



## Department of Health & Human Services

*the health, safety, and well-being of America*



# 2011 Tribal Consultation Report

*Prepared by:*  
The Office of Intergovernmental and External Affairs  
March 2012



**Prepared by**  
**The Office of Intergovernmental and External Affairs**  
**United States Department of Health and Human Services**  
**March 2012**



**Department of Intergovernmental  
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United States Department of Health and Human Services

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United States Department of Health and Human Services  
**2011 Tribal Consultation Overview**

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**Secretary's Tribal Advisory Committee**

**Melanie Knight**, Secretary of State, Cherokee Nation; **Herman G. Honanie**, Vice Chairman, The Hopi Tribe; **Roberta Bisbee**, Tribal Council Member, Nez Perce Tribal Council; **Robert McGhee**, Tribal Council Representative and Treasurer, Poarch Band of Creek Indians; **Ken Lucero**, Chair, Secretary's Tribal Advisory Committee and Tribal Council Representative, Pueblo of Zia; **Rex Lee Jim**, Vice President, Navajo Nation; **Secretary Kathleen Sebelius**, Secretary, Department of Health and Human Services; **Dee Sabattus**, Health Policy Analyst, United South & Eastern Tribes, Inc.; **Jefferson Keel**, Lt. Governor, Chickasaw Nation of Oklahoma; **Gary Hayes**, Chairman Elect, The Ute Mountain Tribal Council; **Roselyn Begay**, Acting Division Director Division of Health, Navajo Nation; **Andy Tueber, Jr.**, Tribal Council Member, Woody Island Tribal Council; **Buford L. Rolin**, Tribal Chairman, Poarch Band of Creek Indians; **Stacy Dixon**, Tribal Chairman, Susanville Indian Rancheria

## 2011 EXECUTIVE SUMMARY

The U.S. Department of Health and Human Services (HHS) and Indian Tribes share the goals of eliminating health and human service disparities of Indians, ensuring maximum access to critical health and human services and advancing the social, physical, and economic status of Indians. To achieve these goals, federally-recognized Indian Tribes and HHS engage in open, continuous and meaningful consultation.

The 2011 Tribal Consultation Report provides a comprehensive summary of the Department's consultation efforts from October 1, 2010 through September 30, 2011. HHS's guiding policy, the Tribal Consultation Policy, was revised in 2010, and signed by Secretary Sebelius on December 14, 2010. In keeping with prior versions, the current policy calls for the Department to measure and report the results and outcomes of its Tribal consultation performance to fulfill the government-to-government relationship with Indian Tribes. This report describes the significant progress that the Department has made over the last year and a half towards reshaping the way that work with Tribes is conducted.

Under the leadership of Secretary Kathleen Sebelius, the U.S. Department of Health and Human Services has been working hard to implement the Affordable Care Act, the landmark health care reform law which was passed on March 23, 2010. Many of the provisions in the Affordable Care Act specifically reference Tribes, urban Indian organizations, the Indian Health Service (IHS), or Tribal and urban Indian health facilities. Tribes, as sovereign nations, have businesses, employ people, and administer health programs and grants, and, therefore, are among the primary beneficiaries of the insurance reforms, grant programs, and cost-saving measures of the Affordable Care Act. Additionally, as part of the enactment of the Affordable Care Act, the Indian Health Care Improvement Act (IHCA) was reauthorized.

The Department has prioritized consultations by operating divisions and regional offices around the Affordable Care Act, the Indian Health Care Improvement Act, and other issues of interest. The Department has made key leaders accessible and available and has created and implemented new advisory structures and policies.

At the December 2011 White House Tribal Nations Conference, Secretary Sebelius echoed her commitment to working closely with Tribal nations:

*"I have been proud to see the relationship between our nations grow stronger and stronger. In the face of immense challenges ahead, we will need one another more than ever. That's why this conference and our consultation are so important. This Administration is committed to shaping a future where every American Indian and Alaska Native has access to the care and support to achieve their highest aspirations. We understand and abide by the true meaning of the government to government relationship. And we believe in true partnership with you. We have made great progress and I know that through our partnership we will continue to move forward, in support of strong healthy Tribal communities."*

The 2011 Tribal Consultation Report's format largely mirrors that of last year's report. Feedback from Tribal leadership indicates that this format is easily readable and accessible. The Office of Intergovernmental and External Affairs (IEA) welcomes any feedback or suggestions readers have on improving the report. Feedback and suggestions can be submitted by email to [consultation@hhs.gov](mailto:consultation@hhs.gov).

**Section I: 2010 HHS Consultation Overview** lists the consultation efforts of the HHS Office of the Secretary. It includes the 2011 Major Outcomes and Accomplishments, an overview of the 13th Annual HHS National Tribal Budget and Policy Consultation and the 8th Annual HHS Regional Tribal Consultations.

**Section II: Regional Offices** lists the consultation efforts of HHS Regional Offices during the last year. In order to distinguish national from local or regional consultation efforts, this section is organized according to type of consultation, including Highlights of Region-Specific Accomplishments, Summary of 2011 Regional Consultation Sessions, Tribal Delegation Meetings, Regional Visits to Tribes, and Tribal Summits. Information about the date(s), sponsoring region and a brief summary are included for each consultation activity. Regions have also been following up quarterly with their respective Tribes on issues identified at the annual regional consultations.

**Section III: HHS Divisions** lists the consultation efforts of HHS Operating Divisions during the last year. This section is organized by type of consultation, including Highlights of Division Specific Accomplishments/Activities Targeted towards AI/AN's, Division Specific Activities, Tribal Delegation Meetings, Workgroups/Task Force Meetings, and Tribal Summits. Information about the date(s), sponsoring division, and a brief summary are included in each consultation activity.

**Section IV: Intradepartmental Council on Native American Affairs (ICNAA)** describes what the ICNAA is, how HHS responds to the ICNAA priorities and what the ICNAA has done in 2011.

Finally, the **Appendices** section offers a wealth of supportive information to maximize the use of the Report as a resource. These include staff lists charts, maps, budget information and the HHS Tribal Consultation Policy as well as the Charter for the Secretary's Tribal Advisory committee and its members.

Please feel free to review this report online at our website: <http://www.hhs.gov/ofta>.

## **2011 MAJOR HHS OUTCOMES AND ACCOMPLISHMENTS**

### **Secretary Sebelius sends letter to State Governors regarding Tribal State Relations and Consultation**

On September 14, 2011, Health and Human Services Secretary Kathleen Sebelius wrote the Governors of the states regarding the importance of Tribal relations and consultation. In the letter, the Secretary reiterated her commitment to the government-to-government relationship with American Indian and Alaska Native Nations and encouraged states to consult with Tribes as they administer health and human services programs supported by federal funding. A copy of the letter is attached in the appendix.

### **Secretary's Tribal Advisory Committee (STAC)**

As part of the Department's efforts to improve services, outreach, and consultation efforts with Tribal partners, Secretary Sebelius established the Secretary's Tribal Advisory Committee in December of 2010. The establishment of a Tribal advisory committee at the Secretarial level has created a coordinated, department-wide strategy to incorporate Tribal guidance on HHS priorities, policies and budget, improve the government-to-government relationships, and mechanisms for continuous improvement with HHS services to Indian Tribes. Since its inception, the STAC has met five times and established three priorities: 1) Eliminating health and human services disparities; 2) Increasing access to HHS resources and funds for Tribes and Tribal populations; and 3) Improving the Tribal/State/Federal relationships. Several accomplishments of the STAC have been:

1. **Supporting Tribal Access to Grants:** On December 6, 2011, a workshop was held for HHS program and grant managers from each HHS operating division designed to give the HHS program and grant reviewers a better understanding of Tribes, how Tribes work, why Tribes are unique and how to work with Tribes.
2. **Tribal Eligibility for Grants:** HHS has taken steps to make sure Tribes have an accessible, accurate, and comprehensive list of every grant offered by HHS for which tribes are eligible. It has been a large undertaking by HHS. It is the goal of HHS to provide a list to the Tribes as well as make recommendations to the Secretary that where she has administrative authority she will make changes to grant eligibility for Tribes where they are not explicitly eligible.
3. **Expansion of Services: Tribal Self Governance:** HHS through the advice of the STAC explored and reviewed the programs that were identified in the 2003 Feasibility Study to determine if we had authority to authorize a demonstration via any of those programs. Through the review HHS was not able to identify any authority that would permit a demonstration project of the sort proposed by the study carried out under Title VI of the ISDEAA. In response these findings HHS has created a Self Governance Tribal Federal Workgroup (SGTFW). The purpose of the SGTFW is to assist HHS in developing further plans for the expansion of Tribal Self-Governance. The workgroup will begin their work in February 2012.

### **Federal Medical Assistance Percentages for Indian Tribes**

On August 1<sup>st</sup>, the rule for the Federal Medical Assistance Percentages (FMAP) for Indian Tribes became effective. FMAP had not previously been calculated for Indian tribes because they had not previously been eligible grantees for programs that use FMAP. However, as a result of the Fostering Connections to Success and Increasing Adoptions Act of 2008, Indian tribes, tribal organizations, and tribal consortia became eligible to operate foster care, adoption assistance, and kinship guardianship assistance programs authorized under title IV-E of the Social Security Act. These programs use the FMAP to calculate the federal share of costs. Because of low incomes, most Indian tribes, tribal organizations and tribal consortia will be



eligible for the maximum FMAP of 83 percent. Of the 158 Indian tribes that either currently have agreements with states to operate title IV-E programs or have expressed interest in operating these programs directly, 121 would receive the maximum FMAP rate of 83%. Most others have per capita incomes that would result in an FMAP lower than the maximum, but still higher than the states within which they are located.

### **National Health Service Corps Designation for Indian Health Service and Tribal Facilities**

The Health Resources Services Administration (HRSA) has designated all IHS/tribal facilities as National Health Service Corps approved sites. This allows IHS/tribal facilities to recruit and retain primary care providers by utilizing the scholarship and loan repayment incentives offered through the National Health Service Corps program. On May 6, 2011, Dr. Mary Wakefield and Dr. Yvette Roubideaux sent welcome letters to all site directors outlining the benefits of becoming a National Health Service Corps approved site. As a second step in the initiative, HRSA and IHS are partnering to designate a Health Professional Shortage Area (HPSA) score for over 300 newly approved IHS/tribal facilities.

### **Medicaid Meaningful Use Incentive**

In coordination with the Centers for Medicaid and Medicare Services (CMS), eligibility for Medicaid Meaningful Use incentives has been modified to allow all Tribal clinics to be treated as Federally Qualified Health Centers for purposes of qualifying for these incentives. This modification allows Tribal clinics to meet the needy individual patient volume threshold, rather than the more stringent Medicaid patient volume threshold, making it easier for tribal clinics to qualify for these incentives.

### **SAMHSA: Uniform Block Grant Application**

On July 26, the Substance Abuse Mental Health Services Administration (SAMHSA) announced a new application process for its major block grant programs which include the Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant (MHBG). The change is designed to provide States greater flexibility to allocate resources for substance abuse and mental illness prevention, treatment and recovery services in their communities. One of the key changes to the block grant application is the expectation that States will provide a description of their tribal consultation activities. Specifically, the new application's planning sections note that States with federally-recognized Tribal governments or Tribal lands within their borders will be expected to show evidence of Tribal consultation as part of their Block Grant planning processes. However, Tribal governments shall not be required to waive sovereign immunity as a condition of receiving Block Grant funds or services. Included within the MHBG application SAMHSA notes that States should identify strategies for the MHBG that reflect the priorities identified from the needs assessment process.

### **Affordable Care Act Outreach**

The Office of Intergovernmental and External Affairs (IEA) has been coordinating and communicating directly with Tribes on the Affordable Care Act on a regular basis. HHS engages tribal partners in monthly conference calls, quarterly reports, listening sessions, and weekly emails, as well as special consultations. It is our intention that this outreach effort will complement and enhance the interagency implementation effort and improve communication between the federal government and tribes. Active partners in this outreach effort include the White House Office of Intergovernmental and External Affairs, Indian Health Service, Centers for Medicaid and Medicare Services, Office of Health Reform, and the Office of Personnel Management.

### **Administration for Children and Families (ACF) Tribal Consultation Policy**

On August 18, 2011 Acting Assistant Secretary George Sheldon signed the ACF Tribal Consultation Policy. This policy sets official protocol on how the agency engages tribes in consultation on legislation, regulations, and policies that affect the services delivered to federally recognized tribes. Representatives from tribes met with ACF staff over the summer of 2010 to discuss how ACF consults with Indian tribes. After months of discussion, including consultation and internal review, a policy specific to ACF programs was listed in the Federal Register for a 45-day comment period in December 2010. This policy provides a clear channel of communication that lays out who responds on behalf of the agency, a timeline for responses, and where the communication takes place with tribal leaders.

### **Centers for Medicaid and Medicare Services Tribal Consultation Policy**

On November 17, 2011, CMS Administrator Dr. Donald Berwick signed the CMS Tribal Consultation Policy. CMS has been working on an agency-specific tribal consultation policy for several years and the policy is consistent with the HHS tribal consultation policy. The purpose of the policy is to establish a clear, concise and mutually acceptable process for consultation between CMS and Indian Tribes and to improve greater access to CMS programs by American Indians and Alaska Natives (AI/ANs). The policy was distributed to all 565 Tribes via a Dear Tribal Leader letter.

### **2011 Annual Tribal Budget and Policy Consultation**

At the 2011 Consultation Session, Tribal representatives provided testimony, received responses from HHS leadership regarding the budgets and policies of nine HHS agencies, and participated in a department-wide discussion on crosscutting issues. The Tribes identified two crosscutting issues that they wanted to specifically consult on: the Affordable Care Act and State Budget Reductions Impacting Medicaid.

In the FY 2012 Budget Congress appropriated an increase of \$237 (5.8%) for IHS over FY 2011 as well as increases for AI/AN programs at ACF and AoA.

### **Regional Tribal Consultation Sessions**

The HHS Regional Tribal Consultation Sessions are designed to solicit Tribes' priorities and needs on health and human services programs. The sessions provide an opportunity for Indian Tribes to articulate their comments and concerns on budgets, regulations, legislation, and HHS policy matters. This year marks the 8th year of these consultation sessions in the field; between March through May of 2011, HHS held ten regional Tribal consultation sessions across the country with the goal of improving the HHS Tribal consultation process, agency policies, and overall communication. These regional sessions were well-attended, with over 350 federally recognized Tribes participating.

### **Secretary Sebelius Tribal Engagement**

Secretary Sebelius actively engaged Tribes throughout 2011. The Secretary wanted to ensure that she was personally involved in the delivery of HHS communication and accomplishments directly to Tribes and elected Tribal leadership. The following is a list of Tribal meetings, speaking engagements, and site visits Secretary Sebelius participated in during 2011:

- Muckleshoot Tribal Nation Site Visit (February)
- National Congress of American Indians Executive Winter Session (March)
- HHS National Tribal Budget Consultation (March)
- Secretary's Tribal Advisory Committee Meetings
  - March 2, 2011

- May 18, 2011
  - September 14, 2011
- Alaska Tribal Site Visits (August)
  - Alaska Tribal Health Consortium
  - South Central Foundation
  - Alaska Native Health Board
  - Village of Anaktuvuk Pass
  - Village of Barrow
  - Village of Tanana
  - Tanana Chiefs Conference
- White House Tribal Nations Conference (December)
- Meeting with President Obama and Tribal Leaders (December)

## **13<sup>TH</sup> ANNUAL NATIONAL HHS TRIBAL BUDGET AND POLICY CONSULTATION**

On March 2-4, 2011, HHS hosted the 13<sup>th</sup> Annual Department-wide Tribal Budget and Policy Consultation Session in Washington, D.C. The registered 82 participants were Tribal leaders and representatives, Indian organization leaderships and staff, such as the National Congress of American Indians and the National Indian Health Board, and HHS leadership and staff.

During the Tribal Resource Day on March 2<sup>nd</sup>, HHS presented on topics selected to assist Tribes in understanding HHS, the federal government, and the resources available. The Tribal Resource Day also provided HHS staff and tribal representatives a valuable opportunity to directly interact.

On March 3<sup>rd</sup>, HHS Deputy Secretary Bill Corr welcomed Tribal leaders and representatives and affirmed the Department's commitment to American Indian and Alaskan Native communities. Tribes expressed the need to consult on policies that impact them and noted they appreciated HHS government-to-government consultation. Tribal representatives also described the difficulties they face operating under the FY 2011 continuing resolution, the need for increased Contract Health funding, and barriers they face in trying to access federal programs.

Agency leadership and staff from ACF, AoA, SAMHSA, HRSA, NIH, AHRQ, and FDA gave updates on their activities that impact Tribes. The Tribal representatives provided highlights of their testimony and had an opportunity to ask questions of the agencies. For example, HRSA reported that a major legal barrier was removed, allowing IHS Facilities greater participation in HRSA's National Health Service Corps, that will help fill vacancies at IHS facilities. Comments from Tribes included requested for increased funding, the value of thoughtfully including Indians in research methodologies, State and Tribal relationships, and the need to consult with Tribes when new tobacco regulations may impact them.

On March 4<sup>th</sup>, the agenda moved to two cross-cutting issues:

1. Affordable Care Act Overview
2. State Budget Reductions Impacting Medicaid

At the conclusion of consultation, Tribal leaders discussed budget priorities for FY 2013 with Secretary Kathleen Sebelius, Assistant Secretary for Financial Resources Ellen Murray, IHS Director Yvette Roubideaux, Administration for Native Americans Commissioner Lillian Sparks, Director of Intergovernmental Affairs Paul Dioguardi, and several of the Secretary's policy advisors.

### ***Tribal Priorities for the FY 2013 Budget:***

- Behavioral Health – Tribes requested additional financial resources, service integration, and coordination across HHS.
- Diabetes – Combating diabetes and its resultant complications remains a top health priority in Indian country.
- Cancer – Tribes noted limited access to cancer screening and lack of specialized care contribute to the increasing cancer mortality rate among AIAN, while cancer deaths have been declining overall among all US races.

***Follow-up -- Impact of the 2011 Consultation:***

The FY 2012 President's Budget proposes an increase in HHS funding targeted specifically toward serving the needs of American Indians and Alaskan Natives, including an increase of \$571 million, or 14 percent over FY 2010, for the Indian Health Service. The budget also includes an increase of \$50 million at SAMHSA for a new Tribal Block Grant Program focused on behavioral health and prevention, and increases for AIAN programs at ACF and AoA.

## 2011 HHS REGIONAL CONSULTATION SUMMARY

On November 5, 2009, at the *White House Tribal Nations Conference*, President Obama demonstrated his commitment to American Indians and Alaska Natives (AI/ANs) and to fulfilling the consultation requirements of Executive Order 13175—originally issued by President Clinton on November 5, 2000—by signing a Presidential Memorandum. Executive Order 13175 - Consultation and Coordination with Indian Tribal Governments calls for all Federal agencies to come into compliance with regards to regular, meaningful consultation and collaboration with Tribal officials in the development of Federal policy that have Tribal implications; to strengthen the U.S. government-to-government relationships with Indian Tribes; and to reduce the imposition of unfunded mandates upon Indian Tribes. In accordance with the President's directive, the U.S. Department of Health and Human Services (HHS) convened 11 regional Tribal Consultations in 2011. Held from January 6, 2011, through June 9, 2011, the consultations' primary purpose was to allow Tribal leaders to discuss programmatic issues and overall concerns of Tribes at the local level with HHS officials. The regional sessions also provided an opportunity for Tribes to hear updates from HHS, discuss the revised HHS Tribal Consultation Policy (signed by HHS Secretary Kathleen Sebelius on December 14, 2010), provide testimony and/or comments on topics of interest, and pose questions on issues that concern Tribal communities and members. This document serves as the executive summary for all of the 2011 HHS Regional Tribal Consultations, summarizing the common themes and overarching priorities. It is national in perspective. This is important to note because, as various Tribes have poignantly articulated, each Tribe is different and unique. Tribes face different challenges and present different needs based on their size, geographic location, structure, etc. To that end, the concerns, issues, and recommendations cited in this document reflect common items shared among them. Information on specific regional sessions is available via individual meeting and executive summaries, under separate cover.

The 2011 HHS Regional Tribal Consultations were held as follows:

January 6, 2011, Green Bay, WI, Region V  
February 24, 2011, Oklahoma City, OK, Regions VI and VII  
March 10, 2011, Las Vegas, NV, Region IX and VIII  
March 24, 2011, Rapid City, SD, Regions VII and VIII  
March 29, 2011, Verona, NY, Region II  
March 30, 2011, Cherokee, NC, Region IV  
March 31, 2011, Boston, MA, Region I  
April 26, 2011, Window Rock, AZ, (Navajo Nation), Regions VI, VIII, IX  
April 28, 2011, Albuquerque, NM, Regions VI and VIII  
June 7, 2011\*, Grand Ronde, OR, Region X  
June 9, 2011\*, Anchorage, AK, Region X

\* Due to a pending government shutdown, the Grand Ronde and Anchorage consultations were rescheduled from April 13<sup>th</sup> and April 15<sup>th</sup> to June 7<sup>th</sup> and June 9<sup>th</sup>, respectively.

Agendas for each regional consultation were tailored for that specific area. Generally, each consultation was conducted as follows: registration; welcome activities; introductions and opening remarks; HHS updates; testimony/comments; panel presentations and response; and wrap-up/next steps. Deliverables resulting from each consultation included an executive summary, as well as a detailed meeting summary comprising the following sections:

1. Overview and Purpose of Session
2. Tribal Priorities

3. Open Tribal Leader Comment/Testimony/Discussion
4. Highlight of Issues Brought up by Tribes
5. Responses from Regional Staff Participants
6. Agenda
7. Wrap-Up and Next Steps

Tribal leaders and representatives voiced their concerns about challenges facing their Tribal communities. Notwithstanding, a few positive remarks were consistently heard across the regions. Namely, the Obama Administration was praised for its commitment to Indian Country—as evidenced by an increase in fiscal year (FY) 2011 and the proposed FY 2012 budgets for the Indian Health Service (IHS) over FY 2010; regional directors were credited for their role in helping to improve the accountability of the Federal government; and IHS Director Yvette Roubideaux was applauded for using her Director’s Blog to keep Tribes updated on relevant issues. Similarly, Tribes and Tribal officials expressed their approval when learning of the following information:

- All Tribal employees will be eligible for Federal Employee Health Benefits.
- Intradepartmental Council on Native American Affairs (ICNAA) is addressing the issue of Tribal access to grants, including eligibility/ineligibility for HHS grants.
- ICNAA is focused on expanding self-governance outside of HHS.
- Methamphetamine/Suicide Prevention Initiative (MSPI) funding is in the proposed 2012 budget.
- Proposed 2012 Behavioral Health-Tribal Prevention grants slated for \$50 million—with a base award to every Tribe that applies of \$50,000. [Remaining \$25 million will be awarded through a distribution formula.]

Across the regions, common themes and priorities centered on the following six categories: Tribal-State relations; funding; service needs; policy; process; and data issues. Highlights pertaining to each of the categories are provided below.

### **Tribal-State Relations**

- Role HHS plays in Tribal-State relations.
- Impact of State budgets on Tribes, especially optional Medicaid Services.
- Tribes’ options/opportunities in regards to States’ lack of consultation with them and/or lack of willingness to move forward on Affordable Care Act (ACA) activities.
- Need for Federal officials to have proof of States’ consultation with Tribes.

### **Funding**

- Need for health care facilities construction/renovation and concern over reduction in IHS’ facilities funding.
- More resources needed for mental health/behavioral health and maternal child health.
- Increased funding needed for contract health services (CHS).
- Request for direct HHS funding to Tribes.
- Community Health Representatives (CHR) program needs increased funding.
- Money needed for prevention programs.
- Concern about the high cost of implementing electronic health records (EHRs).

### **Services**

- Strengthening Indian health providers/programs to improve capacity and access.

- Remote areas' lack of technology, roads, and conditions impact everything from ability to review plan options under ACA, recruit and retain qualified staff and medical professionals, and transport children and individuals for services.
- Need for elder care/long-term care resources.
- Need better way to provide health care in rural settings.
- Concern about suicide, alcoholism, and substance abuse and a need for treatment centers.
- Need for dental partnerships/services.
- Providing services to veterans.
- National Health Service Corps (NHSC) deployment in Indian County.

### **Policy**

- Timely communication of ACA implementation and Tribes' engagement in the process.
- Adopt a broad definition of "Indian" and use it for all ACA benefits/protections.
- Confusion around terms: Indian, essential community providers, Federally-Qualified Health Center (FQHC), community health centers.
- Department of Veteran Affairs (VA) and Tribes cooperation/agreement on payer of last resort and how Tribes submit claims.
- Tribes to be considered 51<sup>st</sup> State for reimbursement purposes.
- Federal officials and Congress members' understanding of Tribal sovereignty, treaties, and issues in Indian County.
- Issues regarding Indian health provider licensing.
- Moving forward the issue of Tribal self-governance.

### **Process**

- Timeliness of CHS referrals is an issue.
- Requests for timely feedback on Tribal comments, questions, and concerns.
- Requests for cross-agency collaboration.
- Need for more non-competitive grants to Tribes.

### **Data**

- Difficult for Indian clinics to collect data and set up electronic systems.
- Tribes not informed of results when they respond to requests for data.
- Tribes' difficulty in understanding health information technology (HIT) and meaningful use.

In response to the concerns raised, at times Federal officials indicated that statutory requirements limited their ability to influence change. Other times, they were immediately able to respond. When that was not possible, they indicated that they needed to follow-up with answers at a later date. Among the Federal responses to some of the Tribal concerns included the following:

- New VA Tribal Consultation Policy was released and a new Memorandum of Understanding (MOU) between the VA and IHS instituted. From the MOU, 12 national workgroups were established to address increasing access to care; and a 13<sup>th</sup> workgroup will focus solely on Alaska.
- Training is underway to train individuals on how to become a Tribal Veteran Representative.
- The issue of payer of last resort is being discussed.



- Tribes can participate on monthly calls for ACA updates.
- SAMHSA will place regional administrators in all the regions over the next two years.
- Enrollment dates for Medicare are now October 1<sup>st</sup> – December 15<sup>th</sup>.
- ACA has provisions for long-term care services.
- CMS release of best practices regarding ways States could consult with Tribes was expected in August/September 2011.
- IHS proposing funding in the 2012 budget for youth tele-mental health projects and innovative facilities construction.
- ACA will yield Health Professions Opportunities grants; funds for Tribal Court Improvement programs; Native Asset Building Initiative, and expansion of the NHSC.

The 2011 HHS Regional Tribal Consultations focused on issues of concern to Tribes. Specifically, issues surrounding implementation of the ACA; adoption of meaningful use of EHRs; Tribal-State relations; and direct funding to Tribes, among other important topics, were voiced by Tribal leaders. Those issues, as well as the resounding requests for benchmarks, timeliness, and tracking of Tribal concerns, were heard by Federal officials. In the end, both Tribal and Federal leadership showed commitment to doing their part to improve outreach and services to AI/ANs.



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United States Department of Health and Human Services  
**2011 Regional Office Reports**

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Figure: U.S. Department of Health and Human Services Regional Divisions and Indian Health Service Areas

## **HEALTH AND HUMAN SERVICES**

### **Region 1: Boston** (*Nashville IHS*)

Connecticut, Maine, Massachusetts,  
New Hampshire, Rhode Island, Vermont

### **Region 2: New York** (*Nashville IHS*)

New Jersey, New York, Puerto Rico,  
Virgin Islands

### **Region 3: Philadelphia** (*Nashville IHS*)

Delaware, District of Columbia,  
Maryland, Pennsylvania, Virginia, West  
Virginia

### **Region 4: Atlanta** (*Nashville, Oklahoma IHS*)

Alabama, Florida, Georgia, Kentucky,  
Mississippi, North Carolina, South  
Carolina, Tennessee

### **Region 5: Chicago** (*Bemidji IHS*)

Illinois, Indiana, Michigan, Minnesota,  
Ohio, Wisconsin

### **Region 6: Dallas**

(*Nashville, Oklahoma, Albuquerque IHS*)  
Arkansas, Louisiana, New Mexico,  
Oklahoma, Texas

### **Region 7: Kansas City**

(*Aberdeen and Oklahoma IHS*)  
Iowa, Kansas, Missouri, Nebraska

### **Region 8: Denver**

(*Aberdeen, Albuquerque, Billings, Phoenix IHS*)  
Colorado, Montana, North Dakota,  
South Dakota, Utah, Wyoming

### **Region 9: San Francisco**

(*California, Phoenix, Tucson, Navajo IHS*)  
Arizona, California, Hawaii, Nevada,  
American Samoa, Commonwealth of the  
Northern Mariana Islands, Federates  
States of Micronesia, Guam, Marshall  
Islands, and Republic of Palau

### **Region 10: Seattle**

(*Alaska, Portland IHS*)  
Alaska, Idaho, Oregon, Washington

## **INDIAN HEALTH SERVICE UNIT**

### **Aberdeen IHS**

North Dakota, South Dakota,  
Iowa, Nebraska

### **Bemidji IHS**

Indiana, Minnesota, Michigan,  
Wisconsin

### **Oklahoma IHS**

Oklahoma, Kansas, Texas

### **Nashville IHS**

Southern and Eastern United  
States

### **Albuquerque IHS**

New Mexico, Colorado, Texas

### **Billings IHS**

Montana, Wyoming

### **Navajo IHS**

Arizona, New Mexico, Utah

### **Phoenix IHS**

Arizona, California, Nevada,  
Utah

### **California IHS**

California, Hawaii

### **Alaska IHS**

### **Portland IHS**

Idaho, Oregon, Washington



**United States Department of Health & Human Services  
2011 Annual Tribal Consultation Report**

**REGION 1: Boston**

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## HIGHLIGHTS OF REGION-SPECIFIC ACCOMPLISHMENTS

Region I Director Christie Hager initiated greater internal and external communications in 2011 primarily by instituting regularly scheduled quarterly conference calls. These quarterly conference calls with Tribal partners typically include Tribal leaders, health directors, human service representatives and the regional HHS leadership.

Region I Director Christie Hager attended two Regional Health Equity Council (RHEC) meetings in 2011. On August 16<sup>th</sup> at Exeter, New Hampshire and again on November 14<sup>th</sup> at the DentaQuest Foundation, Westborough, Massachusetts, Director Hager met with the RHEC which includes tribal representatives from the region. The Region I RHEC is one of ten councils in the United States, each of which covers the same geographical territory as an HHS region. The RHEC serve as leaders and catalysts for strengthening health equity actions within a region in response to the National Partnership for Action's (NPA) National Stakeholder Strategy for Achieving Health Equity; and enhance collaboration between health equity stakeholders in the region, including public-private partnerships, alignment between initiatives and programs, and leveraging of assets to more effectively accomplish health disparity reduction goals.

## SUMMARY OF REGIONAL CONSULTATION SESSIONS

The 2011 Tribal Consultation for Region I was held on March 31, 2011, in Boston, Massachusetts. The primary purpose of Consultation was to serve as a forum Tribal leaders to discuss programmatic issues and overall concerns of Tribes at the local level with U.S. Department of Health and Human Services (HHS) officials. The regional session also provide an opportunity for Tribes to be aware of HHS updates, discuss the updated HHS Tribal Consultation Policy, provide testimonies and/or comments on topics of interest, and pose questions on issues that concern Tribal communities.

Following the Regional Consultation, the ORD immediately began working towards the resolution of the action items and issue requested by the tribes. The ORD will continue to build on its relationship with tribes and their leaders to improve the health and human services provided to tribal citizens in 2011 and beyond.

The Region I Draft Consultation Report was submitted for the Tribes review and comment on May 26, 2011.

Highlights of Consultation: Lynn Malerba, Chief, The Mohegan Tribe, opened the meeting with a Tribal blessing. Chief Malerba, Chairwoman Cheryl Andrews-Maltais of the Wampanoag Tribe of Gay Head, and Christie Hager, Regional Director for HHS Region I, served as co-moderators. Tribal leaders and other consultation attendees provided testimonies and comments on topics of concern.

### **The Tribal priorities cited were:**

1. Administration on Aging (AoA) funding opportunities and limitations because of the size of Eastern Tribes
2. Centers for Medicare and Medicaid Services (CMS) payments
3. Indian health provider licensing
4. Medicare secondary payer
5. End-stage renal disease (ESRD) program
6. Medicare life rates
7. Consistency with grant funding

8. Health Information Technology for Economic and Clinical Health (HITECH) Act and how different attorneys general respond
9. Contract health services
10. Title VI of the Tribal Self-Governance Amendments of 2000, self-implementing and non-self-implementing portions of the Act. To move forward this should be permanently authorized
11. Aging
12. Federal employee health benefits
13. Substance abuse and mental health
14. Executive summary of the Indian Health Care Improvement Act

Pam Hyde, Substance Abuse and Mental Health Services Administration (SAMHSA) Administrator, informed attendees of Secretary Sebelius' new **Tribal Advisory Committee (STAC)** and updated HHS's Tribal Consultation Policy. Administrator Hyde also provided the Keynote Presentation: "*Tribal Law and Order Act*" and addressed SAMHSA's work to improve behavioral health in Indian Country. Hyde characterized the SAMHSA mission is to reduce the impact of substance abuse and mental illness on America's communities whose challenges include higher adolescent death rates, youth suicide rates, binge alcohol use, illicit drug use, sexual assault and homicide against women, intimate partner violence, incarceration and arrest, and historical trauma. Finally, SAMHSA proposed for a \$50M Behavioral Health–Tribal Prevention Grant for FY2012. While it is not competitive, grant recipients are required to apply for must apply every 3 years and submit annual reports. As of the writing of this report, the criteria for the grant have not been set.

Dr. Harry Brown, Chief Medical Officer, IHS–Nashville Area, reported that the 2010 Affordable Care Act (ACA) contains permanent reauthorization of the Indian Health Care Improvement Act (IHCIA). Some important provisions for American Indians are equal access to State-based exchanges with no co-pay or deductible if their income is less than 300% of the Federal poverty level as well as expanded care coverage for dependent children until age 26. Furthermore, tribally hired health care professionals are granted the same status as Federal health care professionals and can be licensed in any state. Dr. Brown further noted that m programs interact around electronic health records (EHR) and meaningful use, e.g., drug–drug and drug–allergy checks, smoking status, or clinical quality measures such as hypertension, tobacco use, and influenza immunization.

#### **Cross-cutting Issue Area #1: Affordable Care Act (ACA)**

Jaye Weisman, CMS, reported that the prescription drug benefit is included to close the coverage gap under Part D, and will gradually increase until 2020. Eligibility is determined by prescription drugs obtained through Tribal pharmacies. Prevention services, e.g., cancer screenings and wellness visits, are given at no cost. Medicaid eligibility will expand and state health insurance exchanges will be introduced. The Tribal Affairs Group in CMS provides technical information; their meetings are listed on the Web site <http://www.cms.gov/default.asp>.

Jeff Reck, **Health Resources and Services Administration (HRSA)** reported that ACA generally does not impact HRSA in any new ways but instead magnifies its resources to carry on its programs. There are now 80 programs for 3000 grantees. HRSA focuses on the uninsured, HIV/AIDS-positive pregnant women and children, primary health care, and maternal and child health. The National Health Service Corps incentivizes providers to work in medically underserved areas. HRSA has a department that focuses on rural health (62% of the country is rural; and 40% of Tribal lands are rural). A HRSA e-mail address list has been compiled, and

they established a website specifically for Native American public health issues with a tool that offers the ability to find a community health center or IHS center by typing in a zip code.

Lisa Wilson and Pete Nakahata, **Center for Consumer Information and Insurance Oversight (CCIIO)** [via telephone], provided an overview of CCIIO's functions as ACA provisions related to private health insurance with the goal of restoring power to consumers and holding insurance companies accountable. Beginning in 2014, the biggest change is helping consumers shop for and enroll in an insurance plan that fits their needs. Wilson and Nakahata noted reported that s-based exchanges will bring individuals and small businesses into a larger purchasing group, which will allow flexibility and one-stop shopping. These exchanges are intended to distribute insurance benefits, and to regulate insurance.

### **Panel #2—Aging, Family & Human Services Issues**

Mary Ann Higgins, Administration for Children and Families (ACF), said ACF administers more than 60 programs, not particularly designed for Tribes. In addition to Head Start, they administer three grants that have a 5% tribal set-aside—Home Visiting Program, Health Professional Opportunities, and Personal Responsibility Education Program—and the Assets for Independence Project. Most ACF grants are not competitive and have no match at all. A 2010 resource directory has been compiled and is available on-line. ACF has begun its own Consultation process.

Kathleen Otte, Administration on Aging (AoA), reported that through the Older Americans Act, AoA funded 256 grants this year, and further announced 218 care-giver grants on April 1. AoA funds are seen as a safety net; thereby reduced monies make collaboration more important. Gene Brown encouraged all Tribes to apply. AoA program eligibility requires the minimum age limit of 60 years. Otte also noted that Title VI programs should be doing more in prevention and wellness, physical activity, health screening, nutrition counseling, and weight watching. For more information on resources, see <http://www.olderindians.org/>. Forward comments on Older Americans Act programming to <http://aoa.gov/>.

### **Panel #3—Health, Wellness and Behavioral Health**

Michael Milner, Office of the Assistant Secretary of Health (OASH), reviewed OASH's functions on prevention and preparedness activities in collaboration with other organization that foster stronger State–Tribe interactions. ADM Milner proposed to discuss ways to bring community health directors and State health directors together and identify opportunities for collaboration to integrate behavioral health and primary care.

Chris Bersani, HRSA reported that while many HRSA programs are not specific to Tribes, many were applicable and multiple collaborative projects were underway. Bersani noted that one of HRSA's immediate goals is to integrate prevention activities with obesity diagnosis because while many patients are screened, measuring prevention proves to be a continuous challenge. This is particularly important for the Tribal communities as members of this population are most often affected by high-risk behavior, e.g., smoking and lack of preventive care.

Peter Delaney, SAMHSA Center for Behavioral Health Statistics and Quality, reported that prevention is SAMHSA's number one goal, followed by promotion of wellness and resilience in order to prepare communities for disasters. In other words, SAMHSA is working to finding good ways of coping and not moving toward drug abuse given that emergency departments' use of prescription drugs has increased 78%). Since problems related to substance abuse are suicide and trauma, the criminal justice system has created trauma-informed systems. To improve access to the community for military families, SAMHSA has also been working with the National



Guard. The goal is to create prepared service systems, improve quality of treatment as well as prevention, and create resilience for emotional health, and a seamless set of care for the military. SAMHSA firmly believe that behavioral health is a critical component of healthcare and therefore emphasizes the need to collect good data. SAMHSA reported that a draft of its Behavioral Health Quality Framework draft will be soon be posted on its website.

