



Indian Health Service Tribal Consultation Summit

July 6-7, 2011

Bethesda North Marriott Hotel and Conference Center
Bethesda, MD





July 6, 2011

Dear Summit Attendees:

I am pleased to welcome you to the first Indian Health Service (IHS) Tribal Consultation Summit (Summit), which is immediately followed by a half-day education session on the Affordable Care Act (ACA). The purpose of this Summit is: to provide a “one stop shop” on Tribal Consultation; to learn about current IHS Tribal Consultation activities and workgroups; and to provide feedback and recommendations on current IHS consultation topics. I look forward to our discussions of these issues during the Summit.

This event originated from a series of recommendations developed by the IHS Director’s Tribal Advisory Workgroup on Consultation (DTAWC). I invited the Chairs of various IHS Committees and Workgroups, including the DTAWC, to present their current Tribal Consultation activities first hand. Each IHS Committee and Workgroup will provide an update on current activities, recommendations, and priorities. Participants will have the opportunity to ask questions and dialogue directly with representatives of each group.

We appreciate your participation and look forward to further strengthening our valued government-to-government relationship.

Sincerely,

/Yvette Roubideaux/

Yvette Roubideaux, M.D., M.P.H.
Director



2011 Indian Health Service (IHS) Tribal Consultation Summit

Bethesda North Marriott Hotel and Conference Center
5701 Marinelli Road Bethesda, MD 20852
Phone: (301) 822-9200 Fax: (301) 822-9201

TABLE OF CONTENTS

Welcome

Agenda

IHS Director's Letter to Tribal Leaders:

- August 13, 2009
- January 15, 2010
- Recommendations from Workgroup on How to Improve Consultation
- Tribal Consultation Policy

IHS Committee/Workgroup Summaries:

- Director's Tribal Advisory Workgroup on Consultation
- Direct Service Tribes Advisory Committee
- Tribal Self-Governance Advisory Committee
- National Tribal Advisory Committee on Behavioral Health
- Director's Workgroup on Improving Contract Health Services
- IHS Budget Formulation Workgroup
- Tribal Leaders Diabetes Committee
- IHS Information Systems Advisory Committee

Consultation Topic Summaries:

- Indian Health Care Improvement Act
- Tribal Epidemiology Centers Data Sharing Agreement
- Suicide Prevention
- Indian Health Care Improvement Fund

Hotel Map



2011 Indian Health Service (IHS) Tribal Consultation Summit

Bethesda North Marriott Hotel and Conference Center

5701 Marinelli Road Bethesda, MD 20852

Phone: (301) 822-9200 Fax: (301) 822-9201

Purpose: To provide American Indians and Alaska Natives the opportunity to attend a “one stop shop” on Tribal Consultation; to learn about current IHS Tribal Consultation activities and workgroups; and to provide feedback and recommendations on current IHS consultation topics.

AGENDA

Wednesday, July 6, 2011

First General Assembly (Grand Ballroom D)

FACILITATOR: CAPT Sandra Pattea, Deputy Director for Intergovernmental Affairs, IHS

8:00 a.m. **REGISTRATION (Grand Ballroom Foyer)**

9:00 a.m. **Opening Ceremony**

- **Presentation of Colors** (IHS Color Guard)
- **Flag Song**
- **Veteran’s Song**
- **Invocation**

9:30 a.m. **Overview** – Yvette Roubideaux, M.D., M.P.H., Director, IHS

10:45 a.m. **BREAK**

11:00 a.m. **Director’s Tribal Advisory Workgroup on Consultation (DTAWC)**

The DTAWC is charged with working in partnership with the IHS Director to recommend improvements on the IHS Tribal Consultation process to make it more meaningful, effective and accountable. The Workgroup also meets to review progress on consultation efforts and provides the IHS Director with guidance on general consultation issues.

- Lincoln Bean, Tribal Council Member – Organized Village of Kake, DTAWC Member: Alaska Area
- Leonard Harjo, Principal Chief – Seminole Tribe of Oklahoma, DTAWC Member: Oklahoma City Area



11:30 a.m.

Direct Service Tribes Advisory Committee (DSTAC)

The DSTAC is established to provide leadership, advocacy and policy guidance by: 1) assisting and advising on the development of Indian health policy that impacts the delivery of health care for Indian Tribes with an emphasis on policies that impact the Direct Service Tribes; 2) actively participating, to the greatest extent possible, in IHS decision-making that affects the delivery of health care; and 3) providing verbal and written recommendations to the IHS Director.

- Dale DeCoteau, Fort Peck Tribal Council Member – DSTAC
Representative: Billings Area
- Rex Lee Jim, Vice President, Navajo Nation – DSTAC
Representative: Navajo Area

12:00 p.m.

Tribal Self-Governance Advisory Committee (TSGAC)

The TSGAC provides advice and assistance to the IHS Director on issues and concerns pertaining to Tribal Self-Governance and the implementation of the Self-Governance within the IHS. The TSGAC represents Self-Governance Tribes by acting on their behalf to clarify issues that affect all compacting tribes specific to issues affecting the delivery of health care of American Indians and Alaska Natives (AI/ANs). They meet on a quarterly basis to confer, discuss, and come to consensus on specific Self-Governance issues. Additionally, the TSGAC provides verbal and written advice about Self-Governance issues to the IHS Director and the Director of the Office of Tribal Self-Governance.

- Lynn Malerba, Chief – Mohegan Tribe of Connecticut, TSGAC
Vice Chairman: Nashville Area
- Carolyn Crowder, Health Director – Aleutian Pribilof Islands Association, TSGAC Member: Alaska Area

12:30 p.m.

LUNCH ON YOUR OWN

2:00 – 3:00 p.m.

Concurrent Breakout Session #1

Grand Ballroom A	Brookside A/B	Grand Ballroom B	Grand Ballroom C
<u>Consultation Topic:</u> Indian Health Care Improvement Act Update*	<u>Consultation Topic:</u> Data Sharing Agreements	<u>Group:</u> National Tribal Advisory Committee on Behavioral Health	<u>Group:</u> Director’s Workgroup on Improving Contract Health Services*

* These sessions will be repeated during breakout session #3.



Grand Ballroom A **Consultation Topic: Indian Health Care Improvement Act (IHCIA)**

On March 23, 2010, President Barack Obama signed the Affordable Care Act, which included the permanent reauthorization of the IHCIA. Along with the Snyder Act of 1921, the IHCIA forms the statutory basis for the delivery of health care to AI/ANs by the IHS. The purpose of this session is to provide an update on implementation activities.

- Panelists:** 1) Yvette Roubideaux, M.D., M.P.H., Director, IHS
 2) Geoffrey Roth, Senior Advisor to the Director, Office of the Director, IHS
- Recorder:** Charles Sockey, Policy Analyst – Office of Tribal Self-Governance, IHS

NOTE: This session will be repeated Thursday, July 7th at 9:00 a.m. in Grand Ballroom A.

Brookside A/B **Consultation Topic: Data Sharing Agreements**

Tribal Epidemiology Centers (TECs) are Tribal organizations funded by the IHS to develop public health data capacity for the benefit of Tribes. In response to TECs being designated as Public Health Authorities under the IHCIA, TECs have requested access to IHS patient data for the purpose of public health surveillance and reporting on community health status of their constituent Tribes. The IHS has worked with the TECs, in consultation with the Office of the General Counsel, Area Directors, and Chief Medical Officers, to develop a draft Data Sharing Contract (DSC) to enable the exchange of health data. The IHS has shared the draft DSC with Tribes and has received numerous comments and feedback.

- Moderator:** Richard Church, Director, Office of Public Health Support
- Panelists:** 1) Victoria Warren-Mears, Director, Northwest Tribal Epidemiology Center
 2) James Cheek, MD, Director, Division of Epidemiology and Disease Prevention
- Recorder:** Andrea Patton, Policy Analyst – Office of Tribal Self-Governance, IHS



Grand Ballroom B Group: National Tribal Advisory Committee on Behavioral Health (NTAC)

The NTAC helps guide the development of, and support for, behavioral health throughout the IHS/Tribal/Urban (I/T/U) systems, and works to ensure that services are as broadly integrated, available and culturally appropriate as possible. The NTAC serves as an advisory body to the IHS Director and to the Division of Behavioral Health by providing guidance and recommendations regarding behavioral health programmatic issues that affect the delivery of behavioral health care for AI/ANs served by the IHS and the entire I/T/U system.

Moderator: Jon Perez, Ph.D., National Behavioral Health Consultant – Division of Behavioral Health, Office of Clinical and Preventive Services, IHS

Panelists: 1) Julia Davis-Wheeler, Nez Perce Tribe
2) Rachel Joseph, Lone Pine Paiute-Shoshone Tribe

Recorder: Sharon Folgar, Program Analyst – Office of Direct Service and Contracting Tribes, IHS

Grand Ballroom C Group: Director’s Workgroup on Improving Contract Health Services (CHS)

The CHS Workgroup is charged with reviewing input received on how to improve the CHS Program. They are also responsible for looking at the Fiscal Year (FY) 2001 CHS distribution formula to determine if changes are needed for the new funding beginning in FY 2011 and beyond.

Moderator: Carl Harper, Director, Office of Resource Access and Partnerships

Panelist: Johnny Hernandez, Santa Ysabel Band of Mission Indians
Representative: Southern California Tribal Chairman’s Association

Recorder: Susan Anderson, Program Analyst – Office of Direct Service and Contracting Tribes

NOTE: This session will be repeated Thursday, July 7th at 9:00 a.m. in Grand Ballroom C.

3:00 p.m.

BREAK



3:30 – 4:30 p.m.

Concurrent Breakout Session #2

Grand Ballroom A	Grand Ballroom B	Grand Ballroom C	Brookside A/B
Consultation Topic: Director’s Tribal Advisory Workgroup on Consultation	Group: IHS Budget Formulation Workgroup	Group: Tribal Leaders Diabetes Committee	Group: IHS Information Systems Advisory Committee

Grand Ballroom A Group: Director’s Tribal Advisory Workgroup on Consultation (DTAWC)

The Workgroup is charged with working in partnership with the IHS Director to recommend improvements on the IHS Tribal Consultation process to make it more meaningful, effective and accountable. The Workgroup also meets to review progress on consultation efforts and provide the IHS Director with guidance on general consultation issues.

Moderator: CAPT Sandra Pattea, Deputy Director of Intergovernmental Affairs, IHS

- Panelists:**
- 1) Lincoln Bean, Tribal Council Member – Organized Village of Kake, DTAWC Member: Alaska Area
 - 2) Leonard Harjo, Principal Chief – Seminole Tribe of Oklahoma, DTAWC Member: Oklahoma City Area
 - 3) Yvette Roubideaux, M.D., M.P.H., Director, IHS

Recorder: Anna Johnson, Program Analyst – Office of Tribal Self-Governance, IHS

Grand Ballroom B Group: IHS Budget Formulation Workgroup (BFWG)

The IHS budget formulation process is comprised of annual forums for Indian Tribes to interact with the IHS to provide program priorities, policies, and budget recommendations. The workgroup provides input and guidance to the IHS Headquarters budget formulation team throughout the remainder of the budget formulation cycle for that fiscal year.

Moderator: Elizabeth Fowler, Director – Office of Finance and Accounting

- Panelists:**
- 1) Rex Lee Jim, Vice President, Navajo Nation
 - 2) Andy Joseph, Jr., Colville Business Council Member, Confederated Tribes of the Colville Reservation

Recorder: Charles Sockey, Policy Analyst – Office of Tribal Self-Governance, IHS



Grand Ballroom C Group: Tribal Leaders Diabetes Committee (TLDC)

The TLDC makes recommendations to establish broad-based policy and advocacy priorities for diabetes to the IHS Director. The TLDC: 1) makes recommendations and provide advice on policy and advocacy issues concerning diabetes; 2) provides advice and guidance to ensure the incorporation of appropriate culture, traditions, and values in program development, research, and community-based activities; 3) provides broad-based guidance and assistance in defining how other Federal Agencies and organizations, States, Tribal epidemiology centers, institutions of higher learning and private health organizations can play a role in addressing diabetes and; 4) serves as a Tribal advisory committee to the Centers for Disease Control and Prevention’s Native Diabetes Wellness Program.

- Moderator:** Lorraine Valdez, MPA, BSN, RN, Acting Director, Nurse Consultant – Division of Diabetes Treatment and Prevention, Office of Clinical and Preventive Services, IHS
- Panelists:** 1) Julia Davis-Wheeler, Tribal Leader – Nez Perce Tribe, TLDC Representative: Portland Area
2) Connie Barker, Tribal Legislator – Chickasaw Nation, TLDC Representative: Oklahoma City Area
- Recorder:** Susan Anderson, Office of Direct Service and Contracting Tribes, IHS

Brookside A/B Group: IHS Information Systems Advisory Committee (ISAC)

The ISAC was established to guide the development of a co-owned Indian health information infrastructure and information systems. The ISAC assists in ensuring that the information systems are available, accessible, useful, cost effective, user-friendly, and secure for local-level providers, and that these systems continue to create standardized aggregate data that supports advocacy for the Indian health programs at the national level.

- Moderator:** Charles Gepford, Chief Information Officer, IHS (Acting Director) – Office of Information Technology (OIT)
- Panelists:** 1) Carolyn Crowder, Health Director – Aleutian Pribilof Islands Association, ISAC Tribal Co-Chair
2) Richard Hall, Director of Statewide Health Information Management Systems, Alaska Native Tribal Health Consortium, ISAC Tribal Representative
3) Lisa DeCora, Management Analyst - Information Technology Tribal Shares Improvement Project, OIT, IHS
- Recorder:** Andrea Patton, Policy Analyst – Office of Tribal Self-Governance, IHS

4:30 p.m.

