nonmedical use of prescription drugs. All four of these outcomes are tracked by the OPNA survey. The OIC has obtained reports specific to each of our four Tribal Jurisdictions that measure these variables for Natives and Non Natives. Tribal Partner data is presented by Jurisdiction in the Tables below.

Table 3: OPNA Native Results of 10th grade Native Students response compared to state average. Monthly use, 2014-2016*

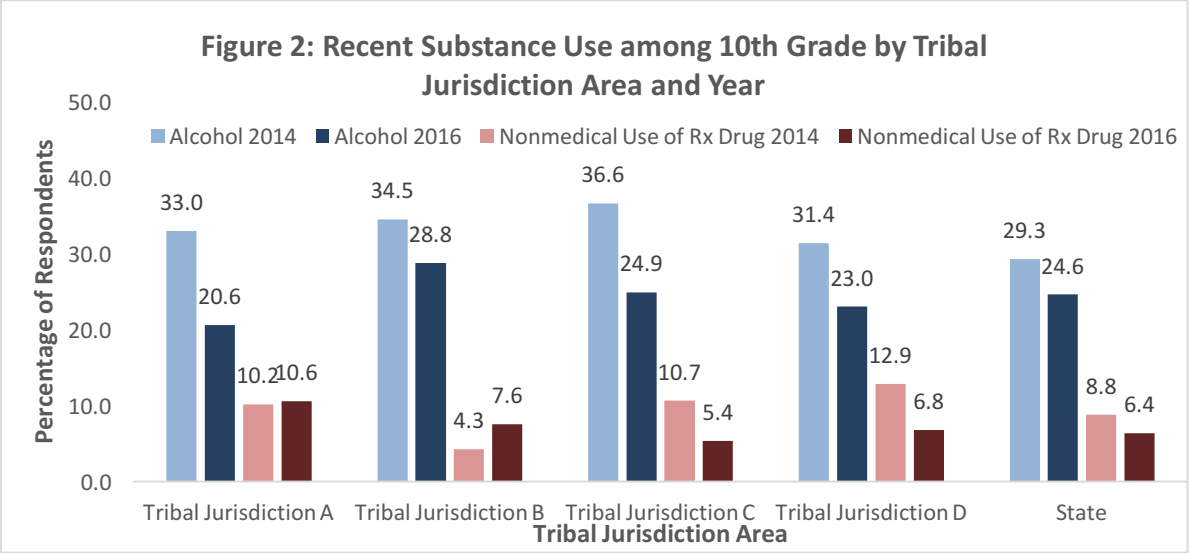
Area	Alcohol 2014	Alcohol 2016	Nonmedical Rx drugs 2014	Nonmedical Rx drugs 2016
Jurisdiction 1	33.0	20.6	10.2	10.6
Jurisdiction2	34.5	28.8	4.3	7.6
Jurisdiction3	36.6	24.9	10.7	5.4
Jurisdiction 4	31.4	23.0	12.9	6.8
State Average	29.3	24.6	8.8	6.4

Note that all four Tribal Jurisdictions decreased their alcohol use and two were lower than state average in 2016. Reductions in nonmedical use of Rx was quite pronounced for two Tribal Jurisdictions.

Note: Alcohol perception of harm increased in three of four Jurisdictions. Nonmedical use perception of harm improved in two Jurisdictions.

[6] https://www.ihs.gov/newsroom/factsheets/disparities/

The figure below summarizes the trends in recent alcohol and recent nonmedical use of prescription drugs. It is clear that all four Jurisdictions improved in recent alcohol consumption while, there was improvement in two of the four Jurisdictions for recent nonmedical use. This is a very useful chart that shows where additional work is needed.



Q 3. The OIC has a SAMHSA approved Evaluation Plan that was developed jointly by our Project Evaluator from the University of Oklahoma and Managing Entity staff. Dr. Gibson our evaluator is associated with the OU ETEAM (Educational Training Evaluation Assessment and Measurement) and works with an excellent group of dedicated evaluators who evaluate the state's System Of Care for Children's mental health. These evaluation results are directly related to the goals of the OIC that were derived from the Epidemiological Profile and Strategic Plan in 2012. Tribal Partners are very pleased with the gains these data show.