Gary Perlman, Agency for Toxic Substances and Disease Registry (ATSDR), reviewed the features of a multi-purpose software to help Tribes deal with contaminated land, which consists of two parts, 1) a tool to inventory and prioritize sites and 2) to analyze health risks. Perlman noted that the tool is Microsoft Access-based and can store documents within it. These features included a 1) Site Visit Guide prompts visual inspection and exposure pathways, and a health risk module that covers edible species and toxins that enter through the skin. Perlman noted that free tool (including technical support and training) has been widely distributed. Mr. Perlman invited the Tribes to provide feedback for improvements.

#### **Panel #4—Preparedness and Response**

Gary Kleinman, Office of the Assistant Secretary for Preparedness and Response (ASPR), gave an overview of the National Health Security Strategy as a way toward ensuring community resilience. While ASPR is primarily responsible for public health and works directly with States and Tribes in planning and preparedness activities and operations during emergencies, the Federal Emergency Management Agency (FEMA) has authority to coordinate all agencies during emergencies... In between emergencies, ASPR provide supports capacity building and training activities that to ensure community resilience such as managing the Medical Reserve Corps (MRC) - the civilian Medical Volunteer Reserve Corps.

Mark Libby, ASPR, presented varying communication options that Tribal nations can access in cases of emergency preparedness and response, primarily through IHS, such as the availability of 24-hour number to call when needed. Libby emphasized that ASPR's mission is to promote preparedness and response, which in turn promotes resilience. ASPR fulfills its mission by helping communities assess risk and hazards in the community, facilitate education and training especially for the health workforce, and coordinate activities across jurisdictions. For response activities, ASPR is the lead Federal agency for HHS, and receives huge support from Regional Health Administrators. ASPR's general concept of operations is helping communities implement their response plans, but they do not provide funds. Their response assets include access to 6,000 to 9,000 members of the Public Health Service Corps, the National Disaster Management Authority (NDMA), HHS, and FEMA, with the core of the Disaster Medical Assistance Teams serving as its core response teams. Pam Hyde, SAMHSA, noted that while SAMHSA has not been part of emergency planning, behavioral health issues happen immediately in an emergency, and should therefore begin to work with ASPR at the beginning of disaster preparedness.

#### **Panel #5—Tribal–State Relations**

The Office of Civil Rights (OCR) provided an overview of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rule and the Health Information Technology for Clinical and Economic Health (HITECH) Act in response to previously expressed concerns from the Mohegan and Eastern Pequot Tribal leaders at Consultation and meetings held in 2010. These tribes expressed interest on the jurisdiction of the State Attorney General's office over the sovereign nations to enforce HIPAA and the HITECH Act and requested further clarification from OCR.

## **REGIONAL VISITS TO TRIBES**

### **Regional Director Visits the Mashpee Wampanoag Tribe— January 2011**

On January 26<sup>th</sup>, 2011, Region I Director Christie Hager met with Mashpee Wampanoag Tribal Councilwoman Cheryl Frye-Cromwell & Tribal Health Development Officer Wanda Lord at the Mashpee Tribal Health Office. Director Hager toured their new IHS facility, met with staff, discussed the benefits of the Affordable Care Act to the Mashpee, and offered to facilitate communication between the Tribe and Commonwealth's health and human services agencies.

### **Regional Director Visits the Mohegan Tribe— December 2011**

On December 2<sup>nd</sup>, Region I Director Christie Hager met with Marilyn "Lynn" Malerba, Chief of The Mohegan Tribe. Director Hager and Chief Malerba discussed Affordable Care Act implementation with specific attention given to Essential Health Benefits. Director Hager also met with Connie Hilbert, Executive Director of Health & Human Services, and they discussed the exchange planning process in Connecticut. After their meeting, Director Hager, Chief Malerba and Director Hilbert toured the new Mohegan Tribal Government Offices.

### **Mashpee Wampanoag Tribe: Ribbon Cutting & Grand Opening of New Health Center, Mashpee, MA— December 2011**

On December 10, 2011, Region I Director Christie Hager attended to the provide remarks at the Grand Opening and ribbon cutting ceremony of the new Mashpee Wampanoag Tribal Health Center.



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**REGION 2: New York**

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## **HIGHLIGHTS OF REGION-SPECIFIC ACCOMPLISHMENTS**

During October 2010-September 2011, Region II Director Torres has held continuous communication with the Tribes via email to forward information, announcements and grant opportunities. Quarterly conference calls were scheduled and now they have been merged with the United South and Eastern Tribes (USET) to maximize Tribal participation.

On March 29, 2011 Region II held the region-specific Tribal Consultation. Region I Director highlighted HHS cross-cutting programs and initiatives and the benefits provided by the Affordable Care Act.

On May 19<sup>th</sup> and 20<sup>th</sup>, the Administration on Aging (AoA) participated in a conference hosted by the Oneida Indian Nation, the "Aging Well Conference". This was a conference for American Indians and their caregivers. All federally recognized Indian Tribes in New York State were invited and over 100 Native Americans and caregivers participated. AoA met with three of the four Title VI grantees in New York State, The Senecas, St. Regis Mohawks and Oneidas. AoA gave a presentation on how to stay healthy, and discussed how new preventive health benefits, authorized by the Affordable Care Act could keep seniors healthy and due to the waiver of deductibles and co-insurance payments, people who were not getting any basic health care due to costs, could now see a physician and start to receive routine health care.

In May 2011, Region II Director Torres facilitated communication between New York State Department of Health, the Centers for Medicare & Medicaid Services (CMS) and Tribal leaders as regards to the Health Insurance Exchange. The Insurance Department sent a letter to invite Tribal leaders to participate in public forums and reached out to the Office of the Regional Director requesting assistance to set up separate meetings with the Tribes for their input on issues related to the Health Insurance Exchange.

On August 17 & 18, IGA Specialist Aguilar participated in the Centers for Medicare & Medicaid Services (CMS) and Indian Health Services (IHS) Training in Niagara Falls, NY. The meeting provided information to a group of tribal representatives from diverse Tribal nations including Onondaga, Seneca, Tuscarora, Shinnecock and St. Regis Mohawk. The training included information about Medicare Basics, Social Security Disability and the Children's Health Insurance Program and the Tribal Technical Advisory Group (TTAG). SAMHSA provided a presentation on behavioral health care and substance abuse specifically related to Tribes. The Veterans Administration provided information on eligibility and benefits. NYS Medicaid eligibility, Health Insurance Exchanges and the NY Bridge Plan.

CMS Region II Native American Coordinator and other regional staff continue to assist the St. Regis Mohawk Tribe Partridge House Treatment Program in their reimbursement issues. CMS participates in calls and workgroups with IHS to help clarify the cross border Medicaid payment issue. The Partridge House is an inpatient substance abuse facility in Hogansville, NY. The clinic has been in operation since 1983 and is licensed by the State of New York. Partridge House provides culturally sensitive treatment that is unique from other non-tribal treatment facilities along with other accepted treatment practices. Partridge House accepts and provides treatment to American Indians/Alaskan Natives (AI/AN) from anywhere in the United States who qualify for their program. They have been unable to collect reimbursement on a regular basis for services provided to out of state patients that may have or are eligible for Medicaid in their home state. The issue is not only an issue for the St. Regis Mohawk Tribe but for many other Tribes who provide services to out of state Tribal members.

In August after Hurricane Irene, the Office of the Regional Director reached out to Gov. Cuomo's Director of State Operations to reiterate the support of all regional components of HHS to help with the response and recovery efforts related to Hurricane Irene. The Office of the Regional Director also reached out to the NYS American Indian Health Program, to confirm that no assistance was needed from the Tribes. All was well, even the Shinnecock Reservation in spite of being located in Long Island, held up remarkably well. There was no flooding to main buildings, no loss of electricity, health and dental clinic was fully functioning with all staff present.

IGA Specialist Aguilar collaborated with the NYS American Indian Health Program coordinator to arrange an informational meeting for the Project Directors of the NYS Health Insurance Exchange Planning on September 13, 2011.

In September 2011, Regional Outreach Specialist Bell joined the Regional Health Administrator, Dr. Davis and the Region II Administration of Children and Families staff to plan and coordinate Let's Move Indian Country activities with the Region II Tribal leaders.

### **SUMMARY OF REGIONAL CONSULTATION SESSIONS**

The 2011 Tribal Consultation for Region II was held March 29, 2011, in Verona, New York. The primary purpose of the consultation was to allow Tribal leaders to discuss programmatic issues and overall concerns of Tribes at the local level with U.S. Department of Health and Human Services (HHS) officials. The regional session also provided an opportunity for Tribes to hear updates from HHS, discuss the updated HHS Tribal Consultation Policy, provide testimony and/or comments on topics of interest, and pose questions on issues that concern Tribal communities and members.

Charmaine Frederick, Oneida Indian Nation, opened the meeting and introduced Mary Blau, Oneida Indian Nation, who gave the opening prayer. Participants were then welcomed by: HHS Regional Director, Jaime R. Torres, Region II; Kim Jacobs, Commissioner of Nation Administration, Oneida Indian Nation; and Dee Sabattus, United South and Eastern Tribes, Inc. (USET). All attendees introduced themselves. Ms. Frederick and Dr. Torres served as co-moderators. Tribal leaders and other consultation attendees provided testimony and comments on topics of concern. Panel presentations highlighted new ACA funding opportunities for Tribal nations.

#### **The Tribal priorities cited were:**

1. Self-identifying as American Indian to ensure appropriate health care.
2. Data, data access, and data-sharing: Statewide Planning and Research Cooperative System (SPARCS), mandated by Article 28, Resource and Patient Management System (RPMS), and EpiCenters.
3. Co-pay issue under HHS regulations; care is provided free and they are not allowed to collect a co-pay, including for people who access two different Tribal clinics.
4. Communications networking with various departments, especially Medicaid.
5. Finding a pool of providers who accept Medicaid rates to whom they can refer people.

#### **Highlights and objectives brought up by Tribes at this meeting were:**

- Indian Health Service (IHS) will provide Tribes with an update on health insurance for Tribal employees.
- Explore data-sharing agreement between USET and New York State on SPARCS-sharing.

- Forward issues on interface or data-sharing between RPMS and SPARCS.
- Kristina Rogers will follow-up with the Seneca Nation on remaining user population issues.
- USET, Maternal Child Health (MCH) will work with the Administration for Children and Families (ACF) to disseminate information on ACF funding opportunities.
- Work more closely with Administration on Aging (AoA) and Dr. Bruce Finke to disseminate information on available AoA grant opportunities.
- Cheryl Donald and IHS, Dr. Ricks or Dr. Brown, will follow-up to encourage Tribes to apply to be a National Health Service Corps (NHSC) site.
- Work with the Health Resources and Services Administration (HRSA) to review section 330 of the Public Health Service Act, and assist Tribes in competing for HRSA grants.
- Cheryl Donald will let Tribes, USET, and IHS know whether Tribes can apply for HRSA grants under a single authority, e.g., USET.
- IHS will find out how to work with the Medical Reserve Corps (MRC) to backfill positions or work on short-term projects.
- Philip Mossman will inform Tribes of upcoming Medicaid Redesign Team (MRT) meetings.
- Michael Melendez will set up Tribal consultation quarterly conference calls, beginning by proposing tentative dates over the next 2 weeks.
- Mr. Melendez will arrange an all-day discussion on Medicaid.

NYS Department of Health assigned an Assistant Medicaid State Plan Coordinator to work on tribal consultation issues. Our policy is to forward written drafts to tribal leaders and health clinic administrators, as well as offering the opportunity for face-to-face discussions if requested.

### **TRIBAL DELEGATION MEETINGS**

#### **St. Regis Mohawk Tribal Nation, July 15, 2011**

Tribal representatives from the St. Regis Mohawk Tribal Nation visited the Regional Office to discuss child support issues. The meeting included the presentation of a letter to commemorate St. Regis Mohawk approval for start-up tribal child support funding.



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**REGION 4: Atlanta**

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## **HIGHLIGHTS OF REGION-SPECIFIC ACCOMPLISHMENTS**

Region 4 Director Anton Gunn presented to a group of tribal representatives from across the nation at the CMS/ITU Training November 16-17 at the Miccosukee Resort in Miami. Gunn provided the group with a comprehensive presentation on the Affordable Care Act, including elements that focus specifically on the tribes. His thorough presentation specifically focused on how the ACA impacted the state of Florida and served to benefit its citizens, including specifically the members of the Miccosukee and Seminole nations. Gunn also used the opportunity to share updates from central office, including the dates and location of the upcoming tribal meetings. The visit to Miccosukee, which included a tour of the tribal grounds, including the health center, school, residential area and new administration building, was significant, even though the Honorable Chairman Colley Billie was unavailable for a meeting. No one from the Office of the Secretary had visited the reservation since former Deputy Secretary Claude Allen and the Region IV acting RD in 2004. The visit was made possible by an invitation extended by CMS tribal liaison Crystal Francis.

The Mississippi Band of Choctaw Indians expressed a concern over a need to be included in the formation and crafting of the state's health insurance exchange in mid-November. Choctaw Director of Financial Services, Donita Stephens contacted the ORD requesting assistance in reaching out to the proper officials regarding the committee that will form the Mississippi State Insurance Exchange. Stephens' correspondence with Choctaw's liaison, Phyliss Williams from the Division of Medicaid, led her to Misty Watson with the Department of Insurance. However, Stephens was unsuccessful in obtaining the information needed regarding the Mississippi Health Exchange and was unsure whether she was communicating with the proper agency in her desire to submit her name as the tribal contact regarding the exchange. In November, Stephens requested assistance with obtaining the Mississippi Title XIX State Plan and a listing of any amendment requests and ARRA waiver requests. Working through CMS, the ORD requested and received the needed documents, which were forwarded to the MBCI financial services director a few days later. Similarly, in October, Poarch Creek Health Director Candace Fayard requested assistance in connecting with the group charged with forming the Alabama State Health Insurance Exchange. Working through the regional CMS office, The ORD was able to connect her to the lead official. Also, in addition to regular disseminating grant announcements and other news of interest from the department, Region IV collaborated with USET to hold three quarterly calls in 2011.

Working with Regional Medical Reserve Corps (MRC) Coordinator Kathy Handra, the ORD was able to connect Handra for an introductory meeting in May, with tribal representatives and begin conversations on the possibility of establishing an MRC unit through the Catawba Tribal Nation of Rock Hill, South Carolina. The new relationship led to an invitation for Dean Canty, Catawba Emergency Preparedness Coordinator, to attend the 2011 Integrated Medical, Public Health, Preparedness and Response Training Summit in Grapevine, Texas. While plans are ongoing for the establishment of the Catawba MRC, Canty was also invited to serve as a co-presenter, along with Seminole Tribe Emergency Management Operations Manager, Jason Dobronz, for the "Tribal Partnership" session at the 2012 Integrated Medical, Public Health, Preparedness and Response Training Summit.



## **SUMMARY OF REGIONAL CONSULTATION SESSIONS**

The 2011 Tribal Consultation for Region IV was March 30, 2011, in Cherokee, North Carolina. In addition to the host Eastern Band of Cherokee Indians (EBCI), the Poarch Creek Band of Indians (PBCI), Vickie Bradley, Health and Medical Director for the Eastern Band of Cherokee Indians, served as Tribal moderator. The HHS co-moderator was Anton Gunn, Director of the Region IV Office of HHS. Other tribal reps (3) included Candace Fayard, PBCI health director and Mary Harrison, Mississippi Band of Choctaw Indians (MBCI) health director. State officials included **Heather Burkhardt**, Planning and Evaluation Coordinator at **NC Division of Aging and Adult Services** and Audrey Edmisten from the Department of Aging and the Division of Medicaid Services, **Kevin Kelley**, Assistant Section Chief of Child Welfare Services (Child Protective Services) of the **NC DHHS** Division of Social Services and **Barbara Pullen-Smith, Director of the Office of Minority Health and Health Disparities for the NC DHHS**. Betty Moses, from the South Carolina Division of Medicaid Services and Alicia Crowder, from the Mississippi Department of Medicaid Services, were also in attendance. RD Anton Gunn co-facilitated the consultation, along with Cherokee Director of Health and Medical Services Director Vickie Bradley. Deputy Director Kidwell provided the HHS headquarters overview. IHS Acting Director Martha Ketcher presented an overview of her agency's work with the tribes and their implementation of the Affordable Care Act. United Southeastern Tribes (USET) Executive Director Kitcki Carroll attended his first Region IV consultation. Among the fifty-plus participants were representatives from CMS, AOA, HRSA, FDA, ACF, ASPR and the OASH.

Following an opening prayer and traditional dancing, RD Gunn opened the Region IV Tribal Consultation. RD Gunn next introduced Lauren Kidwell, Deputy Director of the Office of Intergovernmental Affairs at HHS. Providing an update from the national level, Ms. Kidwell noted that 2010 proved a significant year with the passing of the Affordable Care Act (ACA) and the Indian Health Care Improvement Act (IHCIA).

### **National issues of concern:**

- Major topics of discussion included the shortage of emergency room staff in Indian Country
- Tribal input at State Health Officers' meetings
- Cuts to Centers for Disease Control and Prevention's REACH program. Focus: ethnic health disparities

### **Regional issues of concern:**

Regarding the insurance exchange, Mr. Casey Cooper of the Eastern Band of Cherokee Indians said he wanted to go on record with three main points:

- The issue essential community provider. CMS should issue a statement that Tribal providers and the Indian Health Service (IHS) meet the definition so there is no question or debate.
- Section 206 (Section 206 of the IHCIA clearly states that IHS and Tribal providers have the right to bill as though they are in network, regardless of whether they are in network or not, with private insurance. The challenge comes when insurers choose for the IHS or the Tribal provider to be out of network, then they issue payment to the beneficiary.

- The definition of Indian. Cooper expressed the hope that the CMS definition will be the definition used in the interpretation and the application of the provisions of the law.
- Mr. Gunn will look for ways to encourage a conversation with the Department of Veterans Affairs regarding how the Tribes submit claims to the VA as well as issues surrounding payer of last resort. Tribes seek a greater sense of cooperation with the VA, Department of Defense and all agencies and departments connected to the Indian Health Care Improvement Act. RD Gunn has initiated conversations seeking a solution and expects to report his findings by January 2012.
- HHS staff will inform Tribes of State Health Officers' meetings so Tribal representatives can attend regularly. Deputy Regional Health Administrator Sharon Ricks will keep the tribes updated on upcoming state health officer meetings.
- Mr. Gunn will share information about the CDC Tribal Consultation. RD Gunn will debrief CDC officials during his next meeting with them.
- Improve population wellness by investing in children's health with preventative health services and continuing to address such major concerns as diabetes, depression and substance abuse. Ricks will report back to Regional Health Administrator Cobb so that they can explore possible opportunities to support initiatives around the aforementioned maladies.
- Increase emergency room staffing in Indian Country. The RD defers to CMS on this issue.
- Maintain vigilant focus on racial and ethnic health disparities through the CDC's REACH program and other efforts.
- Secure funding for mental health providers, behavioral health services and the expansion of geriatric services. This concern will be channeled to the new SAMSHA office that will open in Region 4 in January 2012. Also, Martha Ketcher, of IHS directed Toedt to contact Elder Care Consultant Dr. Bruce Finke and Behavioral Health Consultant Dr. Pamela Taylor; both are in the IHS Nashville Area. The consolidated report was disseminated to the tribes July 28. Initial requests to review and commit on transcripts was made May 3<sup>rd</sup> with a request to have them returned to the ORD by May 11.

## **REGIONAL VISITS TO TRIBES**

### **Miccosukee Tribe of Indians of Florida, November 2011**

The November 2011 visit to Miccosukee was an opportunity to meet with contract specialist Mr. Albert of the Miccosukee Health Department and representatives of both the Mississippi Band of Choctaw Indians and the Poarch Creek Band of Indians. During the meeting, Candace Fayard, health administrator for the PCBI Health Department, and Merry Irons, representing MBCI Director of Financial Services Donita Stephens, were able to discuss their tribal concerns and issues. The primary issues of both MBCI and PCBI, centered on inclusion in the development of state health exchanges, as well as MBCI's procurement of copies of both the state plan and state waivers. Connections to the lead officials were provided. No further follow-up needed at this time.



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**REGION 5: Chicago**

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## HIGHLIGHTS OF REGION – SPECIFIC ACCOMPLISHMENTS

On March 11, 2011, Acting HHS Regional Director (RD) James Galloway, in partnership with the Midwest Alliance of Sovereign Tribes (MAST), convened the *HHS-MAST 2011 Tribal Workgroup Quarterly Call*, providing the Regional Workplan to address regional issues identified during the Region 5 Tribal Consultation Session. Representatives from HHS RO5 Divisions and Tribal officials from each state participated in the call. HHS RO5 representatives provided Workplan implementation progress reports on issues specific to their programs. Workplan implementation progress reports continued to be provided at the June 27th and Dec. 12th quarterly calls, which also featured a presentation/dialogue on tribal access to Federal Employee Health Benefits (FEHB), a top issue raised at the Consultation Session. On Dec. 2<sup>nd</sup>, new HHS RD Kenneth Munson sent a personalized, introductory letter to each tribal leader, which included the Dec. 12<sup>th</sup> meeting announcement/FEHB update. [See *Top Issues of Concern under Summary of Regional Tribal Consultation Session below.*]

On December 12th, HHS RD Kenneth Munson met with Ho Chunk District 5 Representatives (elected), who represent approximately 3500 non-WI tribal members across the country, on HHS regional programs, as well as on tribal concerns/HHS follow-up regarding the State of Wisconsin's proposed Medicaid waiver/consultation process. Following the RD's meeting, the Representatives met with HHS RO5 Division Officials on health and human services programs/tribal resources.

## SUMMARY OF REGIONAL TRIBAL CONSULTATION SESSION

On January 6<sup>th</sup>, HHS Regional Director Cristal Thomas convened and facilitated the *2011 Tribal Consultation Session*, co-hosted with the Midwest Alliance of Sovereign Tribes (MAST), in Green Bay, WI. Almost 60 officials participated, representing 17 tribes (35 tribal leadership/officials), 3 tribal organizations, and 7 HHS divisions (including 3 IHS-operated tribal health facilities), dialoguing on health and human services issues/concerns/priorities. The Consultation included a session on HHS Tribal Working Groups (including Secretary's Tribal Consultation Workgroup and the Secretary's Tribal Advisory Committee), with Area Tribal Members highlighting the work/outcomes of the groups (as well as serving as Session moderators). Panels were conducted on HHS Human Services Programs, the Affordable Care Act and Health Information Technology. The Consultation Session followed a special MAST meeting, where a resolution was approved to establish an Area Tribal Health Board (2010 Consultation issue).

### Top National Issues of Concern:

- Increased Funding to Address the Level of Need
- More Direct Tribal Funding
- More Grants/Tribal Set Asides
- Tribal Health/Wellness (continue Special Diabetes Funding)
- Affordable Care Act (ACA)/Indian Health Care Improvement Act (IHCA) Implementation- Tribal Access to Federal Employee Health Benefits (FEHB)\*\*\*
- Health Information Technology/Electronic Health Records Implementation \*\*\*
- State Funding/Federal Advocacy on Behalf of Tribes\*\*\*
- Health Disparities/ Need for Native American Data\*\*\*

### Additional Top Region Specific Issue of Concern:

- WI TANF Funding Levels

On February 4, 2011, RD Thomas provided HHS presenters' speeches/powerpoints to tribal participants, as requested, and included regional updates in the transmittal note. Prior to the first quarterly Tribal Workgroup Meeting, a Tribal Councilwoman, who participated in the Consultation Session, shared concerns regarding on-site, tribal elder long-term care support; and on-site, tribal youth substance abuse/alcohol treatment facility. As follow-up, the HHS RD's office provided a list of potential agency and other federal resources for such support, including BIA, HUD and USDA Rural Development. On March 11, 2011, Acting RD Galloway, in partnership with MAST, convened the first *HHS-MAST 2011 Tribal Workgroup Quarterly Call*. The Acting RD and HHS Division Officials highlighted the HHS RO5 Workplan to address regional issues identified at the Consultation Session (Workplan provided in advance of the call), and included implementation progress reports. The Workplan continued to be updated and highlighted during the June 27th and Dec. 12th quarterly calls, which also featured a presentation/dialogue on tribal access to FEHB, a top issue raised at the Consultation Session (the June 27<sup>th</sup> call also included an update on the ACA, another top Consultation issue, by a national HHS official). Throughout the year, key national/regional tribal announcements, particularly ACA/IHCIA implementation updates (including White House Tribal ACA Conference Calls and national HHS ACA meetings/conferences), as well as grant opportunities, were shared with tribal leadership/Consultation participants. [See *RO5 Tribal Workgroup Meetings under Highlights of Region- Specific Accomplishments above.*]

## **TRIBAL DELEGATION MEETINGS**

### **Wisconsin Tribal Health Directors, Wausau, WI, December 14, 2011**

On Dec. 14<sup>th</sup>, HHS RD Kenneth Munson participated in the WI Tribal Health Directors' Meeting in Wausau, WI. Regional HHS CMS and IHS Officials also participated, as well as WI state officials. The discussion included the Affordable Care Act and the WI Medicaid Waiver proposal/tribal consultation. HHS continues to work with tribes on concerns regarding the waiver and tribal consultation.

## **REGIONAL VISITS TO TRIBES**

### **Chicago Urban Health Program, November 28, 2011**

On November 28<sup>th</sup>, HHS RD Kenneth Munson met with Chicago IHS Urban Health Program Leadership and toured the site. Prior to the visit, the Urban Program Director was invited to, and participated in, the HHS Affordable Insurance Exchanges Listening Session in Chicago in September, where he graciously agreed to include an article on *the Affordable Care Act and Benefits for American Indians* in the Program's newsletter, once provided (subsequently featured in the Fall newsletter).

During the November 28<sup>th</sup> meeting, Urban program leadership highlighted the need for working with tribes to promote utilization of services by local tribal members; more HRSA Health Center New Access Points funding/access; more rapid HIV/AIDS testing kits; and, HHS scholarship and loan programs/access. As follow up, the HHS RD's Office facilitated a connection with a Tribal Representative who represents members in IL and in other states outside the Reservation. The RD's Office also provided information responding to the other issues.

### **Saginaw Chippewa Indian Tribe (Michigan), November 30, 2011**

On November 30<sup>th</sup>, RD Kenneth Munson visited the Saginaw Chippewa Indian Tribe, meeting with Tribal Council Member Michele Stanley, President of the Midwestern Alliance of Sovereign Tribes, and other tribal officials. Topics discussed include the Affordable Care Act. RD Munson also toured the Nimkee tribal clinic and the Andawad assisted-living facility. No follow-up needed.

**Stockbridge- Munsee Community Band of Mohican Indians (Wisconsin), December 14, 2011**

On December 14<sup>th</sup>, RD Kenneth Munson visited the Stockbridge-Munsee Community Band of Mohican Indians in Wisconsin, meeting with tribal officials including: the Honorable Robert Chicks, newly-elected President; the Honorable Scott Vele, Stockbridge Munsee Tribal Council Member & MAST Executive Director; and, Health and Wellness Director Greg Duffek. As follow-up, RD Munson will include a 2012 Tribal Consultation Session "Pre-Scope," as recommended by President Chicks.



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**REGION 6: Dallas**

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## **HIGHLIGHTS OF REGION- SPECIFIC ACCOMPLISHMENTS**

Implemented quarterly calls with Region VI tribes to present current HHS information. Calls included Region VI policy experts from HHS Operating Divisions. (Calls were held on October 7, 2010, February 9, 2011, and June 30, 2011).

Compiled and distributed information from all HHS operating divisions every quarter and shared that information with the tribes in order to assist with identifying opportunities for HHS grants and resources. A CD-ROM with HHS policy lead contact information, grants, resources and web sites, training and program information was provided to the Region VI tribes at the Tribal Consultation sessions.

Provided weekly or bi-weekly Affordable Care Act emails to tribes.

Provided quarterly meetings with HHS Regional Internal Tribal Workgroup policy experts to inform each other and the ORD of important activities, issues of concern, and opportunities for program collaboration with Region VI tribes. Workgroup discussions identified several tribal needs concerning identifying and writing grants that Region VI has been able to address. These include HRSA staff developing technical assistance sessions for tribes to begin in 2012, and a grant template that was developed by Region VI ACF staff in order to facilitate and encourage grant submissions from tribes for Title IV-B child welfare programs. As a result, there are sixty-four of sixty-seven eligible tribes in Region VI that have Title IV-B child welfare grants. The individual that developed the template received Honorable Mention through the HHS Innovates Awards initiative for their work.

## **SUMMARY OF REGIONAL TRIBAL CONSULTATION SESSIONS**

Region VI participated in 3 Tribal Consultations: February 24 in Oklahoma City, Oklahoma (Regions VI and Region VII) for the IHS Oklahoma City Area and IHS USET Tribes; April 26, 2011 at the Navajo Nation in Window Rock, Arizona (Regions VI, VIII and IX); and April 28, 2011 in Albuquerque, New Mexico (Region VI and Region VIII) for the IHS Albuquerque Area Tribes.

Each consultation was attended by tribal leaders and representatives, HHS policy experts and state health and human services officials. Tribal representatives were given the opportunity to present programmatic issues and overall concerns of Tribes at the local level. HHS Region VI Director Marjorie Petty served as co-moderator for each of the consultation sessions on February 24, April 26 and April 28.

### **Tribal Consultation Session, Oklahoma City, Oklahoma, February 24, 2011**

The RD's Petty (Region VI) and Baker (Region VII) worked with Oklahoma, Kansas, and the USET tribes to organize a Tribal Consultation session for tribes. The consultation was held in Oklahoma City, Oklahoma. There were 73 participants with 25 tribes represented. Lt. Governor Jefferson Keel, Chickasaw Nation, along with HHS Region VI Director Marjorie Petty served as co-moderators for the morning sessions; and Chairman Steve Ortiz, Prairie Band Potawatomi Nation, and HHS Region VII Director Judy Baker served as co-moderators for the afternoon sessions.

Topics of discussion included: Affordable Care Act; Aging, Family and Human Services Issues; Health, Wellness and Behavioral Health; Tribal State Relations; and Indian Health Service Budget and Priorities.



### **Top 10 Issues of Concern**

1. Authorization of Indian healthcare units as community health centers so they can manage vaccinations without having to go through the state.
2. Deployment of Commissioned Corp personnel to Indian country.
3. Redesign of contract health care and timeliness of referrals.
4. Recommendation to return to FY 2008 funding levels only as a last resort.
5. Concern about the significant reduction in the Indian Health Services' facilities budget over the years.
6. Concern about contract support costs for indirect costs.
7. Concern about inequities in the Indian Health care Improvement Fund.
8. Opposition to means testing.
9. Request for more mental health dollars/resources.
10. Implementation of the ACA and ensuring that Tribes can participate in opportunities.

### **Tribal Consultation Session, Window Rock, Arizona, April 26, 2011**

The RD's Petty (Region VI), Salazar (Region VIII) and Schultz (Region IX) hosted a Tribal Consultation Session for the Navajo Nation in Window Rock, Arizona. The Navajo Nation covers four states and the nation works with three HHS regional offices on policy and program concerns. There were 150 participants at the session. Topics of discussion included: Education and Social Services programs, Tribal, State, and Federal Relations, Health programs, Aging, Veterans, and Special Populations, innovative technologies and the pending development of a health IT disparities plan.

### **Top 10 Issues of Concern**

1. Proposed budget cuts and the double impact of health cuts to IHS and to CMS Medicaid.
2. Implementation of the ACA and ensuring that Tribes can participate in opportunities
3. The need for additional health care facilities
4. Updating of existing health care facilities
5. Suicide and mental health services funding and support and funding for health care services.
6. Webinars and Internet access to HHS information was also emphasized as non-efficient due to sporadic Internet technology in rural and remote tribal areas.
7. There are concerns about small Tribe's ability to be heard and Tribe's general ability to compete against states for funds.
8. A memorandum of agreement is needed between the Veterans Administration (VA) and local tribes.
9. Setting aside grants for Tribes and technical assistance in grant writing.
10. HHS funding formulas do not work for Tribes.

### **Tribal Consultation Session, Albuquerque, New Mexico, April 28, 2011**

The RD's Petty (Region VI) and Salazar (Region VIII) worked with New Mexico and Colorado tribes to organize a Tribal Consultation Session for tribes. The RD's Petty (Region VI) and Salazar (Region VIII) hosted a Tribal Consultation session for the New Mexico and Colorado tribes served by the Albuquerque Indian Health Service. The consultation was held in Albuquerque, New Mexico. There were 92 participants with 23 tribes represented. Gary Hayes, Chairman, Ute Mountain Tribal Council, along with HHS Region VIII Director Marguerite Salazar served as co-moderators for the morning sessions; and Council Member Ken Lucero, Pueblo of Zia, and HHS Region VI Director Marjorie Petty served as co-moderators for the afternoon sessions. Topics of discussion included: Tribal, Federal and State Relations: Affordable Care Act & Indian Health Care Improvement Act; Health and Behavioral Health; Family and Human

Services Issues; Aging and Long-Term Care Issues; and an Indian Health Service update about new authorities under IHCA.

### **Top 10 Issues of Concern**

1. Need for full Indian Health Service funding
2. Need for funds to operate clinics, build facilities, and obtain equipment
3. Concern about suicide and alcohol abuse, especially among youth
4. Need for mental and behavioral health resources
5. Technical assistance and grants support
6. Education about tribal sovereignty
7. Education about tribal living conditions on reservations
8. Eliminating indirect costs for tribes
9. Proposed budget cuts and the double impact of health cuts to IHS and to CMS Medicaid.
10. Implementation of the ACA and ensuring that Tribes can participate in opportunities

## **TRIBAL DELEGATION MEETINGS**

### **IHS Tribal Consultation, November 5, 2010**

The RD provided remarks that focused on the Secretary's Tribal Advisory Council, updates on tribal consultation, the Affordable Care Act, National Prevention Strategy and regional tribal outreach activities. The meeting included participation from leaders representing twenty-five Oklahoma and Kansas tribes and one Texas tribe. Present at the meeting was Dr. George Howell of the Nation of Oklahoma. Dr. Howell is a member of the HHS Tribal-Federal Work Group focusing on Tribal Consultation. Also present were two former Indian Health Service directors, Dr. Charles Grim and Dr. Everett Rhoades.

### **Tribal Child Care and Development Fund (CCDF) grantee meeting, December 9, 2010**

The meeting was sponsored by the HHS Office of Child Care and the Tribal Child Care Technical Assistance Center. The RD's remarks centered on the Health Care Law, the Secretary's Tribal Advisory Committee and upcoming regional Tribal Consultation sessions.

### **Suicide Prevention Summit, Oklahoma City, Oklahoma, December 13, 2010**

The meeting was co-sponsored by the Cherokee Nation and SAMHSA and included Indian Health Service leadership. Approximately twenty tribes from throughout Oklahoma participated in the summit.

### **Tribal Suicide Prevention Summit, Albuquerque, New Mexico, January 10, 2011**

The meeting was sponsored by the Albuquerque Area Indian Health Service at the National Indian Programs Training Center. Approximately twenty-five tribes participated.

### **Tribal Medical Child Support Meeting, Tulsa, Oklahoma, March 10, 2011**

Region VI Director Petty participated in and provided welcome remarks during a Region VI and VIII meeting held in Tulsa, Oklahoma. The meeting was hosted by the Administration for Children and Families and centered on ways to increase child access to health services and enrollment in health insurance like Medicaid and CHIP. The meeting also focused on tribal child support programs and medical support policies. The RD's remarks focused on the Affordable Care Act and its upcoming anniversary, Healthcare.gov, and Region VI tribal activities. The RD provided information for the participants including Region VI policy staff contact information, grant opportunities, listserv and other HHS resources available to tribes.

**New Mexico Indian Affairs Department, March 25, 2011**

During the visit, the RD discussed the Affordable Care Act and its provisions for Native Americans and an upcoming HHS Tribal Consultation to be held in Albuquerque, New Mexico.

**Albuquerque Area Indian Health Service Consultation, Albuquerque, New Mexico, March 30-31, 2011**

The RD delivered welcome remarks and provided the tribal leaders with information about the April 28 HHS Tribal Consultation, Region VI staff contact information, funding opportunities and other resource material. Fifteen Region VI tribes participated in the meeting.

**HHS Tribal Head Start Consultation, Albuquerque, New Mexico, April 29, 2011**

Region VI Director Petty and ACF Regional Administrator Leon McCowan participated in an HHS Tribal Head Start Consultation. Approximately 60 tribes participated in the meeting.

**IHS Tribal Consultation, Oklahoma City, Oklahoma June 3, 2011**

Region VI Executive Officer Julia Lothrop attended an. During the event, the EO provided current information about the Affordable Care Act and PCIP.

**Oklahoma City Area Inter-Tribal Health Board, July 26-27, 2011**

Region VI Director Marjorie Petty participated in an Oklahoma City Area Inter-Tribal Health Board meeting. The RD was able to visit with Thomas John, Chairman, Oklahoma City Area Inter-Tribal Health Board; Oklahoma Area Epidemiology Manager Tom Anderson and his staff; officials with the Oklahoma Department of Health; Dr. Kristy Bradley, State Epidemiologist with the Oklahoma Department of Health; Pam Iron with the National Indian Women's Health Resource Center, and tribal health leaders from throughout the state. Approximately 50 people participated in the meeting.

**Affordable Care Act and Health Exchanges Listening Session, September 7, 2011**

Region VI Director Marjorie Petty participated with Region VII and IX Regional Directors Marguerite Salazar and Herb Schultz for a tribal listening session with tribal officials focusing on the Affordable Care Act and Health Exchanges. The meeting was held in Denver, Colorado, and Washington IHS and CClIO leaders provided the presentations.

**REGIONAL VISITS TO TRIBES****Chitimacha Tribe, November 12, 2010**

Region VI Director Petty met with health officials at the Chitimacha Tribe. The RD met with Tricia Mora, Division Administrator for Social Services, along with the Executive Officer/Tribal Manager, Clinic Director, and the Director of Health and Human Services. During the meeting, the RD spoke about the Affordable Care Act, Healthcare.gov, the Secretary's Tribal Advisory Council, updates on tribal consultation, National Prevention Strategy and regional tribal outreach activities.