Adjourn for the day



Thursday, July 7, 2011

9:00 – 10:00 a.m. **Concurrent Breakout Session #3**

Grand Ballroom A	Grand Ballroom C	Grand Ballroom B	Brookside A/B
<u>Consultation Topic:</u> Indian Health Care Improvement Act Update*	<u>Group:</u> Director’s Workgroup on Improving Contract Health Services*	<u>Consultation Topic:</u> Suicide Prevention	<u>Group:</u> Indian Health Care Improvement Fund

** These sessions are a repeat of what was presented during breakout session #1.*

Grand Ballroom A Consultation Topic: Indian Health Care Improvement Act (IHCIA)*
NOTE: This session is a repeat of what was presented during breakout session #1, please see page 3 for more information.

Grand Ballroom C Group: Director’s Workgroup on Improving Contract Health Services (CHS)*
NOTE: This session is a repeat of what was presented during breakout session #1, please see page 4 for more information.

Grand Ballroom B Consultation Topic: Suicide Prevention
 Suicide is a public health issue and a top Tribal priority and concern. This year, 10 listening sessions were held by the Department of Interior, the Substance Abuse and Mental Health Administration, and the IHS to hear ideas about how Tribes and Federal agencies can better address the problem of suicide in Tribal communities. The purpose of this session is to report on the listening sessions and to discuss preparations for the upcoming Action Summit for Suicide Prevention.

Moderator: Cheryl Peterson, MN, RN, Senior Public Health Advisor – Division of Behavioral Health, Office of Clinical and Preventive Services, IHS

Panelists: 1) Rachel Joseph, Lone Pine Paiute-Shoshone Tribe
 2) Julia Davis-Wheeler, Nez Perce Tribe

Recorder: Andrea Patton, Policy Analyst – Office of Tribal Self-Governance, IHS



Brookside A/B

Consultation Topic: Indian Health Care Improvement Fund (IHCIF)

A letter to Tribal leaders was sent December 30, 2010 initiating consultation on the IHCIF. The IHCIF was established to determine the overall level of need funded for Federal, Tribal, or Tribal organization health care facilities. A formula was established that assigned facilities a level of need funded percentage relative to funding spent for Federal employees for health insurance through the Federal Employees Health Benefits (FEHB) Program. The average level of need funded for all facilities was determined to be 55 percent of the FEHB benchmark. Many facilities were funded a levels below that average. Each year since 2001, Congress has appointed funding for facilities with the lowest percentage level of need funding, and to date, all facilities have been raised to at least 46% of their estimated level of need. However, additional funding is needed to raise all facilities to the IHS average of 55 percent.

Panelist: Cliff Wiggins, Supervisory Operation Research Analyst – Office of the Director, IHS

Recorder: Sharon Folgar, Program Analyst – Office of Direct Service and Contracting Tribes, IHS

10:00 a.m. **BREAK**

Second General Assembly (Grand Ballroom D)

FACILITATOR: CAPT Sandra Pattea, Deputy Director for Intergovernmental Affairs, IHS

10:30 a.m. **General Session – Summary/Comments/Wrap Up**
Yvette Roubideaux, M.D., M.P.H., Director, IHS

12:00 p.m. **LUNCH ON YOUR OWN**

1:00 p.m. **Affordable Care Act Session**
The purpose of this session is to provide updates on current consultation activities related to implementation of the Affordable Care Act, including an update on the State Exchanges.

4:00 p.m. **Retire the Colors**

Closing Prayer

4:30 p.m. **Adjourn Summit**



Tribal Leader Letters



AUG 13 2009

Dear Tribal Leader:

I am writing to request your input on how to improve the Indian Health Service (IHS) Tribal consultation process.

In my Senate confirmation speech, I indicated that my first priority was to renew and strengthen our partnership with Tribes. I understand the important role of Tribal consultation in the relationship between the federal government and Tribes. I believe in order to improve the health of our communities, we must work in partnership with them. This partnership is vital to the implementation of IHS programs and initiatives.

Since I have been the Director, I have heard from many tribal leaders of the need to improve our Tribal consultation process and the importance of making this process more meaningful. Tribal leaders have shared with me both their support of the existing consultation process, as well as their concerns. Many Tribal leaders have indicated that the IHS Tribal consultation policy is in general a good policy; however, many have indicated that there could be some improvements in the process or in the ways that we conduct Tribal consultation.

IHS has conducted Tribal consultation in a variety of ways over the years on a one-time basis for particular issues or on a regular basis for ongoing initiatives. Various approaches have been used to support this process, including direct correspondence to Tribal leadership, meetings with Tribal leadership at the local, Area or national levels, and/or a variety of standing and ad hoc Tribal advisory groups.

We also recognize that tribal consultation may be taking up an increasing part of your time these days. In addition to all the tribal consultation meetings and workgroups for IHS, we know that you also must participate in tribal consultation meetings and workgroups for other agencies, departments, or even states, as well as the important work you do with national and regional tribal organizations. Some tribal leaders have expressed a concern that the demands of all the various consultation activities are growing and negatively impacting their standing with their own communities given all the time and travel required away from home. Perhaps you have some creative ideas for how to change or reorganize our activities related to tribal consultation so that tribes can participate in a meaningful manner without imposing a huge time and travel burden. We want to work with you on improving the process for tribal consultation. While I am not proposing a change to the current IHS tribal consultation policy, I have attached the current policy for your review as you consider how we can improve how we implement this policy.

Please e-mail your comments and ideas on how to improve IHS' Tribal consultation process to consultation@ihs.gov, by Monday, September 28, 2009.

Page 2 – Dear Tribal Leader

I plan to convene a group of elected Tribal officials to review and discuss your input on this topic and to work with me to come up with recommendations to improve Tribal consultation within the IHS. I would like this group to include two (2) elected tribal officials from each IHS Area, with at least one of the representatives from each Area having experience as a Chair or member of an existing IHS standing or ad hoc tribal advisory committee, board, or workgroup. I have enclosed a list of the current IHS Tribal advisory committees/workgroups for your information. Because I would like to convene this group in October, I am requesting that your nominations be submitted to Area Directors no later than Monday, September 21, 2009. Please only submit names of elected tribal officials; it is important that this discussion happen at the government to government level. Area Directors will provide me with nominations by Thursday, September 24, 2009.

Thank you in advance for your input on how to improve the IHS Tribal consultation process. I look forward to reviewing your ideas and working with you to renew and strengthen our partnership to improve the health of our communities.

Sincerely,

/Yvette Roubideaux/

Yvette Roubideaux, M.D., M.P.H.
Director

Enclosures: IHS Tribal Consultation Policy
IHS Tribal Advisory Committee/Workgroup List



JAN 15 2010

Dear Tribal Leader:

I am writing to report progress to date and request your input on recommendations on how to improve IHS' Tribal consultation process. On August 13, 2009, I sent a letter to all Tribes requesting input on how to improve the IHS Tribal consultation process. I also indicated that I planned to form a workgroup of two tribally elected officials from each IHS Area to review input and make recommendations. I met with this workgroup on December 8, 2009, and on January 5-6, 2010. We reviewed the input received from Tribes on this topic, reviewed the current process for Tribal consultation with IHS, and discussed recommendations on how to improve the process for each of these steps. The workgroup made detailed recommendations, and I have attached a summary of these recommendations.

I believe that these recommendations are consistent with several of my priorities as Director of the IHS, including my priority to renew and strengthen our partnership with Tribes, to reform the IHS, and to make all our work transparent, accountable, fair and inclusive.

I believe that some of the recommendations to improve the Tribal consultation process for IHS can be implemented immediately, and some may take some time. Some of the more immediate recommendations that I plan to implement immediately include the following, organized by the basic steps of consultation:

- Critical event that triggers a Tribal consultation
 - o Consultation activities are defined by a critical event that requires a decision, such as new funding increases, the need for new policies or regulations, or pressing/serious issues

- Announcement of Tribal consultation activities
 - o IHS will develop a process to improve communication about Tribal consultation activities, including updating contact information and improving and clarifying the content of letters to Tribes as indicated in the recommendations
 - o IHS will send out both written and electronic notification of consultation activities to Tribes, and will also send copies of announcements of consultation activities to IHS Area Directors, Tribal health directors, and Tribal organizations
 - o IHS will develop a Web site to announce and provide current information on all Tribal consultation activities, including information on standing workgroup activities

- Gathering input during Tribal consultation activities
 - o IHS will clarify and better utilize both national and regional/Area formats for consultation activities

- IHS will work to ensure that adequate time is provided for consultation in all formats unless there is a pressing need or other urgency for quicker input
 - The IHS Director will create a regular schedule of consultation meetings at major national Tribal conferences to allow for regular in person input on current consultation topics
 - The IHS Director is currently planning on meeting with Tribes in all IHS Areas in the next few months and will continue these Area meetings on a regular basis
 - IHS will conduct a review of all Tribal advisory and consultation workgroups to assess the original charge, current activities and will determine if workgroups need to continue or can be discontinued to focus on more pressing issues. Some workgroups will be continued because of their important recurring role in advising the IHS Director, such as the Tribal Self-Governance Advisory Committee, Direct Service Tribes Advisory Committee, Tribal Budget Formulation Committee, Contract Support Costs workgroup, etc. Some workgroups may be combined or meet less frequently. Cross agency opportunities for consultation will be explored.
 - The IHS Director will continue the Tribal Consultation Workgroup formed during this process as a group of two tribally elected officials from each IHS Area to review progress on these efforts to improve Tribal consultation and to advise the Director on more general consultation issues. The group will now be called the IHS Director's Tribal Advisory Workgroup on Consultation
- Decision-making process
 - The Director will continue to develop a process for working directly with Tribes to develop recommendations and make decisions in partnership
 - Reporting/Follow up of consultation activities
 - IHS will work to improve written follow up of consultation activities and outcomes
 - IHS will develop a Web site as mentioned previously to document and summarize Tribal consultation activities
 - IHS will develop a process to evaluate all Tribal consultation activities

I am requesting your input on the recommendations of the workgroup as a final step in this consultation on the IHS process for consultation. Please send any additional recommendations you have to me at the address that follows (written or e-mail) **by March 15, 2010.**

While I plan to use these recommendations as an ongoing guide to our decisions about how to conduct Tribal consultation on IHS-related issues, I also plan to share these recommendations with other agencies and departments as a part of the current process for our response to the November 5, 2009, Presidential Memorandum on Tribal Consultation. The IHS has had a Tribal consultation policy since 1998 and it is clear that we have extensive experience on consultation that could be shared with other agencies.

I plan to update Tribes regularly on how we are improving the Tribal consultation process. Thank you for your input and recommendations on how to ensure that IHS' partnership with Tribes includes meaningful and accountable consultation with Tribes. I truly believe the only way we can improve the health of our communities is to work in partnership with them. Your recommendations on how to improve the Tribal consultation process help us move forward with our partnership towards improving the health of our people and our communities.

Sincerely,

/Yvette Roubideaux/

Yvette Roubideaux, M.D., M.P.H.
Director

Enclosures:

1. August 13, 2009 consultation letter
2. IHS Director's Tribal Advisory Workgroup on Consultation listing
3. Recommendations from workgroup on how to improve consultation
4. IHS Tribal Consultation Policy (1/2006)

Please send your input/recommendations by March 15, 2010 to:

Yvette Roubideaux, M.D., M.P.H.
Director
Indian Health Service
801 Thompson Avenue, Suite 440
Rockville MD 20850

Or by e-mail consultation@ihs.gov

RECOMMENDATIONS OF THE WORKGROUP

How to improve IHS' consultation process

Discussion notes and recommendations from 12/8/09 and 1/5/10 meeting with tribal consultation workgroup by each step in the consultation process

1. **Critical Event** – what triggers the need for a tribal consultation
 - a. Critical events occur at multiple levels - National (HHS, IHS), Area, SU, and Tribal
 - b. A critical event requires a decision or action on an issue or challenge
 - c. Consultation is needed for critical events
 - d. Examples of critical events: New funding or funding increase or funding decrease, budget formulation, funding formulas, new policy needed, regulations, policy on services to members, legislation, multiple departments/agencies policy when health impacted, serious/urgent health issue/challenge
 - e. Who defines the critical event: either IHS or tribes
 - f. How to decide if do consultation on critical event? – while IHS Director makes ultimate decision on whether to hold the consultation, consultation with tribes can help define priorities when there is limited resources and time. Suggest having a group such as this group of 2 tribal elected officials from each IHS Area to help make the decision. Can also consult NIHB, NCAI, existing tribal workgroups, or do a survey in writing or web portal.