Program Management (15 points)

Q 1. Financial resources come from two sources, the Strategic Prevention Framework for Prescription Drugs (SPF Rx), which is in the planning phase, and the Partnerships For Success which provides $834,000 per year for all four partners, the managing entity and the evaluation contract.

Staff within the OIC are the most important human resource and there is aTribal Specialist at each Tribal Partner. The OIC staff is characterized by diversity in culture. Half are Native American. Staff positions include: Full time Epidemiologist, Full time Graphics and Communications Specialist, Master's level Program Director, Part time contracted subject matter prevention expert (by phone and Go To Meeting), Part time contracted Ph.D level Project Evaluator from the University of Oklahoma, Educational Training, Evaluation, Assessment & Measurement evaluation group.

Partnerships that the OIC member tribes have created are a proven resource that are very beneficial. These include partnerships within the tribal organization departments, local coalitions, state departments, other youth serving organizations, and even national and federal organizations. In kind resources are another tapped into area that the prevention programs have been able to build up. These in-kind resources include parents/volunteers for events, youth volunteers for media and program participation, earned media, and outside staff participation and collaboration.

An example of resource use is having parents/grandparents help facilitate culture classes, chaperone community pro-social events, and help setup and take down informational booths.

In order to maximize these resources there are monthly and quarterly meetings that are held within each of the tribal organizations as well as coalition meetings that are initiated by us or attended by OIC. Constant communication and information dissemination through social media and websites are an important factor in keeping resources available and informed.

The Center for the Application of Prevention Technologies is an important resource that is utilized from time to time. They have assisted us in trainings, helped us develop logic models, and meet with OIC every year to plan for any needed CAPT services.

We have monthly communications with our CSAP Project Officer and she volunteers strategies, provides support, informs us of grant opportunities and relays our concerns when we have any.

Q 2.

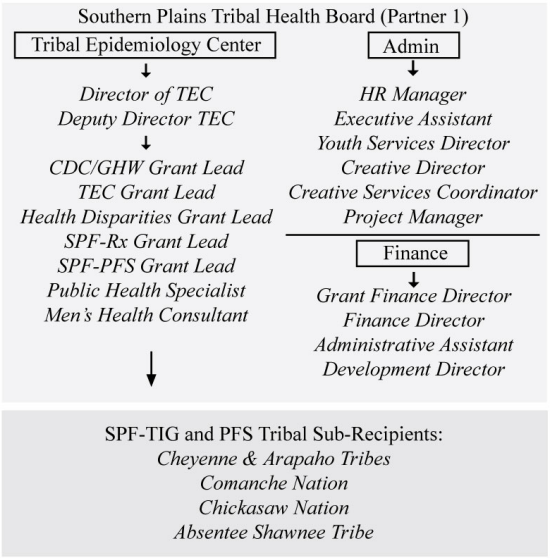
Program Staff & Administration Meetings:- Communications is key to our success. The Managing Entity (ME) held monthly face to face meetings with tribal partners in the early stages of the grant. Due to the long distances of travel for some of our tribal partners, we initiated the use of a web-hosted service called GoToMeeting as a tool for teleconferencing, online meetings, and demonstrations. This method has been cost effective and convenient to administering technical assistance when needed. We find we can accomplish more by having one on one monthly meetings with individual partners. We will be having Quarterly Meetings where all Tribal Partners can meet face to face soon.

Media – Each of our tribal partners have utilized the following media to promote their prevention programs. Facebook, Twitter, Instagram and websites. All four of our tribal partners have initiated substance abuse media campaigns to their target audience. These media messages have been nationally show-cased and have drawn the attention of governmental officials, such as the Surgeon General Vivek H. Murthy, who came to Oklahoma to visit with our tribal youth last year.

Policy Makers – Surgeon General Vivek H. Murthy visited on May 3, 2016. This was an unprecedented event that left a huge impact on our native youth. Because of the innovative work of our tribal partners, it caught the attention of our Surgeon General who is an avid proponent again substance misuse and related consequences.

The above communication efforts may seem commonplace for others, but for those of us who live in Indian Country, it is pioneering the way for the future of our young people.

An Organizational Chart is included below.



Budget Narrative:

The Southern Plains Tribal Health Board (SPTHB) respectfully requested funding in the amount of $179,530 in direct costs, $55,833 in indirect costs, and $599,180 in contractual costs for a total request of **$834,543 for the first year** for the Oklahoma Inter-Tribal Consortium (OITC). Indirect cost is based on the 2011 IDC rate of 31.1% per the SPTHB's federal IDC agreement.