**Coushatta Tribe, November 12, 2011**

The Region VI Director (RD) Petty met with tribal officials with the Coushatta Tribe in Elton, Louisiana. RD was able to meet with Paula Manual, Clinic Director; Milton Hebert, Director for Social Services; the Director of Nursing, and the individual in charge of converting the tribal clinic's medical records to electronic files. During the meeting, the RD spoke about the Affordable Care Act, Healthcare.gov, the Secretary's Tribal Advisory Council, updates on tribal consultation, National Prevention Strategy and regional tribal outreach activities. The RD and

tribal officials also discussed extensively a Tribal Just Move It program started by the Zuni Tribe a few years ago that is very similar to the Let's Move Initiative.

#### **Jemez Pueblo Health Clinic, November 15, 2010**

Region VI Executive Officer Lothrop and Regional Outreach Specialist Stella Chávez joined Luis Rosero, HHS Deputy Assistant Secretary, Office of Public Affairs for a visit to the Jemez Pueblo Health Clinic in New Mexico. The HHS officials were able to fully tour the clinic and its pharmacy while discussing physician recruitment, services and funding. The Pueblo has a Communities Putting Prevention to Work grant, which has propelled them to create a community garden that provides snacks for the school children. They have integrated fitness and exercise in the school schedule and have been emphasizing nutrition and wellness. The Pueblo has a fitness center that has been creative in its programming and has increased participation. They have also sponsored organized bike rides and runs to encourage a spirit of competition and culture of fitness. In addition to touring the location, the HHS officials had the opportunity to meet with all of the directors of health services.

#### **Alabama-Coushatta Tribe, January 13, 2011**

Region VI Director Petty met with officials with the Alabama-Coushatta Tribe in Livingston, Texas. During the meeting the RD discussed the upcoming tribal consultations, the Let's Move initiative, and was introduced to the staff and program sites for Head Start and the service operations.

#### **Navajo Nation, April 27, 2011**

Region VI Director Petty joined Region VIII and IX Directors Salazar and Schultz for a tour of Navajo services sites. Also joining the tour was Jay Angoff, Senior Advisor to the Secretary and Navajo leaders. The group visited the Crownpoint Program for Self-Reliance where they met Navajo staff and toured the facility. They also met with the Crownpoint Child Care Development Fund staff and toured that location. The Smith Lake Head Start visit provided an opportunity to see the facility. During the visit Navajo children dressed in ceremonial attire provided a Navajo culture and language presentation. The group stopped at the Thoreau Community Center to meet with staff and tour that facility. Finally, the HHS officials visited the Thoreau Indian Health Service Clinic where they were able to see the health care services provided for Navajo patients at this location. The visits were most informative and helped HHS officials to recognize the challenges of providing services in rural and remote areas.

#### **Cheyenne and Arapaho Wellness Clinic, May 10, 2011**

Region VI Director Petty met with Chris Tall Bear, Director of the Cheyenne and Arapaho Wellness Clinic, Dakota Robinson, Acting Project Manager for the Diabetes Wellness Program, the director of substance abuse programs, the director of wellness programs, outreach educators, wellness coordinators and other clinic staff. The meeting was held in Concho, Oklahoma. During the meeting the RD was able to tour the clinic and learn about their programs. The clinic serves all tribes and has a wellness and outreach program for children and families, including outreach to Head Start families. After-school wellness and nutrition services were highlighted. The clinic offers obesity and diabetes screening for Head Start children, along with education classes focusing on wellness for parents. A fitness center offers a wide-variety of fitness equipment and activities and includes extended hours and evening classes. The tribe is raising buffalo which can be provided as meat for free to those who engage in wellness center activities. The clinic also offers outpatient drug and alcohol services.

**Inter-Urban Tribal Center, August 2, 2011**

Region VI Director Marjorie Petty and Region VI HRSA management and staff visited the Inter-Urban Tribal Center in Dallas, Texas. During the meeting the RD met with the medical director, executive director and staff and toured the tribal clinic.



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**REGION 7: Kansas City**

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## **HIGHLIGHTS OF REGION-SPECIFIC ACCOMPLISHMENTS**

Region VII Director Baker emphasized throughout 2011 the importance of providing the tools and resources of grant writing to the tribes located in Region VII. In collaboration with the regional Office of the CAPT Jose Belardo, Regional Health Administrator, Assistant Secretary for Health (OASH), the LCDR Tracy Branch, Office on Minority Health and Resource Center, the University of Nebraska Medical Center, and the Missouri Foundation for Health Region 7 conducted six grant training and technical assistance workshops in 2011. Twenty-three tribally affiliated individuals attended these sessions. Tribal leaders were also made aware of sessions planned by other federal agencies such as Housing and Urban Development.

## **SUMMARY OF REGIONAL CONSULTATION SESSIONS**

### **Tribal Consultation Session, Oklahoma City, Oklahoma, February 23, 2011**

On February 24, Region VII Director Baker traveled to Oklahoma City, Oklahoma, to co-facilitate with Region VI Director Petty, the Region VI & VII Tribal Consultation Session. There were approximately 80 in attendance with Tribal representation from both regions. Regional representatives at the session were from Administration on Aging, Agency for Toxic Substances and Disease Registry, Administration for Children and Families, Centers for Medicare and Medicaid Services, Indian Health Service, Substance Abuse and Mental Health Services Administration, and Office of the Assistant Secretary for Health. They provided technical assistance and comments, and also anchored the panels during the session. Also in attendance and providing comments were Jay Angoff, Senior Advisor to the Secretary, and Cindy Padilla, Principal Deputy Assistant Secretary on Aging. Jefferson Keel, Lieutenant Governor, Chickasaw Nation and Steve Ortiz, Chairman, Prairie Band Potawatomi Nation, assisted the Regional Directors in moderating the session.

### **The 10 Region specific issues**

1. Ms. Petty to complete her visits of all Region VI Tribes' land by the end of 2011.
2. Ms. Petty to continue to be a conduit between Tribes and regional and national level officials to get Tribal issues solved.
3. Ms. Baker to continue Region VII quarterly calls with Tribes.
4. Substance Abuse and Mental Health Services Administration (SAMHSA) to have a regional presence in Region VII.
5. The continuation of Region VII grants writing workshops for Tribes.
6. Commitment to working better with state partners in health, improving state relationships, and incorporating state partners who are critical to the mission of Region VII operations.
7. Push for economic development and new models of care.
8. STAC full meeting on March 1, 2011.
9. HHS Budget and Policy Consultation Meeting on March 3-4, 2011, with anticipated aggregate funding amounts to Tribes going back to the 2008 funding level.
10. Encouragement to Tribes that can afford to do so, to buy into group insurance.

### **Consolidated report & Progress on issues**

The consolidated report (Region VI and VII) executive summary was forwarded to the tribes and HHS Tribal Workgroup on April 28, 2011. RD Baker reports on Quarterly calls progress on the following issues:

1. Substance Abuse and mental Health Services Administration (SAMHSA) regional presence will start in Fall of 2011.
2. Free grant writing training session announcements throughout the summer and fall of 2011. Sessions were sponsored by the U.S. Department of Housing and urban Development and the Office of Minority Health. The dates and locations were: June 22-

23 in Topeka, KS; June 29-30 in Osage Beach, MO; July 26-27 in Lincoln, NE; October 17-18 in Scotts Bluff, NE; October 20-21 in Sioux City, IA; and October 24-25 in St. Louis, MO.

3. Tribal Outreach Calls on the Affordable Care Act were organized by the Stacey Ecoffey, Principal Advisor for Indian Affairs, Intergovernmental External Affairs. The monthly call information is forwarded to tribal leaders and members of the HHS regional tribal workgroup.

### **Tribal Consultation Session, Rapid City, South Dakota, March 24, 2011**

On March 24, Region VII Director Baker traveled to Rapid City, South Dakota, to co-facilitate with Region VIII Director Salazar, the Region VII & VIII Tribal Consultation Session. There were approximately 100 in attendance with Tribal representation from both regions. Regional representatives at the session were from Administration on Aging, Agency for Toxic Substances and Disease Registry, Administration for Children and Families, Centers for Medicare and Medicaid Services, Indian Health Service, Substance Abuse and Mental Health Services Administration, and Office of the Assistant Secretary for Health. They provided technical assistance and comments during the session. Also in attendance and providing comments were Stacey Ecoffey, HHS Tribal Intergovernmental Affairs, Cindy Padilla, Principal Deputy Assistant Secretary on Aging, and Yvette Roubideaux, Director, Indian Health Services. In addition, Cecilia Fire Thunder, Oglala Sioux Tribe, and Roger Trudell, Chairman, Santee Sioux Tribe, assisted in moderating the sessions and provided opening prayers and welcome remarks. Also in attendance was Zach Nelson of Senator Ben Nelson's (D-NE) office.

### **The 10 Region specific issues**

1. Commitment to hold four consultations for Region VIII.
2. Ms. Baker to continue her visits to Region VII Tribes' land.
3. Regional Directors to be more prominent in Tribal communities.
4. Regional quarterly conference calls for Tribes.
5. Follow-up on issues from the previous year's consultation report.
6. Monthly conference calls on the ACA.
7. Quarterly reports on the ACA activities/updates.
8. Listening sessions on the ACA.
9. ICNAA to address Tribal access to grants.
10. Educating reviewers on what to look for in Tribal grants.

### **Consolidated report & Progress on issues**

The consolidated report (Region VII and VIII) executive summary was forwarded to the tribes and HHS Tribal Workgroup on June 8, 2011. RD Baker reports on Quarterly calls progress on the following issues:

1. Substance Abuse and mental Health Services Administration (SAMHSA) regional presence will start in fall of 2011.
2. Free grant writing training session announcements throughout the summer and fall of 2011. Sessions were sponsored by the U.S. Department of Housing and Urban Development and the Office of Minority Health. The dates and locations were: June 22-23 in Topeka, KS; June 29-30 in Osage Beach, MO; July 26-27 in Lincoln, NE; October 17-18 in Scotts Bluff, NE; October 20-21 in Sioux City, IA; and October 24-25 in St. Louis, MO.
3. RD Baker visits to all tribal offices in the summer of 2011.



Tribal Outreach Calls on the Affordable Care Act were organized by the Stacey Ecoffey, Principal Advisor for Indian Affairs, Intergovernmental External Affairs. The monthly call information is forwarded to tribal leaders and members of the HHS regional tribal workgroup.

## **TRIBAL DELEGATION MEETINGS**

### **CMS Kansas Tribes Meeting, June 2011**

On June 24, Region VII Director Baker participated in the CMS Tribal Meeting with Kansas Tribes. Director Baker met with about 25 Kansas Tribal leadership and staff to make remarks and facilitate discussions on Health Insurance Exchanges, Early Innovator Grants, and other ACA updates related to Tribes. Sandy Praeger, Kansas Insurance Commissioner, Barbara Langner Medicaid Director, Kansas Health Policy Authority, Nancy Rios, Native American Contact, Centers for Medicare & Medicaid Services and Kevin Meeks, Director, Oklahoma Indian Health Service also attended the meeting and provided remarks.

### **Governor Brownback Native American Tribal Liaison, September 2011**

On September 1, Region VII Director Baker Judy met with Chris Howell, the Kansas Native American Tribal Liaison, recently appointed by Kansas Governor Sam Brownback. Director Baker discussed the Native American Exchange meetings, invited him to the next Senior Staff meeting, and future collaborative opportunities.

### **Consultation with Chairman John Blackhawk, Winnebago Tribe of Nebraska, October 2011**

On October 22, Region VII Director Baker spoke with Chairman John Blackhawk, Winnebago Tribe of Nebraska regarding a Conditions of Participation determination from CMS. She updated him on the technical assistance efforts CMS is providing to the Aberdeen Area and IHS.

## **REGIONAL VISITS TO TRIBES**

### **Iowa Tribe of Kansas & Nebraska, March 2011**

On March 10, Region VII Director Baker traveled to White Cloud, Kansas to meet with newly elected Chairman Tim Rod of the Iowa Tribe of Kansas & Nebraska. Director Baker provided an ACA overview and listened to the Tribal Council's concerns regarding the need for a physician on staff and assistance with grant writing. Director Baker also toured the tribal health clinic

### **Iowa Tribe of Kansas & Nebraska, May 2011**

On May 4, Region VII Director Baker traveled to White Cloud, Kansas, to meet with the Chairman of the Iowa Tribe of Kansas & Nebraska. Director Baker discussed the recent tribal consultation, HIE consultation in KS, and their provider situation. She also provided information about upcoming training as well as ACA updates related to Tribes. Regional staff from ACF and CMS traveled with Director Baker and provided programmatic updates to the Chairman including Asset for Independence and TTAG activities.

### **Sac & Fox Nation of Missouri, May 2011**

On May 4, Region VII Director Baker traveled to Reserve, Kansas, to meet with the Vice Chairwoman of the Sac & Fox Nation of Missouri. Director Baker discussed the recent tribal consultation and HIE consultation in KS. She also provided information about upcoming training as well as ACA updates related to Tribes. Regional staff from ACF and CMS traveled with Director Baker and provided programmatic updates to the Chairwoman including Asset for Independence and TTAG activities.

### **Haskell Indian Nations Health Clinic, May 2011**

On May 5, Region VII Director Baker traveled to Lawrence, Kansas, to meet with the Acting CEO for Haskell Indian Nations Health Clinic. Items discussed included a possible consortium around maternal child health, PCIP in KS, and HIE consultation in KS.

### **Prairie Band Potawatomi Nation, May 2011**

On May 5, Region VII Director Baker met with Chairman Steve Ortiz, in Mayetta, Kansas, to discuss issues related to the Prairie Band Potawatomi Nation. Director Baker discussed the recent tribal consultation and the formation of a tribal workgroup for HIE consultation in KS. She provided information about upcoming training as well as ACA updates related to Tribes. Regional staff from ACF and CMS traveled with Director Baker and provided programmatic updates to the Chairman including Asset for Independence and TTAG activities.

### **Kickapoo Nation May 2011**

On May 5, Region VII Director Baker traveled to Horton, Kansas, to meet with the Chairman of the Kickapoo Nation. Director Baker discussed the recent tribal consultation and the formation of a HIE tribal workgroup in Kansas. She also provided information about upcoming training as well as ACA updates related to Tribes. Regional staff from ACF and CMS traveled with Director Baker and provided programmatic updates to the Chairman including Asset for Independence and TTAG activities.

### **Sac & Fox Nation of the Mississippi in Iowa, May 2011**

On May 24, Region VII Director Baker traveled to Tama, Iowa, to meet with Chairman Pushetonequa and other Council Members of the Sac & Fox Nation of the Mississippi in Iowa. Director Baker discussed the recent tribal consultation and provided information about upcoming training and ACA updates related to Tribes as well as programmatic updates including Asset for Independence, HITECH incentives and TTAG activities.

### **Omaha Tribe of Nebraska, June 2011**

On May 31, Region VII Director Baker traveled to Macy, Nebraska and met with Chairman Amen Sheridan of the Omaha Tribe of Nebraska. Director Baker discussed the recent tribal consultation, the quarterly tribal call, provided upcoming training information and ACA updates related to Tribes. Regional staff from ACF and CMS traveled with Director Baker and provided programmatic updates to the Chairman.

### **Winnebago Tribe of Nebraska, June 2011**

On May 31, Region VII Director Baker traveled to Winnebago, Nebraska and met with Chairman John Blackhawk of the Winnebago Tribe of Nebraska. Director Baker discussed the recent tribal consultation, the quarterly tribal call, provided upcoming training information and ACA updates related to Tribes. Regional staff from ACF and CMS traveled with Director Baker and provided programmatic updates to the Chairman.

### **Santee Sioux Nation, June 2011**

On June 1, Region VII Director Baker traveled to Niobrara, Nebraska and met with tribal leadership of the Santee Sioux Nation. Director Baker discussed the recent tribal consultation, the quarterly tribal call, provided upcoming training information and ACA updates related to Tribes. Regional staff from ACF and CMS traveled with Director Baker and provided programmatic updates to the Chairman.

**Ponca Tribe of Nebraska, June 2011**

On June 1, Region VII Director Baker traveled to Omaha, Nebraska and met with Chairwoman Rebecca White of the Ponca Tribe of Nebraska at the Fred Leroy Health Center. Director Baker toured the clinic, discussed the recent tribal consultation, the quarterly tribal call, provided upcoming training information and ACA updates related to Tribes. Regional staff from ACF and CMS traveled with Director Baker and provided programmatic updates to the Chairwoman.



**United States Department of Health & Human Services  
2011 Annual Tribal Consultation Report**

**REGION 8: Denver**

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## **HIGHLIGHTS OF REGION-SPECIFIC ACCOMPLISHMENTS**

Strengthened relationships with individual tribes, especially the Navajo Nation. This included more region-specific Tribal Consultations, and site visits to the Navajo Nation Head Start Program and the early childhood development center.

Identified and strengthened relationships with urban Indian organizations, which is especially important since there are over 40,000 urban Indians in Denver.

Supported the Heal Resource and Services Administration application for the Denver Indian Health Clinic, which was received.

Identified and met with the Two-Spirit Leaders in Region VIII, specifically those who live in Denver, and have begun to include them in discussions targeting the LGBT community and the National HIV/AIDS Strategy.

Set up quarterly calls with the Indian Health Boards in Region VIII.

Participated as the Regional Director Representative to the Intra-departmental Council on Native American Affairs.

Gathered input from all of the Regional Directors across the country to make improvements to the Tribal Consultation process.

## **SUMMARY OF REGIONAL CONSULTATION SESSIONS**

Region VIII participated in 4 Tribal Consultations: March 10, 2011 in Las Vegas, NV (Region IX and Region VIII); March 24, 2011 in Rapid City, SD (Region VII and Region VIII); April 26, 2011 in Window Rock, AZ (Navajo Nation); and April 28, 2011 in Albuquerque, NM (Region VI and Region VIII).

Each consultation was attended by tribal representatives and chairs, HHS representatives, other federal agencies, state officials, representatives of congressional field offices, and public interest groups. Tribal representatives were given the opportunity to present programmatic issues and overall concerns of Tribes at the local level. Marguerite Salazar, RD for Region 8 served as co-moderator for the sessions on March 10, March 24, and April 28.

### **Top 10 Issues of Concern**

1. Implementation of the ACA and ensuring that Tribes can participate in opportunities.
2. The double impacts of health cuts to IHS and to CMS Medicaid AHCCCS.
3. There are concerns about small Tribe's ability to be heard and Tribe's general ability to compete against states for funds.
4. A memorandum of agreement is needed between the Veterans Administration (VA) and local tribes.
5. Concerns about the identification required to receive medical services.
6. Increased funding to strengthen IHS facilities and Contract Health Services (CHS) to support mental health, alcohol, and substance abuse programs; as well as funding for treatment, wellness, oral health, and fitness centers.
7. Setting aside grants for Tribes and technical assistance in grant writing.
8. Tribes would like to request a serious conversation about becoming the 51<sup>st</sup> state.
9. HHS funding formulas do not work for Tribes.
10. Equal distribution of funds for IT technology.

## **TRIBAL DELEGATION MEETINGS**

### **Utah Indian Health Advisory Board, January 6, 2011**

This meeting included a brief discussion of the upcoming tribal consultation sessions, and a discussion about the new benefits in the Affordable Care Act.

### **Native American Health Council Forum, June 22, 2011**

This meeting focused on how to get beyond barriers to get eligible Native Americans enrolled in Medicaid and other programs.

### **Pathways Conference, August 10, 2011**

Region VIII Director Salazar presented about the Affordable Care Act and the Indian Healthcare Improvement Act at the in Pathways Conference in Greeley, CO. This event included local Tribal Officials and organizations that work with Native Americans.

### **Utah Native American Summit , August 30, 2011**

Region VIII Director Salazar presented about the Affordable Care Act and the Indian Healthcare Improvement Act at the in Salt Lake City.

### **Tribal Exchange Listening Session, September 7, 2011**

Region VIII Director Salazar participated in the listening session held in Denver, Colorado.

### **Sioux Health Summit, October 5-6, 2011**

Region VIII Director Salazar participated in the session held in Rapid City, South Dakota as well as training for providers on serving Two Spirit people.

## **REGIONAL VISITS TO TRIBES**

### **Native American Cancer Research Center, February 23, 2011**

Region VIII Director Salazar met with Brenda Seals, the Director of the Native American Cancer Research Center. She toured the Cancer Research Center, and discussed the needs of Native Americans and their families, when they travel to Denver for cancer treatment.

### **Denver Indian Resource Center, February 23, 2011**

Region VIII Director Salazar met with Jay Grimm, the Executive Director of the center. She also toured the Resource Center and discussed the health needs of the American Indians served at the Center, and other services provided.

### **Denver Indian Family Resource Center, February 24, 2011**

Region VIII Director Salazar met with John Jewett, the Executive Director of the center. She also toured the facility and discussed programs and services provided to Native Americans.

### **Denver Indian Health and Family Services, February 28, 2011**

Region VIII Director Salazar toured and visited with leadership and staff to discuss programs and services provided, and areas of need for the Center.

### **Caring Association for Native Americans, February 28, 2011**

Region VIII Director met with Blanche Zembower, the Director of the Caring Association for Native Americans. Director Salazar learned about the services provided to families visiting Denver to receive health care services.

**Working Dinner with Navajo Nation Vice President Rex Jim Lee, April 25, 2011**

Immediately prior to the Navajo Nation Consultation, Regional Directors from Regions VI, VIII, and IX dined with Navajo Nation Vice President Rex Jim Lee and senior Navajo Nation representatives/program leaders to discuss issues of specific concern to the Navajo Nation and to prepare for the Navajo Nation Consultation.

**Navajo Nation Tour, April 27 - 28, 2011**

Immediately after the Navajo Nation Consultation, Regional Directors from Regions VI, VII, and IX toured health care facilities in the Navajo Nation with the Nation's Leaders and various HHS officials. The tour included visits to the Navajo Nation cities of Window Rock, Crownpoint, Smith Lake, and Thoreau. The tour included meetings with officials, program administrators, and participants in the programs. The tour was led by newly-elected Navajo Nation Vice President Rex Jim Lee.



**United States Department of Health & Human Services  
2011 Annual Tribal Consultation Report**

**REGION 9: San Francisco**

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## **HIGHLIGHTS OF REGION-SPECIFIC ACCOMPLISHMENTS**

Tribal relationships in Region IX continued to be a priority for the Regional Director's office in 2011. Regional Director (RD) Herb K. Schultz remains committed to ensuring Region IX continues to engage in and enhance regular communication with tribal leadership throughout the Region. RD Schultz has made regular use of the Region IX tribal stakeholders email distribution list by developing and emailing weekly bulletins regarding the implementation of the Affordable Care Act, other HHS related news, and funding opportunities. The distribution list includes Tribal leadership and members, health and social service directors, and Indian Health Service (IHS) staff.

Communication with Tribal organizations in Region IX has occurred regularly. In addition to the numerous consultations, site visits, and delegation meetings documented in the following pages, RD Schultz has engaged in numerous individual communications with key Tribal leaders and Tribal organizations in Region IX throughout 2011. These communications frequently take the form of technical assistance, and Tribal leaders in the Region are increasingly relying on Region IX leadership as a valuable asset and resource.

In addition to regular communications outside the Federal government, RD Schultz also uses his chairmanship of the of both the HHS Regional Management Council (RMC) and the Federal Regional Council (FRC) to discuss and troubleshoot cross-cutting Tribal policy issues with the other federal Departments and Agencies represented on the RMC and FRC.

Region IX will build upon the foundation of strong relationships RD Schultz has built in the past two years to carry-out extensive technical assistance, consultation, and relationship development in 2012.

## **SUMMARY OF REGIONAL CONSULTATION SESSIONS**

Region IX participated in three Tribal Consultations: March 10, 2011 in Las Vegas, NV (Region IX and Region VIII, and Utah), April 26, 2011 in Window Rock, AZ (Navajo Nation, Regions VI, VIII, and IX), and August 22 in Seattle, WA (Region IX and X).

Each consultation was attended by tribal representatives and chairs, HHS representatives, other federal agencies, state officials, representatives of congressional field offices, and other public interest groups. Tribal representatives were given the opportunity to present programmatic issues and present overall concerns Tribes had at the local level.

Tribal representatives were given the opportunity to present on issues and concerns related to their tribes. HHS Regional program administrators were on hand to answer any program related questions posed by tribal leaders.

### **Top Issues of Concern**

1. Implementation of the ACA and ensuring that Tribes can participate in opportunities.
2. Necessity of 100 percent federal Medicaid reimbursement for optional benefits.
3. The double impacts of health cuts to IHS and Medicaid approved or being seriously considered by CMS.
4. There are concerns about the ability of smaller Tribes to be heard and Tribes general ability to compete against states for funds.
5. A desire for a memorandum of agreement between the Veterans Administration (VA) and local tribes.

6. Concerns about the identification required to receive medical services.
7. Increased funding to strengthen IHS facilities and Contract Health Services (CHS) to support mental health, alcohol, and substance abuse programs; as well as funding for treatment, wellness, oral health, and fitness centers.
8. Request that specific grants be set aside for Tribes on technical assistance in grant writing.
9. Tribes request a conversation about becoming the 51<sup>st</sup> state.
10. HHS funding formulas do not work for Tribes.
11. Equal distribution of funds for IT technology.

### **August 22 (Region IX and X Affordable Care Act Tribal Consultation on Exchanges)**

- Region IX Director Schultz and Region X Director Johnson attended the Affordable Care Act Tribal consultation in Seattle to discuss eligibility expansions in the notice of proposed rulemaking (NPRM) under the ACA and affordable insurance exchanges.
- Each of the presenters provided short educational sessions as a preface to each discussion. Speakers included:
  - Ken Lucero, Chair Secretary's Tribal Advisory Committee Councilman, Zia Pueblo
  - Stacey Ecoffey, Principal Advisor for Tribal Affairs, Office of Intergovernmental and External Affairs
  - Mayra Alvarez, Director of Public Health Policy, Office of Health Reform
  - Pete Nakahata, Senior Policy Advisor, Center for Consumer Information and Insurance Oversight (CCIO), CMS
  - Helen H. Morrison, Department of the Treasury (IRS), Deputy Benefits Tax Counsel

## **TRIBAL DELEGATION MEETINGS**

### **California Tribal and Urban Indian Health and Social Service Directors' Meeting, January 19, 2011**

Region IX Director Schultz conducted a presentation in Sacramento on implementation of the ACA, its impact on the Native American community, and opportunities for collaboration and partnership at an IHS meeting with Tribal Nations and programs.

### **Tribal Nations and Urban Programs (California), March 31, 2011**

Region IX, led by Health Services Resource Administration (HRSA), hosted a day-long technical assistance and training workshop for Tribal leaders and program directors on federal and state resources for health centers. RD Schultz and Regional HRSA staff provided an overview of the ACA and its impact on Tribes. Topics included:

- Resources to develop and improve health centers
- HRSA Federally Qualified Health Center (FQHC) funding
- HRSA and state services to support primary care services in California, including workforce, and rural programs

### **Inter-Tribal Council of Arizona (ITCA), April 28, 2011**

Region IX Director Schultz convened, in coordination with the ITCA, a meeting in Tucson, Arizona with Arizona Tribal Nations to discuss the state Medicaid program, Arizona Health Care Cost Containment System (AHCCCS), proposed new waivers, and benefit changes that could impact health care for Native Americans. Attendees and presenters included Tom Betlach, Director of AHCCCS, Directors from three IHS Area Offices (Navajo, Tucson, and Phoenix), and

representatives from the CMS regional office. Arizona Tribes sent representatives to the meeting, including elected leaders.

The agenda topics focused on Governor Brewer's proposed Medicaid 1115 Waiver Proposal. Co-facilitators included Pascua Yaqui Tribe Chair Peter Yucupicio and Tohono O'odham Vice Chair Yisidrio Lopez along with RD Schultz and AHCCCS Director Betlach. In attendance were district office representatives from Congressman Raul Grijalva (AZ-7). Representatives from all of Arizona's federally recognized tribes attended and provided comments and feedback on proposals. Arizona representatives included Carol Chicharello, Tribal Liaison, AHCCCS; and, Monica Coury, AHCCCS, Assistant Director, Office of Intergovernmental Relations.

#### **Meeting with California Director of the Department of Social Services, California Stakeholders, including Tribal Representatives, August 24, 2011**

Region IX Director Schultz convened a meeting with George Sheldon, the new Acting Assistant Secretary/Principal Deputy Assistant Secretary of the Administration for Children and Families (ACF), and Earl Johnson, Director, Office of Family Assistance. They met with Will Lightbourne, the newly appointed Director of California's Department of Social Services and key stakeholders to discuss and receive input on priorities and initiatives of ACF that are related to and support ACA implementation.

#### **Region IX Health Equity Council (RHEC), September 14 – 15, 2011**

Region IX Director Schultz presented remarks at the inaugural Regional Health Equity Council in Las Vegas. The Region's Tribal Nations and programs are represented on the Council. This was a Region IX meeting with senior members of HHS (central office) and regional leadership. RD Schultz led the discussion on fostering collaboration between RHEC, local health equity initiatives, and Region IX.

### **REGIONAL VISITS TO TRIBES**

#### **Inter-Tribal Council of Nevada, October 27-28, 2010**

As a follow-up to a recent comprehensive ACA implementation event and dialogue led by RD Schultz, Libby Vianu, Regional Representative for ATSDR, represented RD Schultz at the 44<sup>th</sup> Inter Tribal Council of Nevada Annual meeting in Reno, Nevada. Ms. Vianu presented on HHS tribal activities in Nevada and provided updates on upcoming ACA outreach activities. In attendance were approximately 300 Tribal members and elected officials from the 27 tribal communities throughout Nevada.

#### **Tour of Gila River Health Care Corporation and Phoenix Indian Medical Center, December 10, 2010**

Region IX Director Schultz and Phoenix area IHS Representatives met with leadership, staff, patients, and participants from Gila River Health Care Center and toured the Hu Hu Kam Memorial Indian Hospital.

They also toured the Phoenix Indian Medical Center which serves as a referral center for reservation-based hospitals and clinics in Arizona, Nevada, and Utah as well as primary and acute care services for the urban Indian population of the Phoenix metropolitan area.

### **Visit to Tohono O'odham Nation and Health Programs/Clinics with Tucson Indian Health Service Staff, December 13, 2010**

Region IX Director Schultz met with the George Bearpaw, Director of the Tucson Indian Health Service (IHS) and senior staff, and traveled to the Southwest border for a series of visits with Tribal leaders and program staff in the local service area, including along the Southwest border.

Health service for the Tohono O'odham is centered in Sells, Arizona, capital of the Tohono O'odham Reservation and hub of reservation life. Health centers are also located in the reservation communities of Santa Rosa and San Xavier. Health care in the Sells Service Unit is a combined effort of IHS and the Tohono O'odham Health Department, providing a comprehensive health program of inpatient services, ambulatory care, and community health services. The Regional Director toured numerous facilities in the service area. During these events the Regional Director provided presentations on the ACA and how it serves the Tohono O'odham Nation and current Tucson Area IHS initiatives and activities.

### **Working Dinner with Navajo Nation Vice President Rex Jim Lee, April 25, 2011**

Immediately prior to the Navajo Nation Consultation, Regional Directors from Regions VI, VIII, and IX dined with Navajo Nation Vice President Rex Jim Lee and senior Navajo Nation representatives/program leaders to discuss issues of specific concern to the Navajo Nation and to prepare for the Navajo Nation Consultation.

### **Navajo Nation Tour, April 27 - 28, 2011**

Immediately after the Navajo Nation Consultation, Region IX Director Schultz toured health care facilities in the Navajo Nation with the Nation's Leaders and various HHS officials, including the Regional Directors from Regions VI and VIII. The tour included visits to the Navajo Nation cities of Window Rock, Crownpoint, Smith Lake, and Thoreau. The tour included meetings with officials, program administrators, and participants in the programs. The tour was led by newly-elected Navajo Nation Vice President Rex Jim Lee.

### **California Consortium for Urban Indian Health, June 3, 2011**

Region IX Director Schultz provided a keynote speech on the implementation of health care reform in the state of California at the California Urban Indian Health Conference in Sacramento, CA.

### **Region IX Southwest Border Tour, June 13 – 17, 2011**

Region IX conducted a tour of the Southwest border. Region IX Director Herb K. Schultz, Executive Officer Steven Zerebecki, and Region Health Administrator Captain Nadine Simons traveled to southern California and Arizona to review the public health issues effecting communities along the California/Mexico and Arizona/Mexico borders.

Region IX officials were briefed by the U.S. and State Border Commissions, Tribal officials, health programs directors, local officials, and community health programs on the current status of operations and programs. In addition, they conducted ACA outreach to: federal, state and Tribal officials; providers; and, other community stakeholders in the border regions.

### **CA/San Ysidro Health Care Center/Tribal Health/Minorities/CHCs**

- On June 13, Region IX Director Herb K. Schultz, Region IX Executive Officer Steven Zerebecki, and Region IX RAH Capt. Nadine Simons met with Margo Kerrigan, Director IHS California Area Office; Ed Martinez, CEO; Kevin Mattson, Sr. VP; Terry Whitaker, VP Operations; Matthew Weeks, MD, CMO of San Ysidro Health Care Center.

### **CA/Tribal/Providers/San Diego American Indian Health Center**

- On June 14, Region IX Director Herb K. Schultz, Executive Officer Steven Zerebecki, and Region Health Administrator Captain Nadine Simons visited the San Diego American Indian Health Center and met with the Director, Board Representatives, and staff.

### **AZ/Pascua Yaqui Tribe**

- On Friday June 17, Region IX Director Schultz and Executive Officer Zerebecki met with Council Vice-Chairman Robert Valencia and Reuben Howard, the Executive Director of the Health Services Division and toured their health facility. The major issues included:
  - General public health issues, including, but not limited to: effects of environmental contamination, access to health care, disease outbreaks and response, health disparities;
  - Interagency coordination, collaboration, and partnerships: U.S./Mexico, State/Federal/Tribal; and,
  - Current and future opportunities for HHS outreach on the Affordable Care Act and Let's Move!

### **Alliance for Rural Community Health, June 21, 2011**

Region IX Director Schultz visited the Alliance for Rural Community Health in Ukiah, CA to meet with health care providers and tour several federally qualified health clinics. He also toured a critical access hospital where he met with the head of the tele-health program and saw a demonstration of the project.

In the afternoon, the Alliance met at the Consolidated Tribal Health Project which is an ambulatory health clinic that has served the rural Mendocino County since 1984. Their current projects aim to improve health and increase access to care. The project has helped the FQHCs, Rural Health Clinics (RHCs) (hospital and provider based), and the Tribal clinics agree to join together to contract with Partnership Health Plan for Medi-Cal Managed Care. Participants in the afternoon discussion included:

### **Nevada Tribal Leaders, July 19, 2011**

Region IX Director Schultz was represented by Libby Vianu, Regional Representative for ATSDR at the Nevada Tribal Leaders Meeting for Environmental Health. Environmental Protection Agency (EPA) hosted this meeting in Nevada for Tribal Leaders and federal agencies.

The purpose of the meeting was to gain a better understanding of the environmental, energy, and health priorities and challenges for both tribes and federal agencies, identify opportunities for collaboration where resources and information can be leveraged, and build stronger federal and tribal relationships. The EPA facilitated and used their World Café meeting format, where a discussion among leaders takes place in both small and large groups to generate input, share knowledge, stimulate innovative thinking, and explore action possibilities.

Agency participation included the EPA Regional Administrator, DOE, USDA Rural Development Community Programs, Bureau of Reclamation, IHS Deputy Director, Phoenix Area, HUD Regional Administrator, Administrator of the Southwest Office of Native American Programs, IHS Reno Environmental Health and ATSDR Regional Office. Tribal Leaders from ten Nevada Tribes and the Inter-Tribal Council of Nevada leadership also participated.

**Sonoma County Indian Health Project, Redwood Community Health Coalition, August 8, 2011**

As a part of National Health Center Week, Region IX Director Schultz toured the facility and met with patients and staff and served as a panelist at the Health Care Reform Town Hall & Press Conference hosted by Molin Malicay, Chief Executive Officer of the Sonoma County Indian Health Project. The event was sponsored by the Redwood Community Health Coalition, with the California Primary Care Association and the Latino Coalition for a Healthy California.

Other panelists included Congressman Mike Thompson's Chief of Staff, Melanie Van Tassel, Carmela Castellano-Garcia, CEO of the California Primary Care Association & Executive Director of the Latino Coalition for a Healthy California, Mary Maddux-Gonzalez, MD, Medical Director for Redwood Community Health Coalition & former Public Health Officer for Sonoma County Department of Public Health, and Jason Cunningham, DO, Medical Director of West County Health Centers. Over 200 community leaders and members of the media were also in attendance.



**United States Department of Health & Human Services  
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**REGION 10: Seattle**

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## HIGHLIGHTS OF REGION-SPECIFIC ACCOMPLISHMENTS

RD Johnson welcomed Secretary Sebelius to the Muckleshoot Health and Wellness Center and introduced the Secretary to Virginia Cross, Chair of the Muckleshoot Tribal Council. Chair Cross introduced the Secretary to members of the Tribal Council and the group was led on a tour of the center by the Director, Lisa James. During the tour, the Secretary talked with several tribal members who have benefited from the resources provided at the center. Following the tour, the Secretary and Tribal Council discussed tribal issues. The Secretary was presented with several gifts from the tribe.

RD Johnson accompanied Secretary Sebelius on a trip to Alaska. The trip included visits to the following sites and meetings with tribal leaders and representatives: the DENTEX Training Center, Alaska Native Health Board, Southcentral Foundation, Alaska Native Primary Care Center, Cook Inlet Tribe, and the Alaska Native Tribal Health Consortium in Anchorage; Barrow High School, Samuel Simmonds Memorial Hospital, and Ipalook Elementary School in Barrow; Tanana Community tour, Morris Thompson Cultural Center in Tanana; Anaktuvuk Community tour in Anaktuvuk.

RD Johnson visited with over 200 tribal leaders and representatives during her 20 trips throughout Alaska, Idaho, Oregon, and Washington.