2. **Announcement of consultation** – how we communicate to tribes that a tribal consultation is taking place
 - a. Dear Tribal Leader Letter is the usual form of communication
 - i. To whom is it addressed it important
 1. Need updated information – tribal leaders change with elections
 2. Need an easy opportunity for tribes to update
 3. Who in the tribe is valid addressee – need to clarify
 4. Need confirmation of receipt of letter
 5. Can send letter out via blast email, notify in newsletters
 6. Need to send to health director also, and Area Directors as a back up to ensure notification was received – tribal elected official receive a huge amount of correspondence and don't want letter to be lost in the shuffle
 7. Develop a website on consultation activities – a log of what is going on, history of what is doing

8. Area Directors can help update tribal leader information
 9. Need tribal liaison to contact/a single tribal point of contact – for more information
 10. Send electronic version of letter also in addition to paper version
 11. Send it to the TOP Elected or appointed Tribal leader = Chair, President, Governor, etc. – tribes should determine who that is
 12. Stamp the letter – Time Sensitive, Urgent or Consultation – so it doesn't get lost in pile of mail
 13. Need multiple controls in the process to make sure Tribes receive the letter/notification
- ii. Content of letter – recommendations to help clarify details of consultation
1. Define issue and context, ask leading questions
 2. Describe the process for consultation
 3. Put time/date/place of meetings
 4. Define who is paying travel
 5. Indicate a timeline for input – 60 days from day send out is needed, unless there is an urgency - advance scheduling needed given busy schedules
 6. If use federal register to announce a consultation – make sure to send a letter also
 7. Define a process for alternate/representative if invited member is unable to attend
 8. Indicate if food will be served at the meeting
 9. include way to read what is in attachments – put text of letter in email or send as a word or text document
3. **Gathering input** – how can we improve the process for gathering input during the consultation process
- a. Will be defined by how much time and/or magnitude of critical event
 - b. If quick turnaround – could do a conference call or even use WebEx a couple of times
 - c. If have more time = regional/Area meetings are preferred
 - d. Need to have a clear timeline for the process
 - e. Use a tribal organization to help announce and gather input also - NIHB is health committee of NCAI – they can help gather input
 - f. Use technology – ability for Tribes to comment at any time - if cannot go in person but still can make a comment in writing
 - g. For in person meetings – listening sessions or workgroups – need 2 days sometimes for in depth discussion – important to give enough time for all to provide input
 - h. Develop a Director's advisory workgroup to help gather input, especially when there is limited time

- i. Have different tribal advisory workgroups work together on tasks
- j. Consider Incentive awards
- k. Have Staff and tribal workgroups to do more technical work
- l. Problem of staff interpretation – who is going to do the maintenance after the consultation
- m. What HHS, IHS, Interior, DOE do for the Presidential Memorandum will be important to process – need to avoid creating too many travel demands on tribal leaders
- n. HHS agencies all need to consult with Tribes
- o. Consider liaisons from offices to tribes – collaboration between agency and tribes on the work of the Agency
- p. Existing workgroups – what to do with them, are there too many combine?
- q. What about cross agency workgroups? Need to avoid duplication of effort
- r. How can we work together with different agencies with related funding?
- s. Meetings need to be at same times and locations – reduce travel time for tribal leaders
- t. List objectives of consultation – dialogue with OMB first for sufficient funding for programs
- u. Formats for gathering input – some more specific comments
 - i. Dear Tribal Leader Letter inviting written comments – can just use this format if there is a need to gather input quickly and there is limited time for response or meetings
 - ii. Listening Sessions/Meetings at Conferences – the Director should regularly schedule ½ day or full day meetings at major Tribal conferences throughout the year for consultation and determine the topics based on priorities at the time. Examples include NIHB, NCAI, Tribal Self Governance, and Direct Service Tribes meetings.
 - iii. Regional/IHS Area meetings – need to strengthen consultation in these formats and have IHS Director attend regional consultations with Area Directors
 - iv. Conference Calls/WebEx – only if time urgency or limited resources
 - v. Tribal Advisory Workgroups – the group made reviewed the list of existing workgroups and had an extensive discussion on the following points:
 - 1. Need distinction between tribal leader groups and technical workgroups
 - 2. Tribal leaders – need more at table to be considered a consultation, or technical workgroups can make recommendations to Area boards with tribal leaders
 - 3. Meeting with health directors may be necessary when more technical issues are discussed

4. Technical people work for tribe, do they “represent” the tribe at the table? Need to be clear about representation and whether it is a consultation session
5. Interagency coordination is recommended – nationally and regionally – combine agency workgroups on a common issue
6. Funding of all these workgroups is an issue – combine some? What is purpose of committees? Still valid? A part of a broader process? All these workgroups are costly.
7. The workgroups have been important
8. Some committees should stay and maybe expand? How effective are the workgroups? Careful about what we eliminate in case new administration. Condense into smaller number? Consolidation of some? Is some work being duplicated with multiple groups?
9. Do committees focus on Director’s priorities? Budget, data collection, obesity, diabetes, what want to achieve, etc.
10. Problem – a lot of committees, little time available for both the Tribal leaders and the Director
11. What about the life of the workgroups? Specific purpose of workgroups. Are they still needed?
12. Gather input vs. consultation with tribal leaders (more clout with the latter)
13. Evaluation of purpose of workgroups should occur – do we still need them?
14. The importance of a workgroup like this with tribal leaders at the table
15. After a discussion of what to do with the existing workgroups/committees, some general recommendations were made by the group:
 - a. Some workgroups are fundamental and need to continue, such as TSGAC, DST, Budget Formulation, Contract Support Costs
 - b. Some workgroups might be combined on common issues such as prevention, IT
 - c. Consider interagency collaboration on some workgroups, reduce redundancy of effort on some topics
 - d. Consider reducing the frequency of meetings for some – should only be a consultation session if there is a decision or critical event to consider

- e. Assess the purpose of all existing workgroups – are we discussing the most pressing issues and priorities
 - f. Sunset or discontinue workgroups that are no longer serving original purpose or a current need for consultation
 - g. Update timelines, rules for attendance, logistics for workgroups
 - h. Need follow up, what happened at workgroup, what were recommendations, need evaluation of workgroups
 - i. Develop a website to post current activities of workgroups for easy reference by tribal leaders
 - j. Reconsider how technical experts are used on tribal advisory groups – important role but consultation needs to be with tribal elected officials
 - k. Consider overall framework for consultation
 - l. Consider continuing this group of 2 elected tribal leaders from each Area to advise Director on strategy, pressing consultation issues, consultation priorities
4. Decision – how are decisions made after consultation
- a. Old model is tribes make recommendations individually or through workgroups, then IHS Director makes decision alone
 - b. New model to develop is IHS Director and Tribal leaders make recommendations and decisions together
 - i. Need to develop consultation process that allows time for this to occur whenever possible; needs to have a timeline and process that is responsive to the need and urgency as well
 - ii. Relates to Director's priority of renewing and strengthening partnership with tribes
5. Reporting – how Tribes know what happened as a result of consultation
- a. Common complaint is that there is no follow up, accountability, unaware of outcomes of consultation, and cannot therefore assess whether meaningful consultation occurred
 - b. Strategies for reporting outcomes
 - i. Currently, HHS Annual Report details all tribal consultation activity
 - ii. Recommendations for reporting
 - 1. Written follow up
 - 2. Website with current tribal consultation activity can include report on outcomes

3. Clear timelines and outcomes for consultation activities can help track, and report actions taken as a result of consultation
4. Evaluation of tribal consultation meetings
5. Make sure reporting not too cumbersome
6. Makes sure meetings are at least voice recorded, and then develop meeting summaries that are brief and adequate summarize what occurred and main points – transcripts of all meetings are not necessary and too expensive. However, if summaries are done, tribal leaders are allowed to review and correct any errors before making document public.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service
Rockville, Maryland 20852

Refer to: OTP

INDIAN HEALTH SERVICE CIRCULAR NO. 2006-01

TRIBAL CONSULTATION POLICY

Sec.

1. Introduction
2. Background
3. Tribal Sovereignty
4. Policy
5. Philosophy
6. Definitions
7. Objectives
8. Roles
9. Tribal Consultation Guidelines
10. Consultation Process
11. Establishment of Joint Tribal/Federal
Workgroups and/or Task Forces
12. IHS Budget Formulation
13. IHS Tribal Consultation Performance and
Collaboration
14. Meeting Records, Evaluation, and Reporting
15. Consultation With Other Groups
16. Conflict Resolution
17. Summary
18. Acronyms
19. Supersedure
20. Effective Date

1. INTRODUCTION. The Indian Health Service (IHS) and Indian Tribes share the goals of eliminating the health disparities experienced by American Indians and Alaska Natives (AI/AN) and ensuring that their access to critical health services is maximized. To achieve these goals, it is essential that Indian Tribes and the IHS engage in open, continuous, and meaningful consultation. True consultation is an ongoing process that leads to information exchange, respectful dialogue, mutual understanding, and informed decisionmaking. The importance of consultation with Indian Tribes was affirmed through Presidential Memoranda in 1994 and 2004, and Executive Order in 2000.

Distribution: IHS-wide
Date: January 18, 2006

2. **BACKGROUND.** The United States Government and each federally recognized Indian Tribe has a Government-to-Government relationship grounded in numerous historical, political, legal, moral, and ethical considerations. Treaties and laws, together with court decisions, have defined a relationship between Indian Tribes and the Federal Government that is unlike that between the Federal Government and any other group of Americans. Since the formation of the Union, the United States has recognized Indian Tribes as sovereign Nations. The Federal Government has enacted numerous regulations that implement and support this trust relationship with Indian Tribes.

An integral element of the Government-to-Government relationship is that consultation occur with Indian Tribes on issues that impact them and that Indian Tribes participate in the decisionmaking process to the greatest extent possible. This Government-to-Government relationship with Indian Tribes was reaffirmed on September 23, 2004, by the Executive Memorandum, "Government-to-Government Relationship with Indian Tribes." The implementation of this consultation policy is in recognition of this special and unique relationship.

The requirements for consultation are contained in statutes and various Presidential Executive orders including the:

- Indian Self-Determination and Education Assistance Act, Public Law (P.L.) 93-638, as amended;
 - Indian Health Care Improvement Act, P.L. 94-437, as amended;
 - Memorandum to the Heads of Executive Departments and Agencies from President William J. Clinton, April 29, 1994;
 - Presidential Executive Order 13084, Consultation and Coordination with Indian Tribal Governments, May 14, 1998;
 - Presidential Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, November 6, 2000; and
 - Presidential Memorandum, Government-to-Government Relationship with Tribal Governments, September 23, 2004.
3. **TRIBAL SOVEREIGNTY.** This policy does not waive any Tribal governmental rights, including treaty rights, sovereign immunities, or jurisdiction. Additionally, this policy does not diminish any rights or protections afforded other AI/AN people or entities under Federal law.

Our Nation, under the law of the United States and in accordance with treaties, statutes, Executive orders, and judicial decisions, has recognized the right of Indian Tribes to self-govern. Indian Tribes exercise inherent sovereign powers over their members and territory. The United States continues to work with Indian Tribes on a Government-to-Government basis to address issues concerning Tribal self-government, Tribal trust resources, and Tribal treaty and other rights.

A constitutional relationship among sovereign governments is inherent in the very structure of the Constitution and is formalized in and protected by Article I, Section 8. Increasingly, this special relationship has emphasized self-determination and meaningful involvement for Indian Tribes in Federal decisionmaking (consultation) where such decisions affect Indian Tribes. The involvement of Indian Tribes in the development of public health and human services policy allows for locally relevant and culturally appropriate approaches to public issues.

Tribal self-government has been demonstrated to improve and perpetuate the Government-to-Government relationship and strengthens Tribal control over Federal funding and program management.

4. **POLICY.** It is the IHS policy that consultation with Indian Tribes will occur to the extent practicable and permitted by law before any action is taken that will significantly affect Indian Tribes. Such actions refer to policies that have Tribal implications and substantial direct effects on one Indian Tribe or more regarding the relationship between the Federal Government and the Indian Tribe(s) or on the distribution of power and responsibilities between the Federal Government and the Indian Tribe(s).

Nothing in this policy waives the Government's deliberative process privilege. For example, in instances where the IHS is specifically requested by Members of Congress to respond to or report on proposed legislation, the development of such responses and of related policy is a part of the Executive Branch's deliberative process privilege and should remain confidential. In addition, in specified instances where Congress requires the IHS to work with Tribes on the development of recommendations that may require legislation, such reports, recommendations, or other products are developed independent of an IHS position, the development of which is governed by Office of Management and Budget (OMB) Circular A-19.

The following process objectives and guidelines will be used in the implementation of this policy:

- A. The IHS shall have an accountable consultation process to ensure meaningful and timely input by Tribal Officials in the development of policies that have Tribal implications. (See Section 9 for consultation guidelines.)

- B. To the extent practicable and permitted by law, the IHS shall not propose the promulgation of any regulation that has Tribal implications that imposes substantial direct-compliance costs on Indian Tribes and that is not required by statute, unless:
- (1) the funds necessary to pay the direct costs incurred by the Indian Tribe(s) in complying with the regulation are provided by the Federal Government; or
 - (2) the IHS, prior to the formal promulgation, of the regulation:
 - a. consults with Tribal Officials early and throughout the process of developing the proposed regulation, as guided by these policies;
 - b. provides, in a separately identified portion of the preamble to the regulation as it is to be issued in the Federal Register (FR), a Tribal summary impact statement, which consists of a description of the extent of the prior consultation with Tribal Officials, a summary of the nature of their concerns and the Agency's position supporting the need to issue the regulation, and a statement of the extent to which the concerns of Tribal Officials have been met; and
 - c. makes available to the Director, IHS, any written communications regarding the proposed regulations submitted to the Agency by Tribal Officials.
- C. To the extent practicable and permitted by law, the IHS shall not propose the promulgation of any regulation that has Tribal implications and that preempts Tribal law unless the Agency, prior to the formal promulgation of the regulation:
- (1) consults with Tribal Officials early in the process of developing the proposed regulation, as guided by these policies;
 - (2) provides, in a separately identified portion of the preamble to the regulation as it is to be issued in the FR, a Tribal summary impact statement, which consists of a description of the extent of the prior consultation with Tribal Officials, a summary of the nature of their concerns and the Agency's position supporting the need to issue the regulation, and a statement of the extent to which the concerns of Tribal Officials have been met; and

- (3) makes available to the Director, IHS, any written communications regarding the proposed regulations submitted to the Agency by Tribal Officials.

D. On issues relating to Tribal self-government, Tribal trust resources, or Tribal treaty and other rights, the IHS should explore and, where appropriate, use consensual mechanisms for developing regulations, including negotiated rulemaking.