Personnel costs requested are **$119,938** to fund .05 FTE SPTHB Co-Principle Investigator at $4,500; .20 FTE SPTHB Co-Principal Investigator at $15,000; 0.8 FTE Project Coordinator at $48,000; 0.20 FTE Data Manager at $9,000 and a 0.5 FTE Administrative Assistant at a rate of $19,000. The roles and responsibilities for each position are described in the Key Personnel section. **Fringe** benefits are requested at the rate of 25% totaling **$25,438**. The SPTHB's fringe benefits package include: employee health insurance, dental insurance, vision insurance, life insurance, short-term and long-term disability insurance, 401K, Section 125 Medical and Dependent Care accounts, and paid annual leave, sick leave, and holidays.

Travel funds are requested in the amount of **$10,754**. Travel is required to meet objectives set forth in the work plan and includes both in and out of state travel. Instate travel is proposed to meet with tribal partners, Advisory Councils and Steering Committees, and to attend Regional and State Epidemiological Outcomes Workgroup meetings, as well as community coalition meetings

Supplies are requested in the amount of **$5,087**. Supplies include notebooks, pens, pencils, paper, computer printer supplies and office files for 1.8 FTE at $46 per month for 12 months

Contractual funds being requested are **$592,930.** As specified in the RFA, our community partners must receive 70% of the award. There are four tribal partners that the TEC will be contracting with and the aggregate total is **$549,180**. Therefore, each tribal partner will receive $137,295. There are no indirect costs associated with the four tribal partner contracts. The evaluator, will have a contract for **$20,000** per year of the grant. Our outside consultant, who provides subject matter expertise to both TEC SPF staff and tribal partner Tribal Liaisons, will have a contract renewal of **$18,750** per year. The TEC will contract to develop a database that will support the efforts of developing a SPF database for **$5000**.

Tribal Epidemiological Outcomes Workgroup (**TEOW**) funds are being requested in the amount of **$50,000** as specified in the RFA.

Indirect costs are requested in the amount of **$55,833**. This is consistent with the SPTHB's Federal IDC agreement.

Future Budget Years

Data Collection & Performance Measurement	Year 1	Year 2	Year 3	Year 4	Year 5	Total Costs
Personnel	$9,550	$9,836	$10,131	$10,435	$10,755	$50,707
Fringe	$2,444	$2,459	$2,532	$2,608	$2,689	$12,732
Travel	$1,075	$773	$762	$450	$383	$3,443
Supplies	$0	$0	$0	$0	$0	$0
Contractual (Tribal Partners)	$82,377	$82,377	$82,377	$82,377	$82,377	$411,885
Contractual (Evaluator)	$20,000	$20,000	$20,000	$20,000	$20,000	$100,000
Direct Costs	$33,069	$33,068	$33,425	$33,493	$33,827	$166,882
Indirect Costs	10,251	10,251	10,362	10,383	10,486	$51,733
Total	$158,766	$158,764	$159,589	$159,746	$160,517	**$797,382**

Narrative

The above spreadsheet provides yearly dollar amounts for data collection and performance measurement for the five year grant cycle. Personnel, fringe, travel, and evaluator are grantee level direct costs that are eligible for indirect cost revenue for the parent organization. The yearly amounts for personnel, fringe, and travel are 10% of the total for that line item for the grant budget, which is provided elsewhere in this application. These items are eligible for collection of indirect costs. The evaluator is contracted for $20,000 per year. Because the amount is less than the threshold of $25,000, the whole amount is eligible for collection of indirect costs. There are four Tribal Partners. The Tribal partners are to receive 70% of the grant after the deduction of the TEOW expense per year. $834,543 - $50,000 = $784,543 x 0.7 =$549,180. This amount will be divided evenly among the four Tribal Partners with each receiving $137,295. 15% of the Tribal Partner budget will be used for data collection and performance assessment. $137,295 x 0.15 = $20,594 x 4 = $82,377. This amount will remain the same for all 5 years. The Tribal Partner budget is not eligible for collection of indirect costs. The total of $797,382 is **19%** of the cumulative grant total of $4,172,715.