In addition to two Regional Tribal Consultations, RD Johnson co-hosted two 477 Tribal Consultations. On March 7, 2011, RD Johnson co-moderated, along with Margaret Zientek of the Potawatomi Nation and co-chair of the 477 Tribal Work Group, a Tribal Consultation on the topic of PL 102-477 Indian Employment, Training, and Related Services Demonstration Act. Director Johnson was joined in Seattle by Jodi Gillette, Deputy Assistant Secretary, Indian Affairs, DOI, Earl Johnson, Director, Office of Family Assistance, HHS, and Stacey Ecoffey, Principal Advisor for Tribal Affairs, HHS. On March 9, 2011 RD Johnson co-moderated a Tribal Consultation on the topic of PL 102-477 Indian Employment, Training, and Related Services Demonstration Act. Director Johnson was joined in Anchorage by Francis Dunne, Acting 477 Director, Indian Affairs, DOI; Earl Johnson, Director, Office of Family Assistance, HHS; and Stacey Ecoffey, Principal Advisor for Tribal Affairs, HHS.

On August 22, 2011 RD Johnson also co-hosted and facilitated the West Regional Tribal Consultation on the Affordable Care Act all day in Seattle, Washington.

## SUMMARY OF REGIONAL CONSULTATION SESSIONS

### **Tribal Consultation Session, Portland, Oregon, June 7, 2011**

RD Johnson hosted a Tribal Consultation Session for tribes in Idaho, Oregon, and Washington. There were 54 participants representing 14 tribes and topics of discussion included: Reducing toxicity of the Columbia River; improving Tribal-State relations, especially regarding health care reform; seeking early Tribal input/engagement on issues that impact Indian Country; building capacity for electronic health records, meaningful use, and data collection; and addressing long-term care needs in Indian Country. Attendees included: Pearl Capoeman-Baller (Quinault Nation), Vice Chair, Northwest Portland Area Indian Health Board and Jay Angoff, Senior Advisor to the Secretary, HHS.

#### **The top 5 National issues of concern were**

1. Seeking early Tribal input/engagement on issues that impact Indian Country.
2. Addressing long-term care needs in Indian Country.
3. Increasing IHS funds.



4. Expanding the definition of Federally Qualified Health Centers for the Medicaid Electronic Health Records Incentive Program.
5. Building capacity for electronic health records, meaningful use, and data collection.

**The top 5 Region specific issues of concern were**

1. Reducing the toxicity of the Columbia River.
2. Improving Tribal-State relations, especially regarding health care reform.
3. Integrating mental health and substance abuse services.
4. Increasing oral health services.
5. Increasing funds for Head Start programs.

**Regional Tribal Consultation Session, Anchorage, Alaska, June 9, 2011**

RD Johnson hosted a Tribal Consultation Session for the tribes of Alaska. There were 55 participants representing 11 tribal governments and 9 tribal health organizations and topics of discussion included: Need for more information about the timeline for the implementation of the ACA; increasing transparency to ensure collaboration throughout planning and implementation of HHS programs; need for suicide prevention services; importance of long-term care projects; importance of village-based clinics; focus on entering Title VI demonstration projects under the Indian Self-Determination and Education Assistance Act (ISDEAA), rather than using a competitive grant process; addressing concerns about the definition of “Indian” in the Affordable Care Act; and addressing homelessness. Attendees included: H. Sally Smith, Chair, Board of Directors, Bristol Bay Area Health Corporation and Anne Herron, Director, Division of Policy Liaison for SAMHSA.

**The top 5 National issues of concern were**

1. Increasing transparency to ensure collaboration throughout planning and implementation of HHS programs.
2. Addressing long-term care needs.
3. Expanding opportunities to enter Title VI demonstration projects under the Indian Self-Determination and Education Assistance Act, rather than using a competitive grant process.
4. Addressing concerns about the definition of “Indian” in the Affordable Care Act.
5. Increasing information about the implementation of the Affordable Care Act, including implementation of insurance exchanges, electronic health records, and qualifications as Federally Qualified Health Centers.

**The top 5 Region specific issues of concern were**

1. Holding an Alaska-specific summit to share best practices and discuss ways to reduce suicide.
2. Improving collaborative efforts with HHS to ensure village-built clinics continue to play a key role in communities.
3. Addressing homelessness.
4. Improving Tribal-State relations, especially regarding health care reform.
5. Providing training to health care providers to address rural setting of Alaska.

**Consolidated Report & Progress on Issues**

The consolidated (Seattle and Anchorage Consultations) report was forwarded to the tribes on September 29, 2011. During the first quarterly Tribal Consultation Quarterly Call (October 6, 2011) following the Consultations, participants were encouraged to provide feedback on the report. The following updates were specifically noted:

- The scheduled Suicide Summit held in Anchorage on October 25-27, 2011.

- The expectation that the Regional SAMHSA representative would be placed by the end of 2011.

## **TRIBAL DELEGATION MEETINGS**

### **Alaska Tribal Leaders, January 11, 2011**

RD Johnson met with tribal leaders in Alaska to discuss the tribal consultation and other issues of importance.

### **Healing Lodge of the Seven Nations, February 7, 2011**

RD Johnson and IGA Specialist Heahlke met with the Healing Lodge's Executive Director, Martina Whelshula, and received a tour of the facility. The group was joined by the Healing Lodge's Board President, Julia Davis-Wheeler (Nez Perce), for lunch and participated in a conversation with staff about the successes and challenges faced by the Lodge.

### **Northwest Portland Area Indian Health Board, February 22, 2011**

RD Johnson met with Joe Finkbonner, Executive Director for the Northwest Portland Area Indian Health Board, to discuss tribal issues and the April 13<sup>th</sup> Region 10 Tribal Consultation in Grand Ronde, Oregon.

### **Alaska Native Tribal Health Consortium, March 10, 2011**

RD Johnson met with Andy Tueber, the Chair of the Alaska Native Tribal Health Consortium, to talk about the Tribal Consultation and other related issues.

### **Alaska Native Health Board, March 10, 2011**

RD Johnson met with Lanie Fox, President and CEO of the Alaska Native Health Board, and Chris Mandregan, Area Director for the Alaska Area IHS, to talk about the upcoming tribal consultation and other relevant issues.

### **Northwest Portland Area Indian Health Board Quarterly Meeting, April 27, 2011**

RD Johnson spoke at the quarterly meeting about regional issues including the rescheduled Tribal Consultation, Affordable Care Act, 477 funding, and the new SAMHSA representative who will be based in Region X.

### **Alaska Native Tribal Health Consortium, August 2, 2011**

RD Johnson met with Valerie Davidson, the Senior Director of Intergovernmental Affairs at the Alaska Native Tribal Health Consortium, to discuss ACA issues.

### **Tribal Mega Meeting (Alaska), August 3, 2011**

RD Johnson spoke at the Alaska Tribal Mega Meeting, and talked about ACA issues of relevance to tribes.

### **Alaska Native Tribal Health Consortium, August 3, 2011**

RD Johnson met with Garvin Federenko, the new President of the Alaska Tribal Health Consortium.

### **Alaska Native Medical Center, August 3, 2011**

RD Johnson met with Dr. Ted Mala, the Director of the Alaska Native Medical Center, to talk about ACA and tribal issues.

**Tribal Emergency Preparedness Conference, August 16, 2011**

RD Johnson spoke at a Tribal emergency preparedness conference, and talked about the challenges to providing healthcare to rural communities in times of disaster, and opportunities to work more closely with tribes. Healthcare providers and tribal leaders attended.

**Alaska Federation of Natives, August 18, 2011**

RD Johnson provided remarks at the Alaska Federation of Natives Leadership Meeting in Bethel, AK.

**Alaska Federation of Natives, October 20-22, 2011**

RD Johnson participated in the Alaska Federation of Natives Convention, which focused on suicide prevention and unifying communities to improve health.

**Senate Field Hearing (Alaska), October 22, 2011**

RD Johnson participated in a U.S. Senate field hearing hosted by Senator Murkowski (R-AK) on suicide prevention in Anchorage, AK.

**Meeting with Alaska Tribal Leaders and Senator Begich, October 24, 2011**

RD Johnson met with Senator Begich and tribal leaders to follow up on issues raised during the Secretary's August visit to Alaska.

**Alaska Area Action Summit for Suicide Prevention, October 26, 2011**

RD Johnson provided remarks at the Alaska Summit to 200 attendees, covering ACA and behavioral health.

**REGIONAL VISITS TO TRIBES****Tanana Chiefs Conference (Alaska), March 8, 2011**

Region X Director Johnson accompanied HHS headquarters staff on a tour of Tanana Chiefs Conference in Fairbanks, Alaska, as well as a visit to Kaltag.

**Suquamish Tribe (Washington), March 18, 2011**

Region X Director Johnson met with Leonard Foresman, the Chair of the Suquamish Tribe.

**Lower Elwha Klallam Tribe (Washington), March 18, 2011**

Region X Director Johnson met with Chairwoman Frances Charles and CEO Sonya Tetnowski of the Lower Elwha Klallam Tribe.

**Nez Perce Tribal Council (Idaho), April 4-5, 2011**

IGA Specialist Heahlke attended two health forums hosted by the Nez Perce Tribal Council and NIMIIPUU Health in Lapwai, ID. At the forums, a presentation was given by Jim Roberts, with the Northwest Portland Area Indian Health Board, summarizing how ACA impacts tribal health care. Over 60 people attended the informative sessions.

**Quinault Tribe (Washington), April 26, 2011**

RD Johnson attended a facilities tour and the Community Dinner hosted by the Quinault Tribe as part of the Northwest Portland Area Indian Health Board Quarterly Meeting.

**Nez Perce Tribe, April 27, 2011**

RD Johnson met with representatives from the Nez Perce Tribe and IHS, Portland Area Office, to discuss how the Affordable Care Act will impact the Tribe's health care budget and services provided by IHS.

**Coeur d'Alene Tribe (Idaho), May 13, 2011**

RD Johnson met Coeur d'Alene Tribal Chairman Allen in Plummer, ID to talk about tribal issues and concerns his tribe may present at the upcoming Tribal Consultation. She also toured their health facility and meet with staff and other tribal leaders to talk about the benefits for tribes in the ACA.

**Klamath Tribe (Oregon), June 6, 2011**

RD Johnson met with representatives from the Klamath Tribe to discuss a new youth facility.

**Squaxin Tribe (Washington), August 16, 2011**

RD Johnson met with members of the Squaxin tribe, toured their health facility, and spoke with providers at the clinic about rural health delivery challenges.

**Cook Inlet Tribe (Alaska), August 30, 2011**

RD Johnson participated in a tour and event with the Secretary and Cook Inlet Tribal elders, families and health providers.

**Anaktuvuk Community Site Visit (Alaska), August 31, 2011**

RD Johnson participated with the Secretary in a community tour of the Robert T. Ahgook Health Clinic, the Anniyak Senior Housing facility, Nunamiut Store, and the Nunamiut High School.

**Samuel Simmonds Memorial Hospital (Alaska), August 31, 2011**

RD Johnson participated with the Secretary in a tour and meeting with providers at the Samuel Simmonds Memorial Hospital in Barrow.

**Ipalook Elementary School (Alaska), August 31, 2011**

RD Johnson participated with the Secretary in an event with the Ipalook Elementary School health clinic and patients in Barrow.

**Barrow High School (Alaska), August 31, 2011**

RD Johnson participated with the Secretary in an event featuring Eskimo dancers at Barrow High School.



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United States Department of Health and Human Services

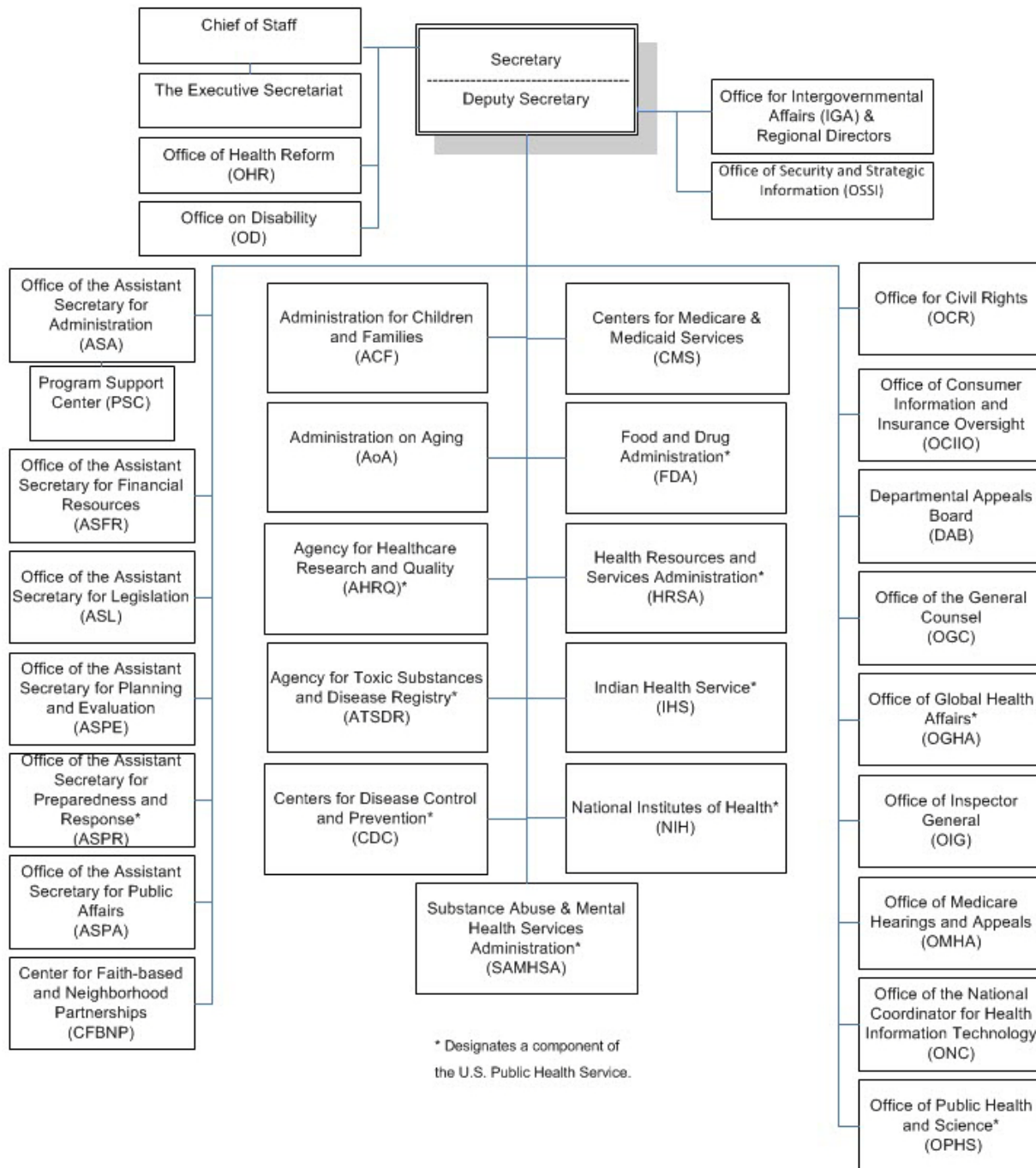
## 2010 HHS Divisions

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**United States Department of Health and Human Services, HHS Division Directors**

Left to Right: *Ellen Murray* (ASFR), *David Hansell* (ACF), *Kathy Greenlee* (AoA), *Dr. Carolyn Clancy* (AHRQ), *Thomas Frieden* (CDC, ATSDR), *Dr. Donald Berwick* (CMS), *Secretary of Health Kathleen Sebelius*, *Dr. Margaret Hamburg* (FDA), *Dr. Mary Wakefield* (HRSA), *Dr. Yvette Roubideaux* (IHS), *Dr. Francis Collins* (NIH), *Daniel Levinson* (Inspector General, OIG), *Pamela Hyde, J.D.* (SAMHSA)



**Figure: U.S. Department of Health and Human Services Organizational Chart**  
 An accessible Text Version can be found at <http://www.hhs.gov/about/orgchart/>



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United States Department of Health and Human Services

## **Administration for Children and Families (ACF)**

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The Administration for Children and Families, within the Department of Health and Human Services is responsible for Federal programs that promote the economic and social well-being of families, children, individuals, and communities. ACF programs aim to achieve the following: families and individuals empowered to increase their own economic independence and productivity; strong, healthy, supportive communities that have a positive impact on the quality of life and the development of children; partnerships with individuals, front-line service providers, communities, American Indian Tribes, Native communities, States, and Congress that enable solutions which transcend traditional agency boundaries; services planned, reformed, and integrated to improve needed access; and a strong commitment to working with people with developmental disabilities, refugees, and migrants to address their needs, strengths, and abilities.

### **Contact information:**

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### **Intradepartmental Council on Native American Affairs Liaison**

Lillian Sparks  
Commissioner, Administration for Native Americans  
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Email: Lillian.sparks@acf.hhs.gov

Website: <http://www.acf.hhs.gov/>  
Tribal Consultation Policy: Yes

## **HIGHLIGHTS OF DIVISION SPECIFIC ACCOMPLISHMENTS/ACTIVITIES TARGETED TOWARD AMERICAN INDIAN/ALASKA NATIVES (AI/AN)**

1. ACF has placed strong emphasis on interoperability and has worked to ensure that tribes are a part of the process and kept informed of our efforts. This topic was highlighted in our Fiscal Year (FY) 2010 and FY 2011 tribal consultation sessions. We recognized that through necessity, many tribes have already implemented interoperability with their ACF programs and other federally funded programs they have received.
2. OCS' AFI Program provided support to the ANA to conduct outreach in Native communities with the goals of increasing access to and awareness of asset-building strategies in Native communities. With support from OCS, ANA implemented an AFI pre-application training curriculum for tribes and Native groups interested in building financial education and Individual Development Account (IDA) projects in their communities. ANA conducted AFI pre-application trainings in Oklahoma City, OK; Reno, NV; Juneau, AK; and Fairbanks, AK.
3. The Administration for Native Americans (ANA) and the Office of Community Services (OCS) worked together this past year to issue a joint funding agreement for the Native Asset Building Initiative (NABI) grants. Under this partnership, applicants completed one application and received funding from both ANA and OCS via the NABI grant. The ANA money is used for grant administration, outreach, financial literacy, and similar items, while the OCS money will be the matching dollars. Five grants were awarded for a total amount of \$727,275. The recipients were:
  1. Wai'anae Community Re-Development Corporation, HI;
  1. American Indian Community Development Organization, MN;
  2. The Peoples Partner For Community Development, MT;
  3. Warm Springs Community Action Team, OR; and
  4. Crow Creek Housing Authority, SD.
1. The Office of Head Start (OHS) convened four tribal consultation sessions with Tribal Leaders operating a Head Start/Early Head Start Program(s). The purpose of the consultations was to discuss delivery of Head Start services to American Indian/Alaska Native (AI/AN) children and families, "taking into consideration funding allocations, distribution formulas, and other issues" that may affect services in the various geographic areas. Sessions were held in conjunction with other Tribal Leader meetings to reduce the burden of additional travel for the participants.
1. OFA participated in two 102-477 tribal consultations (March 7 in Seattle, WA, and March 9 in Anchorage, AK). At the consultations, HHS and Department of Interior (DOI) leadership provided 477 Program tribes with updates and addressed several issues regarding the 477 Program.

## **DIVISION SPECIFIC ACTIVITIES**

### **Administration for Children, Youth and Families Children's Bureau (CB)**

CB continued its outreach to tribes, particularly with regard to Public Law 110-351, the Fostering Connections to Success and Increasing Adoptions Act of 2008, which authorized tribes to apply to receive direct funding under Title IV-E of the Social Security Act. Beginning October 1, 2009, tribes, tribal organizations, and tribal consortia (hereafter, tribes) became eligible to receive



direct funding from the Federal Government for Title IV-E programs that provide entitlement funding for foster care, adoption assistance, guardianship assistance payments, and related administrative expenses for eligible children. Before that date, tribes had access to these funds only through negotiated agreements (commonly referred to as Title IV-E agreements) with States. CB has worked to ensure that tribes understand the Title IV-E program and the issues they will need to explore in considering whether to apply to receive direct funding under the program. No tribe has yet been approved to operate a Title IV-E program. One tribe, Port Gamble S'Klallam, Kingston, Washington, submitted a Title IV-E Plan to directly operate a Title IV-E program. Staff in CB's Region X office in Seattle continue to work with the tribe to achieve an approvable plan. No other tribe has yet submitted a plan.

The Fostering Connections to Success and Increasing Adoptions Act of 2008 authorized funding for grants of up to \$300,000 to be used over a 2-year budget period for tribes to develop an approvable Title IV-E Plan. Thus far, 12 tribes have been awarded grants. The first six grantees, which began their projects in September 2009, requested and were granted no-cost extensions of their grants, which will allow them up to one additional year to complete work under the grant.

In-depth Technical Assistance (TA) to each grantee is provided during on-site visits by both Central Office and Regional Office staff. Each grantee has received several visits. Grantees have also attended TA sessions in their respective CB regional offices. Regular on-going phone calls occur between the visits. Several grantees have weekly calls for TA in developing their infrastructure and to discuss Federal review and comments on draft materials they are developing to meet the Title IV-E plan requirements (e.g., tribal codes, court orders, policies/procedures, agreements, etc.).

TA is also provided to tribes by CB's National Resource Centers (NRC). Along with Federal staff providing on-site TA to Keweenaw Bay Indian Community, TA was provided by the National Resource Center for Child Welfare Data and Technology for a pilot project to develop a manual Adoption and Foster Care Analysis and Reporting System (AFCARS). Several of the grantees have been interested in this manual system. This NRC has also been holding monthly calls for the grantees to discuss data needs and for grantee peer-to-peer sharing related to data and technology issues. Another regional office facilitated a number of requests for Training and Technical Assistance (T/TA) from the NRCs resulting in a peer-to-peer visit between the Washoe Tribe of California and Nevada, and the Confederated Tribes of Warm Springs regarding an administrative review process, family group decision making, and recruiting/retaining/training resource caregivers. The Washoe Tribe was excited about their visit and thought it was very productive. In addition, training has also been provided to interested grantees so they can participate as reviewers on individual State Title IV-E reviews. Grantees who participated all expressed how valuable the experience was.

In December 2011, all the tribal grantees participated in a meeting in Palm Springs, CA. The grantees helped plan the meeting. Port Gamble S'Klallam, although not a grantee, has submitted a Title IV-E plan and was invited to and participated in the meeting.

Grantees have been requesting that CB and DOI/Bureau of Indian Affairs (BIA) develop a working relationship so that the Federal offices better understand the programs each is responsible for, allowing Federal staff to provide more comprehensive TA to the grantees. BIA is very open to developing a closer collaborative effort between our agencies.

In furthering this effort:

2. CB attended and presented on Title IV-E at BIA's annual social worker meeting in Phoenix in May.
3. A BIA social worker participated in an on-site visit CB had with Shoshone-Bannock Tribes.
4. CB Regional staff presented on Title IV-E options and provisions in the Fostering Connections legislation at the BIA – New Mexico Children, Youth and Family Division Indian Child Welfare/Child Protection Conference in Isleta, NM, on June 1-2, 2011.
5. BIA held a Tribal Conference for tribes in Regions V and VII on August 8 – 9, 2011. CB staff from CB's Region V office presented on the Title IV-E program and provided information regarding the Tribal IV-E Plan Developmental Grant.
6. In Region VI, CB has provided outreach to the BIA regional offices in Albuquerque, NM; Anadarko, OK; and Muscogee, OK. As a result, staff shared key contact information on the Oklahoma, Texas, and New Mexico tribes, and share relevant child welfare information such as training, meetings, and State/tribal relationships. Region VI continues to partner with the BIA on a variety of topics including conferences, information sharing, audits, abuse/neglect referrals, legal opinions, etc.
7. At a meeting with the Yurok Tribe on September 26-28, 2011, attendees included CB's Regional Office program and fiscal staff and BIA's Regional Office staff. Central Office staff from CB and BIA participated by phone.

CB sponsored three national tribal gatherings about the Fostering Connections to Success and Increasing Adoptions Act legislation. The NRC for tribes had the lead responsibility (in conjunction with the NRC for Organizational Improvement and the NRC for Permanency and Family Connections) for designing, developing, and delivering the three gatherings. The NRC for tribes utilized the extensive expertise and experience of partner agencies to meet this challenge, enlisting substantial tribal involvement (teams of three persons from each tribe representing tribal leadership, tribal court, and tribal child welfare) while also including CB's input. The three national Fostering Connections tribal gatherings were very successfully conducted. A total of 335 people (representing 92 tribes) participated in these three tribal gatherings. Tribal participants from tribes throughout the country expressed strengths, challenges, and needs that closely matched the findings of the NRC for tribes' national T/TA needs assessment. Feedback from these three gatherings has generated more T/TA requests for the TTA Network. As a follow-up to these tribal gatherings, in 2012 there will be two more such tribal gatherings focused on capacity building for tribes to apply for the Title IV-E demonstration grants.

CB conducted tribal-specific public consultations on the Child and Family Services Review (CFSR) process in August 2011 (Seattle, WA, and Oklahoma City, OK) and in September 2011 (Minneapolis, MN). CB Regional Program Managers and/or the Acting Associate Commissioner were present for these sessions. The sessions were held pursuant to a Federal Register notice published on April 5, 2011, which solicited comments from stakeholders and tribes about the CFSR process. Tribal leaders as well as tribal administrators were invited to and attended each of these sessions. The consultation sessions clarified for CB that tribal leaders and administrators as a group have had limited experience with the CFSRs. The consultation sessions also surfaced other issues related to how States, CB, and BIA work with tribal leaders and administrators, as well as Federal funding concerns.

CB regional offices provided outreach to all federally recognized tribes to provide information and TA on Title IV-E. One venue CB participated in was the Indian Child Welfare Act (ICWA)

association meetings in Michigan and Oklahoma. CB Central Office and Regional Office staff participated in the BIA Child Abuse Conference in April, presenting on both the Title IV-E and IV-B programs. Intensive TA on Title IV-B and the application process was provided using various outreach efforts including on-site visits, regionally based meetings, calls, and webinars. These efforts have resulted in an increase in the number of tribes applying for Title IV-B, including an increase of seven tribes in Regional VI. One of the seven is a new federally recognized tribe, the Delaware Tribe of Indians. At the same time, tribes requested additional TA from the NRCs.

The Shinnecock Nation, Southampton, New York (which recently was designated a federally recognized tribe) hosted a meeting with the ACF's Region II CB, Child Support and Child Care staff. The Tribal Council members and the Social Services component learned of ACF programs, services, and application processes related to obtaining services for the Shinnecock community.

CB's New York Regional Office (Region II) has been invited as a permanent participant in meetings of the New York Federal-State-Tribal Courts and Indian Nations Justice Forum. The group membership includes Federal, State, tribal, and local judges, attorneys, law enforcement representatives, other court and legal staff, and child welfare staff. The Regional Office was also formally on the agenda for making a 10-minute presentation on the Child and Family Services Improvement and Innovation Act with respect to opportunities for tribal groups to access Court Improvement funds. The Regional Office also took the opportunity to highlight our current work with tribal Nations and our "extended hand" to expand the partnership with others, which resulted in a first-time invitation from the Tonawanda Seneca Nation of Indians to do a meeting and site visit with them on a date to be determined later.

The New York Regional Office staff met with the Saint Regis Mohawk Tribe at the Akwesasne Territory. The visit consisted of learning of the many child welfare programs implemented by the Saint Regis Mohawk people through the Adult Services Unit; the Differential Response Program (Family Assessment Response Presentation); Preventive Services; Foster Care and Adoptive Services; and the Akwesasne Group Homes. Staff learned of the unique interventions that are utilized to address the needs of their people. The Regional Office also met with the Seneca Nation of Indians and discussed their child welfare programs, relationships with the State and local jurisdictions, and their unique cultural programs. The Regional Office also conducted Joint Planning sessions and discussed updates on Federal programs and policies.

CB's Region VI has established a relationship with the United Southern and Eastern Tribes (USET), which serves tribes located in Texas and Louisiana. The USET group asked the Regional Office to present at their annual conference this coming year.

CB had a week-long Leadership Academy for Middle Managers training with selection based on recommendations, support, and nominations through the Regional Office. One member from the Seneca Nation of Indians, the Saint Regis Mohawk Tribe, and the Onondaga Nation, and eight tribes in Region X participated in the regionally based week-long training.

In Region VIII (Denver), CB staff are collaborating on a project with Utah's Court Improvement Program which has developed a joint State/Tribal committee to improve collaboration between entities. The committee is chaired by the Honorable William Thorne and includes two State Juvenile Court Judges, an Ute Indian Tribal Court Judge, the Utah Department of Human Services ICWA Administrator, the Division of Child and Family Services Director, the Ute Tribal

Social Services Director, Legal Aide, and Region VIII CB staff. The goal of the committee is to improve service delivery to the Utah Native American population being served through the child welfare system. Initial focus is on service delivery on or near the Ute Indian Tribe. A work plan is being developed that will address the following topics: ICWA, Foster Care and Foster Care Licensing. The State/Tribal committee started meeting in April 2011, and will continue its work into 2012.

As part of CB's T/TA network, each of the five Implementation Centers covers two of CB's regions. Implementation Centers are uniquely placed to provide long term TA. Presently, Mountain and Plains Child Welfare Implementation Center is providing long term TA for the following projects:

- Shawnee Area Native American Child Protection Team (SANACPT) is comprised of six tribes: Absentee Shawnee, Citizen–Potawatomi, Kickapoo Tribe of Oklahoma, Sac and Fox, Seminole, and Iowa Tribe of Oklahoma. SANACPT is receiving technical assistance and resources to develop a culturally appropriate foster parent training curriculum and implement a training model. Focus is on Native American children rather than on a specific tribe. Learning will be shared using a train-the-trainer model. Project site visits were made in September and October 2011.
- Three Affiliated Tribes and Turtle Mountain Band of Chippewa's implementation project (Skun-eyah or Garden Project) is designed to develop and put into practice a culturally responsive, family centered practice model, and create system change at the direct practice level of intervention with families. Tribal Child Welfare staff have new skills and a new approach to providing services, along with an increased level of support from the communities through increased awareness, understanding, and engagement in keeping children safe. The process to define and implement a culturally responsive, family centered practice model for each tribe has been documented for replication in other tribal programs.
- The Osage Nation implementation project goal is three-fold: develop a business mapping model; develop and articulate a culturally based, family centered practice model; and create a decision support data system to help facilitate the first two. Underlying the goal and ultimate purpose of the project is to create system change on the management and direct practice level to improve the coordination and delivery of child welfare service to Osage Nation families and children.

CB Central Office and Region VIII staff participated in the Colorado Court Improvement International Site Visit to the Southern Ute, Ute Mountain Ute and Navajo Nation reservations. A Welcome Dinner was held at Tribal Judge Plewe's home. The visit included a tour of the Tribal Park, a meeting with stakeholders, observation of a tribal/administrative court, and ICWA training from the Navajo Nation. Southern Ute is also a part of the Mountain and Plains Child Welfare Implementation Center project with Colorado, which is doing some one-on-one with the agency as part of the practice model implementation.

### **Family and Youth Services Bureau (FYSB)**

Through a 10 percent set aside for Indian tribes, Alaska Native Villages, and tribal organizations, the Family Violence Prevention and Services Act (FVPSA) Program supports emergency shelter and related assistance for victims of domestic violence and their dependents. In FY 2011, 237 federally recognized tribes, Alaskan Native Villages, and tribal

organizations received FVPSA grants totaling \$12,979,190, ranging from \$23,599 to \$2,064,871.

Technical Assistance (TA) Support Services: The FVPSA Program has increased TA support through monthly TA calls, on-site monitoring, webinars, peer mentoring meetings, and email. These efforts were intended to assist grantees in establishing and maintaining their domestic violence programs, to encourage collaboration, and to enhance their awareness and responses to FVPSA's programmatic and financial obligations. Through the support provided, the FVPSA Program has increased the number of tribes reporting in a more unified, substantive, and timely manner, and increased collaboration among peers.

Peer Mentoring: In April 2011, the FVPSA program sponsored and facilitated its 2<sup>nd</sup> pilot Tribal Peer Mentoring meeting. It consisted of six individuals from four tribal domestic violence and sexual assault programs in California, New Mexico, and Nevada. The intent of this meeting was to discuss key issues specific to tribal consortiums and to allow individuals the opportunity to utilize expertise from peers with experience addressing similar issues. The topics of discussion included: 1) TA for consortium member tribes; 2) program presentations; 3) precarious trauma; 4) cultural awareness to non-tribal providers; and 5) peer mentoring. The meeting was piloted successfully and the next session is expected to convene in May 2012.

Reporting: In FY 2010, FVPSA continued to provide the Standard Form – Performance Progress Report (SF-PPR) reporting requirements training via telephone and webinar. In 2011, FVPSA was able to capture useful information using data compiled from the reports to provide a more comprehensive and data-driven assessment of the FVPSA Tribal programs - as well as the kind of support services provided and the number of individuals served in tribal communities annually. Some highlights from the report showed that local tribal domestic violence programs served 32,840 victims of domestic violence and their children; FVPSA funds supports approximately 68 domestic violence shelters and 160 non-residential sites; and over one hundred thousand crisis calls were made to local tribal domestic violence programs for crisis counseling, shelter services, or other services. Eighty percent of the 137 FVPSA tribal grantees contributed to this report.

National Indigenous Women's Resource Center (NIWRC): As mandated in the December 2010 reauthorization of FVPSA, in September 2011, FVPSA awarded a National Indian Resource Center addressing domestic violence and safety for Indian women. The resource center offers a comprehensive array of TA and training resources to AI/ANs to enhance the capacity of the tribes and organizations to respond to domestic violence. NIWRC's headquarters is located in Montana. Their website is [www.niwrc.org](http://www.niwrc.org).

### **Runaway and Homeless Youth Programs (RHY)**

Funded RHY Grants in Indian Country: In 2011, RHY grants to tribes totaled approximately \$1.1 million across two program areas: Transitional Living Programs and Basic Center Programs.

Runaway and Homeless Youth Programs (Region X)/Alaska T/TA Initiative: An Alaska T/TA Initiative is underway to address some of the unique challenges faced by grantees providing services in RHY programs. One major challenge is that Alaska grantees are unable to participate in most lower 48 T/TA workshops and training opportunities, and there are specific unique T/TA grantee needs that can be most effectively addressed in Alaska. The Alaska Initiative began the end of last fiscal year with an onsite T/TA assessment of all four (now five)

Alaska grantees. The basis of this work will lead to continued Alaska-specific T/TA targeted toward trauma-informed care and other issues of concern to Alaska Native people.

RHY meeting with delegation – Lummi Nation: In July 2011, the Division Director of Youth Services met with a delegation of youth and adults representing the Lummi Nation who shared their experiences as part of the Transitional Living Program on the reservation.

The following are AI/AN activities that cross FYSB's program areas:

Interagency Working Group on Indian Affairs (IWGIA): is a government-wide group of Federal agency representatives who work with tribal governments. Federal agency members include the Advisory Council on Historic Preservation; the Corporation for National and Community Service; individual agencies of the Departments of Agriculture, Commerce, Defense, Energy, Health and Human Services, Homeland Security, Housing and Urban Development, Interior, Justice, Transportation, Treasury, and Veterans Affairs; the Environmental Protection Agency; the Internal Revenue Service (IRS); the National Oceanic and Atmospheric Administration; the Small Business Administration; and the U.S. Institute for Environmental Conflict Resolution. The main focus of this workgroup is to discuss potential coordination of TA efforts, particularly in the areas of tribal courts and justice, youth victims of crime, family/youth violence issues, youth mentoring, and youth programs in general, as well as potential collaboration efforts.

Strengthening outreach and building relationships in the areas of trauma-informed care, protective factors for youth, and better research to improve service to Native communities: FYSB increased outreach and developed partnerships at the Native Research Network Conference (June 2011) and the National Tribal Youth Summit (cross-Federal agency supported event, July 2011). Additional linkages with the Indian Health Service (IHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) were developed in Fall 2011.

### **Administration on Developmental Disabilities (ADD)**

The Developmental Disabilities Assistance and Bill of Rights Act of 2000, Public Law 106-402 (DD Act of 2000) authorizes support and assistance to States, public agencies, and private non-profit organizations, including faith-based and community organizations, to assure that individuals with developmental disabilities and their families participate in the design of, and have access to, culturally competent services, supports, and other assistance and opportunities that promote independence, productivity, integration, and inclusion into the community.

There are four programs authorized by the DD Act of 2000:

- State Councils on Developmental Disabilities (Councils)
- Protection and Advocacy Systems (P&A)
- University Centers for Excellence in Developmental Disabilities Education, Research, and Service (UCEDD); and
- Projects of National Significance (PNS)

In FY 2011, \$169 million was available to support these programs. Each of these programs engages in systemic change, capacity building, and advocacy activities both as a collaborative network and as independent entities to improve the lives of individuals with developmental disabilities (DD) and their families and enhance participation in community life in the State, including American Indian reservations and Native American communities.

Native American Protection & Advocacy Agency: ADD funds one P&A, the Native American Disability Law Center, Inc. (NADLC) which covers the Four Corners region of Arizona, New Mexico, Utah, and Colorado, and serves individuals of the Navajo Nation and the Hopi Reservation. This P&A received \$205,808 in FY 2011.

Activities and Achievements: The issues NADLC addresses include civil rights, special education, health care, and rights to public and private services. NADLC staff investigates abuse and neglect in care facilities, and provides rights-based training for people with disabilities, their families, educators, and service providers.

It currently focuses on five priorities:

1. Responsible agencies will be more responsive to investigating and protecting individuals with disabilities from abuse and neglect.
2. Increase the employment opportunities of individuals with disabilities who are receiving Social Security benefits.
3. Individuals with disabilities will have improved access to appropriate special education services.
4. Increase community awareness of the needs of Native Americans with disabilities in order to decrease discrimination and stigmatization based on disability.
5. Increase financial resources of individuals with disabilities.

Thirty-eight clients were served in 2010 - 2011. The majority of the clients identified themselves with intellectual disabilities, followed by autism, and then other disabilities. Education was listed as the most common issue area.

#### Examples of Other DD Network Projects for Tribal Communities

**Arizona** – The Sonoran University Center for Excellence in Developmental Disabilities at the University of Arizona, in conjunction with the Native American Research and Training Center (NARTC) is performing a needs assessment of AI/ANs to explore their familiarity with and utilization of DD Network Program agencies, the availability of services and support for individuals with DD and their families in AI/AN communities, and the needs of DD tribal members and their families.

#### **South Dakota** University Center on DD (UCEDD)

The UCEDD Center for Disabilities/University of South Dakota (CD/USD) administers two developmental clinics on the reservations of Cheyenne River and Pine Ridge. These clinics address health, nutrition, and developmental needs of children from birth through 5 years of age.