5. PHILOSOPHY. Indian Tribes have, through the cession of more than 400 million acres of land to the United States in exchange for promises, among other things, of health care, often reflected in treaties, secured the right to health care from the United States based on the moral, legal, and historic obligations of the United States to AI/AN people.

Indian Tribes have an inalienable and inherent right to self-govern. Self-government means a government in which decisions are made by the people who are most directly affected by them. As sovereign Nations, Indian Tribes exercise inherent sovereign powers over their members, territory, and lands.

The IHS exists to provide health services to Indians and has a commitment to working in partnership on a Government-to-Government basis with Indian Tribes. The IHS is committed to enhancing collaboration and partnership between its operating units and Area Offices with Indian Tribes to ensure that the requirement for Tribal consultation permeates the entire IHS system. The IHS is further committed to assisting Indian Tribes to advocate for their priorities with all Department of Health and Human Services (HHS) Divisions including Regional Offices and State governments/agencies.

The Office of Tribal Programs and the Office of Tribal Self-Governance within the Office of the Director are identified as the responsible offices within the IHS for monitoring compliance with the IHS Tribal Consultation Policy.

6. DEFINITIONS.

- A. Consultation. An enhanced form of communication that emphasizes trust, respect and shared responsibility. It is an open and free exchange of information. Consultation is integral to a deliberative process, which results in effective collaboration and informed decisionmaking with the ultimate goal of reaching consensus on issues.
- B. Critical Events. Planned or unplanned events that have or may have a substantial impact on Indian Tribes or Indian communities, e.g., issues, policies, or budgets.

- C. Deliberative Process Privilege. A privilege exempting the Government from the disclosure of Government agency materials containing recommendations, opinions, and other communications that are part of the decisionmaking process within the agency.
- D. Executive Order. An order issued by the Government's executive branch on the basis of authority specifically granted to the executive branch (as by the U.S. Constitution or an Act of Congress).
- E. Indian. A person who is a member of an Indian Tribe. (25 United States Code (U.S.C.) 450b(d)) Throughout this circular, Indian is synonymous with American Indian or Alaska Native.
- F. Indian Organization. Any group, association, partnership, corporation, or legal entity owned or controlled by Tribes or Indians, or with a majority of members who are Indian.
- G. Indian Tribe. Any Indian Tribe, Band, Nation, or other organized group or community including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians. (See 25 U.S.C. Sec 450b.)
- H. Joint Tribal/Federal Workgroups and/or Task Forces. A group composed of individuals who are Tribal Officials, appointed by federally recognized Indian Tribes and/or Federal agencies, to represent their interests while working on a particular policy, practice, issue and/or concern.
- I. Policies with Tribal Implications. Regulations, legislation, and other policy statements or actions that have substantial direct effects on one Indian Tribe or more on the relationship between the Federal Government and Indian Tribes or on the distribution of power and responsibilities between the Federal Government and Indian Tribes.
- J. Sovereignty. The ultimate source of political power from which all specific political powers are derived.
- K. Substantial Direct Compliance Costs. Costs incurred directly from the implementation of changes necessary to meet the requirements of a Federal regulation. Because of the large variation in Indian Tribes, "substantial costs" is also variable by Indian Tribes. Each Indian Tribe and the Director, IHS, shall mutually determine the level of costs that represent "substantial costs" in the context of the Indian Tribe's resource base.

- L. Treaty. A legally binding and written agreement that affirms the Government-to-Government relationship between two or more nations.
- M. Tribal Officials. An elected/appointed Tribal Leader or official delegate designated in writing by an Indian Tribe.
- N. Tribal Resolution. A formal expression of the opinion or will of an official Tribal governing body that is adopted by vote of the Tribal governing body.
- O. Tribal Self-Government. The governmental actions of Tribes exercising self-government and self-determination.

7. OBJECTIVES.

- A. To formalize the requirement of the IHS to seek consultation and participation by representatives of Indian Tribes in policy development and program activities to ensure that Tribal health priorities and goals are recognized.
- B. To establish a minimum set of requirements and expectations with respect to consultation and participation for the three levels of IHS management: Headquarters, Area Offices, and service units.
- C. To identify critical events for which Tribal consultation and participation will be required for the three levels of IHS management: Headquarters, Area Offices, and service units.
- D. To require the IHS to consult with Indian Tribes on proposed, new, and existing health policies and programs.
- E. To identify critical events where partnerships and the inclusion of Indian organizations would complement consultation with Indian Tribes.
- F. To promote and develop innovative methods of involving Indian Tribes in IHS policy development and in the decisionmaking processes of the IHS.
- G. To coordinate with the HHS Divisions/Regional Offices, State agencies, supporters of Indian Health, and others to assist Indian Tribes to advocate for their priorities.
- H. To charge and hold responsible all levels of management within the IHS for the implementation of this policy.

8. ROLES.

- A. Indian Tribes. The Government-to-Government relationship between the United States and Indian Tribes dictates that the principal focus for IHS consultation is with individual Indian Tribes.
- B. Indian Organizations. It is frequently necessary that the IHS communicate with Indian organizations/committees to solicit consensual Tribal advice and recommendations. Although the special "Tribal-Federal" relationship is based on a Government-to-Government relationship, other statutes and policies exist that allow for consultation with Indian organizations. These organizations by the nature of their business serve and represent Indian Tribal issues and concerns that might be affected if these organizations were excluded from the consultation process.

Even though some of the organizations/committees do not represent federally recognized Indian Tribes, the IHS is able to consult with these groups individually.

- C. Headquarters. The IHS has the responsibility to engage and oversee open, continuous, and meaningful consultation with Indian Tribes to the extent practicable and permitted by law. True consultation is an ongoing process that leads to information exchange, mutual understanding, and informed decisionmaking.
- D. Area Offices. The Area Director, in consultation with Indian Tribes located in his/her respective region, must designate a committee/workgroup comprised of delegated Tribal Officials from all Indian Tribes served by the respective Area Office. If all Indian Tribes are not represented by the committee/workgroup, the Area Director will develop a process to ensure that full consultation with all Indian Tribes within the Area is coordinated. The designated committee/workgroup shall provide advice and consultation to the Area Director and Area Office staff.

Meetings between the designated committee/workgroup and Area Office staff shall occur on an as-needed basis, but at least once each year. Each Area Director has the responsibility to coordinate, communicate, and collaborate with the HHS Regional Directors for the specific regions of which the IHS Area is a part of on issues that are pertinent to Indian Tribes in the respective regions and Area.

- E. Service Units. The service unit Chief Executive Officer (CEO), in consultation with Indian Tribes located in his/her respective service unit, must designate a committee/workgroup comprised of delegated Tribal Officials from all Indian

Tribes served by the respective service unit. If all affected Indian Tribes are not represented by the committee/workgroup, the CEO will develop a process to ensure that full consultation with all Indian Tribes within the service unit is coordinated. The designated committee/workgroup, shall provide advice and consultation to the CEO. Any decisions/recommendations made through consultation at this level will be formally communicated to the respective Area Director.

9. TRIBAL CONSULTATION GUIDELINES. A critical event may be identified by the IHS and/or an Indian Tribe. Upon identification of a critical event significantly affecting one Indian Tribe or more, the IHS will initiate consultation regarding the event.
 - A. Consultative Relationship. Trust between the IHS and Indian Tribes is an indispensable element in establishing a good consultative relationship. The degree and extent of consultation will depend on the identified critical event. While this policy does not provide specific guidelines, all levels of IHS management shall use the following criteria to ensure that the requirements of this policy are satisfied:
 - (1) Identify the critical event. This includes complexity, implications, time constraints, and issue (funding, policy, programs).
 - (2) Identify affected/potentially affected Indian Tribes, etc.
 - (3) Determine the level of consultation. This can be done after considering the critical event and the Indian Tribe(s) affected/potentially affected.
 - B. When Consultation Occurs.
 - (1) When the IHS Director/Deputy Directors, and/or their designee, and a Tribal Official and/or his/her designee meet or exchange written correspondence to discuss any issue(s) concerning either party.
 - (2) When an Area Director, and/or his/her designee meets or exchanges written correspondence with a Tribal Official and/or his/her designee to discuss any issue(s) concerning either party.
 - (3) When a service unit CEO and/or his/her designee meet or exchanges written correspondence with a Tribal Official and/or his/her designee to discuss any issue(s) concerning either party.

- C. Level of Consultation. Upon the determination of the level of consultation necessary, proper notice of the critical event and the level of consultation to be used shall be communicated to affected/potentially affected Indian Tribes using all appropriate methods. These methods include but are not limited to the following:
- (1) Correspondence. Written communications should clearly provide affected/potentially affected Indian Tribe(s) of the critical event and the manner in which to provide comment. The IHS frequently uses a "Dear Tribal Leader Letter" to notify individual Indian Tribes of consultation activities. Other forms of correspondence include broadcast e-mail, an FR notice, and other outlets.
 - (2) Meetings. When the critical event is determined to have substantial direct impact, the IHS shall convene a meeting(s) to the extent practicable and permitted by law with the affected/potentially affected Indian Tribe(s) to discuss all pertinent issues. This meeting(s) may be in a national, regional, and/or Area forum, as appropriate.

Other types of meetings and/or conferences occur that may not be considered consultation sessions, but these meetings/conferences may provide an opportunity to share information, conduct workshops, and provide technical assistance to the Indian Tribe(s).
 - (3) Federal Register Notice. An FR notice is the most formal method used by the IHS for communication and/or consultation. This method can be used for a variety of purposes including but not limited to requests for comments by the affected Indian Tribe(s) regarding critical events.
- D. Official Tribal Correspondence. Correspondence submitted by Indian Tribes to the IHS shall be referred to the appropriate IHS program office.
- (1) Tribal Resolution. Communications from Indian Tribes frequently come in the form of Tribal resolutions. A resolution may be the most formal declaration of an Indian Tribe's position for the purpose of Tribal consultation. Once the IHS receives a Tribal resolution, the Agency should respond appropriately. An appropriate response may include Tribal consultation.
 - (2) Tribal Executive Correspondence. The IHS will give equal consideration to correspondence received from the executive branch of an Indian Tribe as is provided to a Tribal resolution.

- (3) Response. A response regarding a Tribal resolution and/or Tribal executive correspondence shall be provided by the IHS within 60 calendar days to the Indian Tribe(s).
 - E. Schedule for Consultation. The IHS must establish and adhere to a formal schedule of meetings to consult with the Indian Tribe(s) and their representatives concerning the planning, conduct, and administration of applicable activities. The IHS must involve Tribal Officials in meetings at every practicable opportunity. The IHS is encouraged to work with Indian Tribes to establish additional forums for Tribal consultation, participation, and information sharing.
 - F. Policy Development through Tribal Consultation. The need to develop a policy may be identified from within the IHS or may be identified by an Indian Tribe(s). This need may result from external forces such as Executive, Judicial, or Legislative Branch directives. Once the need to develop a policy is identified, the IHS will respond within 60 calendar days to the request. The consultation process must begin in accordance with critical events and level of consultation upon the receipt of the IHS response. (See Section 9A, B, and C to determine the level of consultation.)
10. CONSULTATION PROCESS. The IHS shall develop instructions for the submission of comments and will report on all outcomes of the consultation.
 - A. Tribal. Specific consultation mechanisms that will be used to consult with an Indian Tribe(s) include but are not limited to mailings, meetings, teleconferences, and roundtables.
 - (1) Consultation sessions will be held to solicit official Tribal comments and recommendations on policy and budget matters affecting the Indian Tribe(s). These sessions at roundtables, forums, and meetings will provide the opportunity for meaningful dialogue and effective participation by the Indian Tribe(s).
 - (2) An Indian Tribe may meet one-to-one with the IHS or a designated representative to consult on issues specific to that Indian Tribe.
 - (3) Upon completion of a consultation session, the IHS will document and follow up on any unresolved issue(s) that would benefit from the ongoing involvement of the Indian Tribe(s).
 - (4) All IHS policies are posted on the IHS Web site.

B. HHS Divisions and Regional Offices.

- (1) Upon the request of an Indian Tribe(s), the IHS will advocate for and facilitate collaboration between HHS Divisions, Regional Offices, and the Indian Tribe(s) to assist with consultation.
- (2) The IHS will assist the Indian Tribes and HHS Divisions in addressing any identified issue(s), such as access to HHS programs and services that could be provided directly to an Indian Tribe(s).
- (3) The IHS and/or Area Office will work with the HHS Office of Intergovernmental Affairs (IGA) to assist Indian Tribes in advocating for improved HHS Division-Tribal relations.

C. States.

- (1) Upon the request of an Indian Tribe(s), the IHS will advocate for and facilitate collaboration between States and the Indian Tribe(s) to address the identified issue(s).
- (2) The IHS and/or Area Office will work with the HHS/IGA to assist the Indian Tribe(s) in advocating for improved State-Tribal relations.

11. ESTABLISHMENT OF JOINT TRIBAL/FEDERAL WORKGROUPS AND/OR TASK FORCES.

A. Consultation. When a new or revised national policy(ies) affect an Indian Tribe(s), the IHS Director and/or Area Director may establish a workgroup and/or task force to develop recommendations on various technical, legal, or policy issues. In such cases, the following process is generally followed:

- (1) Joint Tribal/Federal Workgroups and/or Task Forces. Although the special "Tribal-Federal" relationship is based in part on the Government-to-Government relationship, it is frequently necessary for the IHS, with Tribal concurrence, to establish joint Tribal/Federal workgroups and/or task forces. These workgroups/task forces will be charged to address issues and complete work needed to develop and/or modify any policies and practices. These workgroups and/or task forces do not take the place of Tribal consultation but offer an enhancement by gathering individuals together with expertise on a particular policy, practice, issue and/or concern to work collaboratively and offer recommendations for consideration by Indian Tribes and Federal agencies. The subsequent work products and/or outcomes developed by these workgroups and/or task forces will be handled in accordance with this policy.

- (2) Membership Notices. Membership on workgroups shall be widely solicited with the intent to reach all Indian Tribes by requesting membership nominees from all Indian Tribes and Indian organizations, in accordance with Section 15 below, as applicable.
- (3) Meeting Notices. The purpose, time frame, and specific tasks shall be clearly identified in the notice. All meetings will be open and widely publicized, at a minimum through the Office of Tribal Self-Governance, the Office of Tribal Programs, and the office initiating the policy.
- (4) Workgroups/Task Forces. The Indian Tribe(s) and the IHS should be equally represented in workgroups, if not, then Tribal members should be in the majority. Tribal members should be selected based on volunteer responses received as a result of the notice, and if possible, should represent a cross-section of the affected parties. The IHS and/or Tribal staff may serve in a technical advisory capacity. Tribal staff may accompany the workgroup leader and serve to advise him/her. The IHS staff may serve in a technical advisory capacity to the workgroup.

B. Participation.

- (1) Attendance at Meetings. Workgroup members must make a good faith effort to attend all meetings. Other individuals may accompany members as the members believe it is appropriate to represent their interest.
- (2) Appointment of Alternates. Unless the charge states otherwise, each workgroup member may appoint an alternate by written notification. In cases where a Tribal Official appoints an alternate who is not an elected official, the alternate shall represent the primary member in the workgroup. The alternate will have the same voting rights as the primary member, as designated in the letter by that Tribal Official.
- (3) Workgroup Protocols. The workgroup may establish protocols to govern the meetings. Such protocols will include but are not limited to the:
 - a. selection of workgroup co-chairs (Tribal/Federal), if applicable,
 - b. role of workgroup members,
 - c. process for decisionmaking (consensus-based or otherwise), and
 - d. process for determining drafting and availability of all final workgroup products and documents.

- (4) Workgroup Charge. Prior to the workgroup formulation, the IHS may develop an initial workgroup charge in enough detail to define the policy concept. Once established, the workgroup will develop recommendations for the final workgroup charge for the approval of the Director, IHS.
- (5) Workgroup Final Products. Early consultation with the IHS Management Policy and Internal Control Staff (MPICS) is recommended to discuss options for the policy format and placement in the Indian Health Manual.
 - a. Upon completion, the draft policy documents will be distributed informally to the Indian Tribe(s) and Indian organization(s) for review and comment and to allow for maximum possible informal review.
 - b. A concurrent internal IHS review and comment period will be initiated by MPICS in accordance with Part 1, Chapter 1, "Indian Health Manual System," Indian Health Manual.
 - c. Comments from the Indian Tribe(s) will be returned to the workgroup, which will meet in a timely manner to discuss the comments and determine the next course of action.
 - d. Comments from IHS staff will be coordinated by MPICS, compiled, and provided to the Office of Tribal Programs for its review and recommended action, which may include further discussion with the workgroup.
 - e. If the proposed policy is considered to be substantially complete as written, the workgroup will forward the proposed policy to the Director, IHS, as final recommendations for general endorsement.
 - f. The workgroup will also recognize any contrary comments in its final report.
 - g. If it is determined that the policy should be rewritten, the workgroup will rewrite it and begin informal consultation again at the initial step above.
 - h. If the proposed policy is generally acceptable to the IHS Director, final processing of the policy by MPICS will be accomplished.

C. Recommendations and Policy Implementation. All final recommendations by the workgroup shall be considered by the Director, IHS. Once the consultation process is completed and a policy decision is finalized, the final policy shall be broadly distributed to all Indian Tribes and Indian organizations.

12. IHS BUDGET FORMULATION. The IHS deals with multiple fiscal-year budgets on a regular basis. The IHS budget formulation process is comprised of annual forums for Indian Tribes to interact with the IHS to provide program priorities, policies, and budget recommendations.

A. Budget Formulation. The IHS will solicit the active participation of Indian Tribes and Indian organizations in the formulation of the IHS budget request and annual performance plan.

B. Timeframe. In order to ensure that Indian Tribes are able to provide meaningful input for the IHS budget request, the IHS shall use the following timeframe to coincide with the HHS schedule:

- (1) October through December - Individual IHS Area budget formulation work sessions.
- (2) February through March - National IHS budget formulation work session.
- (3) May - Tribal presentation of national priorities and recommendations to the National HHS Tribal Budget Formulation and Consultation Session, including the Intradepartmental Council on Native American Affairs.
- (4) May through June - The IHS will assist in the development of a meeting among the co-chairs of the National Tribal Budget Formulation Workgroup, representatives from Indian organizations as appropriate, and the Director of the Office of Management and Budget (OMB).

C. Area Budget Formulation Teams. In preparation for the IHS Area-wide Tribal consultation session, Area budget formulation teams will provide ongoing support to the budget formulation activities at the Area level. Each Area budget formulation team shall consist of Tribal Officials and IHS staff.

The IHS Headquarters provides standard instructions to the Areas for the development of Area budget priorities:

- (1) The Area budget formulation team solicits Area-wide input in establishing the health and budget priorities for the Area.

- (2) The Area budget formulation team identifies two of its members to attend the National Tribal Budget Formulation Workgroup session on behalf of the Area.
- (3) The health priorities established at the Area work sessions provide the basis for developing the IHS Annual Performance Plan that is submitted as a part of the IHS budget request.

D. Headquarters Budget Formulation Work Team.

- (1) Provides staff support to the Director, IHS, for budget formulation.
- (2) Develops the IHS budget request in accordance with HHS and OMB guidelines.
- (3) Provides information on the budget request and formulation process.
- (4) Adheres in all activities to the priorities established at the national work session and to the guidance provided by the National Tribal Budget Formulation Workgroup.

E. National Tribal Budget Formulation Workgroup Session. The national budget formulation work session is conducted yearly to consolidate budget and health priority recommendations into a comprehensive set of national health priorities and the IHS proposed budget request.

F. National Tribal Budget Formulation Workgroup. The workgroup consists of two Tribal representatives from each of the 12 IHS Areas as identified at the Area work sessions. Additional representatives from Indian organization(s) will participate in the workgroup at the discretion of the Director, IHS. The workgroup provides input and guidance to the IHS Headquarters budget formulation team throughout the remainder of the budget formulation cycle for that fiscal year. Costs incurred by the Indian Tribe(s) or Indian organization(s) for the purpose of participating in the National Tribal Budget Formulation Workgroup shall be the responsibility of the IHS.

G. New Funding. It is IHS policy to involve Indian Tribes in decisionmaking that concerns the allocation of new funding (i.e., funding that is not in the existing base funding of an Indian Tribe(s) or congressionally earmarked for a specific Indian Tribe(s) that is provided as a result of the appropriations process). This policy is described in IHS Circular No. 92-5, "Budget Execution Policy (Allocation of Resources)." Barring legislative or administrative direction to the

contrary, the appropriate consultative process for this purpose may use any tool or mechanism as agreed to by the IHS Area Director and the Indian Tribe(s) that is not inconsistent with IHS Circular No. 92-5.

- H. Budget Information Disclosure. The IHS must initiate a process that provides the Indian Tribe(s) and Indian organization(s) with the following IHS budget-related information on an annual basis: appropriations, allocations, expenditures, and funding levels for programs, functions, services, and activities. Tribal requests for additional information shall be reviewed on a case-by-case basis and answered to the extent practicable, unless embargoed and/or prohibited by law.

13. IHS TRIBAL CONSULTATION PERFORMANCE AND COLLABORATION.

- A. Annual Report. As part of the annual HHS Tribal consultation report, the IHS will report on an annual basis how the results and outcomes of Tribal consultation performance fulfill the Government-to-Government relationship with Indian Tribes. This will include:
- (1) the development and utilization of individualized critical performance elements to ensure consistency with the HHS Tribal consultation policy and its objectives;
 - (2) the development of Tribal budget recommendations through the budget formulation process;
 - (3) the promotion of a cooperative atmosphere with Indian Tribes to gather, share, and collect data between the IHS and Indian Tribes that demonstrates the effective use of Federal resources in a manner that is consistent with the Government Performance and Results Act (GPRA) performance measures and the OMB Program Assessment Rating Tool;
 - (4) the consultation, to the greatest extent practicable within available resources and permitted by law, with Indian Tribes before taking actions that affect Indian Tribes, including regulatory practices on Federal matters and unfunded mandates;
 - (5) the adequate assessment of the impact of the IHS activities on Tribal trust resources and of whether Tribal interests are considered before the activities are undertaken;
 - (6) the removal of procedural impediments to working directly with Indian Tribes on activities that affect trust property or governmental rights of the Indian Tribes;

- (7) the streamlining of the application process for and increasing the availability of waivers to Indian Tribes; and
 - (8) the operation of the IHS in a collaborative manner with other HHS Divisions and Indian Tribes to carry out Executive Order 13175.
14. **MEETING RECORDS, EVALUATION, AND REPORTING.** The IHS is responsible for appropriately reporting on and evaluating consultation activities and outcomes. The level of reporting should be consistent with the level of consultation described in Section 9C of this circular. The IHS will report on major consultation activities and communicate the nature of these sessions and outcomes to HHS, Indian Tribes, and Indian organizations using the following means:
- A. **IHS Report to HHS.** The IHS is responsible for preparing and submitting an annual report describing Tribal consultation activity, including outcomes, to the HHS. The IHS report is subsequently included in the "HHS Annual Tribal Consultation Report." In order to effectively evaluate the effectiveness of Tribal consultation and the success of IHS in incorporating Tribal recommendations made as a result of consultation, the IHS annual report will address:
 - (1) a discussion of the past year's consultation process and activities and whether they resulted in meaningful outcomes for both the IHS and Indian Tribes,
 - (2) a description of the level of support for the past year's consultation activities from the perspective of Indian Tribes and IHS management, and
 - (3) a discussion of the effectiveness of collaboration with Indian organizations and other Federal agencies that complemented the Tribal and IHS consultation process.
 - B. **IHS Report Submitted to Indian Tribes and Indian Organizations.** The IHS is responsible for preparing and submitting an annual report to Indian Tribes and Indian organizations describing the past year's consultation activity. The report should include an assessment of the IHS implementation of this policy and a description of outcomes related to issues that were the subject of major consultation activity. Upon completion of a major consultation activity (e.g., policy development), the report should address follow-up action items resulting from consultation and the plan for implementation.
- All major consultation meetings of national importance shall be appropriately recorded with a summary made available to Indian Tribes and Indian organizations. At a minimum the report should include:

- (1) a description of the issue(s) that was the subject of consultation,
- (2) a description of the process that was used,
- (3) a discussion of the recommendations that resulted from the consultation meeting(s),
- (4) a list of any follow-up action items and a time line for addressing these items, and
- (5) a discussion of the level of IHS and Tribal satisfaction with the consultation process that was used.

C. IHS Budget Formulation Report to HHS, Indian Tribes, and Indian Organizations.

The IHS is responsible for preparing and submitting an annual report to HHS, Indian Tribes, and Indian organizations describing the consultation process used and outcomes related to the formulation of the proposed budget of the IHS. To effectively evaluate the budget formulation process and the ability of the IHS to incorporate Tribal recommendations, the IHS will assess:

- (1) the effectiveness of the methods used to receive verbal comments from participating Indian Tribes, Indian organizations, IHS management, and other invited participants regarding the consultation process used to formulate the budget;
- (2) the results summary obtained from the evaluation forms provided to participating Indian Tribes, Indian organizations, and other invited participants to collect written feedback regarding the consultation process used to formulate the budget;
- (3) the effectiveness of the consultation method implemented, including IHS and Tribal views regarding the level of attendance and the number of responses received from Tribal Officials;
- (4) the effectiveness of IHS activities related to promoting Tribal consultation regarding the process used to formulate the budget;
- (5) the effectiveness of collaboration with Indian organizations and other Federal agencies to resolve issues for the mutual benefit of the IHS and Indian Tribes;

- (6) the recommendations received from IHS, Indian Tribes, and Indian organizations to improve the consultation process and promote meaningful outcomes; and
- (7) the action plans to improve the consultation process used to formulate the budget.

D. IHS Reports Regarding Specific Issues Assigned to Workgroups/Task Forces.

The IHS is responsible for preparing reports at the conclusion of each workgroup/task force meeting and providing these reports to participating Indian Tribes and Indian organizations in advance of the next scheduled meeting of the workgroup/task force. Recommended actions should be appropriately recorded in these reports. The reports should include, as appropriate:

- (1) a description of the issue(s) that is the subject of consultation in the workgroup/task force meeting,
- (2) a description of the process including an identification of workgroup members,
- (3) an up-to-date summary of the efforts of the workgroup/task force including recommendations provided, and
- (4) a description of the likely agenda items for subsequent meetings.

Subsequent to the final meeting of a workgroup/task force, a final report will be prepared that will provide a listing of recommendations made to the IHS. A discussion of Tribal and IHS satisfaction with the particular workgroup/task force will be provided.

E. Tribal Consultation Results. All documents developed to communicate decisions arrived at through Tribal consultation will be posted on the IHS Web site.

15. CONSULTATION WITH OTHER GROUPS. Although the unique Federal relationship with Indian Tribes is based in part on the fundamental concept of Government-to-Government relations, other statutes and policies exist that allow for Federal consultation with Indian organizations that, by the nature of their business, serve Indian people and might be affected if excluded from the consultation process. Even though such Indian organizations may not represent Indian Tribes, the IHS is able to consult with these Indian organizations individually or collectively.