Pediatric professionals from CD/USD fly by charter plane once a month to work with local professionals to implement these clinics. Two teams provide a comprehensive evaluation to determine if the child may be eligible for early intervention services. Each team works through an arena-based style and evaluates motor development, communication, cognition, and adaptive behavior. In addition, each child receives a nutrition consult. Quarterly, an audiologist provides hearing examinations to the children that appear to be at-risk for a hearing loss. On a quarterly basis a developmental pediatrician also sees children who have been through the developmental clinic but still have questions regarding health/development that need to be addressed.

Approximately eight children are seen at each monthly clinic. Prior to the clinics, local staff provides developmental screenings in the local reservation communities. Children that appear at-risk as a result of the screening process are referred into the clinic. After clinic, the local staff, along with the Birth-to-3 Service Coordinator for the area, provides a follow-up visit to the family. At this visit all of the information from the clinic is shared and appropriate releases are signed. If the child qualifies and if the family wants it, the child is then connected to the Individualized Family Services Plan (IFSP) or Individualized Education Plan (IEP) and a service plan is developed. Children qualifying for services are usually receiving services within 2 weeks and always within 30 days.

Many products have been developed in conjunction with these clinics. Some of the products have been translated into Lakota depending on the wishes of the local advisory committee.

### **Administration for Native Americans (ANA)**

In July 2011, Commissioner Sparks accompanied the Acting Assistant Secretary George Sheldon on a visit of three Native American communities in New Mexico. At San Ildefonso and Pueblo of Pojoaque, Mr. Sheldon had the opportunity to tour community gardens, providing healthy and nutritious food for the community. At Tesuque Pueblo, Mr. Sheldon had a tour of the wellness center and learned about the activities being conducted with “Let’s Move! in Indian Country,” an ANA grant supplement. These visits have helped Mr. Sheldon to learn more about ACF’s work with Native American communities and the impact that ACF grants, programs, and services can have in our Indian communities.

Significant groundwork has been laid in 2011 to establish and enhance partnerships with the Department of Education and the Department of Interior for Native Language Instruction programs to help instill language programs in future grants between the three agencies. These discussions are expected to continue in 2012.

In September of 2011, ANA held a Language Symposium for all new and continuing grantees with the intent to build a core of knowledge in what works for native language retention, renewal, and survival. Sixty-three ANA grantees from 17 States and the U.S. territory of Guam convened to learn tools and techniques from experts in the field and to share their experiences. Another goal was to provide input to Health and Human Services, primarily ANA and other ACF programs, and other Federal agencies (and for their own State and local communities) on how to make the programs and projects more effective in Native communities.

In a roundtable discussion of challenges and opportunities for native language maintenance and revitalization, groups discussed what resources and support would be necessary in the areas of language policy, professional development for instructors, curriculum development for language programs, and encouraging native language use beyond the classroom setting. While many of the suggestions are State or local in nature, several of these are changes the Federal Government can make to existing programs, services, and funding to make the most impact on communities seeking to maintain and/or revitalize their languages. ANA will be sharing the information gathered at the symposium with ACF and other Federal agencies that provide funding or assistance to Native American communities in the area of education.

In Fiscal Year 2011, ANA participated in a series of 1-day workshops, titled “Growing Economies in Indian Country,” with nine other Federal Government agencies to share information on various Federal grants, loans, and programs that support economic development activities for Native Americans. Taking place in seven cities from Maine to Hawaii, the



workshops used regional experts to gain perspective on the challenges that are unique to that area, as well as drawing out successes or barriers that may be local or national in character. Through attendance at these events, ANA was able to promote their grants and services, as well as highlight successful economic development projects that ANA grantees have undertaken. Additionally, ANA used these meetings as a way to increase outreach for NABI, a new joint funding opportunity with OCS, and increase attendance at their Project Planning and Development training sessions, 2-day workshops conducted at the same locations as the “Growing Economies in Indian Country” meetings either immediately prior or immediately following the interagency meeting.

ANA implements three types of trainings - project development, pre-application, and post award. Each type of training is free and designed for a specific audience. Project planning and development training provides potential ANA applicants with the skills to identify and develop project ideas for their community, while pre-application training teaches potential applicants how to fit their project idea into the framework of that year’s ANA Funding Opportunity Announcement. Post award training is for current ANA grantees and provides details about the rules and regulations required to implement an ANA funded project. In FY 2011, ANA held 95 trainings across the lower 48 states, Alaska, Hawaii, and the Pacific territories. One thousand twelve participants and 594 tribes or organizations attended these trainings. In addition to the trainings, ANA offers TA to potential applicants and grantees. In FY 2011, ANA provided TA to 35 grantees and 97 applicants.

### **Office of Child Care (OCC)**

The Office of Child Care revised the Child Care and Development Fund (CCDF) Tribal application (Plan Preprint) for the FY 2012-2013 funding year. The revision marked the first changes to the Plan Preprint since 1997. During the public comment period, OCC consulted with CCDF Tribal grantees and other interested parties via two conference calls to obtain input on the proposed revisions. The final Plan Preprint was approved by the Office of Management and Budget (OMB) on May 18, 2011.

OCC conducted regional and multi-regional training sessions on the revised CCDF Tribal Plan in the months of April and May 2011. Over 246 tribal registrants participated in these training sessions. The content was comprehensive, allowing participants to review each section of the new Plan in depth. Group discussions took place on key topics including market rate surveys, sliding fee scales, and health and safety standards. The trainings were hands-on and grantees used their laptops to walk through the Preprint. Many of the participants were able to begin developing portions of their Plans.

The Tribal CCDF New Administrators training was held December 7-9, 2010, in Dallas, Texas. The training provided 116 tribal representatives an opportunity to gain knowledge and skills related to the administration of their CCDF grants. Training focused on program eligibility, fiscal and program accountability, reporting, payment rates/sliding fee scales, and quality activities.

The 17<sup>th</sup> National American Indian & Alaska Native Child Care Conference was held April 6-7, 2011, in Minneapolis, Minnesota. The theme “Pathways to Excellence: Planning the Future of Tribal Child Care” supported the OCC Pathways and Partnerships for Child Care Excellence. Over 322 tribal representatives attended this event. The workshops were designed to help attendees strengthen program administration, encourage collaboration, enhance program quality, and ensure healthy and safe child care environments.

OCC convened the first National Public Law 102-477 Child Care Conference, “Tribal Interoperability for Higher Quality Child Care: Building Pathways and Partnerships, Strengthening Program Integrity and Accountability within the 477 Tribal Communities,” to address the unique needs of CCDF programs administered under 102-477. The conference was held in Washington, D.C., on June 28-30, 2011. Thirty-three tribes consolidate the CCDF program into their Public Law 102-477 Plans. The two and one-half day event consisted of plenary sessions, training workshops, and open dialogue that focused on supporting the early childhood workforce through improved professional development opportunities. The meeting also focused on strengthening the integrity of CCDF activities while building a child care subsidy system that is child-focused, family-friendly, and works in partnership with child care providers. OCC collaborated with DOI; the Federal lead agency responsible for the administration of the 477 tribes. DOI staff conducted several training workshops.

OCC has taken a systematic approach to address the issue of Program Integrity and Accountability including efforts established by tribal governments that ensure effective internal controls to reduce programmatic or financial risks in the administration of CCDF funds. OCC in consultation with the tribes developed exploratory questions that were incorporated in the Biennial CCDF Tribal Plan Preprint application. The goal of the exploratory questions is to obtain a snapshot of policies and procedures that tribes have adopted and to determine future strategies that will allow tribes to enhance their overall accountability.

As a next step to support program integrity, OCC developed a draft Tribal Grantee Internal Controls Self-Assessment instrument that will allow tribal grantees to measure their internal controls. OCC conducted an onsite visit to consult with the Cherokee Nation on the validity for use with tribal programs. The feedback obtained from Cherokee Nation will be used to make additional adjustment and further field-testing will be necessary before the instrument is finalized and shared with all of the CCDF Tribal grantees.

OCC sponsored a “Let’s Move Child Care! in Indian Country” track (in support of the First Lady’s “Let’s Move! Child Care”) at the National Indian Child Care Association (NICCA) Bi-Annual Conference in Las Vegas, Nevada, on August 24-26, 2011. The track included sessions on: (1) “I Am Moving, I Am Learning;” an obesity prevention strategy developed by the Office of Head Start (OHS) to promote children’s healthy development and physical activity through movement, music, and nutrition. OCC has been working with OHS to build a capacity around healthy weight and strategize for larger-scale rollout of “I Am Moving, I Am Learning” in States, Territories, and tribal child care programs; (2) “Physical Activity Kit” (PAK) - training conducted by representatives from IHS that provides an effective and efficient method to package, implement, evaluate, and disseminate culturally appropriate physical activity for AI/AN communities. Seventy-three tribal representatives from participating CCDF tribes completed the training sessions and received certificates of completion. *Participants also received information on how to join the “Let’s Move! in Indian Country 25,000 Presidential Activity Lifestyle Award (PALA) Challenge.”*

OCC received and approved five new Tribal Plans for the CCDF FY 2012-2013 biennium. The new tribes include the Mashpee Wampanoag Tribe and Mohegan Tribe in Region I, the Shinnecock Nation in Region II, and the Nooksack Indian Tribe and Sun’aq Tribe of Kodiak in Region X. OCC funds 259 tribes or tribal consortia that represent 539 tribes who have access to the CCDF program services.

### **Office of Community Services (OCS)**

The Office of Community Services' AFI and the ANA's Social and Economic Development Strategies (SEDS) Program launched the Native Asset Building Initiative (NABI), a joint funding opportunity for tribes and Native organizations to administer comprehensive asset-building projects. Under NABI, grantees implement one comprehensive asset-building project with two funding streams. The majority of the AFI award must be used to match participant savings in an IDA, while the SEDS funding can be used to support program administration, financial education, and other complementary asset-building and/or social and economic development strategies. In September 2011, OCS and ANA awarded five grants to tribes and Native organizations through NABI.

OCS' AFI Program provided support to the ACF regional offices to conduct outreach about the AFI Program and to integrate asset-building strategies into existing ACF programs. With OCS support, the regional offices presented to tribes and Native groups at tribal consultations and conferences and met with Tribal Child Welfare Directors and Tribal TANF Directors across the country:

1. Tribal Child Welfare Directors Meeting, June 9, 2011, Oklahoma City, OK
2. Tribal TANF Directors Meeting, August 2, 2011, Denver, CO
3. Family Conservancy and Tribal Consultation, July 18, 2011, Kansas City, MO
4. Tribal Consultation and Regional Community Meeting, March 23-25, 2011, Rapid City, SD
5. National Indian Child Care Association Conference, August 25, 2011, Las Vegas, NV
6. 2011 ACF/OFA Region IX Tribal TANF Meeting, September 26, 2011, San Francisco, CA
7. AFI Workshop with Arizona Assets Alliance, September 28-29, 2011, Phoenix, AZ
8. Affiliated Tribes of Northwest Indians Conference, February 2-3, 2011, Northbend, OR
9. Tribal TANF Directors in Washington and Oregon Meeting, April 26, 2011, Seattle, WA
10. Tribal Coalition Meeting, April 6, 2011, Seattle, WA
11. State and Tribal TANF Meeting, May 4-5, 2011, Seattle, WA
12. Tribal TANF Directors Meeting, September 27, 2011

On October 30 – November 4, OCS presented and distributed information about OCS' programs at the National Congress of American Indians Convention in Portland, Oregon. The presentation to the Economic, Finance, and Community Development committee focused on how two OCS programs – NABI and Community Services Block Grant (CSBG) – can support economic and community development in Indian country. OCS's information booth at the conference included materials about all OCS programs as well as information about OCS' partner office, the Administration for Native Americans.

During the fall of 2010, the Strengthening Communities Fund (SCF) developed several affinity groups made up of grantees, based on organizational and project characteristics. Convening a group of Tribal Governments and Tribal Organizations' grantees was a priority, and the invitation extended to this targeted group was well-received. With the help of the SCF National Resource Center, the Tribal Governments and Tribal Organization – SCF Tribal Affinity Network collaborated remotely to identify topics of interests related to capacity building and grant management. During the meeting, the Tribal Governments and Tribal Organizations – SCF

Tribal Affinity Network had the opportunity to learn about tribal capacity building efforts from a Federal Government's perspective and interact with Lillian Sparks, Commissioner of the Administration for Native Americans, as well as Thom Campbell, former SCF Program Manager. One of the meeting objectives was to create a network where grantees could continue to develop connections, share information, and exchange ideas after the SCF grant period had concluded. The SCF Tribal Affinity Network planned to collaborate on a project to gather promising practices, lessons learned, and stories of impact related to capacity building in a tribal community.

OCS' Division of Energy Assistance (DEA) held a Webinar on Administrative costs for the Low Income Home Energy Assistance Program (LIHEAP) tribal grantees on February 17, 2011.

In April 2011, DEA distributed an Information Memorandum (IM) to all LIHEAP tribal grantees announcing the FY 2012 LIHEAP Model Plan. The IM included a section on the Program Integrity Assessment, which is now a permanent, required component of a LIHEAP Plan for all grantees. In an effort to ensure that the Program Integrity Assessment provided reliable, useful information, the IM clarified the meaning and intent of questions in the Program Integrity Assessment, reflecting lessons learned by DEA and input from the LIHEAP Program Integrity Working Group.

In addition to the IM, DEA hosted two teleconferences/webinars on the subject of the Program Integrity Assessment for tribes. DEA staff provided guidance and clarification on the Program Integrity Assessment, and grantees had the opportunity to ask questions and provide feedback. The teleconferences were held on June 15 and July 12, 2011.

National Energy and Utility Affordability Conference – LIHEAP. The National Energy and Utility Affordability Conference was held June 26-29, 2011, in Fort Lauderdale, Florida. It was a nationally targeted conference for all LIHEAP State directors, fuel vendors, and local providers, which included tribes. Six individuals from the DEA staff attended and assisted in various workshops offering guidance for new coordinators. Many tribal groups participated at this conference.

On August 10, 2011, DEA staff held a training teleconference and webinar for LIHEAP tribal grantees to ensure that all new and past LIHEAP coordinators are aware of the LIHEAP statute and regulations. The training was intended to help grantees to administer a successful LIHEAP program. Each grantee was forwarded a training PowerPoint presentation that was used during the presentation. Also during the presentation, time was set aside to answer questions from grantees.

### **Office of Child Support Enforcement (OCSE)**

OCSE Commissioner Vicki Turetsky held an OCSE-specific tribal consultation session following the ACF Tribal Consultation Session.

Commissioner Turetsky meets with tribal child support program directors that have Tribal IV-D programs while she is traveling. In FY 2011, she met with the Chickasaw Nation, the Pueblo of Zuni, and the Oneida Nation.

OCSE hosted the International Heads of Agency Meeting in August 2011. One of the topics on the agenda was working with indigenous populations. OCSE led the discussion with a presentation on tribal child support enforcement programs. In addition, the Nez Perce Tribe

made a presentation to the international delegation describing its child support enforcement program and answered questions about working with indigenous populations.

OCSE invited tribal leaders to engage in written consultation on a State regulation that could potentially impact the tribal child support enforcement programs.

OCSE Region I Regional Program Manager (RPM) met in Boston with four members of Mashpee Wampanoag Tribe (a federally recognized Massachusetts tribe), including a member of the Tribal Council and two Tribal Social Services Program Directors, to discuss possible tribal participation in several ACF programs, including the Tribal Title IV-D program. The Tribal IV-D program was explained and promoted, and the Tribe was invited to seek further information and TA if they were interested in applying for Tribal Title IV-D program funding.

OCSE Region I provided ongoing TA to the Penobscot Nation (Maine) Tribal Child Support Program, particularly in connection with tribal child support financial and statistical reporting matters, as well as general child support policy guidance.

Start-Up Grant Approval and Award Letter received in the New York Regional Office (Region II) for formal presentation to the tribe. As the first tribe to receive OCSE start-up funding for the New York Regional Office, arrangements were made to have a photo opportunity and a brief welcome meeting with the Regional Administrator, Tribal Fiscal Specialist, Child Care RPM, and Centers for Medicare and Medicaid Services (CMS) staff.

OCSE Tribal Specialist, accompanied by Child Welfare Region II RPM and Specialist, participated in first official site visit to St. Regis Mohawk Tribe for a combined meeting and to become better acclimated with the reservations unique layout and tribal member concerns.

The New York Regional Office invited Tribal Chief Judge (Interim Director) to attend and participated in their Annual IV-D Directors meeting held in New York City with the intent to welcome the tribe and introduce them to the subjects that are of current concern to programs that are fully operational.

OCSE Region II provided ongoing TA to the St. Regis Mohawk (NY) Tribal Child Support Program for general child support policy guidance and more recently in connection with financial and statistical report matters.

OCSE Tribal Specialist accompanied Region II Child Welfare RPM and Specialist and Child Care Specialist in providing a brief overview of OCSE and presentation of ACF-wide program and grant opportunities to the recently federally recognized Shinnecock Nation (NY).

Bi-Regional Tribal –State IV-D Directors meeting held in Chicago, July 2011. Region V and Region VII hosted its annual IV-D Directors meeting with participation from Leech Lake Band of Ojibwe Indians, Mille Lacs Band of Ojibwe Indians, and Red Lake Band of Ojibwe Indians of Minnesota; Forest County Potawatomi Community, Oneida Nation, Menominee Nation, Stockbridge –Munsee Community, and Lac Courte Oreille of Wisconsin; and Keweenaw Bay Indian Community of Michigan. Besides the representation of State IV-D Directors from Illinois, Indiana, Wisconsin, Ohio, and Michigan, the tribes had the opportunity to discuss challenges and opportunities for their programs with Commissioner Turetsky and Roy Nix, Director of Regional Operations, OCSE.

The Region V Tribal Program Specialist provided on-site TA and information to the Lac Courte Oreille Tribal IV-D start-up program in November 2010. In attendance from the Tribe included Tribal Administrator Norma Ross, Tribal Judge Moore, members of the Tribal Council, and IV-D Director Susan Smith. Topics of discussion included tribal program regulations, program operations, and transfer of cases.

Region V Tribal Program Specialist provided on-going TA to the Oneida Nation IV-D Program and the State of Wisconsin Bureau of Child Support on transfer of cases due to concerns with the Uniform Child Custody Jurisdiction and Enforcement Act.

Region V OCSE Program Manager and Tribal Program Specialist participated in a meeting and provided TA to the Minnesota IV-D tribes and the State of Minnesota Division of Child Support regarding mutual operational issues affecting these programs. The State and tribes agreed to work together on revising its Individual Memorandum of Agreements and Work Plans in order to expedite the transfer of cases between the State and the respective tribes.

Region V Office of Child Support Enforcement conducts monthly phone calls with Region V Tribal IV-D Programs to provide information and TA where needed.

Region VI met with representatives of the Pueblo of Isleta, Pueblo of Laguna, Pueblo of San Ildefonso, Jicarilla Apache Tribe, Santa Clara Pueblo, and Pueblo of Acoma, to provide an overview of Tribal Child Support.

Region VI conducted an onsite TA visit with the Alabama Coushatta Tribe regarding start-up application.

Region VI conducted an onsite TA visit with Kickapoo Tribe of Oklahoma. The Tribe was approved for comprehensive program funding October 2011.

Region VII held three quarterly intergovernmental TA conference calls among Region V and VII tribal and State IV-D program staff. The purpose of the calls was to discuss processes, issues, and best practices affecting case processing when parties reside in different jurisdictions. All Region V and VII funded tribes (comprehensive and start-up) were invited to participate.

Region VII held quarterly IV-D Director calls that included invitations to Tribal IV-D Directors in Region VII (Winnebago Tribe, Kickapoo Tribe in Kansas, Prairie Band Potawatomi Nation). The purpose was to provide TA and regional communications among tribal and State grantees.

At the invitation of the Prairie Band Potawatomi Nation, Region VII OSCE staff visited the tribal council and Child Support Enforcement program planners to provide TA and discuss progress in their first year of start-up funding.

Region VII provided T/TA on the completion of Federal reporting forms: OCSE-34A, SF-269A, and OCSE-75 to the Kickapoo Tribe in Kansas Tribal IV-D Director and staff.

At the invitation of Sac and Fox Tribe of Mississippi in Iowa, the Region VII RPM made a presentation to the tribal council and other tribal government and court officials about the IV-D program on September 28, 2011. On November 2, 2011, the tribal council passed a resolution to apply for IV-D start-up funding.

Region VII conducted regular conference calls (monthly and occasionally bi-monthly) with Winnebago Tribe of Nebraska to provide TA and Federal guidance as needed. Primary topics included case transfer, coordination with TANF, Federal reporting, and working with the States of Nebraska and Iowa on shared case processing procedures.

Region VIII conducted 11 site visits to tribal child support offices to provide T/TA to the Sisseton Wahpeton Oyate Sioux Tribe, Three Affiliated Tribes, Northern Arapaho Tribe, Eastern Shoshone Tribe, Blackfeet Tribe, Ft. Belknap Indian Community, Standing Rock Sioux Tribe, and the Confederated Salish and Kootenai Tribes of the Flathead Nation.

Region VIII held two meetings with Tribal IV-D Directors, Rocky Mountain Tribal Child Support Association meeting in December, 2010; plus a meeting with Northern Arapaho Tribe and Three Affiliated Tribes on official OCSE site review procedures and a question and answer session with the Regional Financial Specialist in charge of reviewing tribal child support financial reports.

Region VIII provided training at the request of Tribal IV-D Directors for overview of the Child Support Program services based on 45 CFR 309 and program compliance with the regulation for Sisseton Wahpeton Oyate Sioux Tribe, Three Affiliated Tribes, Northern Arapaho Tribe, Eastern Shoshone Tribe, Blackfeet Tribe, Ft. Belknap Indian Community, Standing Rock Sioux Tribe, and the Confederated Salish and Kootenai Tribes of the Flathead Nation.

Region VIII provided TA on procedures of Federal reporting issues, interpretation of Federal regulations and compliance, and Letters of Inquiry for Sisseton Wahpeton Oyate Sioux Tribe, Three Affiliated Tribes, Northern Arapaho Tribe, Eastern Shoshone Tribe, Blackfeet Tribe, Ft. Belknap Indian Community, Standing Rock Sioux Tribe, and the Confederated Salish and Kootenai Tribes of the Flathead Nation.

Region IX staff met during the Western Interstate Child Support Enforcement Council annual conference with the OCSE Commissioner and several members of the Navajo Nation Child Support Enforcement program.

Region X Program Specialists conducted 12 site visits with Tribal IV-D programs throughout the region. Some site visits also included grants management staff.

Region X participated in the Tribal IV-D and OCSE Medical Support Conversation co-hosted by the Tulalip Tribe.

Region X participated in five training sessions on the Model Tribal System and the OCSE 75 Reporting requirements via Webinars.

### **Office of Head Start (OHS)**

OHS convened four tribal consultation sessions with Tribal Leaders operating a Head Start/Early Head Start Program(s). The purpose of the consultations was to discuss delivery of Head Start services to AI/AN children and families, "taking into consideration funding allocations, distribution formulas, and other issues" that may affect services in the various geographic areas. Sessions were held in conjunction with other Tribal Leader meetings to reduce the burden of additional travel for the participants. These sessions were held in the following locations:

1. October 18, 2010 – Auburn, WA
2. October 20, 2010 – Fairbanks, AK

3. March 25, 2011 - Rapid City, SD
4. April 29, 2011 - Albuquerque, NM

The OHS Director met with Tribal Leaders and/or their designated representative and dialogued about many issues and concerns. Some of the major issues of concern, which have been raised in prior years as well, included:

1. Program quality and funding
  - a. Increased professional credentialing requirements for teachers without additional resources to meet these requirements;
  - b. Retention of qualified teachers once they get their degrees;
  - c. The need for clearer guidance from OHS on what credentials will be accepted in lieu of an Early Childhood Development Degree; and
  - d. Health specialty services for mental health and oral health care are lacking.
2. Transportation costs are high and impinge upon the rest of the program services' budget because of the rural and remote locations of tribes. Need more buses also.
3. Facilities replacement and renovation.
4. Equipment replacement.
5. Funding level disparities and parity with other Head Start Programs.
6. Improve the quality of AI/AN Regional T/TA services to tribal grantees.
7. Redesignation and how it will be implemented in very rural and remote areas. Understanding the triggers, e.g., Classroom Assessment Scoring System.
8. Broaden the definition of expansion funding.
9. Support language and culture integrated into program and with family engagement.
10. Improve the quality of communication and coordination between tribal grantees and OHS program and ACF grant staff.
11. Revisit Head Start program policies that are impacting tribal communities, e.g. in conflict with tribal culture and values or because of the very rural and remote geographic locations of Tribal Nations:
12. Eligibility
13. Policy council membership
14. NFS Match requirement
15. Monitoring reviews:
  - a. Don't send out review team leaders who have never been to a tribe
  - b. Timeliness of review reports
16. Fiscal issues: Indirect Cost rate agreements and applicability to Head Start grant and administrative cap limitations further burden programs with limited funding increases. Tribes bear the additional costs.

#### AI/AN OHS Grant Funding

In FY 2011, OHS funded 153 grantees including three Early Head Start (EHS) only; 96 Head Start (HS) only; and 54 HS/EHS programs located in 26 States. AI/AN Head Start Programs were awarded **\$214,818,190** to provide HS and EHS services to **24,288** children.

Of this amount:

- The program base for HS/EHS Programs was **\$202,807,206**.
- **\$8,277,909** was awarded (American Recovery and Reinvestment Act (ARRA funds)) to launch **17** additional tribal programs and serve an additional **1,286** children for EHS services primarily.
- An additional **\$3,733,075** in ARRA one-time funding was awarded to provide quality improvements such as:
  - Facility repairs and replacement



- Upgrade playgrounds
- Equipment and furniture
- Replacement of buses

### Training and Technical Assistance (T/TA)

The redesign of the National T/TA Program expands the expertise available to all OHS grantees, and to more effectively identify and respond to grantee needs for T/TA, now includes: (1) Six National Centers under which 'best practices' are communicated with content-rich resources and information, (2) AI/AN, Migrant and Seasonal (MSHS), and State T/TA Centers reconfigured in order, and (3) direct funding to AI/AN and other Head Start programs to address the T/TA priorities they have identified in their planning.

To augment the National redesigned T/TA Program, and as part of The Head Start Roadmap to Excellence, an administration-wide effort to close achievement gaps and promote early learning through the first 8 years of life for the nation's most vulnerable children, OHS has awarded the following grants to Tribal Head Start grantees:

- The Centers of Excellence Program was established in the Improving Head Start for School Readiness Act of 2007. Twenty Centers of Excellence were designated for a period of up to 5 years. Applicants had to be nominated by the Regional Program Manager. Among these Centers is the first AI/AN Head Start program, Pueblo Laguna, Department of Education, Laguna, NM. They received this designation for excellence in their utilization of the Touch Points parent-staff interaction/reflection approaches, family support and financial literacy services, and enhancement of culture and home language experiences for children with their families.
- Early Learning Mentor Coaches is a 17-month pilot to explore core elements or attributes critical to the successful implementation of mentoring programs. As part of this pilot, the grantees will share their approaches and mentoring strategies with other Tribal Head Start grantees. Among the awardees this year were the following tribal grantees:
  - a. Sault Ste. Marie Tribe of Chippewa Indians
  - b. Mille Lacs Band of Ojibwe
  - c. Cheyenne and Arapaho Tribes
  - d. Rosebud Sioux Tribe

The expanded requirement for education credentials for teaching staff has been a primary concern, given the rural and remote nature of tribal communities. Head Start partnered with the National Center for Quality Teaching and Learning held four Child Development Associate Academies for AI/AN grantees in:

- Denver, CO
- Rapid City, SD
- Anaheim, CA
- Fairbanks, AK

The National Center for Cultural and Linguistic Responsiveness provided management T/TA related to development of home-based program option for grantees in Fairbanks, AK.

### Joint Risk Management Meetings

During FY 2011, approximately 128 Risk Management meetings were convened with Tribal Head Start grantees approximately 90 days prior to refunding for the purpose of identifying strengths as well as areas of performance that need improvement. Such meetings also

provided opportunities for AI/AN grantees, OHS program staff, and grant specialists to collaborate to develop action plans to address areas in need of improvement and to sustain areas of strength.

#### Collaborations and Partnerships

The Head Start AI/AN Collaboration Office participated in a DOI/Bureau of Indian Education-sponsored meeting on "Let's Move in Indian Country," an obesity-prevention program championed by First Lady Michelle Obama that "seeks to end childhood obesity within a generation through improved nutrition and increased physical activity."

The Head Start AI/AN Collaboration Office met with the U.S. Department of Education's (ED) Special Assistant on Early Learning to share basic information on Head Start's program and its mandate to collaborate with local education agencies/school districts. Information was provided on Title 1 funding and formula grants used by ED to provide support for schools. As a follow-up, this was sent to all AI/AN Tribal Head Start grantees.

OHS coordinated with OCS on education, resources, and implementation of the AFI Program in tribal communities to assist families with low incomes and limited economic assets improve their financial stability. Many programs have already begun to use asset building strategies, such as financial education, to ensure that parents and staff have the information and skills they need to remain financially secure.

#### **Office of Family Assistance (OFA)**

During FY 2011, OFA provided TA to Tribal TANF programs across 16 states. The interventions provided critical support and trainings for helping programs improve services to TANF participants within their communities.

T/A interventions provided through Welfare Peer TA Network included:

- Training on wraparound case management services to the Chippewa Cree Tribe in Box Elder, MT. The training focused on planning and implementing a wraparound services model with Tribal TANF participants. The training also discussed policies, skills, and knowledge needed by the staff to put a wraparound services model into place and addressed the procedures for communicating with other important social services.
- A webinar on the *Domestic Violence and TANF Partnership in Indian Country* was held on June 27, 2011, and provided an overview of models for partnering with domestic violence agencies, culturally appropriate ways of addressing domestic violence when working with Native survivors, and resources available for engaging Native survivors. The Webinar was attended by about 70 participants, representing 20 States and the District of Columbia.

TA interventions carried out through the OFA T/TA Initiative included:

- Seven regional Tribal TANF Conferences, which featured experts and presenters who helped Tribal TANF programs strategize to develop stronger programs that will better serve their participants.
- Training on *Wraparound in Indian Country: The Ways of the People are Who We Are*, was provided to the Squaxin Island Tribe of Washington State to improve internal processes by the Native American Training Institute in a two-part training, held over a total of 4 days in Union, Washington. The training brought together social service agencies from the Squaxin Island Tribe as well as community advocates and tribal council members. The training helped attendees conceptualize how they can better

provide and coordinate services among their agencies while integrating culturally appropriate practices into the social services.

#### Region I:

Regional TANF staff participated in the HHS Regional Director's initiative to better coordinate with and provide information to all tribes in Region I and provided an overview of the TANF Program to representatives from the Mashpee Wampanoag Tribe in a follow-up meeting held on August 9, 2011.

Region I TANF staff provided TA to the Penobscot Nation in response to a 2010 letter of intent to implement a Tribal TANF program and assisted with their annual Native Employment Works (NEW) program and financial reports and coordination.

#### Region V:

TANF staff sent periodic messages to all Tribal TANF grantees with updated information on the ARRA TANF Emergency Fund's status and assisted grantee tribes in completing required reports.

TANF staff members worked intensively with three tribes that submitted Letters of Intent to become Tribal TANF grantees. The tribes' plans are in various stages of development, and the tribes involved are progressing in the process to become Tribal TANF grantees. Staff efforts included coordination between affected States and tribes on program transition issues.

TANF staff provided TA to a tribe requesting a partial retrocession of their service area. The tribe was guided through the process to ensure minimal disruption of services to clients.

TANF staff participated in the 2011 Region V Tribal Consultation Session planning group and presented on TANF and NEW issues at the January 6-7, 2011, consultation. The issue of inadequate TANF funding to meet the identified needs of their programs was raised by tribes at the consultation session.

TANF staff met twice by conference call with a delegation of the Lac du Flambeau Tribe, including the Tribal chairman, to discuss the Tribe's lack of adequate resources for its Tribal TANF program.

Tribal TANF staff conducted a workshop on tribal policies, case management, program and fiscal administration, partnerships, and domestic violence prevention and treatment at a Region V and VII OFA-sponsored, bi-regional event held in Mystic Lake, MN, on August 16-17, 2011. Approximately 35 people from fourteen tribes attended the workshop. The workshop ended with a teleconferenced discussion on administrative flexibility with ACF leadership in Washington, D.C.

#### Region VI:

Region VI TANF staff provided samples of Letters of Intent, held TA phone calls with the Delaware Tribe in Oklahoma and offered other TA opportunities to the Administrator Assistant to the Chief who had requested information about operating a Tribal TANF program.

Region VI TANF staff worked with the Muscogee-Creek Nation's Tribal TANF program as they developed a Tribal Plan amendment to include members of the Kialegee Tribal Town in their service population. The amendment became effective April 1, 2011.

Region VI TANF staff, in partnership with Region VIII OFA/TANF staff, developed and delivered a Rapid Response TA forum for the Tribal TANF grantees within the bi-regional area. The event was held in Denver, CO, on August 1-4, 2011. TA focused on the following:

- A Tribal TANF Forum allowed participants to have a dialogue with ACF Deputy Assistant Secretary for Policy and with the Director of the Office of Family Assistance.
- Forum included sessions on “Effective Assessment and Service Options for Domestic Violence Survivors” and “Tribal TANF, Child Welfare and Kinship Care” issues.
- Addressed “Improving State/Tribal Relations,” and allowed Tribal and State TANF administrators to communicate for the purpose of developing effective partnerships to ensure that all TANF participants become self-sufficient.
- Provided session on “Preventing Fraud, Waste and Abuse” led by representatives from the Office of Inspector General.
- Provided session on “Tribal TANF Program Accountability: Challenges and Strategies for Success,” which focused on effectively managing programs by ensuring an effective set of internal controls, policies, and procedures are in place.

Region VI TANF staff participated in a Regional Tribal Workgroup with the Regional Management Financial team to ensure program and financial issues are effectively coordinated in terms of delivering effective services, ensuring accurate reporting, etc.

Regional staff is working with OFA Central Office and the Chickasaw Nation of Oklahoma in their submittal of a Tribal NEW program application.

#### Region VII:

The Regional Office assisted the Santee Sioux Nation in implementing a Tribal TANF program in Knox County, NE, effective October 1, 2011.

The Regional Office provided guidance to the Sac and Fox Tribe of the Mississippi in Iowa in response to their interest in implementing a Tribal TANF program in Tama County, IA.

Region VII TANF staff provided TA to NEW non-102-477 grantees (Kickapoo Tribe of Kansas, Omaha Tribe of Nebraska, and Santee Sioux Nation) in the completion of the requirement to use Standard Form 425 (Federal Financial Report).

In January 2011, the Region VII TANF program facilitated the connection of the IRS (Stakeholder Partnerships, Education and Communication) and the Kickapoo Tribe of Kansas, resulting in the set-up and operation of a Volunteer Income Tax Assistance (VITA) site on the reservation. In all, 15 tribal members and non-tribal members were served, receiving free tax preparation and financial literacy information for and during the 2010 tax season.

The Region VII TANF program assisted with the facilitation and hosting of a quarterly Social and Rehabilitation Services (SRS) meeting on February 18, 2011, and presented on various tax credits available as well as asset building information.

In collaboration with the Office of Regional Administrator, the Region VII TANF program introduced the ASSET Initiative at a tribal consultation meeting July 19, 2011. Information was presented on AFI and comprehensive asset building strategies. In attendance were tribal leaders, tribal council members, and tribal staff from the Iowa Tribe of Kansas and Nebraska,

Kickapoo Tribe of Kansas, Prairie Band Potawatomie Nation, and Sac and Fox Nation of Reserve Kansas.

To promote awareness of Asset Building and Financial Literacy, the Region VII TANF program hosted a conference call for tribes operating a NEW Program on August 9, 2011. This call focused on culturally relevant financial education curriculums and resources for tribes. Topics discussed were IDAs, AFI, Children's Savings Accounts, program implementation and TA. Additionally, the tribe was informed of the IRS' VITA sites and Tax Care for the Elderly Program, specifically for the upcoming tax season. Information was shared with the Santee Sioux Nation and Omaha Tribe of Nebraska.

Region VII TANF program, in collaboration with the Office of Regional Administrator, hosted a call on Tribal TANF, AFI, IDAs, Children's Savings Accounts, financial education resources, and Voluntary Income Tax Assistance with the Economic Development Director of the Sac and Fox Tribe of the Mississippi in Iowa on September 28, 2011.

Regional Office leadership, including TANF, met with Chris Howell, Executive Director of Native American Affairs for the State of Kansas, October 19, 2011, to discuss the opportunities and challenges facing Kansas tribes and how ACF programs can help tribes take advantage of those opportunities and meet any challenges.

#### Region VIII:

During the week of August 1-4, 2011 in Denver, CO, a Bi-Regional State/Tribal TANF conference was held. On August 3-4, the conference featured tribal centered presentations with topics that included a Tribal TANF Forum with Mark Greenberg and Earl Johnson presenting; Child Welfare and Kinship Care; Improving State/Tribal Relations (with specific breakouts for each State/Tribal program); Preventing Fraud, Waste and Abuse; and Increasing Tribal TANF Program Accountability.

Each fiscal year, quarterly conference calls are held with Tribal TANF grantees. FY 2011 topics included, but were not limited to: Emergency Procedures for Natural Disasters (as several tribal programs had been impacted by flooding), Administrative Costs Caps, Time Limits for TANF on Reservations serving areas that are not considered Indian Country, Effects of ARRA on Tribal Communities (presented by Center for Medicare and Medicaid Services), OFA-100 applications and finalization. The conference calls were held December 2010, February 2011, and June 2011.

Regional Office staff also held a conference call with all NEW administrators on the new financial reporting form SF-425.

Provided training on Tribal TANF (TTANF 101) to four of the region's seven Tribal TANF grantees. Regional staff was able to conduct onsite training for two of the four training sessions. The audience for all presentations included tribal leaders/council and staff from Tribal TANF, the NEW program, tribal courts, child welfare and tribal fiscal offices.

Two site visits to the Wind River Reservation in Wyoming were conducted to visit the Northern Arapaho Nation and the Eastern Shoshone Tribe. The first visit in November 2010 was with Earl Johnson to discuss FY 2011 budgeting. A follow-up visit was conducted in September 2011 to continue budget discussions as well as determine training and program needs for the newly appointed TANF administrator and the acting Chief Financial Officer.