Such consultation is encouraged to the extent that there is not a conflict of interest with the Snyder Act of 1921 (P.L. 83-568), the IHS authorizing legislation, other applicable Federal statutes, or administrative policy.

When the IHS uses workgroups to assist the consultation process, the Federal Advisory Committee Act (FACA) requirements apply. The intergovernmental committee exemption to the FACA is found at 2 United States Code 1534. When forming workgroups, the IHS adheres to the "HHS Tribal Consultation Policy" (Section 10A1b).

16. CONFLICT RESOLUTION. The intent of this policy is to provide an increased ability to solve problems. However, it is inherent in the Government-to-Government relationship that Indian Tribes may elevate an issue of importance to a higher decisionmaking authority.
- A. Conflict Resolution Process. The IHS will establish a clearly defined conflict resolution process in collaboration with Indian Tribes, under which Indian Tribes:
- (1) bring forward concerns which have a substantially direct effect on them, and
 - (2) apply for waivers of statutory and regulatory requirements that are subject to waiver by the IHS.

Consistent with Presidential Executive Order 13175, this policy is not intended to create any right, benefit, or trust responsibility, substantive or procedural, enforceable at law by a party against the United States, its agencies, or any persons.

17. SUMMARY. This circular considers a wide range of needs and unique characteristics in crafting these guidelines; therefore it is important for the IHS consultation policy to remain dynamic and be responsive to changing circumstances that affect Indian Tribes. The IHS will seek to integrate its efforts with those of other Federal Departments and agencies. Such intra-governmental coordination will benefit the Federal Departments and agencies as well as Indian Tribes and Indian organizations.

18. ACRONYMS.

AI/AN: American Indian and Alaska Native

CEO: Chief Executive Officer

FACA: Federal Advisory Committee Act

FR: Federal Register

GPRA: Government Performance and Results Act

HHS: Department of Health and Human Services

ICNAA: Intradepartmental Council on Native American Affairs

IGA: Intergovernmental Affairs

IHS: Indian Health Service

OMB: Office of Management and Budget

PART: Program Assessment Rating Tool

P.L.: Public Law

U.S.C.: United States Code

19. SUPERSEDURE. This circular supersedes IHS Circular No. 2001-07, dated September 21, 2001.
20. EFFECTIVE DATE. This circular is effective on the date of signature by the Director, IHS.

Charles W. Grim, DDS

Charles W. Grim, D.D.S., M.H.S.A.
Assistant Surgeon General
Director, Indian Health Service



IHS Committee and Workgroup Summaries



IHS Tribal Consultation Summit

Director's Tribal Advisory Workgroup on Consultation
SUMMARY/UPDATE

July 6-7, 2011



MEMBERSHIP:

The Director's Tribal Advisory Workgroup on Consultation (DTAWC) is comprised of 24 Tribal Leaders, 2 from each of the 12 IHS Areas: **Aberdeen:** Robert Cournoyer, Chairman, Yankton Sioux Tribe; **Alaska:** Lincoln Bean, Tribal Council Member, Organized Village of Kake; Andrew Jimmie, Tribal Council Member, Native Village of Minto; **Albuquerque:** Walter Dasheno, Governor, Santa Clara Pueblo; **Bemidji:** Derek J. Bailey, Chairman, Grand Traverse Band of Ottawa and Chippewa; Rose Gurnoe-Soulier, Chairwoman, Red Cliff Band of Lake Superior Chippewa; **Billings:** Ernest "Bud" Moran, Chairman, Confederated Salish & Kootenai Tribes; **California:** Arch Super, Chairman, Karuk Tribe; **Nashville:** Buford Rolin, Chairman, Poarch Band of Creek Indians; Lynn Malerba, Chief, Mohegan Tribe of Connecticut; **Navajo:** *vacant*; **Oklahoma City:** Steve Ortiz, Chairman, Prairie Band Potawatomi; Leonard Harjo, Principal Chief, Seminole Tribe of Oklahoma; **Phoenix:** Alvin Moyle, Chairman, Fallon-Shoshone Paiute Tribe; Eldred Enas, Chairman, Colorado River Indian Tribes; **Portland:** Andrew Joseph, Jr., Colville Business Council Member, Confederated Tribes of the Colville Reservation; Julia Davis-Wheeler, Nez Perce Tribal Executive Committee; and, **Tucson:** Peter Yucupicio, Chairman, Pascua Yaqui Tribe.

PURPOSE:

The DTAWC advises the IHS Director and provides recommendations to improve the IHS Tribal Consultation process to make it more meaningful, effective, and accountable. The DTAWC meets when needed to review progress on Tribal consultation efforts and provide the IHS Director with guidance on general consultation issues.

BACKGROUND:

On August 13, 2009, the IHS Director sent a letter to all Tribes requesting input on how to improve the IHS Tribal consultation process and indicated plans to form a Workgroup to review input and make recommendations. The DTAWC convened their first meeting in December, 2009 and again in January 2010 to review input the IHS received from Tribes and to discuss the current Tribal consultation process. The DTAWC developed detailed recommendations identifying actions for the IHS to implement to improve the consultation process. The Workgroup has met subsequently both in-person and via conference call to advise to the Director, IHS on various consultation-related issues.

CURRENT ISSUES/RECOMMENDATIONS:

The IHS has implemented six recommendations from Tribes to improve the Tribal consultation process, which include: forming the IHS Director's Tribal Advisory Workgroup on Consultation; developing an electronic mail (e-mail) address to encourage feedback via e-mail in addition to submitting a letter (consultation@ihs.gov); developing a Tribal Consultation website (under the Director's Blog); posting all letters to Tribal Leaders on the Director's Blog and electronically mailing them via list serves; conducting listening sessions in IHS Areas and meeting individually with Tribes; and, hosting listening sessions and meetings at National conferences (such as the National Congress of American Indians annual convention and the National Indian Health Board consumer conference).

Submitted by: CAPT Sandra Pattea, Deputy Director for Intergovernmental Affairs, IHS





IHS Tribal Consultation Summit

Direct Service Tribes Advisory Committee

SUMMARY/UPDATE

July 6-7, 2011



MEMBERSHIP:

The Direct Service Tribes Advisory Committee (DSTAC) is comprised of two representatives from the ten IHS Areas with one or more Indian Tribes receiving primary health care from the IHS. The DST Areas are Aberdeen, Albuquerque, Bemidji, Billings, Nashville, Navajo, Oklahoma, Phoenix, Portland and Tucson.

PURPOSE:

The DSTAC was established to provide leadership, advocacy, and policy guidance on behalf of Direct Service Tribes (DST). The DSTAC advises the IHS Director on the development of Indian health policy, participates in IHS decision-making, and regularly provides their recommendations to the Agency.

BACKGROUND:

The DST Initiative was announced in November 2003, in response to tribal request and comment that there were no appropriate national forums for the discussion of issues and concerns that are of primary interest to DST. The first National Meeting, planned and conducted by DST, was held in June 2004 in Phoenix, AZ. In April 2005, during the second DST National Meeting, the IHS Director signed IHS Circular No. 2005-02, DSTAC Charter, establishing the DSTAC as an advisory committee to the IHS Director. In 2009, the IHS Director officially established the Office of Direct Service and Contracting Tribes in the Office of the Director at IHS headquarters.

Since its establishment the DSTAC has successfully advocated for an Office within the immediate Office of the Director to provide Agency-wide guidance, support, consultation, leadership, and advocacy for DST and for an executive level position to lead this Office. The Committee also met with the Obama-Biden Presidential Transition Team to assure DST healthcare issues and priorities were provided to President-elect Barack Obama.

Additionally the Committee represents DST on IHS and Department-level committees and workgroups; actively participates in the IHS budget formulation process; and hosts an annual meeting in which DST issues, concerns and best practices are shared with direct service tribal leaders and tribal and federal health care administrators.

CURRENT ISSUES/RECOMMENDATIONS:

The top DSTAC issue is the need for increased levels of appropriations for the benefit of the entire IHS and tribal service areas. The DSTAC fully supports the IHS in the current delivery of health care services and prevention activities but also recognizes the need for additional funding to address the chronic health care issues affecting Indian patients. Through the DSTAC's annual budget recommendations submission, the DSTAC has helped to positively influence increased budget requests for the contract health service (CHS) program, behavioral health program, and subsequent appropriations.

The second issue of importance for the DSTAC is leveling the field of funding available for DST and contracting and compacting Tribes. Recently, the DSTAC examined the distribution of competitive funds awarded to DST and contracting and compacting Tribes and recommended modifications to distribution ratio of these awards.

A third activity the DSTAC supports is the agency's efforts to consult with Indian Tribes with respect to the implementation of provisions in the Indian Health Care Improvement Act (Section 10221 of P.L. 111-148). The DSTAC believes true progress cannot be made without consultation and collaboration.

OTHER:

The DSTAC is hosting the 8th Annual DST National Meeting this August 16-18, 2011 in Nashville, TN. For more information on the National Meeting or the DSTAC, visit www.ihs.gov/NonMedicalPrograms/otp/dst.

Submitted by: Roselyn Tso, Acting Director, Office of Direct Service & Contracting Tribes, IHS Headquarters



IHS Tribal Consultation Summit

Tribal Self-Governance Advisory Committee (TSGAC)

SUMMARY/UPDATE

July 6-7, 2011



MEMBERSHIP:

The TSGAC membership consists of two representatives (one primary Tribal Leader and one alternate) from each of the nine Areas that have Self-Governance Tribes, including: Alaska, Albuquerque, Bemidji, Billings, California, Nashville, Oklahoma, Phoenix and Portland. TSGAC leadership: Jefferson Keel, Lt. Governor (**TSGAC Chairman**); Marilyn (Lynn) Malerba, Chief (**TSGAC Vice Chairman**), Mohegan Tribe of Connecticut; and, Dan Winkleman (**TSGAC Secretary**), Alaska Area.

PURPOSE:

The TSGAC provides advice and assistance to the Director, IHS on issues and concerns pertaining to Tribal Self-Governance and the implementation of Self-Governance within the IHS. The TSGAC represents Self-Governance Tribes by acting on their behalf to clarify issues that affect all compacting Tribes, specific to issues affecting the delivery of health care of American Indians and Alaska Natives. They meet on a quarterly basis to confer, discuss, and come to consensus on Self-Governance issues.

BACKGROUND:

Established in 1996 by statute, the TSGAC provides information dissemination, education, advocacy and policy guidance for implementation of Self-Governance within the IHS. The passage of Title V, The Tribal Self-Governance Amendments of 2000 (P.L. 106-260) and the subsequent promulgation of the Title V regulations, published in 2002, further strengthen the role of the TSGAC in implementing this Act. The TSGAC operates on consensus, and works in a government-to-government partnership with the IHS on all issues. The TSGAC is served by a Technical Workgroup comprised of both Federal and Tribal representatives that serves as a resource to support the TSGAC leadership, as requested.

As of 2011, the TSGAC represents the interests of 334 Self-Governance Tribes (approximately 60 percent of all Federally-recognized Tribes); who manage approximately 34 percent of the overall IHS budget and serve approximately 552,000 users (37 percent of all IHS users).

Historical Decisions and Recommendations: (1) Developed process to streamline and improve implementation of Self-Governance under Title V; (2) Worked with IHS on development of Title V regulations; (3) Served as active partners in the development of the Affordable Care Act/Indian Health Care Development Act; (4) Developed an Annual National Tribal Self-Governance Strategic Plan that identifies all priorities of Self-Governance Tribes; and (5) TSGAC membership actively participates in all HHS/IHS Committees and Workgroups to advance Self-Governance Tribal interests.

CURRENT ISSUES/RECOMMENDATIONS:

TSGAC on-going discussions and recommendations include: (1) Budget/data issues related to budget formulation process, funding formulas and distribution of new appropriations, and addressing GPRA-related issues; (2) Advocating for the appointment of an OMB Assistant Director for Native American Programs; (3) Developing position paper regarding moving IHS Committee of Jurisdiction; (4) Developing framework to implement Title VI-Expansion of Self-Governance within HHS; (5) Active involvement in implementation of the Affordable Care Act/Indian Health Care Improvement Act and implementation of the Special Diabetes Program for Indians; (6) Working with IHS to develop improvements to the grant process; (7) Developing recommendations regarding consistent application and implementation of the Contract Support Cost (CSC) policy, including funding allocation and development of annual CSC Shortfall report; and (8) working with the IHS Office of Information Technology on data and budget issues including transparency and identifying gaps.

OTHER:

Please visit www.tribalselfgov.org for more details and information on upcoming meetings, which include the TSGAC Quarterly Meeting (July 12-14, 2011) and the Tribal Strategy Session (September 8-9, 2011).

Submitted by: Hankie Ortiz, Director, Office of Tribal Self-Governance, IHS Headquarters



IHS Tribal Consultation Summit

National Tribal Advisory Committee on Behavioral Health
SUMMARY/UPDATE
July 6-7, 2011



PURPOSE:

The National Tribal Advisory Committee (NTAC) on Behavioral Health serves as an advisory body to the IHS Director and to the IHS Division of Behavioral Health. The NTAC provides guidance and recommendations regarding behavioral health programmatic issues affecting the delivery of behavioral health care for AI/ANs served by the IHS.

BACKGROUND:

Created in July of 2008, the NTAC is composed of elected Tribal officials—one member and one alternate from each IHS Area chosen by Area Directors—who are charged to “help guide the development of, and support for, behavioral health throughout the IHS/Tribal/Urban (I/T/U) systems, and work to ensure that services are as broadly integrated, available and culturally appropriate as possible.”

From its inception, NTAC has been engaged in providing significant input and recommendations on behavioral health funding, program, and system development. They were instrumental in collaborating on the national Methamphetamine and Suicide Prevention Initiative funding from the Consolidated Appropriations Act of 2008; the national Domestic Violence Prevention Initiative funding from the Omnibus Appropriations Act of 2009; and preparing recommendations for the IHS Behavioral Health 5 Year Strategic Plan.

The NTAC recommendations for funding distributions and program development for both initiatives were accepted by the IHS Director and represent concrete successes for IHS/Tribal collaboration on significant national funding and program issues.

CURRENT ISSUES/RECOMMENDATIONS:

- Establishing the IHS Division of Behavioral Health 5 Year Strategic Plan. This plan is the foundation for program and service development of behavioral health services across the Indian Health System (Tribal, Federal, and Urban programs).
 - The NTAC recommendations are currently under review.
- Monitoring the development and implementation of the Methamphetamine and Suicide Prevention Initiative that NTAC helped to create.
- Monitoring the development and implementation of the Domestic Violence Prevention Initiative that NTAC helped to create.
- Continuing to provide advocacy, recommendations, and close collaboration among national Tribal, Urban, and Federal leadership in behavioral health for the Indian Health System.

Submitted by: Jon Perez, National Behavioral Health Consultant, IHS





IHS Tribal Consultation Summit

Director's Workgroup on Improving Contract Health Services
SUMMARY/UPDATE
July 6-7, 2011



MEMBERSHIP:

Tribal Members

Roselyn Begay
Jefferson Keel
Carolyn Crowder
Andy Teuber
Mark Chino (Co-Chair)
Cathy Chavers
J. David Roundstone
Molin Malicay
Johnny Hernandez

Elizabeth Neptune
Walt Moran
Cheryl Donovan
Mickey Peercy
J. David Roundstone
Amber Torres
Andy Joseph
Eric Metcalf
Reuben Howard
Gary Quinn

Federal Members

Maria Rickert
Roberta Bellanger
Garfield Littlelight
Harry Brown
Marie Begay
Charles Rhodes
Randy Grinnell (Co-Chair)

Staff

Carl Harper
Cliff Wiggins
Clayton Old Elk
Debbie Feathers
Terri Schmidt

PURPOSE:

The Director's Workgroup on Improving Contract Health Services (CHS) reviews Tribal input to improve the CHS program; evaluates the formula for distributing new CHS funds; and recommends methods to streamline CHS business operations within the IHS and the Indian health system.

BACKGROUND:

January 15, 2010, Dr. Roubideaux began formal consultation with Tribes by sending a letter requesting input about how to reform the CHS program. She requested input feedback through several means: (1) written input by March 15, 2010; (2) two Tribal listening sessions; (4) two CHS Best Practices Meetings; and, (5) the Director's CHS Workgroup deliberations. In March 2010, Dr. Roubideaux established the Workgroup on Improving Contract Health Services. Since March 2010, the Workgroup has held four meetings, one conference call and two CHS Listening and Best Practices Sessions.

CURRENT ISSUES/RECOMMENDATIONS:

Recommendation #1 - Creating a technical subcommittee charged with calculating total current CHS need and estimates of future CHS need.

Recommendation #2 – Convening twelve Area work sessions to review current CHS policies and procedures and develop recommendations on specific measurable changes that will improve CHS business practices, including IHS and Tribal best practices. Workgroup members facilitated these Area work sessions. The Workgroup recommended each Area develop standardized methods and strategies to: enhance staff training in customer service; improve patient outcomes; conduct case management review; review and update medical priorities; evaluate best practices; evaluate the return on investment for providing preventive medical services; communicate CHS program requirements, revisions to the IHS Manual, strategic plans to modernize CHS, and efforts to measure the effectiveness of these changes.

Recommendation #3 – Using the existing CHS formula for funds distribution during FYs 2011 and 2012. The Workgroup felt the full impact of these increases needed to be reviewed before making recommendations to change the formula. They recommended a subcommittee be created to review the CHS distribution formula for equity across Indian Country in FY 2013.

OTHER:

The Unmet Needs Subcommittee conducted a pilot study to adapt the existing FDI methodology to breakout CHS and direct care funding needs. All Areas held work sessions, and the workgroup is developing recommendations offered during those sessions.

Submitted by: Carl Harper, Director, Office of Resource Access and Partnerships, IHS



IHS Tribal Consultation Summit

IHS Budget Formulation Workgroup
SUMMARY/UPDATE

July 6-7, 2011



MEMBERSHIP:

The IHS Budget Formulation Workgroup (BFWG) has two Tribal representatives from each of the 12 IHS Areas who are designated on an annual basis. Technical staff also participate and support Area Tribal representatives. Additional representatives from national Indian organizations participate in the workgroup at the discretion of the IHS Director.

PURPOSE:

Tribes, Indian organizations, and other key stakeholders are actively involved in the budget formulation process to ensure that the IHS budget reflects the evolving health needs of American Indian and Alaska Native people and communities. The IHS budget formulation process is comprised of annual forums for Indian Tribes to interact with the IHS to provide program priorities and budget recommendations. Area budget formulation teams solicit Area-wide input in establishing health and budget priorities and recommending two Tribal representatives to serve on the BFWG. The workgroup is convened annually to consolidate Area budgets and health priority recommendations into a comprehensive set of national health priorities, which are used in IHS budget decision-making throughout the remainder of that fiscal year. The workgroup also meets to prepare and testify before the HHS leadership at the HHS Annual Tribal Budget Formulation and Consultation Session. Finally, the BFWG evaluates the budget formulation process annually, making recommendations to improve the process for the next budget formulation cycle.

BACKGROUND:

The BFWG was first convened to formulate the FY 2000 budget request. The IHS Tribal Consultation Policy outlines the IHS, Tribal, Urban budget formulation process. To ensure that Tribes are able to provide meaningful input for the IHS budget request and inform the HHS process, the BFWG activities align with the HHS schedule. The process strengthens the partnership between HHS, IHS, and Tribes and establishes greater trust and confidence in HHS' support for American Indian and Alaska Native health care.

CURRENT ISSUES/RECOMMENDATIONS:

In FY 2013, the top Tribal budget priorities include: protecting base funding and obtaining increases for Hospitals & Health Clinics, Contract Health Services, and Contract Support Costs. Tribes have also identified the following health priorities for FY 2013: behavioral health; diabetes and chronic disease; cancer; health promotion, disease prevention, and obesity; heart disease, stroke, and cardiovascular; maternal child and child adolescent health; dental; injuries and injury prevention; elder health; and, long-term care.

OTHER:

The BFWG completed an evaluation of the FY 2013 process in May 2011; BFWG will present its recommended improvements for the FY 2014 to the IHS Director. The FY 2014 Area sessions are scheduled to take place from October through December 2011.

Submitted by: Elizabeth Fowler, Director, IHS Headquarters Office of Finance & Accounting





IHS Tribal Consultation Summit

Tribal Leaders Diabetes Committee

SUMMARY/UPDATE

July 6-7, 2011



MEMBERSHIP:

The Tribal Leaders Diabetes Committee (TLDC) membership is comprised of Tribally-elected primary and alternate representatives from each IHS Area. Membership includes:

TLDC: Robert Cournoyer, Aberdeen; Lincoln Bean, Alaska; Martha Garcia, Albuquerque; Cathy Abramson, Bemidji; Bud Moran, Billings; Rosemary Nelson, California; Buford Rolin, Nashville; Rex Lee Jim, Navajo; Connie Barker, Oklahoma City; Elwood Emm, Phoenix; Julia Davis-Wheeler, Portland; and, Grace Manuel, Tucson.

Technical Advisors (non-voting): Reno Franklin, National Indian Health Board; Irene Cuch, National Congress of American Indians; Tom John, Tribal Self-Governance Advisory Board; Donald Rogers; Direct Service Tribes Advisory Committee; and, D'Shane Barnett, National Council of Urban Indian Health.

Federal: Lorraine Valdez, Acting Director, IHS Division of Diabetes Treatment and Prevention.

PURPOSE:

The TLDC operates based on a Charter approved and signed by the IHS Director in 2007. The TLDC makes recommendations for the establishment of broad-based policy and advocacy priorities for diabetes and related chronic disease activities to the IHS Director. Objectives are to: (1) make recommendations and provide advice on policy and advocacy issues concerning diabetes and related chronic diseases; (2) provide advice and guidance to ensure the incorporation of appropriate culture, traditions, and values in program development, research, and community-based activities; (3) provide broad-based guidance and assistance in defining how other Federal agencies and organizations, States, Tribal epidemiology centers, institutions of higher learning, and private health organizations can play a role in addressing diabetes and related chronic disease; and, (4) serve as a Tribal advisory committee to the Centers for Disease Control and Prevention Native Diabetes Wellness Program.

BACKGROUND:

The Special Diabetes Programs for Indians (SDPI) was created by Congress, as part of the Balance Budget Act of 1997, Public Law 105-33, in recognition of the disproportionate impact of diabetes in AI/AN communities. The TLDC was created by the IHS Director in 1998. The TLDC recommends a process to the IHS Director for distributing SDPI funds. The TLDC also provides the IHS and Tribal leadership with an ongoing forum to discuss matters related to diabetes and the impact of other chronic diseases on AI/AN communities. The current operating funding for the TLDC activities and travel to meetings is supported through the IHS administrative budget from the SDPI appropriation.

CURRENT ISSUES/RECOMMENDATIONS:

SDPI Funding for FY 2012-13: Congress approved a 2-year extension of the SDPI for FY 2012 and 2013 as passed in HR 4994, Medicare and Medicaid Extenders Act of 2010 at \$150 million per year. The IHS Director initiated a consultation with Tribes on January 25, 2011 by requesting input on the following recommendations of the TLDC: (1) employ a continuation grant process, instead of a competitive grant process, for transition programs from current funding (FY2010-11) to the new funding (FY 2012-13), and (2) given the short extension, the distribution of funding should remain the same. In a letter to Tribes on May 2011, the IHS Director concurred with TLDC recommendations.

Submitted by: Lorraine Valdez, Acting Director, Division of Diabetes Treatment & Prevention, IHS





IHS Tribal Consultation Summit

Information Systems Advisory Committee

SUMMARY/UPDATE

July 6-7, 2011



MEMBERSHIP:

Permanent: National Indian Health Board Member, Open (Vice Jessica L. Burger); IHS Office of Environmental Health and Engineering Member, Darren Buchanan; IHS Chief Information Officer, Charles Gepford (Acting); Tribal Self-Governance Advisory Committee Member, Carolyn Crowder; Information Systems Coordinator Committee Member, Scott Anderson; Council of Chief Medical Officers Member, Harry Brown; National Council of Urban Indian Health Board Member, Donna Keeler; National Council of Executive Officers, Floyd Thompson ISAC Co-Chair; National Clinical Councils Member, Vacant;

2-year term: Ian Erlich (Tribal); Carol McCurdy (Tribal); Richard A. Hall (Tribal); Danny “Skip” Leader (Tribal); Chuck Walt (Tribal); David Battese (IHS); Michael Belgarde (IHS); Jenny Jenkins (IHS), Steve Lopez (IHS); one vacancy

PURPOSE:

The Information Systems Advisory Committee (ISAC) was established to guide the development of a co-owned Indian health information infrastructure and information systems. The ISAC assists in ensuring that (1) the information systems are available, accessible, useful, cost effective, user-friendly, and secure for local-level providers and (2) these systems continue to create standardized aggregate data that supports advocacy for the Indian health programs at the national level.

BACKGROUND:

The ISAC was initially established in 1997-98 by the IHS Executive Leadership Group and subsequently chartered by the IHS Director in 2001. The Committee is comprised of 19 Tribal, IHS, and Urban (I/T/U) representatives and guides the development of information systems in IHS and enhances collaboration and communication among I/T/U programs. The ISAC meets at least twice annually to carry out its responsibilities. The ISAC is charged with making recommendations on the following:

- Annual prioritization of key initiatives in information systems to be addressed by the IHS.
- Advice on direction, priorities, and resource allocation for information systems through development, review, and approval of the IHS Information Technology (IT) strategic plan, enterprise project management plan, enterprise architecture, and investment reviews.
- Promotion of the adoption and use of standard data sets, dissemination of information regarding the status of existing data sets, and marketing the need for maintaining standardized aggregate data.
- Establishment of ad-hoc technical workgroups composed of industry experts and representatives of Indian health programs to provide advice and perform activities dealing with current IT issues.
- Communication with all I/T/U partners.

CURRENT ISSUES/RECOMMENDATIONS:

- Approved the 2011-2015 IHS Information Technology Strategic Plan, the Annual Information Technology Strategic Planning Cycle, and the 2012-2013 ISAC Information Technology priorities.
- Participated in annual regional budget formulation meetings.
- Participating in quarterly Tribal Self-Governance Advisory Committee meetings.
- Recommended the Director, IHS establish the Information Technology Tribal Shares Improvement Project Workgroup in response to Tribal leader issues and participated on the Workgroup.
- Participated in recently held 12 Area based Tribal listening sessions related to the IHS Information Technology Tribal Shares Improvement Project.
- Formulating recommendations based on input from the 12 Area Tribal listening sessions for the IHS Director.

Submitted by: Charles Gepford, Acting Chief Information Officer, IHS Headquarters





IHS Consultation Topic Summaries



IHS Tribal Consultation Summit

Indian Health Care Improvement Act

SUMMARY/UPDATE

July 6-7, 2011



PURPOSE:

The primary purpose of this document is to provide information on the Indian Health Care Improvement Act (IHCIA).