A site visit to the Sisseton-Wahpeton Oyate in South Dakota occurred on September 16, 2011. The purpose of this visit was to provide TA to Tribal TANF staff with an increasing caseload and limited funding.

OFA staff provided detailed Tribal TANF related T/TA, including guidance on plan renewals, program development, and regulatory compliance to all 7 Tribal TANF and 17 NEW grantees in Region VIII, via regular telephone and e-mail contact, general outreach, and when specific requests were made.

The Ely Shoshone Tribe is proposing a new Tribal TANF program and Region VIII and Region IX TANF staff are working to gather necessary data to ensure the Tribe has an approvable plan. The proposed plan would have a service area that includes States within both Regions IX and VIII. Region IX staff are taking the lead.

The Region worked with staff from the ED on a proposed initiative involving Tribal TANF families living on the Wind River Reservation. Region VIII staff held discussions with the Tribal TANF program directors and ED staff about acceptable ways to gather the needed information.

Region VIII staff provided resources and information to Tribal TANF and NEW grantees regarding the ASSET initiative and VITA sites, as this was a major priority for ACF this fiscal year.

Region VIII staff assisted the Chippewa Cree Tribe with a Peer-to-Peer TA request to help them implement wraparound services. The Chippewa Cree Tribe is now implementing wraparound services by partnering with their tribal court, chemical dependency treatment, mental health, and social services to serve their TANF clients more effectively.

### Region IX

Region IX provided extensive Tribal TANF related T/TA, including guidance on plan renewals, program development, and regulatory compliance to all 23 Tribal TANF grantees in Region IX, via regular telephone and e-mail contacts, general outreach, etc. Additional T/TA was also provided during individual meetings at the Regional Office with: Torres Martinez Tribe, Hoopa Valley Tribe, Washoe Tribe, Owens Valley Career Development Center, Soboba Tribe, and the Scotts Valley Tribe.

Region IX provided extensive guidance and TA to the Pechanga Tribe in the process of their withdrawal from an existing Tribal TANF program and the development and approval of their Tribal TANF program. The Region also provided guidance and TA in the development and approval of the San Carlos Apache Tribe's TANF program plan and worked closely with the Soboba Tribe, Scotts Valley Tribe, Salt River Pima Tribe, and the Washoe Tribe in the development, review, and approval process of their Tribal TANF renewal plans. Provided guidance to the Pascua Yaqui and the Hoopa Tribe to assist them in the completion of their final OFA-100 reports for TANF Emergency Contingency Funds received under ARRA.

Worked closely with the Ely Shoshone Tribe through the complex process of establishing a new Tribal TANF program involving multiple partner tribes, covering multiple shared service areas in multiple States; acted as the lead, primary contact, and technical advisor for both the State(s) and the Tribe in understanding the process requirements, roles, and guidelines.

Conducted on-site TA and monitoring oversight at the White Mountain Apache Tribe, Scotts Valley Tribe, and the Washoe Tribe.

Developed and hosted three comprehensive TA workshops for Region IX Tribal TANF program grantees, in both Arizona and California, with training which focused on subsidized employment development, program capacity building, improvement in fiscal and program management, and other critical program issues that had been identified through tribal input and ongoing communication/site visits with tribal grantees. Two of the workshops were held in San Francisco for California and Nevada tribes; a third workshop was held in Arizona for Arizona tribes and the State.

### Region X

The Region X Fiscal and Data Meeting held on April 26-27, 2011, in Seattle, WA, for Washington, Oregon, and Idaho tribes provided further guidance on data management, processing, reporting, and fiscal procedures.

The Region X Alaska Tribal Case Managers Training was held in Anchorage, AK, on May 3-5, 2011, to address Alaska Tribal TANF organizations' request for case management training. The training addressed case management activities, such as engaging TANF participants, motivational interviewing, and building self-sufficiency plans for participants. In addition, the meeting incorporated strategies for detecting fraud, working with Child Support Enforcement agencies, providing supportive services, and improving fiscal and data management practices.

The 2011 Annual Region X Tribal TANF Conference was held in Tulalip, WA, at the Tulalip Resort from September 27-29, 2011. The Conference provided Tribal TANF programs from Alaska, Idaho, Oregon, and Washington an opportunity to discuss and strategize methods for improving their programs and services to better serve their families and communities. Best practices and lessons learned were shared throughout the conference on a wide range of topics, including asset building, child care, child welfare, economic development, program evaluation as a method for program enhancement, and subsidized employment.

The Tribal Coalition, an ACF-wide team of the tribal related programs, meets monthly to discuss issues and related activities. The team provides oversight and opportunities where the different teams can collaborate.

TANF staff provided TA to grantees to prepare and submit Tribal TANF and NEW plan renewal materials by required deadlines. Five Tribal TANF plans were renewed during 2011.

Region X is taking an active role in helping tribes be up to date on reporting. Two fiscal/data meetings were held this year: one in Seattle for Washington, Oregon, and Idaho Tribes, and one in Anchorage at Cook Inlet Tribal Council for the Alaska Native Organizations.

## **AFFORDABLE CARE ACT ACTIVITIES SPECIFIC TO TRIBES**

### **Administration for Children, Youth and Families**

#### **Children's Bureau (CB)**

Section 10909 of the Affordable Care Act extends and expands the adoption tax credit that eligible families may claim for qualifying expenditures relating to the adoption of an eligible child.

**Family and Youth Services Bureau (FYSB)  
Tribal Personal Responsibility Education Program (Tribal PREP authorized by the  
Affordable Care Act)**

Conducted Tribal PREP consultation sessions. In October 2011, FYSB completed in-person consultation sessions and opportunity for written comments on Tribal PREP. Consultation directly informed the development of the funding opportunity announcement released in June 2011.

Funded Tribal PREP grants. In September 2011, FYSB awarded 16 grants to tribes and tribal organizations under the Tribal PREP discretionary grant program. During the Planning Year (Phase I) of the project, grantees will conduct needs assessments, develop data collection protocols and performance measures, create frameworks for evaluation, and select/adapt evidence-based programs that have potential for success in AI/AN communities.

Strengthened partnerships within HHS around teen pregnancy prevention in Native American communities. Significant groundwork has been laid in 2011 to establish and enhance partnerships with other agencies within HHS around the issue of teen pregnancy prevention among Native youth; of particular importance are relationships with IHS and Center for Disease Control and Prevention.

**Office of Child Care (OCC)**

The Affordable Care Act of 2010, Public Law 111-148 provides funding to States, tribes, and Territories to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation model(s). Model options would be targeted at reducing infant and maternal mortality and its related causes by producing improvements in prenatal, maternal, and newborn health, child health and development, parenting skills, school readiness, juvenile delinquency, and family economic self-sufficiency.

Five non-competitive grants were awarded for Tribal Maternal, Infant, and Early Childhood Home Visiting (TMIECHV) programs in FY 2011.

**Office of Child Support Enforcement (OCSE)**

The OCSE program has statutory responsibility to secure health care coverage for the children in its caseload called medical child support. The program is reassessing its medical support role in light of the Affordable Care Act and moving towards a focus on expanding children's health care coverage rather than cost recovery. In winter 2011, OCSE held a series of tribal conversations to discuss the implications of the Affordable Care Act for tribal medical support enforcement about improving coordination with Medicaid and outreach to families regarding new health care options. Each conversation was co-hosted with a tribal child support program. In July 2011, OCSE participated in medical child support group discussion at the National Child Support Associations Annual Conference in Denver. The conversations and discussions supplement, but do not replace, consultation. This model for communication was very well received and will be carried forward for additional discussions with tribal child support directors.

**TRIBAL DELEGATION MEETINGS**

**Tribal Early Learning Consortium, Washington, D.C.**

ACF's Deputy Assistant Secretary and Inter-Departmental Liaison for Early Childhood Development met with tribal grantee participants in a wrap-up session to gain feedback on issues of concern in implementing their early childhood programs in tribal communities.



### **Bristol Bay Association of Alaska**

Bristol Bay Native Association is a non-profit tribal consortium organized to provide educational, social, economic, and related services to the Native people and communities of Alaska's Bristol Bay region. The Tribal Council met with the OHS Leadership to discuss challenges in operating a Head Start Program in several remote villages and the need for buses to address health and safety issues.

### **Hualapai Tribal Delegation Meeting, Washington, D.C.**

The Chairman of the Hualapai Tribe met with the Director to discuss program issues including the recent termination of the Tribe's Head Start Director.

### **Havasupai Tribal Head Start, Supai, AZ**

The OHS Director made a site visit to this Tribal Head Start program, which is located at the bottom of the Grand Canyon and only accessible by helicopter or mule. A meeting was held with Tribal Leadership and discussions were centered on the challenges of operating a Head Start program in such an isolated location.

### **Laguna Head Start, Laguna, NM**

The OHS Director made a site visit to the Laguna Head Start and Early Head Start and met with the Head Start Director.

### **Omaha of Nebraska Tribal Delegation Meeting, Washington, D.C.**

The OHS Director met with the leadership of the Omaha Tribe of Nebraska at their request for a "face-to-face" meeting.

### **ACF Tribal Consultation Session, Washington, D.C.**

OHS Director and staff attended the first ACF-wide Tribal Consultation Session held in 5 years. The first ACF Tribal Consultation Policy was signed.

### **Navajo Nation Head Start Tribal Delegation Meeting, Washington, D.C.**

Navajo Tribal leadership met with the OHS Director to discuss issues related to the potential closure of their Head Start Program which would impact 2,000 Navajo children.

## **AGENCY TRIBAL CONSULTATION POLICY**

The ACF Tribal Consultation Policy was signed on August 18, 2011, in front of 42 North American tribes who attended the ACF Tribal Consultation session held in Washington, D.C. This policy sets official protocol on how the agency engages tribes in consultation on legislation, regulations, and policies that affect the services delivered to federally recognized tribes. Representatives from tribes met with ACF staff over the summer of 2010 to discuss how ACF consults with Indian tribes. Prior to this meeting, ACF relied on policy guidelines provided by the U.S. Department of Health and Human Services. This effort to establish a more formal policy was in direct response to Executive Order 13175, Consultation and Coordination with Indian Tribal Governments and the President's memorandum on Tribal Consultation issued by President Barack Obama in November 2009. After months of discussion, including consultation and internal review, a policy specific to ACF programs was listed in the *Federal Register* for a 45-day comment period in December 2010. This policy provides a clear channel of communication that lays out who responds on behalf of the agency, a timeline for responses, and where the communication takes place with tribal leaders. A copy of the policy can be found at the following website: <http://www.acf.hhs.gov/tribal/index.html>



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United States Department of Health and Human Services

## **Agency for Healthcare Research and Quality (AHRQ)**

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As 1 of 12 agencies within the Department of Health and Human Services, the Agency for Healthcare Research and Quality (AHRQ) supports health services research initiatives that seek to improve the quality of health care in America. AHRQ's mission is to improve the quality, safety, efficiency, effectiveness, and cost-effectiveness of health care for all Americans. The Agency works to fulfill this mission by conducting and supporting health services research, both within AHRQ as well as in leading academic institutions, hospitals, physicians' offices, health care systems, and many other settings across the country. The Agency has a broad research portfolio that touches on nearly every aspect of health care.

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Tribal Consultation Policy: Yes

## **HIGHLIGHTS OF DIVISION SPECIFIC ACCOMPLISHMENTS/ACTIVITIES TARGETED TOWARD AMERICAN INDIANS/ALASKA NATIVES (AI/AN)**

In FY 2011, AHRQ funded/supported seven efforts (grants, Interagency Agreements) that specifically focus on American Indian/Alaska Native populations. Also, AHRQ is working closely with the Indian Health Service (IHS) on two comparative effectiveness research projects supported with the Office of the Secretary's (OS') ARRA funds. These efforts are being led out of one of AHRQ's research centers and is headed by an IHS staff person on detail to AHRQ.

## **DIVISION SPECIFIC ACTIVITIES**

**AHRQ supports a research infrastructure development project run by the Montana-Wyoming Tribal Leaders Council which includes several studies addressing in-depth topics.**

In addition to supporting the development of a sustainable research infrastructure for the Montana/Wyoming Tribal Leaders Council, Black Hill State University, and the Black Hills Center for American Indian Health, this project funded a study aimed at designing, implementing, and evaluating the effectiveness of a structured process in which tribal members and IHS providers jointly developed strategies to improve performance based on priority issues identified through a consumer survey (developed by AHRQ). Investigators developed a targeted research agenda that addressed tribally identified priority issues, such as hepatitis C, West Nile virus, and methamphetamine use.

In addition, three other research studies were planned: evaluation of interventions to promote healthy weight among women, examination of factors that contribute to breast and cervical cancer outcomes, and design and implementation of a "healthy reservations" model program for system wide health improvement on reservations.

**AHRQ supports a research project to assess AIs'/ANs' perceptions of their care.**

The Quality Improvement (QI) Project undertaken by Yale University is being conducted with the Eastern Shoshone and Northern Arapaho Tribes of the Wind River Reservation in Wyoming and with the Fort Peck Indian Reservation (Assiniboine and Sioux Tribes) in Montana. During Fiscal Year 2011, they conducted and analyzed the tailored American Indian CAHPS survey at each reservation, and presented the findings to the Tribal-Indian Health Service (IHS) Working Group at each site. The Wind River Tribal-IHS Working Group identified Customer Service as the specific QI area that they would pursue; they developed a work plan for implementing a QI project with staff. This work plan has included bringing in speakers on customer service, regular meetings to discuss customer service improvement strategies with staff members, and holding a monthly competition between the two clinic sites on the reservation to achieve positive and measureable improvement in customer service, using a short satisfaction survey. Results for the first three months have been positive with both clinics producing higher scores on the short survey each month through August. The Fort Peck reservation site has determined that it is over-committed to other activities and chose not to implement a new QI strategy, but is continuing to participate as a control site in the project and will cooperate in the final year follow-up CAHPS survey (FY12). They have conducted site visits and follow-up telephone interviews with key staff at each Reservation to document their ongoing quality improvement activities (general and specific to this project), organizational changes, and other factors that may be expected to affect patient satisfaction and ratings of health care. During the final year of the project (FY12), monitoring and documentation of the QI interventions will continue, another round of site visits will be conducted, and the follow-up CAHPS surveys will be conducted at

each site. Results of the project will be presented to each Tribal-IHS Working Group during the final month of the study.

### **Medical home model for Alaska Natives to be assessed for impact on patient care delivery**

The Southcentral Foundation (SCF), a tribally-owned organization, implemented a patient-centered medical home (PCMH) in 1999 and 2000 in Anchorage, Alaska. The SCF PCMH has three key characteristics: patient selected family match to a primary care team, patient-driven care, and advanced access. In this project, the University of Alaska and the SCF are partnering to determine the impact of the PCMH transformation on the characteristics and quality of patient care delivery, and to assess changes in healthcare delivery, such as quality and safety efforts, efforts to bring evidence to the point of care, use of information systems, and costs. This PCMH model could have national implications for improving the health of the AI/AN population and may also be relevant to other practices serving diverse populations with multiple health disparities. The project is in its final stages.

### **Improving the Delivery of Self Management Support Services to American Indian/Alaska Native (AI/AN) People**

The purpose of this Intra-Agency Agreement was to transfer funds from AHRQ to IHS for the purpose of supporting the improvement of the delivery of prevention and care management services through the IHS Improving Patient Care Program (IPC). This project was designed to help understand, develop and test Electronic Health Record (EHR) elements that improve the delivery, documentation, and tracking of self-management support services.

### **Improving Patient Care Learning Networks**

In this effort, AHRQ provided (directly or through funding) subject matter experts for 16 presentations to the IHS learning network teams. The project builds on a previous IAA that provided clinical staff training and skill-building in self-management support for 38 clinical sites and teams participating in the IPC learning collaborative. Self-management support is a key component of patient-centered health care and the Chronic Care Model.

**AHRQ continued to support the annual American Indian/Alaska Native (AI/AN) Health Research Conference providing funding to support a Tribal College and University pre-meeting as part of the conference.**

## **AMERICAN RECOVERY ACT SPECIFIC TO TRIBES**

### **Project to improve race and health status data for Pacific Northwest States**

The Improving Data and Enhancing Access-Northwest Project seeks to more accurately characterize health status and clinical outcomes data for Northwest tribal people, while working to minimize and eventually eliminate racial misclassification errors in State surveillance data systems. To identify and correct racial misclassification, the project will conduct record linkages with an array of health-related data systems in a three-State region. Ultimately, it will disseminate results and develop concrete methods by which other States and Tribal Epidemiology Centers may implement similar programs. AHRQ is providing support for this project through funding received from the American Recovery and Reinvestment Act of 2009.

### **Project to improve the quality of race and ethnicity data in hospital discharge and emergency Department databases in New Mexico**

New Mexico's Improving the Quality of Race and Ethnicity Data Project will contribute to reducing racial and ethnic health and health care disparities by improving the reliability of race,

ethnicity, and tribal affiliation hospital data in the State. Guided by a State advisory committee, between 5 and 10 pilot hospitals will field test training materials that will be developed for the project. These will include hospital procedure, data collection, patient education, and train-the-trainer materials. Hospital discharge records will be linked with birth certificate records and IHS records to track improvements. New Mexico expects to establish a model for the collection, reporting, and appropriate dissemination of tribal identifier data which will be informally disseminated to other States and through a published manuscript. AHRQ is providing support for this project through funding from the American Recovery and Reinvestment Act of 2009.

**AHRQ is continuing its efforts to work with IHS on several fronts including two large ARRA programs funded with OS ARRA funds:**

**Electronic clinical data to assist in assessing comparative effectiveness of quality improvement efforts**

Over the past decade, the IHS has developed a national information technology infrastructure that allows for the routine, reproducible measurement of ambulatory quality of care across a spectrum of conditions for AI/AN communities. This infrastructure represents a model for evaluating the use of a nationally integrated health information system to conduct comparative effectiveness research (CER) and ultimately identify the most capable quality improvement activities. This project will use electronic clinical data from the IHS national health information systems to create a longitudinal database linking quality of care measures for diabetes, cardiovascular disease, and cancer screening over a 9-year period. A second objective will be to conduct two comparative analyses to determine the effectiveness of delivery system interventions, such as the use of an advanced electronic health record and a chronic care model (Improving Patient Care) to assess health care quality and outcomes for diabetes, cardiovascular care, and cancer screening.

This project is currently in month 14 of 24 (as of October 2011). The development of a longitudinal data infrastructure (LDI) is in process. One of the CER projects plans to test the LDI by looking at the association between EHR utilization and quality of care (QOC) by physicians by assessing effectiveness of organizational interventions on quality of care using breast cancer, diabetes, and cardiovascular disease measures. The second project plans to define the best method of linking patients to individual primary care providers within the IHS. The IHS has received a review of IHS data systems, a beta version of the CER dataset, and two social determinants of health review papers (adverse childhood outcomes & distance to care). The contractor is working on a final CER study plan and future work involves a Tribal dissemination plan, interim report, final study report, 2 external manuscripts and a final report.

AHRQ is providing staff support to IHS in this project. Funding was received from the American Recovery and Reinvestment Act of 2009 (Office of the Secretary funding).

**Project studies comparative effectiveness of disease management by IHS advanced practice pharmacists**

The purpose of this project is to support the development of data infrastructure and enhance data collection methodology with the IHS. The Contractor will link service data, pharmacy cost data, and health status measures and assess utilization and spending for a population subset in 12 IHS regions. The Contractor will then conduct a targeted CER project focusing on health delivery system strategies, such as advanced pharmacy practice, to reduce cardiovascular disease (CVD) risk among AI/AN adults.

Update (October 2011): This project is currently in month 13 of 24. The development of a dataset to test the use of CER studies is ongoing. The subcontractor has been working with the IHS and tribal organizations to obtain institutional review board (IRB) approvals and data use agreements. The first of three site visits to the 14 selected sites are being conducted. The CER study will use observational research methods to provide critical information on health status, utilization, and treatment costs. The project findings will assist IHS in prioritizing and evaluating chronic disease management strategies. In addition, this project will offer CER methods training modules/webinars to identify lessons learned concerning dataset limitations and methods for controlling bias for future CER studies.

AHRQ is providing staff support to IHS in this project; funding is from the American Recovery and Reinvestment Act of 2009 (Office of the Secretary funding).

#### **AGENCY TRIBAL TECHNICAL ADVISORY GROUP**

AHRQ is actively involved in the work of the AI/AN Health Research Advisory Council which provides input to the Department on health research matters. Given its small size and limited budget, AHRQ does not have a technical advisory group of its own. AHRQ participated in all meetings of this group in FY11.

AHRQ is also actively involved in the Department-wide Intradepartmental Council on Native American Affairs (ICNAA) and participated in all of its meetings during FY11.

#### **AGENCY TRIBAL CONSULTATION POLICY**

AHRQ updated its Tribal Consultation Policy during FY11. AHRQ mailed a copy of the draft Tribal Consultation Policy to all tribal leaders requesting feedback and comments in the spring of 2011. It further disseminated the draft policy statement through HRAC members and their networks. AHRQ made changes to the draft policy based on the tribal comments received. AHRQ is in the process of disseminating the finalized Tribal Consultation Policy to all tribes. It will soon be uploaded onto the AHRQ website.



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United States Department of Health and Human Services

## Administration on Aging (AoA)

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The Administration on Aging (AoA), an agency in the U.S. Department of Health and Human Services, is one of the nation's largest providers of home- and community-based care for older persons and their caregivers. Our mission is to develop a comprehensive, coordinated and cost-effective system of long-term care that helps elderly individuals to maintain their dignity in their homes and communities. Our mission statement also is to help society prepare for an aging population.

Created in 1965 with the passage of the Older Americans Act (OAA), AoA is part of a Federal, State, Tribal and local partnership called the National Network on Aging. This network, serving about 7 million older persons and their caregivers, consists of 56 State Units on Aging; 655 Area Agencies on Aging; 244 Tribal organizations; two organizations that serve Native Hawaiians; 29,000 service providers; and thousands of volunteers. These organizations provide assistance and services to older individuals and their families in urban, suburban, and rural areas throughout the United States. While all older Americans may receive services, the OAA targets those older individuals who are in greatest economic and social need: the poor, the isolated, and those elders disadvantaged by social or health disparities.

The Office for American Indian, Alaskan Native, and Native Hawaiian Aging was established in the Older Americans Act under Title II, Section 201. The Director of the Office has several responsibilities to include serving as the effective and visible advocate in behalf of older individuals who are Native Americans within the Department of Health and Human Services and with other departments and agencies of the Federal Government regarding all Federal policies affecting such individuals and administering and evaluating the grants provided under this Act to Indian tribes, public agencies and nonprofit private organizations serving Native Hawaiians.

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## HIGHLIGHTS OF DIVISION SPECIFIC ACCOMPLISHMENTS/ACTIVITIES TARGETED TOWARD AMERICAN INDIANS/ALASKA NATIVES (AI/AN)

### **Nutrition and Supportive Services Grants to 254 Indian Tribal Organizations**

AoA awarded \$25,891,231 to Indian Tribal Organizations for nutrition and supportive services, including transportation, homemaker and chore services, in order to help their elders remain independent in their homes and communities.

### **Native American Caregiver Support Grants to 218 Indian Tribal Organizations**

AoA awarded \$6,319,367 to Indian Tribal Organizations to help them support unpaid family members in caring for their elders and grandparents raising their grandchildren by providing training on caregiving, caregiver support groups, and respite.

### **Nutrition Service Incentive Grants to 252 Indian Tribal Organizations**

AoA awarded \$3,153,093 to Indian Tribal Organizations to support their congregate and home delivered meals programs.

## TRIBAL SUMMITS

The National Title VI Training and Technical Assistance Forum was held in Washington, DC from August 23 to 25, 2011. Approximately 200 Tribal Council members, Tribal Senior Program Directors and Tribal staff attended the Forum. Assistant Secretary for Aging, Kathy Greenlee, convened a Tribal Listening Session in conjunction with the National Forum. The following is a summary of the testimony given by Forum participants during the Listening Session.

### *Increased Funding*

- The testimonials point to a need for increased funding in Title VI, Part A/B and C and NSIP grants. Participants repeatedly informed the audience that their elder population was growing and that elders are living longer, while Title VI funds were not keeping pace. The need for funding to increase program staff to meet the growing elder population was also expressed.
- Participants repeatedly voiced the need for elder abuse funding for awareness, education, prevention, and program development in Indian country.
- Participants cited a need for vehicles and transportation program operating costs.
- Several participants discussed the success and need for funding health promotion and wellness programs, including evidence-based programs.
- Several participants pointed out the need to increase funding levels for programs that coordinate with, or provide services to, tribal elders, such as the USDA Farmer's Market Nutrition Program and the Foster Grandparent Program.
- Testimonials support the need for increased health funding and the need to provide training to in-home care workers.

### *Title VI and Title III*

- Multiple participants cited their appreciation of the Title VI program's flexibility and indicated their Title VI funds serve as a "base" for leveraging Title III funds.
- Participants indicated there was a need for increased coordination with the States.
- Participants were concerned about the lack of comparability of allowable services between the caregivers programs under Title III-E and Title VI-C.



### *Elder Abuse*

1. Forum participants testified that the current laws and support for prevention of elder abuse and neglect are inadequate. As one participant stated, “We have those kinds of needs on our reservation and they are not very different from other reservations.”
2. Numerous participants expressed the need for adequate funding to establish and develop elder abuse and neglect programs.

### *Transportation*

- There was frequent reference to a severe lack of transportation services and transportation funding on reservations. One participant expressed frustration at the current state system; calling it a “headache” for elders.
- Participants suggested increased collaboration with local, state, and national organizations as a way to bring better transportation services to the elders.
- One testimony described a need for vehicles to assist elders in getting to and from meal sites.
- Many participants testified to the urgent need for viable transportation services for seniors living in rural and frontier communities. One participant from Alaska said, “The cost of home delivered meals in southeast Alaska is three times higher than in the lower 48.”

### *Access*

- 1) One participant testified that many Native communities qualify as “food deserts”, places without access to fresh fruits and vegetables. Studies have shown an increase in chronic disease and diet.
- 2) Several testimonies were heard concerning the high cost of providing services to seniors living in rural and frontier areas that directly limits access to those services.

### *Long-term Care Services and Livable Communities*

1. Testimony points to a need for tribal specific long-term care services and to the need for Tribes to train States on culturally appropriate long-term care service delivery.
2. Testimony included the need to involve tribal elders in planning long-term care services. One participant said to always “listen to the quiet” voice for direction and need.
3. Testimony indicates a need for trained tribal in-home workers working with elders.
4. Several participants testified asking for support for the severe health care needs of tribal elders. One participant said, “They don’t have money to buy teeth so they can enjoy a meal that someone cooks for them or they cook for themselves. They don’t read the newspaper or watch the news anymore because they cannot see the screen or read the print. So, they suffer in silence because we don’t have that kind of funding.”

### *Health Promotion and Disease Prevention*

1. Many participants testified that funding for health promotion/disease prevention programs should be increased and available directly to the Tribes.
2. Testimony demonstrated a need for training in how to implement evidence-based health promotion programs.
3. Several participants stated that a successful ADRC in Indian Country would require tribal input during the planning and development process.



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United States Department of Health and Human Services

## Centers for Disease Control and Prevention (CDC)

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The mission of CDC is to promote health and quality of life by preventing and controlling disease, injury, and disability. CDC seeks to accomplish its mission by working with partners throughout the nation and the world to:

1. monitor health,
2. detect and investigate health problems,
3. conduct research to enhance prevention,
4. develop and advocate sound public health policies,
5. implement prevention strategies,
6. promote healthy behaviors,
7. foster safe and healthful environments,
8. provide leadership and training.

Those functions are the backbone of CDC's mission. Each of CDC's component organizations undertakes these activities in conducting its specific programs. The steps needed to accomplish this mission are also based on scientific excellence, requiring well-trained public health practitioners and leaders dedicated to high standards of quality and ethical practice.

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Tribal Consultation Policy: Yes

## **HIGHLIGHTS OF DIVISION SPECIFIC ACCOMPLISHMENTS/ACTIVITIES TARGETED TOWARD AMERICAN INDIANS/ALASKA NATIVES (AI/AN)**

### **A Prospective Birth Cohort Study Involving Environmental Uranium Exposure in the Navajo Nation, Health Investigations Branch (ATSDR)**

Extensive uranium mining and milling operations have occurred on the Navajo Nation during the last half century. Due to these anthropogenic activities, there remains a level of potential uranium exposure to the Navajo people from various sources including abandoned uranium mills/mines, contaminated drinking water, soil, and homes built with mining waste. While there have been many studies of occupational exposure to uranium and renal effects, there have been very limited studies on other adverse health effects. There is also limited toxicological and epidemiological data that indicates that uranium may pose a risk to the developing fetus. The purpose of this study is to quantify fetal risk from uranium by recruiting Navajo mothers, assessing their uranium exposure at key developmental milestones, and then following the children post-birth to evaluate any associations with birth defects in developmental delays. The study also has applied public health goals to provide educational outreach to increase prenatal care utilization, earlier assessment and referral for developmental delays, and mitigation of uranium exposure among Navajo mothers. In 2011, the study protocol was developed and received clearance from the Institutional Review Boards from all involved institutions. We have initiated clearance with the Office of Management and Budget and anticipate beginning study participant recruitment in 2012. Funding-\$2 million.

### **Petition for Health Assessment Regarding Potential Contamination from Shellfish Consumption on the Port Gamble S'Klallam Reservation (ATSDR)**

The Port Gamble S'Klallam tribe requested ATSDR Region 10's involvement as they investigate their concerns regarding potential chemical exposures through shellfish consumption. After a formal consultation discussion with the Port Gamble S'Klallam tribe, it was agreed by all parties that a Public Health Consultation be conducted through ATSDR's Cooperative Agreement Program with the Washington State Department of Health (WDOH). Funding in-kind.

### **Site Investigation at the Cyprus Tohono Mine Located on the Tohono O'odham Nation (ATSDR)**

As part of ATSDR's congressional mandate to evaluate public health impacts associated with National Priority Listing (NPL) sites, the US Environmental Protection Agency (EPA) designated the Cyprus Tohono Mine Site, located on the Tohono O'odham Nation, a Superfund Alternative (SA) approach site and requested ATSDR to evaluate human exposures and advise on actions needed to mitigate exposures, if necessary. ATSDR used the tribal consultation process to inform the tribe about the upcoming evaluation process and to determine who would assist with the evaluation. Efforts to conduct the evaluation at the Cyprus Tohono Mine Site will continue in FY2012. Funding in-kind.

### **Office of Infectious Diseases (OID): National Center for Enteric and Zoonotic Infectious Diseases (NCEZID)**

Infectious Diseases: Published a description of the occurrence of overall and specific infectious disease hospitalizations among the AIAN population. This analysis provides recent rates and identifies high-risk diseases and areas to focus further study and prevention measures for the reduction of infectious diseases in AI/AN communities.

Gastroenteritis: Completed analysis of the occurrence of gastroenteritis hospitalizations among AI/ANs prior to and after the introduction of the rotavirus vaccine to describe the effect of the

vaccine on hospitalizations. The findings underscored the importance of rotavirus vaccine among this population.

Molluscum Contagiosum: Case control study to describe the epidemiology and risk factors that contribute to the high incidence of molluscum contagiosum in certain AI/AN communities. This work will help target outreach and education activities with the long term goal of reducing disease incidence in these communities.

Prion disease: Ongoing analysis of mortality data for AI/ANs with prion disease. Analyzing currently available data to determine the occurrence of the disease among this population in chronic wasting disease endemic areas.

### **Indian Health Service/National Death Index (IHS/NDI) Linkage Project**

Committee member and investigator on studies analyzing deaths among overall AI/AN infants and infectious diseases among all AI/ANs.

Rabies: Ongoing collaborative projects with the US Department of Agriculture (USDA) and Navajo in AZ on dog rabies control issues. Findings increase awareness of specific infectious diseases. Published papers on dog rabies vaccination and bait development.

Lymphocytic choriomeningitis virus: Medical chart review of a subset of IHS patients diagnosed with Lymphocytic choriomeningitis virus (LCMV) to verify diagnosis and estimate incidence of this rodent-borne disease. The medical chart review found that LCMV was diagnosed very rarely, and is thought to occur infrequently in AI/AN populations.

High rates of pediatric dental caries in Alaska Native children: Dental caries among Alaska Native children represent a substantial and long-standing health disparity. Results of an Arctic Investigations Program (AIP) investigation concluded that pediatric dental caries are approximately 5 times more common in the region than for the general US childhood population. The published article (CDC MMWR, Sept 23, 2011) was used to support village council decisions to fluoridate water supplies in 3 rural Alaska communities in Oct 2011.

### **Responding to pandemic H1N1 influenza in AI/AN populations: Arctic Investigations Program (AIP)**

Working to address the increased influenza mortality among AI/AN people by leading a 5-State investigation into risk factors for deaths. We hope the results of this study will be used to find ways to prevent death due to influenza.

Rocky Mountain Spotted Fever: In 2011, CDC provided design input and printing of 5,000 coloring book calendars that were distributed to children of the San Carlos and White Mountain Apache tribes, with a goal of educating children about RMSF. Following the distribution of these calendars, CDC assisted the tribes with an evaluation of the efficacy of the coloring book calendar campaign, by conducting a door to door survey in August 2011. CDC assisted tribes with the first-ever census of dogs on the reservations. The census identified that 70% of dogs on the reservation were free-roaming, which contributes greatly to the problem of tick distribution. CDC developed a pilot program for a remote dog treatment baiting system, using food as an attractant and treating dogs for ticks. CDC provided eight staff members who assisted with summer prevention efforts for both tribes, working in the field in Arizona for two weeks at the end of June, 2011. CDC worked with both tribes to conduct a systematic chart review of severe and fatal RMSF cases to identify risk factors for poor outcome; chart reviews

were conducted throughout the year, with CDC IRB exemption and tribal approval from both the San Carlos and White Mountain Apache tribes. On Gila River Indian Community, CDC provided 4 staff members during April 2011; staff conducted a canine serosurvey to assess possible spread of RMSF from an affected housing district, and to assess efficacy of prior year's prevention efforts on the reservation.

### ***Epidemiology Training***

Two OSELS/SEPDPO staff epidemiologists deployed with Public Health Service (PHS) Applied Public Health Team-4 (APHT-4) to the Pine Ridge Reservation in South Dakota during the week of August 21–27, 2011. This was in conjunction with a clinical and public health training mission funded by the PHS Office of Force Readiness and Deployment. The SEPDPO epidemiologists worked with the Oglala Sioux Tribe and other CDC, APHT-4, and Indian Health Service epidemiologists to plan for an upcoming Community Health Profile and to conduct training on epidemiologic tools for accomplishing this activity. Funding-Direct Assistance.

### **Public Health Associate Program (PHAP)**

PHAP is a competitive, two-year, paid Centers for Disease Control and Prevention (CDC) fellowship. A PHAP associate is assigned to a state, tribal, local or territorial public health agency and works alongside local public health professionals. After completing the program, PHAP graduates will be qualified for future jobs with federal, state, tribal, local and territorial public health agencies, and will be uniquely prepared to pursue an advanced degree in public health. Three students are currently working in Indian County: Shoalwater Bay Tribal Health Department and Wellness Center in Tokeland, Rocky Mountain Tribal Epidemiology Center, California Tribal Epidemiology Center. Funding-Direct Assistance.

## **DIVISION SPECIFIC ACTIVITIES**

### **CDC/IHS American Indian and Alaska Native Health Analyses Collaborations (OID)**

Ongoing epidemiologic collaborative projects with the Indian Health Service (IHS), Alaska Native Tribal Health Consortium (ANTHC), CDC Arctic Investigations Program (AIP), other agencies/divisions and universities to detect and describe disease burden and health disparities for overall and specific infectious diseases among American Indian and Alaska Native (AI/AN) communities. Studies provide information for developing prevention strategies, vaccination policies, and reducing health disparities related to infectious diseases. Findings increase awareness of specific infectious diseases, and highlight disease, person and geographic target areas to further investigate health disparities. For example, the identification of lower respiratory tract infections disparities among Alaska Native children led to more in-depth respiratory studies and educational efforts for children in Alaska. Funding-\$140,000.

### **Arctic Investigations Program (AIP)**

Arctic Investigations Program - AIP's program mission is the prevention of infectious disease in people of the Arctic and subarctic, with particular emphasis on indigenous people's health. AIP coordinates disease surveillance and operates one of only two Laboratory Response Network labs in Alaska. Highlights include: Sanitation services and infectious disease risk in rural Alaska: AIP assessed increased infectious disease risk due to lack of in-home sanitation services. The study has been used to advocate for increased funding for water and sanitation services in Alaska. Response to emergence of replacement pneumococcal disease in Alaska Native infants: AIP supported introduction of a new pneumococcal vaccine, PCV 13, in southwest Alaska. Usage results clarified that it provides protection for up to 75% of serious pneumococcal illnesses. Since routine use of this vaccine was begun in 2010, rates of serious pneumococcal infections have decreased in rural Alaska Native children. Support for Alaska

Native Health Research: AIP promotes research activities by Tribal health organizations and supports Alaska Native/American Indian health researchers. Funding \$3,204,301.

### **Prevention and Control of Rocky Mountain Spotted Fever (RMSF) on tribal lands in Arizona**

Since 2003, Rocky Mountain spotted fever (RMSF) has emerged as a significant public health threat in American Indian communities in Arizona, on the White Mountain Apache, San Carlos Apache, and Gila River Indian Community reservations. Human infection is associated with transmission from *Rhipicephalus sanguineus*, the brown dog tick, and is supported by large numbers of free-roaming community dogs that provide a food source for the ticks. Through 2011, over 200 human cases of RMSF with > 14 human deaths have been reported. The region's reported incidence (527 cases per million persons) is 70X the national incidence of RMSF. Over 50% of deaths occur in children. The problem appears to be worsening: in 2011, there were 5 reported fatalities from the White River and San Carlos Apache tribes, compared to an average fatality of 1-2 cases per year. CDC, working together with the Arizona Department of Health Services and the Indian Health Service, are assisting tribes with developing and implementing prevention efforts to control the RMSF problem. CDC offers consultation, clinical evaluations of patients, educational materials, and guidance for environmental control. In addition, CDC provides field staff each year to support San Carlos and White Mountain's summer prevention campaigns, consisting of treating tick-infested homes with pesticide and placing tick collars on dogs. Funding not awarded directly to the tribes. Funding-\$170,000 in Direct Assistance.

### **IHS National HIV/AIDS Program (NCHHSTP)**

Develop multimedia tools targeting AI/AN youth 13-21 years old For example: HIV prevention and sexual health promotion topics, HIV, STD and viral Hepatitis prevention. Funding-\$1,000,000.

### **Capacity Building Assistance (CBA) To Improve the Delivery and Effectiveness of Human Immunodeficiency Virus (HIV) Prevention Services for High Risk and Racial/Ethnic Minority Populations (NCHHSTP)**

CBA is designed to assist in implementing and sustaining science-based and culturally proficient HIV prevention behavioral interventions and HIV prevention strategies. This project is funded under Category B (Strengthening community access to and utilization of HIV prevention services) to provide CBA to Community Planning Groups (CPGs), community-based organizations (CBOs), health departments (HDs) and other HIV prevention stakeholders. It focuses on the following goals: 1) Improve the capacity of CBOs to strengthen and sustain organizational infrastructures that support the delivery of effective HIV prevention services; 2) Improve the capacity of CBOs and HDs to implement, improve, and evaluate HIV prevention interventions; 3) Improve the capacity of CBOs and other stakeholders to implement strategies that will increase access to HIV prevention services for racial/ethnic minorities at high risk; and 4) Improve the capacity of CPGs and HDs to include HIV-infected and affected racial/ethnic minority populations and subpopulations in the community planning process, and increase parity, inclusion, and representation (PIR) on CPGs. Colorado State University, Funding-\$406,125. Great Plains Chairmen's Health Board, Funding-\$369,587

### **Capacity Building Assistance (CBA) To Improve the Delivery and Effectiveness of Human Immunodeficiency Virus (HIV) Prevention Services for High Risk and Racial/Ethnic Minority Populations (NCHHSTP)**

CBA is designed to assist in implementing and sustaining science-based and culturally proficient HIV prevention behavioral interventions and HIV prevention strategies. This project provides CBA to HIV prevention planning groups, community-based organizations, health departments and other HIV prevention stakeholders. It focuses on the following goals: 1) Strengthening Organizational Infrastructure for HIV Prevention: Improve the capacity of CBOs to strengthen and sustain organizational infrastructures that support the delivery of effective HIV prevention services and interventions for high-risk racial/ethnic minority individuals; and 2) Strengthening Interventions for HIV Prevention: Improve the capacity of CBOs and Health Departments to implement, improve, and evaluate HIV prevention interventions for high-risk racial/ethnic minority individuals of unknown serostatus, including pregnant women, who are living with HIV/AIDS and their partners. The National Native American AIDS Prevention Center. Funding-\$406,125.

### **Epi-Aid 2011-67, "Investigation of Increased Number of Tuberculosis Cases Among American Indians, Navajo Nation Reservation, Arizona and New Mexico, USA," July 5-22, 2011**

Surveillance, Epidemiology, and Outbreak Investigations Branch (SEOIB) provided supervision, with staff from International Research and Programs Branch (IRPB), Field Services & Evaluation Branch (FSEB), and also from DSTDP on the ground. During 2010–2011, the Navajo Nation Division of Health (NDOH) identified an increase in the number of tuberculosis (TB) cases among residents of the Navajo Nation reservation, which spans a large region primarily in Arizona and New Mexico. On May 27, 2011, the NDOH and Arizona Department of Health Services (AZDHS) notified CDC of a TB outbreak associated with a hospital serving the Tuba City Indian Health Service (IHS) service unit. This service unit provides clinical and public health services to Native persons (primarily Navajo and Hopi) in the northwestern area of Arizona. AZDHS and partners assisted the NDOH TB Control Program in the initial outbreak investigation. Subsequently, on June 16, NDOH and AZDHS informed CDC of a second outbreak of seven TB cases diagnosed over <12 months in a community in the Fort Defiance IHS service unit, located in eastern Arizona and primarily serving a Navajo population. Epi-Aid Overall Objectives: 1) Describe the current epidemiology of TB on the Navajo Nation reservation, 2) Identify chains and recent transmission within TB clusters on the reservation, 3) Identify and prioritize contacts of infectious TB cases for evaluation and treatment and 4) Provide recommendations to interrupt further transmission of TB. Funding-no specific award for this activity.

### **Office of Non-communicable Diseases, Injury and Environmental Health (ONDIEH)**

Lummi Indian Seafood Consumption Survey Project: The Lummi Indian Nation is working to establish tribe-specific fish consumption rates in order to develop appropriate risk assessments which will aid in cleaning up contaminated sites, improving habitat conditions, and improving water quality standards on tribal lands. Funded - \$75,000

### **Project CHOICES Pilot Implementation and Evaluation for American Indian and Alaska Native (AI/AN) Women (NCBDDD)**

Fetal Alcohol Syndrome (FAS) and other prenatal alcohol-related conditions are highest among American Indian and Alaska Native (AI/AN) populations (2.5 to 5.6 per 1,000 population) according to published reports. CDC's CHOICES project is an effective behavioral approach for preventing alcohol-exposed pregnancy (AEP), targeting both alcohol use and effective

contraception. In 2010, CDC and Indian Health Service (IHS) entered into a 3-year interagency agreement to adapt and implement CHOICES in American Indian communities. This project will reach out to American Indian women of reproductive age of the Oglala Sioux Tribe in South Dakota. In October 2011, implementation of the intervention began in three clinics (Native Women's Health Center in Rapid City – Oglala Sioux tribe clinic, and IHS clinics in both Kyle and Wanblee on the Pine Ridge reservation). Feasibility and acceptability of the intervention by American Indian women will be evaluated. Funding-\$150,000.

#### **Strategic Alliance for Health (NCCDPHP)**

The intervention area includes the Tribal Jurisdictional Service Area (TJSA) of 9,200 sq. miles with a population of 399,385 in 14 counties. The Cherokee Nation has developed, implemented, and expanded a comprehensive plan to implement promising strategies for healthy eating, active living, and tobacco-free environments in the Cherokee Nation of Oklahoma -- the Eastern band of the Cherokee Nation. Their interventions are guided by the research, collaboration, and recommendations of the public health experts and stakeholders via the Healthy Eating Active Living Convergence Partnership. Funding-\$400,000.

#### **Preventive Health and Health Services Block Grant (NCCDPHP)**

The funds are used to compliment existing funds to support the tribal EMS system. Data development and training are two areas of need. Funding- \$22,083. Funds a Boys/Girls Club Youth Leadership Initiative which entails attendance at a National Youth Leadership Conference and local activities. Funding- \$22,083

#### **Coordinated School Health (NCCDPHP)**

The Maine Department of Education is funded for HIV Prevention, Coordinated School Health (CSH)/Physical Activity, Nutrition, and Tobacco, and the YRBS. Maine's three tribal schools were selected in a competitive process to participate as priority schools in the state's coordinated school health program. All tribal schools participated in professional development tailored to their needs, mini-grants of \$5,000 per school per year, and on-going technical assistance. All tribal schools completed CDC's School Health Index (SHI) and used the results to revise and improve their wellness policies. Every tribal school implemented new healthy eating and/or physical activity promotion initiatives. Highlights include: new physical activity breaks during the academic day policies, recess before lunch policies, and inclusion of students in school menu choice, before school walking clubs and establishing school gardens and healthy cooking clubs. In addition, the Maine Indian Unified School Committee augmented their tobacco policy passed last year with implementation of an alternative to suspension tobacco cessation program. The tribal schools represent a small portion of students served with Maine's CSH program. Funding-\$369,557.

#### **Cherokee Nation YRBS and School Health Profiles (NCCDPHP)**

The Cherokee Nation receives funding to conduct the Youth Risk Behavior Survey (YRBS). The goal of this program is to advance the knowledge of critical health related behaviors among high school students through data collection and dissemination. With technical assistance from CDC/DASH, in 2011, Cherokee Nation administered the YRBS in high schools within the Tribal Jurisdictional Service Area to obtain data representative of students in grades 9-12. To plan, promote, and disseminate results from the YRBS, the Cherokee Nation also collaborated with multiple community partners. The Cherokee Nation also started to prepare sampling frames to conduct the 2012 School Health Profiles. Funding-\$10,000.



### **Bureau of Indian Education (BIE) and Navajo YRBS and BIE School Health Profiles**

CDC/School Health provides technical assistance to the BIE and Navajo Nation to conduct the YRBS. Both the BIE and Navajo YRBS are conducted every 3 years. BIE administers the YRBS to middle and high school students attending Bureau-funded schools across the United States. The Navajo Nation, working with the Indian Health Service, conducts the YRBS among middle school and high school students attending public and private schools on the Navajo Reservation and in a small number of "bordertown" schools with high Navajo student enrollment. This surveillance activity is designed to determine the prevalence of health-risk behaviors among students, assess trends in these behaviors, and examine the co-occurrence of health-risk behaviors. The YRBS collects data on health risk behaviors among young people so that health, education, and tribal agencies can more effectively target and improve programs. Both BIE and the Navajo Nation most recently conducted the YRBS in the fall 2011. Data will be processed in spring 2012 at which time CDC/DASH will provide technical assistance to BIE and the Navajo Nation to help generate YRBS reports. During 2011, CDC/DASH provided technical assistance to the BIE to conduct the School Health Profiles survey to obtain representative information about current school health policies and practices within BIE-funded schools. BIE will administer the School Health Profiles survey in spring 2012. Funding-in kind.

### **Winnebago Tribe Youth Risk Behavior Survey (YRBS):**

The Winnebago Tribe of Nebraska receives funding to conduct the Youth Risk Behavior Survey (YRBS). The goal of this program is to advance the knowledge of critical health related behaviors among middle and high school students through data collection and dissemination. The Winnebago Tribe obtained weighted data (allowing for generalized results) in 2011 for both their middle school and high school YRBS. Funding-\$10,000.

### **Colorectal Cancer Control Program (NCCDPHP)**

The CRCCP's goal is to increase colorectal (colon) cancer screening rates among men and women aged 50 years and older from about 64% to 80% in the funded states by 2014. The program provides population-based approaches to increase colorectal cancer screening rates among the U.S. population 50 years of age and older that can lead to health systems change, outreach, case management and limited provision of direct screening services. Funded Programs include: Arctic Slope Native Association, Funding-\$385,878, Alaska Native Tribal Health Consortium, Funding-\$750,000, South Puget Intertribal Planning Agency, Funding-\$650,000 and South Central Foundation. Funding-\$740,000.

### **EARLY ACT AIAN Project - "Walking Together: Making A Path Toward Healing (NCCDPHP)**

The purpose of this Intra-Agency Agreement (IAA) is to support the Phoenix Indian Medical Center (PIMC) Oncology Program to identify and describe the impediments to care physically, psychologically and spiritually faced by young AI/AN women diagnosed with breast cancer under the age of 45 from their own viewpoint. Through focus groups, the patients understanding of the barriers they faced in getting care for their breast cancer as well as their viewpoints regarding services available or unavailable to them will be studied. The information gathered will be used to develop recommendations for targeted interventions that will address common concerns in these patients breast cancer journey. Funding-\$112,347.

### **Enhancing Cancer Prevention and Control Programs for American Indian/Alaskan Native Women (NCCDPHP)**

1) As part of Native American Cancer Research Corporation's (NACR) ongoing CDC grant, NACR is coordinating 2 Regional meetings each grant year. NACR will be implementing and

evaluating 10 Regional Planning Conferences / working meetings in collaboration with local public health professionals and organizations that actively work with American Indian or Alaska Native (AI/AN) organizations and communities. 2) NACR will address gaps in AIAN cultural awareness materials (including designing, developing, and distributing AI/AN cultural appropriate public education and awareness materials. This includes one Native Wellness booklet annually and one case study annually. 3) NACR will provide technical assistance related to cultural appropriateness and awareness, as approved by the CDC, to states' Indian Health Service, tribal and urban programs and others, on an as needed basis. 4) Lastly, NACR will implement and evaluate cultural awareness trainings. Funding-\$400,000.

#### **Tribal BRFSS Project (NCCDPHP)**

The purpose of this Intra-Agency Agreement (IAA) is to support the Tribal BRFSS Project at Northwest Portland Area Indian Health Board. The objective of this project is to provide Tribal grantees of the National Comprehensive Cancer Control Program with accurate health behavior data that is not readily available through the state BRFSS for Tribal communities so that programs can use these data to assess cancer risk factors for their population and monitor progress toward reaching cancer plan objectives. Northwest Portland Area Indian Health Board will be subcontracting with Intertribal Council of Arizona to support a Tribal BRFSS Project with the Tohono O'odham Nation. Funding-\$280,000.

#### **National Breast and Cervical Cancer Early Detection Program (NCCDPHP)**

Early Detection Program provides access to breast and cervical cancer screening services to underserved women. Programs funded include: Arctic Slope Native Association Funding-\$561,519, Cherokee Nation Health Service Group Funding-\$846,660, Cheyenne River Sioux Tribe Funding-\$409,708, Hopi Tribe Funding-\$516,917, Kaw Nation of Oklahoma, Funding-\$369,358, Native American Rehabilitation Association, Funding-\$488,163, Navajo Nation, Funding-\$871,458, Poarch Band of Creek Indians, Funding-\$86,150, South Puget Intertribal Planning Agency, Funding-\$508,752, Southcentral Foundation, Funding-\$1,339,709, Southeast Alaska Regional Health Consortium, Funding-\$670,000 and Yukon-Kuskokwim Health Corporation, Funding-\$615,000.

#### **The Northern Plains Comprehensive Cancer Control Program (NPCCCP) (NCCDPHP)**

Established in July 2005, NPCCCP is in the fourth year of a five year implementation funding opportunity. NPCCCP has initiated, facilitated, and assisted in several projects throughout the last project period. We have leveraged numerous partnerships on the local and state level, regionally, and nationally and work continuously to foster these partnerships while identifying new ones at every organizational level. In the following narrative we have identified several projects, activities, and accomplishments that have contributed to the success of our program. Participation includes representation from all Tribal Health/Indian Health Service (IHS) programs in the region, all four state departments of health (IA, NE, SD, ND), and many AI cancer organizations, cancer centers, and universities. The coalition has grown to 266 registered members, many of whom are active in workgroups, community event participation, and cancer survivorship activities. Within our coalition, we have a steering committee that, in addition to providing guidance, has been instrumental in the development of the NPCCCP Cancer Plan. We are currently in the planning stages for the revision of the cancer plan and anticipate the second NPCCCP cancer plan to be completed in early 2012. Data/Surveillance- NPCCCP works very closely with the Northern Plains Tribal Cancer Data Improvement Initiative and assists in conducting data collection, analysis, and surveillance activities. A manuscript on cancer risk and screening use based on Behavioral Risk Factor Surveillance System data was accepted by the Public Health Report journal for publication in April 2011.

### **Fond du Lac (NCCDPHP)**

With the support of Fond du Lac (FDL), Wiidookaage Cancer Team members, FDL HSD staff, FDL Tribal Leadership, FDL community members and several external cancer partners continued to expand implementation of the Fond du Lac Band of Lake Superior Chippewa Wiidookaage Cancer Plan 2007 -2012. Maintained contact and mutually beneficial interaction with the 39 cancer partners from tribal, local, state and national cancer related agencies. Piloted the National American Cancer Society's revised "Circle of Life" program during fall 2010. The revisions were based, in part, on Fond du Lac's model, "Circle of Life Plus" adding all screenable cancers, supportive resources information and cancer prevention information to the previously breast and cervical cancer focused program. The new "Circle of Life" will be introduced nation-wide in 2011 to interested tribal programs. Funding-\$261,346.

### **Other funded projects include (NCCDPHP)**

Alaska Native Health Consortium Funding-\$326,132, Cherokee Nation Health Service Group Funding-\$379,019, Northwest Portland Area Indian Health Board Funding-\$300,000, South Puget Intertribal Planning Agency Funding-\$275,000 and Tohono O'odham Nation Funding-\$177,575.

### **Aleut Diet Program (NCCDPHP)**

The Aleut Diet Program includes sustainable hands on activities focusing on the healthy preparation and utilization of local traditional foods. The purpose of these activities is to promote health and prevent type 2 diabetes in the Aleutian and Pribilof Islands Region of Alaska. The program focus is to improve the nutritional health of people in the region through increased awareness of the benefits of traditional foods and the important role these foods play in reducing rates of dietary-related diseases such as diabetes, obesity, cancer, heart disease, hypertension, and dental caries. The program also seeks to encourage increased consumption of traditional foods from the land and sea by all members of the community as part of a healthy diet. The activities of the program are centered on culturally relevant information dissemination and the development of written resources that speak to the nutritional benefits of traditional foods. Funding-\$100,000.

### **Catawba Lifestyle and Gardening Project (NCCDPHP)**

The Catawba Cultural Preservation Project (CCPP) in South Carolina is increasing awareness and the use of traditional foods and food practices by supporting individual and community gardens, and increasing fruits, vegetables, beans, and herbs in tribal members' diets by providing access to local gardens and a tribal farmer's market. The tribe is adopting policies that include preferred ecological methods for gardens using traditional growing methods to encourage a new generation of environmental stewards to care for the reservation ecosystem. The tribe is increasing physical activity with gardening, fishing, and traditional dancing and drumming. Innovative partnerships between the tribal Senior Center, CCPP, the Catawba Tribal Offices, and a Master Gardener have yielded a successful community garden project that is increasing local access to fresh, locally grown, and in some cases traditional foods. Elevated box gardens have been constructed for the senior center that mitigates the effects of aging on being able to fully participate in gardening. Additionally, changes in local practice within the Children's Programs are becoming a precursor to policy change. Emphasis is on elimination of sugar-sweetened beverages, incorporation of fresh, locally-grown produce into lunch menus, and healthy snack alternatives are the focus of changes enacted thus far. Funding-\$100,000.

### **Cherokee Nation - Health Nation (NCCDPHP)**

The “Cherokee Nation – Health Nation” project incorporate a variety of activities including community and school gardens, traditional foods gathering trips, traditional Cherokee foods cultivation, gathering, preparation, and preservation, traditional Cherokee foods education, and incorporation of the traditional Cherokee games Stickball and marbles into community and school activities. Over 55,000 members of the Cherokee Nation and their families benefited from the initiative’s focus on nutrition, fitness, personal responsibility and a renewed awareness of their shared heritage. Youth activities focused on summer camp activities, organized sports and traditional games. Adult fitness activities were year round and centered on recreation center classes, league sports walking clubs and community races. Traditional games such as stickball and marble saw an exponential increase from the year before. Nutrition classes, healthy cooking classes, community garden classes and recipe exchanges (all with a focus on traditional Cherokee foods) were offered in all fourteen of the counties within the Cherokee Nation jurisdiction. Funding-\$100,000.

### **Indian Health Care Resource Center of Tulsa: Strengthening Traditional Ties (NCCDPHP)**

The program encourages American Indian families to eat nutritious diets and adopt healthy active lifestyles. Families participate in school-based health, nutrition, and physical education programs, including summertime wellness camps and a theatrical production. The program also engages in educational programs that emphasize healthy lifestyle choices within the context of traditional cultural practices, such as expanding existing and creating new neighborhood and school-based gardening projects. "Building Community" established gardening partnerships with two local elementary schools, summer camp programs featuring the Coordinated Approach To Child Health curriculum, and worked with state-level leaders on healthy food initiatives to address the problem of food deserts. Funding-\$100,000.

### **Listen to the Elders Project (NCCDPHP)**

Nooksack Indian Tribe, Listen to the Elder’s Project involves gardening and planting activities, distributing garden related materials, increasing community knowledge, awareness and use of traditional foods, and increasing physical activities, such canoeing and hunting. Funding-\$100,000.

### **Return to a Healthy Past (NCCDPHP)**

Return to a Healthy Past” (RTHP) has reintroduced traditional foods and physical activities in the Prairie Band of Potawatomi Nation (PBP) to promote health and prevent diabetes among other chronic conditions. Serving as a model, for rural and urban communities, RTHP has established gardens, increasing production and access to traditional produce. Through partnerships with the Land Department, Tribal Council, local hunters and the Diabetes Prevention Program, a wider variety of indigenous produce and meats were offered in diabetes education courses, Elders’ Center and Language Department gatherings and the Fall Harvest Feast. Traditional forms of physical activity have been broadened through nature hikes, camping trips, and gardening activities. RTHP continues to engage tribal members of all ages, at risk for or living with diabetes. Community members have increased access to traditional and other physical activities due to their exposure to this project’s activities such as hiking to identify wild plants and traditional foods such as wild onions, milk weeds and individual/family gardens. Funding-\$100,000.

### **Empowering Ramah Navajos to Eat Healthy (ERNEH) (NCCDPHP)**

This Project provides materials, training and technical assistance to families to help them grow fresh vegetables in their own yards by using conventional in-ground gardens, developing raised

bed gardens, or planting in commercially-viable garden boxes. The Project also encourages physical activity and works to improve access to a greater variety of physical activities through community support. The Project also provides technical assistance and training regarding food use, preservation, and assistance in selling excess produce. Finally, the book, "Traditional Navajo Foods & Cooking", will be updated, first published by the Ramah Navajo School Board in 1983. Forty-five community members participating in the gardening project have increased access to healthy traditional food fully as a result of the efforts of the ERNEH Project; another fifty-nine have increased access partially as a result of project efforts. Sixty-seven Honor Walk participants have increased access to information about traditional food fully as a result of the ERNEH Project. Funding-\$100,000.

#### **Old Ways for Today's Health: Red Lake Traditional Foods Project (NCCDPHP)**

Red Lake Nation's Old Ways for Today's Health: Red Lake Traditional Foods Project works to reinstate the consumption of a traditional healthy diet at the Red Lake Nation utilizing family and community gardens, traditional food gathering encampments such as fishing, berry picking, hunting, wild ricing and maple sugar gathering and cooking camps. The project will collaborate with partners, including the tribal diabetes programs, Chemical Health, and community center boards to provide community education through media, demonstrations and community participation. Through the traditional foods gathering activities, Red Lake Nation members have an increased opportunity to be physically active. The level of physical activity is dependent on the type of activities associated with gathering these foods. Deer hunting and buffalo canning has the lowest level of exertion of energy while berry picking and sugar bushing require a high level of physical energy for an extended period of time. With a total of 120 participants in activities during the first six months of Year Two, there has clearly been an increase in community members being physically active. Funding-\$100,000.

#### **Traditional Living Challenge in Contemporary Times: Indigenous Knowledge for Community Wellness (NCCDPHP)**

Salish Kootenai College (SKC) is building on programming that focuses on physical activity in relation to traditional foods gathering efforts. The overall project activities are blending the ancestral wisdom of traditional foods and lifestyles with contemporary realities. Two major components regarding traditional foods will be utilized to support active healthy lifestyles and physical activities based on traditional activities with a focus on youth: first, activities surrounding the permaculture of indigenous plants, and second, continuation of the Ancestors' Choice social marketing campaign to promote a healthy diet and lifestyle for the prevention of type 2 diabetes. Funding-\$100,000.

#### **Wiconi Unki Tawapi - Healing Our Live (NCCDPHP)**

The program focuses on educating tribal members on the importance of traditional healthy foods and physical activity/exercise by the use of traditional techniques and teaching traditional practices. This will be accomplished through a variety of activities such as: gardening, canning and pressure-cooking classes, diabetes classes, diabetes awareness activities (booths, health fairs), weight loss classes, and the Young Braves Program. Funding-\$100,000 .

#### **Uniting to Create Traditional and Healthy Environments (NCCDPHP)**

Sault Ste. Marie (SSM) Tribe of Chippewa Indians, "Uniting to Create Traditional and Healthy Environments". Project serves seven county service units. Partnership and collaborations with other Tribal programs and surrounding health services help the Project organize support and serve SSM Tribal members. The Project has created a Healthy Traditions Advisory Council (HTAC), which will help the Project to carry out Traditional Foods, Social Support and Physical

Activities and/or events, such as berry picking camp, workshops, training master preservers, implementing garden projects, building a Hoop House, implementing the harvest feast celebration, involvement in the local farmer's market, implement fitness promotion, healthier food fundraising event, and digital storytelling. Funding-\$100,000.

### **WISEFAMILIES through Customary and Traditional Living (NCCDPHP)**

WISEFamilies Traditional Foods program supports community driven programs that helps people adopt healthy lifestyles. The program builds on traditional ways of eating, being active and communicating by storytelling. All activities are developed with the goal to prevent chronic illness. Prior to the CDC Traditional Knowledge program, tribal members have expressed concern that the "old ways" of gathering and preparing traditional foods were being lost. The Wrangell program has impacted 85% of Alaska Native families in the community and the media exposure has included near weekly newspaper articles and numerous stories on the local radio station. Members of the Local Community Advisory Board have commented on how instrumental this program has been for invigorating the community's awareness of traditional foods and the importance it plays in health and culture. Funding-\$100,000.

### **Siletz Healthy Traditions Project (NCCDPHP)**

The Confederated Tribes of Siletz Indians' (CTSI) "Siletz Healthy Traditional Project" promotes health and prevention of diabetes through traditional foods and sustainable ecological approaches in the Siletz Indian community, engaging the local communities in identifying and sharing healthy traditional ways of eating, physical activity, communicating healthy messages and supporting efforts for diabetes prevention and wellness. The program emphasizes traditional foods education, growing, harvesting and preserving of locally grown/caught foods, engagement of community leadership to facilitate food behavior changes, and preserving wisdom through collection of traditional stories. Participation in the program is expected to increase as more tribal members learn about the Healthy Traditions project and what resources are available to them. The Steering Committee is currently working on developing healthy policies for CTSI and suggestions to be included in the 2015-2025 Comprehensive Plans. Funding-\$100,000.

### **The Native Gardens Project: An Indigenous Permaculture Approach to the Prevention and Treatment of Diabetes (NCCDPHP)**

By reclaiming cultural knowledge and traditions of companion gardening through their Native Gardens Project, the Standing Rock Sioux Tribe strives to prevent diabetes and contribute to a better quality of life for individuals and families living with diabetes. The Nutrition for the Elderly Program Advisory Council, the Standing Rock Special Diabetes Program, the state and county Extension Service, Sitting Bull College, and other partners support the Native Gardens' efforts to make local foods from farms and family gardens available and accessible. In collaboration with the USDA Nutrition for the Elderly program, the program documented that 60 percent of 3000 vouchers distributed to elders generated \$9,000 in 2010, encouraging local, certified farmers to keep growing. Through 4-H and Boys and Girls Clubs, youth are engaged; gathering berries and other wild edibles on hikes. Well advertised "Winter" and "Summer" markets consistently operate, providing opportunities to preserve food and share stories through the cold months of winter. Funding-\$100,000.

### **Tohono O'odham Food, Fitness & Wellness Initiative (NCCDPHP)**

The Tohono O'odham Food, Fitness, and Wellness Initiative increases knowledge of and access to Traditional Foods, while engaging IOBUSD and tribal legislation in identify ways to improve school health environments. Through strengthened partnerships with IOUSD and Head

Start, Traditional Foods were offered in meals and snacks at least weekly during the school year (2010-2011). Trainings and educational workshops were offered to teachers and cooks. Y.O.U.T.H Members continue to demonstrate leadership and innovative approaches to education, youth engagement, and other TOCA endeavors. Funding-\$100,000.

#### **Food is Good Medicine (NCCDPHP)**

"Food is Good Medicine" offers a model that embraces traditional food-ways, physical activity, and community empowerment. Implementation of projects, such as the Young Adult Leadership Program and "Got Acorns" Campaign, have been well received throughout the communities served by UIHS. Featuring the local traditional staple food, tanoak acorn, the "Got Acorns" Campaign was developed and launched to promote the health benefits of traditional foods and food ways. Young adults participating in the Leadership Program were empowered to explore their identity, interview elders and youth significant in their lives, and create digital stories that will be shared at community events, including the Youth Summer Camps. The digital stories capture the history that binds each generation and upholds traditional wisdom that protects health. A plan was proposed to continue offering this program to young adults twice a year for a period of three months. Funding-\$100,000.

#### **WISEWOMAN (NCCDPHP)**

SEARHC provides services to Alaska Native/American Indian women representing 18 tribes in Southeast Alaska. Funding-\$427,823. Southcentral Foundation (SCF) provides services to Alaska Native/American Indian women at the Anchorage Native Medical Center and the Valley Native Primary Care Clinic. SCF was recognized by the American Public Health Association for making WISEWOMAN screening a standard of care for all women 40 - 64 years old presenting for their annual exam and/or a clinical breast exam. Funding-\$581,427.

#### **Follow up to response to a cluster of AI fetal and infant deaths (NCCDPHP)**

In 2008, in response to a request from the Oglala Sioux tribe (OST), assistance was provided to the OST health administration to examine infant deaths. The tribe made an official request to CDC's Division of Reproductive In response to this request, a site visit was made to conduct an assessment. In May of 2011, in response to an OST health administration request, Dr. Barradas returned to Pine Ridge to conduct a formal presentation, describing the assessment, findings, recommendations, and resources, before members of the OST Tribal Council. Funding-\$1,000 (approximately 1% of one staff member for technical assistance).

#### **Pregnancy outcomes in Alaska Native smokeless tobacco users (NCCDPHP)**

The primary objective of this study was to explore the potential effects of maternal smokeless tobacco use on pregnancy outcomes. The secondary objectives were to explore the effects of maternal smokeless tobacco use on glucose tolerance, complications of labor and delivery, maternal hospital length of stay and readmission, fetal growth, severity of preeclampsia and on infant complications. The study was based in the Yukon Kuskokwim area of Alaska. Data collection is complete. In FY 2011, the two persons who led the research developed two manuscripts reporting on the study outcomes. Funding-\$34,000 for intramural staff salary/technical assistance.

#### **South Dakota Tribal Pregnancy Risk Assessment (NCCDPHP)**

The Yankton Sioux Tribe (YST) and the Aberdeen Area Tribal Chairmen's Health Board (AATCHB) identified maternal and child health as the highest health priority in response to persistently high rates of infant mortality among the 9 American Indian tribes in South Dakota. Between 2007 and 2010, CDC funded the South Dakota Tribal (SDT) PRAMS project that

collected information exclusively from mothers of AI infants who recently gave birth to a live infant in SD, and Sioux County North Dakota. Although the project has formally ended, CDC continues to provide technical assistance to support preparation of SDT reports for individual tribes, topic-specific briefs requested by AATCHB, development of a manuscript describing the successful SDT methodology, and capacity development through mentoring the first Council of State and Territorial Epidemiologist AI maternal and child health fellow, who was assigned to AATCHB. Funding-\$83,830 intramural/technical assistance.

### **Effective strategies to Reduce Motor Vehicle Injuries among AI/AN (NCIPC)**

This program is to design/tailor, implement and evaluate Native American community-based interventions with demonstrated effectiveness for preventing motor vehicle injuries within the following areas: 1) strategies to reduce alcohol-impaired driving among high risk groups; 2) strategies to increase safety belt use among low use groups; and 3) strategies to increase the use of child safety seats among low use groups. An overriding intent of this funding is to assist tribes in developing evidence-based effective strategies in programs, which take into consideration the unique culture of Native Americans. Funding was awarded to 8 grantees: Colorado River Indian Tribe Funding-\$101,885, Southeast Alaska Regional Health Consortium Funding-\$70,000, California Rural Indian Health Board Inc. Funding-\$101,972, Sisseton-Wahpeton Oyate of the Lake Traverse Reservation Funding \$102,000, Rosebud Sioux Tribe Funding-\$90,000, Office of Health Services Funding-\$101,486, Caddo Nation of Oklahoma Funding-\$70,000 and Oglala Sioux Tribe, Department of Public Safety Funding-\$70,000.

### **Community Preparedness (OPHR)**

The funds will be used to support emergency preparedness planning activities, trainings and exercises. Funds will also be used to support cooperative planning efforts and engagement with the tribe's public health and public safety partners in neighboring communities, and with its partners in state government. Projects funded under this effort include: Alaska Native Tribal Health Consortium Funded-\$350,000, White Mountain Apache Tribe \$83,000, Tohono O'odham Nation \$65,000, San Carlos Apache Tribe Funded \$72,700, Northern Arapaho Funded-\$40,000, Eastern Shoshone Preparedness Funded-\$40,000, Eastern Band Of Cherokee Indians Funded-\$35,044, Northwest Portland Area Indian Health Board: Representing 55 tribes Funded- \$456,039, Santa Domingo Pueblo Funded- \$3,000, Santa Ana Health Center Funded- \$3,000, San Felipe Pueblo Funded- \$3,000, Jemez Pueblo Funded- \$3,000, Isleta Pueblo Funded- \$3,000, Cochiti Pueblo Funded- \$3,000, Sandia Pueblo Funded- \$3,000, Winnebago Tribal Health Funded- \$30,000, Santee Health Center Funded- \$30,000, Ponca Tribe Funded- \$30,000, Omaha Tribe Funded- \$30,000, White Earth Tribal Council Funded-\$17,000, Upper Sioux Community Funded- \$17,000, Red Lake Band of Ojibwe Funded-\$17,000, Prairie Island Funded- \$17,000, Mille Lacs Band Funded- \$17,000, Lower Sioux Indian Community Funded- \$17,000, Leech Lake band Funded- \$17,000, Grande Portage Reservation Funded- \$17,000, Fond du Lac Band Funded- \$17,000, Bois Forte Reservation, Tribal Council Funded- \$17,000, Tribal Health Programs: Funded- \$27,000, Sault Ste. Marie Tribe Funded- \$38,126, Saginaw Chippewa Indian Community Funded-\$24,221, Pokagon Band of Potawatomi Funded- \$21,531, Match-E-Be-Nash-She-Wish Potawatomi Funded-\$20,000, Little Traverse Band of Odawa Indians Funded-\$22,250, Lac Vieux Desert Band of Lake Superior Chippewa Indians Funded- \$20,899.00, Little River Band Funded-\$21,346, Keweenaw Bay Indian Community Funded-\$23,232, Huron Potawatomi Funded-\$20,735, The Wampanoag Tribe of Gay Head Funded-\$3,143, The Wampanoag Tribe (Mashpee) Funded-\$50,741, Kickapoo Tribe Funded-\$8,250, Iowa Tribe of Kansas and Nebraska Funded-\$4,977, The Sac and Fox Nation Funded-\$4,017, Prairie Band Potawatomi Tribe Funded-\$6,300,



Southern Ute Indian Tribe: Funded-\$ 14,000, Ute Mountain Ute Indian Tribe: Funded-\$14,000 and Meskwaki Tribal Health Funded-\$7, 594

### **Division of Public Health Performance Improvement National Public Health Improvement Initiative (OSTLTS)**

Funding will support increased efficiencies of program operations, promotion of evidence-based strategies, policies and practices, and acceleration in public health accreditation readiness. The action plan outlines planned activities and milestones this funding will achieve. The Division of Community Health Services (DCHS) will increase Public Health Performance Management – Capacity Development and provide leadership in positioning ANTHC for national public health accreditation. Efforts will focus on developing an internal quality/performance improvement environment within DCHS, forming a multi-sector, cross-jurisdictional partnership coalition, disseminating and facilitating use of public health data among regional tribal health organizations and communities, and promoting implementation of evidence based strategies, policies and laws. Assessments will be completed using the National Public Health Performance Standards Program assessment tool and the Public Health Accreditation Board self-assessment. Strong collaboration and strategic partnerships will be encouraged by fostering extensive community participation with representatives from state, tribal and local public health entities, stakeholders, academia, businesses, private and non-profit health agencies and organizations, professional organizations, private care providers, philanthropic groups and third party payers. In addition, subject matter experts in key areas such as workforce development, laboratory capacity, and epidemiology, will be solicited to ensure the most recent information for public health practice is embodied in the assessment, analysis and strategic planning process.

- The Mille Lacs Band of Ojibwe (MLBO) will continue work to identify public health needs of the community and to react by organizing prevention activities to address those concerns. MLBO will advance it's accreditation process and improve overall care of patients. Funds will allow access to a software system to chart patient's data and enable on-going dialog between health care professionals. Funding-\$250,000
- Increase efficiencies of Montana and Wyoming Tribal Health Department operations
- Increase the use of evidence-based policies and practices among Montana and Wyoming Tribal Health Department;
- Increase Montana and Wyoming Tribal Health Departments' readiness for applying for and achieving accreditation by the Public Health Accreditation Board – PHAB  
MTWYTLC/RMTEC intends to perform this by funding the top three Tribal Health Department capacity building priorities the Tribal Health Departments committed to during their most recent strategic planning sessions, tailored towards the activities listed above. Each of the 10 Montana and Wyoming Tribal Health Departments will be awarded funds to carry out those activities, hence building their capacity towards Public Health Accreditation readiness. Funding-\$250,000.
- Through this grant, the Navajo Nation will continue to build upon and strengthen its public health infrastructure by implementing in year 2, key components of the Navajo Nation Strategic Plan developed in year 1 of the grant. In this regard, the Focus Areas for year 2 will be; Addressing identified deficiency areas in preparation for PHAB accreditation; Development of a Navajo Nation wide Community Health Assessment; Developing a Quality Improvement Initiative addressing the effectiveness of a key NDOH service provided; Developing key cross-jurisdictional partnerships with at least one local health department in each of the 3 states (NM, AZ, Utah) where Navajo residents are located; Identifying and Implementing traditional healing best practices in one of the following areas: Behavioral Health (alcohol), HIV, and Diabetes. Funding-\$250,000

- The Tribal Public Health improvement project will continue to increase the Northwest Portland Area Indian Health Board’s ability to provide education and technical support to increase the organizational capacity of its 43 member tribes. The Board will facilitate access to quality improvement training and promote integration of a “QI culture” into tribal health departments as well as link quality improvement with public health accreditation. Funding-\$250,000
- Gila River will conduct a comprehensive review and analysis of existing programs and develop recommendations for improving the health care management structure. Long term activities across three distinct entities will be integrated under a new health authority which will result in increased efficiencies. Activities planned include developing organizational structure to increase quality and accountability; establish roadmap for an integrated consolidated sustainable health care system; supporting a stable well-trained workforce and increasing efficiencies in prevention and treatment for patients, clients and residents. Funding-\$250,000
- Cherokee Nation is currently working towards expanding and improving our current Tribal Public Health infrastructure in an effort to better serve our people as well as having our Tribal Public Health System achieves accreditation through the Public Health Accreditation Board. Funding- \$843,662
- SEARHC will increase its capacity to improve the effectiveness of its organizations, practices, partnerships, program resources, and systems. Project deliverables include a consortium-wide emergency preparedness plan and engagement with a “Lean” management consulting company to improve our referral. Funding-\$250,000/

**AFFORDABLE CARE ACT ACTIVITIES SPECIFIC TO TRIBES**

**Community Transformation Grants (NCCDPHP)**

Total Funding \$3,824,699

- The Sault Ste. Marie Tribe of Chippewa Indians is receiving \$500,000 to serve an estimated tribal population of over 176,000 within the state of Michigan. Work will target tobacco-free living, active living and healthy eating, quality clinical and other preventive services, and healthy and safe physical environments.
- The Sophie Trettevick Indian Health Center is receiving a \$218,929 planning award to build capacity to support healthy lifestyles among an estimated tribal population of 2,200 within the state of Washington. Work will target tobacco-free living, active living and healthy eating, and quality clinical and other preventive service.
- The Southeast Alaska Regional Health Consortium is receiving \$499,588 to serve an estimated population of 72,000 within the state of Alaska. Work will focus on expanding efforts in tobacco-free living, active living and healthy eating, and quality clinical and other preventative services.
- The Toiyabe Indian Health Project is receiving a \$500,000 planning award to build capacity to support healthy lifestyles among an estimated tribal population of 3,000 within the state of California. Work will target tobacco-free living, active living and healthy eating, quality clinical and preventive services, social and emotional wellness, and healthy and safe physical environments.
- The Yukon-Kuskokwim Health Corporation is receiving a \$193,340 planning award to build capacity to support healthy lifestyles among an estimated tribal population of 25,000 within the state of Alaska. Work will focus on expanding efforts in tobacco-free living, active living and healthy eating, quality clinical and other preventive services, and healthy and safe physical environments.