BACKGROUND:

In March 2010, the President signed the Affordable Care Act which included the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA). The law continued the statutory authorization for many long standing Indian Health Service (IHS) programs like the Indian Health Care Improvement Fund (IHCIF), the IHS scholarship and loan repayment program, Contract Health Services (CHS), and health care facilities construction. It added new authorities for long term care, dialysis services, and use of tele-mental health. The IHCIA implementation began in Spring 2010 with the identification of milestones, timelines, and opportunities to coordinate with other agencies and partners. Consultation with Tribes was initiated in May 2010.

CURRENT ISSUES:

IHS continues implementation of the IHCIA. Several letters have been sent to Tribes with updates. The IHS Director has provided updates at every meeting with Tribes.

By March 2011, IHS accomplished on time, all statutory requirements with a specific “not later than one year after the date of enactment” deadline. This included the development or submission of: plans and reports on behavioral health training, health facilities needs, a Nevada Area Office, mental health care needs; the Department of Interior (DOI)-IHS Memorandum of Agreement (MOA) on substance abuse and mental health issues; and domestic and sexual violence prevention and treatment policy and protocols.

IHS also collaborated with the Office of Personnel Management (OPM), and the Centers for Medicaid and Medicare Services (CMS) on planning for the implementation of key provisions expanding access to health care coverage for American Indians and Alaska Natives (AI/ANs). OPM announced its plans for the implementation of the “Access to Federal Insurance” provision in May 2011 which will include Tribal consultation. IHS, DOI and the Substance Abuse and Mental Health Services Administration (SAMHSA) jointly conducted 10 listening sessions on Indian youth suicide prevention. IHS and the Department of Veterans Affairs (VA) initiated implementation of the VA provisions to improve access to both systems for health care services to AI/AN veterans.

IHS funded outreach and education efforts on the IHCIA through the National Indian Health Board, National Congress of American Indians, and the National Council on Urban Indian Health. Multiple national and regional meetings were conducted by these organizations to inform Indian Tribal leaders, Indian health programs, State and local health entities, and Tribal communities on the opportunities offered by the IHCIA to advance the efforts to improve the health status of AI/ANs.

Submitted by: Geoffrey Roth, Senior Advisor to the Director, IHS





Tribal Consultation Summit

Tribal Epidemiology Centers Data Sharing Agreement

SUMMARY/UPDATE

July 6-7, 2011



ISSUE:

Tribal Epidemiology Centers (TECs) are Tribal organizations funded by IHS to develop public health data capacity for the benefit of Tribes. In response to TECs being designated as Public Health Authorities under IHCA, TECs have requested access to IHS patient data for the purpose of public health surveillance and reporting on community health status for their constituent Tribes.

Background:

Tribal Epidemiology Centers (TECs) are established by cooperative agreements with the IHS. The TECs are authorized by Section 214(a)(1), Public Law 94-437, Indian Health Care Improvement Act, as amended by P.L. 573. They are authorized users of health information collected by the IHS for public health activities that are within the scope of work of their Cooperative Agreements with the IHS Division of Epidemiology and Disease Prevention (DEDP).

A standardized data sharing agreement template has been developed to facilitate data sharing while ensuring compliance with the Health Insurance Portability and Accountability Act (HIPAA) and Privacy Act regulations. The data sharing template provides TECs access to de-identified data from IHS Epidemiology Data Mart/National Data Warehouse (NDW). Access to data that contains protected health information can be obtained through the current process that involves a specific protocol for this data use and Institutional Review Board (IRB) approval.

Current Situation:

Many Tribes have assumed management of their health systems through Compacts and Contracts negotiated under the Indian Self-Determination Education and Assistance Act. They are not required by law or by contract to submit patient data to IHS, but most choose to share data and participate in the Government Performance and Results Act process. Once data is transmitted to IHS, the information becomes part of IHS System of Records and is subject to all of the protections, policies and procedures of applicable laws such as the HIPAA and Privacy Act. IHS has a long-standing practice of seeking Tribal permission for any publication that presents information that is specific to a Tribe, especially if the Tribe is to be named in the publication. In addition, the IHS has taken several steps to address concerns of Tribes:

1. **Standard agreements.** The IHS created a general template for data sharing agreements and contracts with input from Epidemiology Centers.
2. **Control of access to personal identifiers.** The General Data Mart in the National Data Warehouse has been restructured to provide better control of access to personal identifiers. This ensured that data use by TECs complies with federal regulations.
3. **Implement a secure on-line data access tracking mechanism.** DEDP has developed a tracking application that is in final testing.
4. **Ensure data security.** Users will access a de-identified mirrored copy of the NDW's EpiData Mart located outside the IHS firewall on an external server.
5. **Tribal consultation.** The IHS Director has initiated a Tribal Consultation process for input on the data sharing agreement.

Action Plan:

1. The IHS developed a standardized template for routine data sharing.
2. The IHS Director sent a letter to Tribes on January 24, 2011 for comments and suggestions on the draft Data Sharing Contract.
3. Additional discussion and input is being sought through the National Tribal Consultation Summit in July 2011.

Submitted by: Richard Church, Director Office of Public Health Support, IHS





IHS Tribal Consultation Summit

Suicide Prevention Initiative
SUMMARY/UPDATE

July 6-7, 2011



PURPOSE:

In partnership with Tribes, the American Indian/Alaska Native (AI/AN) Task Force will implement suicide prevention strategies to reduce the rate of suicide in AI/AN communities.

BACKGROUND:

To help guide the overall Indian health system effort, the National Tribal Advisory Committee on Behavioral Health, the Behavioral Health Work Group, and the Suicide Prevention Committee developed the framework for the National Suicide Prevention Strategic Plan. It is an important document that will serve to pave the way over the next five years to address suicide in Indian Country in a planned, collaborative approach.

CURRENT ISSUES/RECOMMENDATIONS:

- IHS maintains the IHS Community Suicide Prevention Web site which provides culturally appropriate information about best and promising suicide prevention and early intervention programs and training opportunities. Further information and resources can be found at the following address: <http://www.ihs.gov/NonMedicalPrograms/nspn/>
- Tele-behavioral health technology is being adopted as an effective way to improve access to behavioral health services. Currently, over 50 IHS and Tribal facilities in eight IHS Areas are augmenting on-site behavioral health services with tele-behavioral health services.
- Several Tribal and urban Indian communities have been implementing a number of innovative and culturally sensitive prevention initiatives. For example, many communities are implementing the Native H.O.P.E. (Helping Our People Endure) curriculum, the American Indian Life Skills Development, the Sources of Strength model, ASIST (Applied Suicide Intervention Skills Training), QPR (Question, Persuade, Refer), and other promising approaches.
- The Methamphetamine & Suicide Prevention Initiative (MSPI) project supports 127 community based suicide prevention and intervention pilot programs. These projects have trained community members in best and promising suicide prevention models such as those listed above.
- IHS serves on the Federal Partners for Suicide Prevention Workgroup and closely collaborates with CDC, SAMHSA, VA, and BIA/BIE.
- Ten Regional Listening Sessions throughout the country were held November 2010 to February 2011 to gather information on the needs, concerns, programs, and practices on this critical issue. The information obtained at the Listening Sessions provides the foundational trainings and topics to be presented at the IHS, BIA, BIE, SAMHSA Action Summit for Suicide Prevention scheduled for August 1-4, 2011 in Scottsdale, AZ. Various suicide prevention, intervention, postvention trainings will be provided as well as the use of best and promising practices; incorporation of traditional medicine in treatment will be highlighted. Informational tool-kits of the best and promising practices will be made available to conference attendees.

Submitted by: Cheryl Peterson, Public Health Advisor, IHS Headquarters





IHS Tribal Consultation Summit

Indian Health Care Improvement Fund (IHCIF)

SUMMARY/UPDATE

July 6-7, 2011



PURPOSE:

The IHCIF formula, adopted in 2001 following national Tribal consultation, was originally developed by an IHS/Tribal workgroup. A Data/Technical Work Group recently evaluated technical and data aspects of the formula. Members of the technical work group included Tribal and IHS health statisticians, analysts, and executives. The IHS is evaluating the IHCIF formula. In the first step, the data and technical aspects of the formula were examined. The technical group recommended 6 technical improvements. In the second step, a letter sent to Tribes on December 31, 2010, initiated Tribal consultation by asking four questions (see below).

BACKGROUND:

The IHCIF was established to determine the overall level of need funded for Federal, Tribal, or Tribal organization health care facilities (facilities). A formula was established that assigned facilities a level of need funded percentage relative to funding spent for Federal employees for health insurance through the Federal Employees Health Benefits Program (FEHB). The average level of need funded for all facilities was determined to be 55 percent of the FEHB benchmark. Many facilities were funded at levels below that average. Each year since 2001, Congress has appropriated funding for facilities with the lowest percentage level of need funding, and to date, we have been able to raise all facilities to at least 46 percent of their estimated level of need. However, additional funding is needed to raise all facilities to the IHS average of 55 percent, which was the original goal after Tribal consultation on this issue. In addition, the Indian Health Care Improvement Act (IHCIA) reauthorizes the IHCIF and including 1) An updated list of services that the IHCIF may support; 2) a requirement to report on resource deficiencies for facilities in the IHS system and, if available, provide updates on “waiting lists” and Indians “turned away” due to resource deficiencies; and 3) a requirement that affirms the IHS must consider services and resources provided by any Federal programs, private insurance, and programs of State and local governments.

CURRENT ISSUES/RECOMMENDATIONS:

A letter sent to Tribes on December 31, 2010 asked several questions:

- 1) Should we change the IHCIF formula?** The original goal was to get all facilities to at least average. 150 of the 270 facilities are funded at less than the IHS average of 55 percent and approximately 75 facilities are funded at 46 percent. Should we update the formula now or wait until all facilities are at 55 percent?
- 2) Should we make technical improvements to the current formula?** A technical workgroup recommends improvements related to user counts, the cost benchmark, site differences, data procedures, health status and alternate resources. Should we make these technical improvements now?
- 3) Should we make changes in the basic methodology of the formula?** The formula would need to be changed in a more fundamental manner to incorporate new authorities for services such as long term care. It would also need to be modified if Tribes want other changes, such as adding or deleting basic formula factors.
- 4) How should we consult with Tribes on the questions above?** Options include holding national listening sessions/consultation sessions, forming an IHS/Tribal workgroup to make recommendations, and/or holding Area sessions and working with Area health boards/national Indian organizations/existing workgroups.

OTHER:

Responses to the December 31, 2010 letter to Tribes show a variety of views on these questions. Some respondents said that in the current budget climate that now is not a good time to change formulas and that we should wait until impacts of national health reforms become clearer. Others support changes including replacing the flat rate alternate resource estimate and said that waiting until all sites get to 55 percent might not happen in the foreseeable future.

Submitted by: Cliff Wiggins, Operations Research Analyst, IHS Headquarters





Hotel Map & Notes

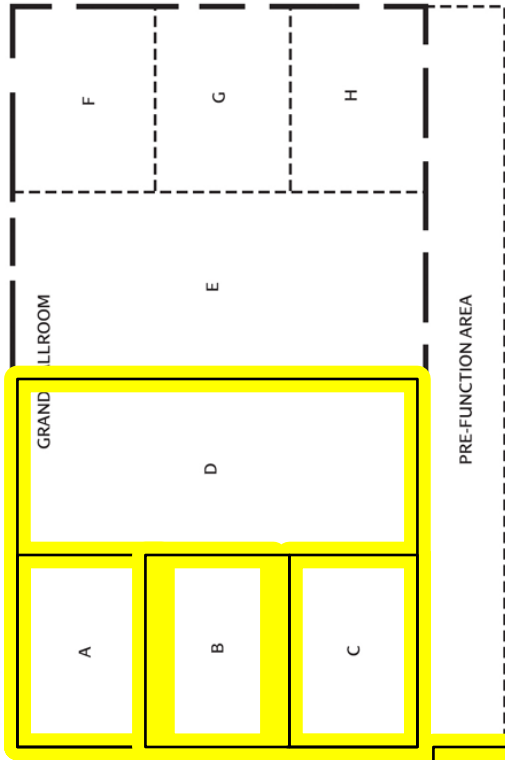
Elevator



Restroom



MAIN LEVEL



Escalator



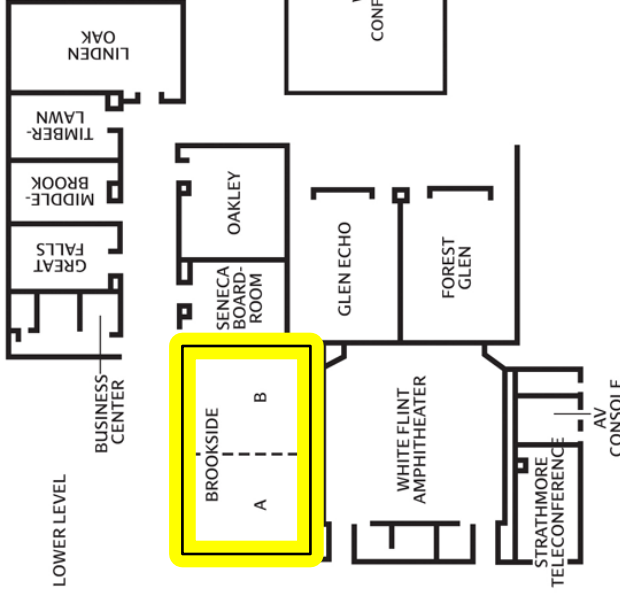
Registration



Escalator



LOWER LEVEL



Bethesda North Marriott Hotel &

Conference Center

5701 Marinelli Road

Bethesda, Maryland 20852

Phone: 1-301-822-9200

Fax: 1-301-822-9201