- The Confederated Tribes of the Chehalis Reservation is receiving a \$498,663 planning award to build capacity to support healthy lifestyles among an estimated tribal population of 1,500 within the state of Washington. Work will target tobacco-free living, active living and healthy eating, and quality clinical and other preventive services.
- The Great Lakes Inter-Tribal Council, Inc. is receiving a \$499,982 planning award to build capacity to support healthy lifestyles among an estimated tribal population of over 8,000 within the state of Wisconsin. Work will target tobacco-free living, active living and healthy eating, quality clinical and other preventive services, social and emotional wellness, and healthy and safe physical environments.

### **Racial and Ethnic Approaches to Community Health for Communities (REACH U.S.)**

Overarching Goal: Reduce the rate of infant mortality among American Indians on the Wind River Indian Reservation through community-based approaches that will serve as a model for other Tribes and communities.

- The Northern Arapaho Tribe of the Wind River Indian Reservation (WRIR) Action Community (AC) Infant Mortality Prevention Program (IMPP) plans to reduce the rate of infant mortality among American Indians on the WRIR through community-based approaches. Funding-\$398,807. These approaches include increasing community awareness and commitment to eliminating infant mortality disparities through coordinated and multi-organizational action; increasing the number of Northern Arapaho and Eastern Shoshone women initiating early, and sustaining, prenatal care; ultimately achieving measurable improvements in infant mortality rates. This will be done through community organization, education, inter-agency coordination and partnership, systems development and modification, and increasing access to health services. For grant year five, an important aspect of the Community Action Plan (CAP) will be to convene and organize all partners to consider how to sustain the momentum the IMPP has created around the healthy priority while expanding the breadth and the depth of their programmatic efforts.
- The Cherokee Choices Program of the Eastern Band of Cherokee Indians works to change social norms, engage formal and informal leaders, and engage communities to reduce the risk for type 2 diabetes and cardiovascular disease in rural western North Carolina. Funding-\$415,390.
- The Choctaw Nation of Oklahoma (CNO) Action Community (AC) Lifetime Legacy Program (LLP) plans to decrease heart attack and stroke risk in the CNO population through education, awareness and community based active living and healthy eating policy and environmental change efforts. Funding-\$415,390.
- For year five, ITCM REACH will continue to implement community-based intervention activities to reduce cardiovascular and diabetes related disparities that are culturally tailored to each of the three original tribal communities, while providing overall technical assistance to the tribes and disseminating results of the culturally tailored interventions among consortium partners. Funding-\$415,390.

## **TRIBAL DELEGATION MEETINGS**

### **October 13-14, 2010**

ATSDR and UNM hosted the Navajo Prospective Birth Cohort Study Kick-off meeting at the University of New Mexico (UNM) Center for Development and Disability in Albuquerque. Attendees included representatives from UNM, Navajo Area Indian Health Services (NAIHS), Navajo Nation Division of Health (NNDOH), Navajo Nation Environmental Protection Agency (NNEPA), Community Liaison Group, and Navajo Nation's Growing in Beauty Program. The

purpose of the meeting was to discuss stakeholder roles and responsibilities and other issues that needed to be addressed before commencing the study. ATSDR staff from the Division of Health Studies, Office of Tribal Affairs (OTA), and Region 9 were also in attendance.

#### **October 27-28, 2010**

The ATSDR Region 9 Representative gave a presentation on behalf of Ms. Schultz, HHS Region 9 Director, at the 44th Inter-Tribal Council of Nevada Annual Meeting in Reno, NV. The ATSDR Region 9 Representative discussed HHS tribal activities in Nevada and provided updates on upcoming ACA outreach activities.

#### **December 2010**

ATSDR and UNM representatives presented the Navajo Birth Cohort Study objectives to the Navajo Nation Human Health and Review Board (NNHHRB) and sought approval for elements of the study protocol. After numerous discussions with the NNHHRB members, a decision to approve the protocol was postponed until additional information could be gathered by UNM and ATSDR.

#### **December 1, 2010**

At the invitation of the EPA Tribal Science Council, the NCEH/ATSDR Tribal Liaison traveled to Seminole, FL to provide a presentation on NCEH and ATSDR environmental health activities and to discuss ways in which to collaborate. Tribal and EPA participants also provided presentations on various activities related to data gathering and data analysis.

#### **February 4, 2011**

CDC/ASTHO/NIHB held a meeting to discuss Tribal/State relations. Attendees of the meeting included representatives from the three agencies, CDC Tribal advisory Committee members and State Health Officials. The meeting was an opportunity to begin dialog on the issue. An outcome of the meeting was to have additional meetings on the subject. The next meeting will be in Atlanta, GA on February 3, 2012.

#### **February 23, 2011**

At the request of a concerned citizen, the NCEH/ATSDR Tribal Liaison and the ATSDR Region 6 Representative traveled to the Ponca Nation in Oklahoma to conduct a tour of the tribal community in order to observe nearby permitted facilities. ATSDR also met with Ponca Nation's Environmental Director to discuss environmental health and environmental protection concerns from the emission sources and to discuss ways in which to conduct an appropriate assessment of potential exposure pathways.

#### **March 28, 2011**

Communities Putting Prevention to Work (CPPW), ONDIEH: NCCDPHP-DACH, Atlanta, GA. The Annual Meeting was a training to strengthen and expand agency capacity to achieve program goals to reduce obesity and tobacco use, network with peers, and accelerate successes by building peer-to-peer consultation. Participants included: Cherokee Nation representatives, CDC, contractors, and technical assistance providers.

#### **April 12, 2011**

The 2nd Annual Nevada Tribal Methamphetamine Summit was held in Fallon, NV. 62 participants attended including tribal representatives from Nevada, California, and South Dakota. Also in attendance were representatives from the Indian Health Service (IHS), Washoe County Health District, Nevada Department of Environmental Protection and Nevada Health

Division. ATSDR provided coordination support and faculty from American College of Medical Toxicology (ACMT). The event was also sponsored by the Inter Tribal Council of Nevada, Statewide Native American Coalition and Nevada Tribal Chiefs of Police Association. The training included a presentation by EPA Brownfield program on grant opportunities for meth lab cleanup and assessment for tribes. The agenda also included a panel/open discussion of issues concerning residential meth contamination which was well received. Participant evaluation forms were overwhelmingly positive and many indicated they would like additional training opportunities.

#### **April 26, 2011**

The first Annual Tribal Consultation Session for the Navajo Nation was held in Window Rock, AZ. The primary purpose of the consultation was to provide an opportunity for Navajo tribal leaders to discuss programmatic issues and overall concerns of the Navajo Nation with U.S. Department of Health and Human Services (HHS) officials and HHS agency representatives. The ATSDR Division of Health Studies Branch Chief provided an update on the Navajo Birth Cohort Study activities and the NCEH/ATSDR Tribal Liaison provided updates on various CDC activities including plans to fill the Associate Director for Tribal Support position at CDC/OSTLTS and to field questions regarding CDC's Emergency Preparedness and Response Program.

#### **May 2, 2011**

Strategic Alliance for Health, ONDIEH: NCCDPHP-DACH, Chicago, IL. Strategic Alliance for Health Action Institute provided an opportunity for states and Strategic Alliance for Health communities to come together to learn best practices on implementing policy, systems, and environmental change strategies. Cherokee Nation leaders met with their CDC project officer to discuss the initiative and other projects. In addition, a Cherokee Nation representative presented Cherokee Nation Strategic Alliance for Health Tobacco-Free Policy for City Parks Implementation Guide to the Action Institute participants. Six participants came to the Action Institute. The intervention area includes the Tribal Jurisdictional Service Area (TJSA) of 9,200 sq. miles with a population of 399,385 in 14 counties. The Cherokee Nation has developed, implemented, and expanded a comprehensive plan to implement promising strategies for healthy eating, active living, and tobacco-free environments in the Cherokee Nation of Oklahoma -- the Eastern band of the Cherokee Nation. Their interventions are guided by the research, collaboration, and recommendations of the public health experts and stakeholders via the Healthy Eating Active Living Convergence Partnership.

#### **June 1, 2011**

CDC/IHS American Indian and Alaska Native Health Analyses Collaborations: OI: NCEZID-DHCPP. Meeting held with a Navajo Tribal Veterinarian. Ongoing epidemiologic collaborative projects with the Indian Health Service (IHS), Alaska Native Tribal Health Consortium (ANTHC), CDC Arctic Investigations Program (AIP), other agencies/divisions and universities to detect and describe disease burden and health disparities for overall and specific infectious diseases among American Indian and Alaska Native (AI/AN) communities. Studies provide information for developing prevention strategies, vaccination policies, and reducing health disparities related to infectious diseases. Findings increase awareness of specific infectious diseases, and highlight disease, person and geographic target areas to further investigate health disparities. For example, the identification of lower respiratory tract infections disparities among Alaska Native children led to more in-depth respiratory studies and educational efforts for children in Alaska.

### **July 19th, 2011**

ATSDR Region 9 was invited to attend and participate in an EPA hosted meeting entitled, “Nevada Tribal Leaders Meeting for Environmental Health” in Reno, NV. The purpose of the meeting was to gain a better understanding of the environmental, energy, health priorities, and challenges for both tribes and federal agencies; identify opportunities for collaboration where resources and information can be leveraged; and build stronger federal and tribal relationships. The following federal agencies participated including EPA Region 9 Regional Administrator and EPA program staff, Department of Energy (DOE), USDA Rural Development Community Programs, Bureau of Reclamation, IHS Deputy Director, IHS Phoenix Area Office and IHS Sparks Office, Housing & Urban Development (HUD) Regional Administrator and Administrator of the Southwest Office of Native American Programs, and ATSDR Regional Office. Tribal Leaders from 10 NV Tribes and the Inter-Tribal Council of Nevada leadership also participated. Participants were all engaged in the process.

### **June 10, 2011**

SIP 10-033: Innovative Approaches to Preventing Teen Pregnancy among Underserved Populations, ONDIEH: NCCDPHP-DACH, Peach Springs, AZ, also 7/25/11 at Whiteriver, AZ and 8/2/2011 at Camp Verde, AZ, Hualapai Tribe. To get approval to implement the project with the Tribe. Approval to implement both phases of the project was obtained. Meeting participants included ITCA staff, and Hualapai Tribal Council.

### **July 26-27, 2011**

The NCEH/ATSDR Office of Tribal Affairs kicked off the first meeting of the National Tribal Environmental Health (NTEH) Think Tank in Washington, DC. The agenda for the first meeting was to convey the purpose of the Think Tank and the roles and expectations of the members; provide an overview of OTA and NCEH and ATSDR; analyze and discuss the OTA purpose, mission, and vision; revise mission and vision statements as necessary. At the end of the meeting the Think Tank members were asked to reach out to their respective tribal colleagues and develop list of 5-8 issues of major environmental public health concern to tribes.

### **August 14-15, 2011**

At the invitation of the Association of Environmental Health Academic Programs (AEHAP), the NCEH/ATSDR Tribal Liaison was asked to participate in discussions to work towards the development of a joint strategy for linking students from Tribal Colleges and Universities (TCUs) with National Environmental Health Science and Protection Accreditation Council (EHAC) programs. The goal of the joint strategy would be increase the number of American Indians/Alaska Natives (AI/AN) entering the environmental health workforce. Participants included TCU representatives and students, representatives from adjacent colleges and universities, CDC, and AEHAP members. Discussions continue to occur between all parties.

### **August 16, 2011**

ATSDR Division of Regional Operations (DRO) coordinated with the Pechanga Band of Luiseño Indians Environmental Department to host a training course entitled “Environmental and Health Consequences of Clandestine Methamphetamine Laboratories” in Temecula, CA. 120 participants representing tribal, county, state and federal agencies were in attendance for this event. Chairman Mark Macarro and Council Member Andrew Masiel, Sr., both with the Pechanga tribe, gave opening remarks and a welcome address. Feedback about the course was positive.

### **August 25, 2011**

A second meeting of the National Tribal Environmental Health (NTEH) Think Tank took place in Suquamish, WA following the CDC/ATSDR Tribal Advisory Committee (TAC) meeting and tribal consultation session on August 22-24, 2011. The agenda for the second meeting included the discussion and prioritization of major environmental health concerns/issues as compiled by NTEH Think Tank members; the development of clear goals statements based on top ten broad issue areas; and a brainstorming session on long- and short-term strategies and tactics which can be undertaken by OTA to address priority issues.

### **September 14, 2011**

Outcomes of Screening AI/AN Women of Reproductive Age for Chronic Conditions, ONDIEH: NCCDPHP-DRH, South Dakota. The project was reviewed by the Oglala Sioux Tribe Research Review Board and the project was approved. On 9-29-2011 we held a conference call for the initial kick-off of the project. On this call was Lisa Schrader-Dillon, Health Administrator and other representatives from the Tribal Health Department.

### **September 24-25, 2011**

The third meeting of the National Tribal Environmental Health Think Tank took place in Anchorage, AK. The agenda for the third meeting included activities to discuss and finalize specific approaches OTA must take to accomplish the outlined goals; discuss implementation of the OTA strategic plan, including any potential barriers and/or challenges; and compile a draft the OTA Strategic Plan based on deliberations. At the end of the third meeting, the members requested that the Think Tank effort continue in future years. They felt strongly that in order to support the efforts of tribes, a continual mechanism needed to be established. The OTA hopes to continue the effort in future years.

### **September 26 to 28, 2011**

Communities Putting Prevention to Work (CPPW), ONDIEH: NCCDPHP-DACH, Orlando, FL. Healthy Communities Meeting increased knowledge of strategies and resources to assist in development and implementation of policy, systems and environmental changes that increase access to healthy foods and physical activity, and reduce secondhand smoke exposure.

### **September 27, 2011**

NCEH/ATSDR staff and members of the National Tribal Environmental Health (NTEH) Think Tank gave a presentation of their efforts to develop and implement an NCEH/ATSDR OTA Strategic Plan at the National Indian Health Board's (NIHB) Annual Consumer Conference (ACC) in Anchorage, AK. Feedback was sought from the audience regarding their environmental health concerns and priorities.

## **AGENCY TRIBAL TECHNICAL ADVISORY GROUP**

CDC/ATSDR held two formal Tribal Advisory Committee (TAC) meetings during FY 2011 along with regularly scheduled conference calls. The TAC meeting was held February 1 and 2, 2011 in Atlanta GA and August 22 and 23, 2011 in Suquamish, Washington. The OD/Office for State, Tribal, Local and Territorial Support (OSTLTS)/Senior Tribal Liaisons worked in collaboration with the TAC co-chairs and membership to develop substantive agendas. TAC members provide an area report to inform and discuss public health issues affecting their tribe and other tribes in their area, and CDC provides a progress report on actions taken in response to TAC recommendations. The meetings focused on resource allocations and budget priorities, public health preparedness and emergency response, epidemiology and disease surveillance, and environmental public health in Indian Country.

This past year the focuses of the Tribal Consultation Sessions were CDC's Winnable Battles. Discussions regarding Smoking, Physical Activity, Obesity and Nutrition, Teen Pregnancy, HIV/AIDS, Hospital Associated infections and Motor Vehicle Safety were very lively. The exchange of information was very useful. CDC leadership listened to powerful tribal testimonies reflecting critical health needs present in many AI/AN communities and responded to specific questions asked by tribal leaders. These Consultation Sessions are helping CDC understand the scope and difficult realities tribal nations are facing. Consultations have provided opportunities for meaningful dialogue between tribal leadership and CDC leadership resulting in new initiatives, programs, and collaborations to address public health needs while maintaining CDC's commitment to uphold the tenets of tribal consultation and to have a positive impact on the health of AI/AN people.





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United States Department of Health and Human Services

## **Centers for Medicare and Medicaid Services (CMS)**

The mission of CMS is to ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries CMS' Vision, to achieve a transformed and modernized health care system, to ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries. CMS will accomplish our mission by continuing to transform and modernize America's health care system. CMS' Strategic Action Plan Objectives Skilled, Committed, and Highly-Motivated Workforce Accurate and Predictable Payments High-Value Health Care Confident, Informed Consumers Collaborative Partnerships.

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Tribal Consultation Policy: Yes

## HIGHLIGHTS OF DIVISION SPECIFIC ACCOMPLISHMENTS/ACTIVITIES TARGETED TOWARD AMERICAN INDIANS/ALASKA NATIVES (AI/AN)

CMS held training for Indian CHIPRA grantees on October 31, 2011 in conjunction with CMS's 2nd National Children's Health Insurance Summit held November 1 -3, 2011 in Chicago, IL. 37 of the 41 Indian CHIPRA grantees participated, along with their CMS project officers, regional Native American Contacts and CMS Medicaid and CHIP leadership. The purpose of the training was to share promising practices of outreach and education efforts. This was the first opportunity for the grantees and project officers to meet face to face. The Oglala Sioux Tribe's CHIPRA grantee program received an ECHOE award for enrolling one thousand children in CHIP and Medicaid. Gale Marshall, Two Feathers Media, received an ECHOE award for the video entitled: ***Medicaid & the Children's Health Insurance Program: Working Together for Our Children, For Our Future.***

Throughout 2011, CMS developed and presented workshops focusing on Medicaid and CHIP at four national social service and education conferences: Native American Child and Family Conference, National AI/AN Child Care Conference, National Indian Head Start Directors Association conference, and the National Indian Education Association annual conference.

CMS produces the Medicine Dish broadcasts, a series of broadcasts for professional, administrative, and medical staff in the Indian health care system. These programs serve as a path to open communication, providing information and promoting discussion about Medicare, Medicaid, and Children's Health Insurance Programs (CHIP), and other issues important to the health of American Indians and Alaska Natives.

- For 2011, CMS produced Medicine Dish broadcasts featuring Medical Nutrition Therapy, Medicaid and Medicare Data for AI/AN, Medicare Part D and CHIPRA Grantees' Outreach and Enrollment activities.
- The Medicine Dish broadcasts featuring the CHIPRA grantees were filmed on location at the Pueblo of San Felipe in NM, Indian Health Care Resource Center in Tulsa, OK, Indian Health Board of Billings, Blackfeet Tribe Po'Ka System of Care in MT and Lake County Tribal Health Consortium in CA.
- The CHIPRA grantees shared information from their tribal communities:
  - Outreach and enrollment activities
  - Challenges encountered and actions taken to overcome them
  - Effective partnerships
  - Advice to others interested in outreach and enrollment of AI/AN children in the Medicaid and CHIP programs

CMS developed a CHIP Public Service Announcement (PSA) featuring Olympic gold medalist Billy Mills (Lakota Sioux). It was aired on radio, TV and at the Gathering of Nations Pow-wow. During the spring of 2011 it was aired on 121 native radio stations and ran 252 live internet streams. The PSA aired on nine ABC/CBS television stations that service the AI/AN communities: Bismarck (spring and fall), Albuquerque (spring and fall), Oklahoma City, Rapid City, Sacramento, Billings, Tulsa, Anchorage (spring and fall) and Portland. In the fall, additional local radio stations aired the PSA in Albuquerque, Anchorage and Portland to coincide with three national AI/AN conferences: National Indian Education Association, National Indian Health Board and the National Congress of American Indians.

CMS participated in several conference calls with Tribes and Tribal organizations on the EHR Incentive Program that facilitated Tribal understanding of the EHR Incentive Program and CMS understanding of Tribal hospital and clinic operations.

CMS sponsored “CMS DAY” at the 28<sup>th</sup> National Indian Health Board (NIHB) Annual Consumer Conference. The theme of the NIHB conference was *Health, Hope & Heroes: Using the Foundations of Tribal Values and Knowledge to Advance Native Health*. For the last five years, CMS has sponsored a “CMS Day” to raise the awareness and elevate the understanding of Medicare, Medicaid and CHIP and the impact these programs have on the health of American Indians and Alaskan Natives (AI/ANs). On CMS Day, Wednesday, September 28<sup>th</sup>, Dr. Berwick, CMS Administrator, presented the Keynote Address: *CMS’s Role in Improving Access to Medicare, Medicaid, Children’s Health Insurance Programs and Health Insurance Exchanges*. Teresa Niño, Director of Office of Public Engagement, presented an overview of AI/AN outreach and education activities within CMS, followed by an outreach and enrollment video: *Medicaid and the Children’s Health Insurance Program: Working Together: For Our Children For Our Future*. While in Anchorage, Dr. Berwick visited with senior leadership at the Alaska Native Tribal Health Consortium (ANTHC), toured the Telemedicine programs and traveled to the Dental Health Aid Therapy (DHAT) Training Center. Dr. Berwick met with the Secretary’s Tribal Advisory Committee (STAC) and participated in a Joint Session with Indian Health Services Director, Dr. Yvette Roubideaux, to discuss with Tribal participants payment reform under the Affordable Care Act. In addition, Dr. Berwick visited the Alaskan Native Medical Center (ANMC) and the South-central Foundation primary care center.

CMS in collaboration with the Native American Contacts organized a series of trainings in the HHS Regions for IHS, Tribal and Urban Indian health programs (I/T/Us). The goal of the CMS ITU training is to improve services to beneficiaries and aid in increasing the revenue stream to the I/T/Us by providing information on the Medicare, Medicaid, and CHIP. The trainings include an overview of CMS programs including Medicare, Medicaid, CHIPRA, new provisions in the Affordable Care Act, and other CMS program related topics.

CMS sponsored a series of All Tribes’ Calls, national conference calls to obtain advice and input from Indian Country regarding CMS related provisions in the Affordable Care Act. There were approximately, 80 -100 participants on each call. A brief summary of each call are posted on the AI/AN Center on the CMS website. The All Tribes’ Calls held in 2011 were as follows:

- A. May 13th: To obtain tribal input regarding how eligible professionals within tribal programs can meet the eligibility criteria for purposes of the Medicaid EHR program.
- B. June 17th: Section 5006 protections for AI/ANs under Medicaid and CHIP.
- C. July 15th: Section 2402(a) of the Affordable Care Act: *Oversight and Assessment of Home and Community Based Services* (HCBS).
- D. December 9<sup>th</sup>: CMS Tribal Consultation Policy.

### **All Regions**

Native American Contacts (NACs) from nine Regional Offices (ROs) and the Consortium TD presented in breakout sessions on Medicare, Medicaid and CHIP 101, Affordable Care Act “No Wrong Door”, and Outreach/Eligibility in Indian Country at the National Indian Health Board CMS Day on 9/28.

RO Staff served as project officers for the 41 CHIPRA Grants for Outreach and Enrollment of Indian Children. The 41 Grantees enrolled nearly 10,000 children in the first year of the grant cycle, which ended 3/31.

The ROs participated in eight HHS Regional Consultation sessions, including the first session ever held specifically for the Navajo Nation.

RO Medicaid Staff worked with the States, the Consortium and CMCS to approve 32 of the 36 State Plan Amendments required to comply with the ARRA 5006 requirement for States to seek advice from Indian Health Service, Tribal/Tribal Organization Health Programs and Urban Indian Organizations (I/T/Us) on Medicaid/CHIP matters impacting Indians and I/T/Us

### **Region I (CT, ME, MA, NH, RI VT)**

CMS issued guidance to its Medicare contractors clarifying that practitioners in I/T/Us need only be licensed somewhere in the United States and local State licensure is not required. The issue was raised by the Houlton Band of Maliseet Tribal clinic in Maine.

The RO continues to work with Maine on issues related to non-emergency transportation provided by tribal programs. Consultation and provider enrollment/payment issues were initially raised by the Passamaquoddy Health Center.

### **Region II (NJ, NY, PR, VI)**

The RO assisted the St. Regis Mohawk Nation with questions related to their receipt of a Start-up Grant for a Child Support Program. St. Regis Mohawk Nation was the first tribal nation to receive the grant.

On 8/17-18, the RO and Nashville Area IHS presented its annual training in Niagara Falls, NY. The focus of the training was improvement of services to beneficiaries and maximizing revenue to I/T/Us and 50% of the Nashville Area tribes were in attendance.

### **Region IV (AL, NC, SC, FL, GA, KY, MS TN)**

In 8/2011, the RO NAC attended the IHS Direct Service Tribes Conference in Nashville and worked with the CMS Tribal Affairs Group and local SHIPs to provide attendees with information regarding CMS programs.

The RO provided PCIP outreach materials to two tribal clinics in South Florida (Seminole and Miccosukee).

The RO facilitated the relationship between the Poarch Creek Tribe and the Alabama State Exchange Committee in an effort to assist the Tribes in complying with the provisions of the Patient Protection and Affordable Care Act of 2010 (ACA).

### **Region V (IL, IN, MI MN, OH, WI)**

The RO NAC provided outreach and education about Medicaid and CHIP at the ACF Tribal Child Welfare Conference in response to a request by the Tribal Affairs Group.

The RO worked with MI to assure compliance with the requirement that States establish outstation locations at DSH hospitals and FQHCs participating in the state's Medicaid program.

As a result, the State has assigned an outstation worker at the American Indian Health and Family Services Center of Southeastern Michigan.

On 7/21, the CMS/IHS annual training for part of the Bemidji Area was held in Prior Lake, MN.

The RO NAC participated in DHHS quarterly consultation calls for the Regional tribes. During the calls, the NAC routinely addresses questions and provides technical assistance to participating tribes.

RO staff attended mid-year consultation with WI tribes in May and provided updates on WI Medicaid issues and discussed upcoming SPAs and waiver submittals aimed at improving health care and outcomes.

#### **Region VI (AR, LA, NM, OK, TX)**

The RO NAC participated in a broadcast of Native America Calling, a live stream webcast/radio program which focuses on issues affecting Indian communities. The April broadcast focused on the need to enroll eligible children and families in the CHIP program, which provides relief to underfunded I/T/U programs.

#### **Region VII (IA, KS, MO, NE)**

The RO NAC worked with the Nebraska (NE) Medicaid Director to appoint Tribal representatives to the Medicaid Assistance Advisory Committee.

The NAC facilitated conference calls between the Ponca Tribe and the NE Medicaid Agency that resulted in a MOU that allows the AI/AN CHIPRA grantee access to N-Focus and redetermination data.

On 11/29/10, the RO NAC facilitated a State/Tribal Consultation meeting between the NE Tribes, IHS, NE Urban Indian Health Coalition, and the State Medicaid Agency. A draft Consultation Policy was revised to include feedback and changes proposed by Tribal Leaders and I/T/Us.

The RO NAC and the Regional Public Affairs Specialist worked with the Cycle I and AI/AN CHIPRA grantees to coordinate a live in-studio phone bank with KETV-ABC in Omaha, NE. The phone bank, held on 3/7/11, provided a great opportunity to educate the community about the NE CHIP and promote the grantees as local resources for enrollment assistance. The grantees' outreach workers answered approximately 120 calls during the call-in show.

On 3/8/11, the RO NAC and Public Affairs Specialist held a Regional CHIPRA Anniversary Event at OneWorld Community Health Centers. The event brought together approximately 65 community-based organizations to recognize OneWorld's and the Ponca Tribe's CHIP outreach, enrollment, and retention efforts.

The RO NAC held a meeting with the MO Department of Social Services and the American Indian Council to discuss the AI/AN Medicaid/CHIP cost sharing exemptions and explore opportunities for collaboration and partnership to address the needs of Urban Indian people in KC.

The HHS RD, ACF Regional Administrator, and RO NAC visited all 8 Tribes in KS and NE. During those visits, the NAC answered question related to PCIP, the Medicaid New Eligibility Group, Health Exchanges, HITECH, and Medicare Part D.

In FY 2011, the RO NAC coordinated the first series of meetings with the KS and NE DOIs and Tribes to discuss Health Exchanges and its impact on Indian Country.

On 7/12/11, the RO NAC met with the Ponca and Winnebago Tribes, NE SHIP, Eastern NE Office on Aging, and NE Medicaid to discuss AI/AN elder issues and the services and resources available to them.

The RO NAC continues to work with NE on compliance issues related to the out stationing requirement under 42 CFR §435.904. Follow up meetings to include the participation of Tribal Leaders, Health Directors, CHRs, and Patient Benefits Coordinators are scheduled for January and February 2012.

#### **Region VIII (CO, MT, ND, SD, UT WY)**

The RO NAC assisted staff from three ND tribes and the State to resolve HCBS issues on the reservations. As a result of this effort, the tribes will hire their own Licensed Social Workers to conduct HCBS case management services.

The RO NAC assisted with arrangements and attended filming of two MT CHIPRA Grantees (Blackfeet Tribe and Indian Health Board of Billings) and the State Health Director for an episode of the Medicine Dish broadcast.

On 9/20, the IHS/CMS training session for the Wyoming tribes was held at Fort Washakie, WY. Approximately 30 I/T/U staff attended the session, which was coordinated by the RO NACs.

The RO NAC assisted the Indian Walk In Center of Salt Lake City, a CHIPRA grantee, with application processing difficulties they encountered with the State.

#### **Region IX (AZ, CA, HI, NV)**

In September 2011, the RO NACs collaborated with local partners to provided statewide CMS Medicare, Medicaid and CHIP outreach and training to the California I/T/Us.

In January 2011, the RO NAC assisted in getting three high level Indian Health executives in Sacramento, CA to participate in the one year anniversary of First Lady Michelle Obama's "Let's Move" campaign to fight childhood obesity.

The RO NAC assisted California Tribal Health Programs with receipt of retroactive reimbursements from the State Medicaid Agency for calendar year 2010. The payments, resulting from IHS rates published in 6/2010, were released in 2/2011.

The RO initiated six CMS/CA Medicaid Monthly Tribal Calls to provide an opportunity for CMS and the State to work together on mutual concerns and divert or resolve issues for tribal health programs.

The RO and Consortium staff worked with AZ to clarify receipt of 100% FMAP for services provided through the IHS or Tribal 638 programs and payment requirements for off-site dental services.

### **Region X (AK, ID, OR, WA)**

The RO NAC assisted 5 tribal providers, enrolled as FQHCs, with Medicare revalidation issues resulting from the MAC transition.

The RO, Consortium and CMCS worked together with WA to resolve issues regarding ARRA Protections for Indians in the 1115 Bridge Waiver submitted to provide early expansion of Medicaid eligibility.

### **AFFORDABLE CARE ACT ACTIVITIES SPECIFIC TO TRIBES**

As the Affordable Care Act provisions are implemented, CMS communication and outreach to Tribal officials will be ongoing: through the new AI/AN Outreach and Education Campaign, national All Tribes' Calls, IHS/CMS Training Opportunities, the Medicine Dish, the CMS TTAG, and in collaboration with IHS, HHS/IGA, other agencies within HHS, national Indian organizations and other partnerships.

On July 15, 2011 and August 17, 2011, CMS published notices of proposed rulemaking (NPRM) on the establishment of Exchanges and Qualified Health Plans, Exchange Functions in the Individual Market: Eligibility Determinations; and Medicaid Program: Eligibility Changes. As part of the outreach and education efforts in Indian Country, staff from the Center for Consumer Information and Insurance Oversight (CCIIO) and Center for Medicaid, CHIP, and Survey & Certification (CMCS) hosted a series of webinars for Indian Country; participated in the IHS Consultation Summit – July 7, 2011; a meeting with the National Indian Health Board – July 29, 2011; a meeting with the Secretary's Tribal Advisory Committee - September 13, 2011; and three face to face HHS Tribal Consultation Sessions held August 22, 2011 – Seattle; September 7, 2011 – Denver; and September 15, 2011 – Washington, DC; and a workshop presentation at the National Indian Health Board Consumer Conference on September 28, 2011, and a presentation during the California Rural Indian Health Board 42<sup>nd</sup> Annual Board of Directors Meeting – October 29, 2011.

### **AGENCY TRIBAL TECHNICAL ADVISORY GROUP**

#### **Highlights of TTAG Agenda Items:**

#### **February Face to Face Meeting (February 23- 24, 2011)**

1. Medicare/Medicaid Additional Screenings, Application Fees, State Licensure Requirements and Tribal provider participation in Medicaid – John Spiegel, CMS Medicare Program Integrity Group
2. Discussion with CMS Leadership - Dr Donald Berwick , CMS Administrator, Richard Gilfillan, M.D., CMS Director, Center for Medicare and Medicaid Innovation Center, Teresa Niño, Director, CMS Office of Public Engagement.
3. Introduction to the Center for Consumer Information and Insurance Oversight (CCIIO) - Laurie McWright, Director, Health Plans & Exchange Standards Team
4. Tribal funded health benefits and Medicare/Medicaid secondary payer issues – Jim Roberts, Portland Area TTAG Alternate, Kitty Marx, Director of CMS Tribal Affairs Group (TAG), Rodger Goodacre – Senior Health Insurance Specialist, TAG/CMS

#### **July Face to Face Meeting (July 27-28, 2011)**

1. ICD-10-Overview- Christi Dant, MPM, Office of E-health Standards & Services, (OESS/CMS) Kyle Miller, MPP, Health Insurance Specialist, (OESS/CMS)

2. Center for Medicaid, CHIP and Survey Certification (CMCS/CMS) - Cindy Mann, Deputy Administrator and Director CMCS/CMS
3. Centers for Consumer Information and Oversight (CCIIO) – Lisa Wilson, CCIIO/OA Pete Nakahata, CCIIO, Lisa Marie Gomez, CCIIO

**November Face to Face Meeting (November 16-17, 2011)**

1. Verification of Indian Status: *Medicaid Expansion* – Sarah deLone, Senior Policy Advisor Children and Adults Health Program Group, CMCS/CMS, Lane Terwilliger, Technical Director, Division of Eligibility, CMCS/CMS, *Health Exchanges* – Amy Erhardt, Health Insurance Specialist, CCIIO/CMS, Lisa Marie Gomez, Public Health Analyst, CCIIO/CMS, *IHS Data* – Jim Garvie, Senior Subject Matter Expert, OIT/IHS/HQ
2. Low Income Health Program for California – Jim Crouch, Executive Director, California Rural Indian Health Board and California TTAG Representative
3. Eligibility Overview & CHIPRA Summit Update – Linda Nablo, Director, Division of Children’s Health Insurance Programs, CMCS/CMS, Kitty Marx, Director of Tribal Affairs Group, OPE/CMS
4. Long Term Care Update – John Johns, Health Insurance Specialist, TAG/OPE/CMS, Mike Myer, Director of Research & Evaluation, KAI, Jeanette Hassin, Project Manager, KAI
5. SAMHSA – Updating and forging new partnerships – Sheila Cooper, Senior Advisor for Tribal Affairs, SAMHSA
6. Office of the Inspector General Update – Melinda Golub, Senior Counsel, Office of Counsel to the Inspector General, DHHS, Amitava “Jay” Mazumbdar, Senior Counsel, Office of Counsel to the Inspector General, DHHS

**AGENCY TRIBAL CONSULTATION POLICY**

On November 17, 2011, CMS Administrator, Dr. Donald Berwick signed the CMS Tribal Consultation Policy. CMS has been working on an agency specific tribal consultation policy for several years and the policy is consistent with the HHS tribal consultation policy. The purpose of the policy is to establish a clear, concise and mutually acceptable process for consultation between CMS and Indian Tribes and to improve greater access to CMS programs by American Indians and Alaska Natives (AI/ANs). The policy was distributed to all 565 Tribes via a Dear Tribal Leader letter.

A signed copy of the CMS Tribal Consultation Policy is located at:  
[http://www.cms.gov/AIAN/Downloads/CMSTCP\\_FINAL%2011\\_17\\_11.pdf](http://www.cms.gov/AIAN/Downloads/CMSTCP_FINAL%2011_17_11.pdf)





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United States Department of Health and Human Services

## **Food and Drug Administration (FDA)**

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The FDA is responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation. The FDA is also responsible for advancing the public health by helping to speed innovations that make medicines and foods more effective, safer, and more affordable; and helping the public get the accurate, science based information they need to use medicines and foods to improve their health.

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## **HIGHLIGHTS OF DIVISION SPECIFIC ACCOMPLISHMENTS/ACTIVITIES TARGETED TOWARD AMERICAN INDIANS/ALASKA NATIVES (AI/AN)**

### **Health Promotion and Disease Prevention**

In 2011 FDA's Office of Minority Health (OMH) held informal conversations with IHS and the Native Research Network to share the mission of the new office and seek out opportunities for collaboration.

In late 2010 the MIN-DO PAS exhibited at the Many Faces of Community Health Conference. The focus of that gathering was to examine the impact of health reform on the delivery of health care for medically underserved populations. The goals were to enhance understanding of how community-based primary care might develop and change under the 2010 national healthcare reforms and Minnesota reforms.

On October 14, 2010 ORA NWE-DO visited the Schaghticoke Indian Tribe in Kent, Connecticut. There the Tribe briefed FDA on current tribal leadership status, projected building of tribal hospice building, pollution problems with fish taken for food from rivers flowing through reservation as well as economic hardships tribe is experiencing. ORA/NWE-DO provided an overview of FDA's regulatory activities and issues plus programs, materials and literature available for tribal educational outreach. A talk emphasized proper food inspection and handling and provided contact information for FDA outreach support and contact information for other federal agencies. NWE-DO personnel also toured the reservation.

The Public Affairs Specialist from ORA-PRO Los Angeles provided an exhibit and made a presentation at the 34th Annual California Conference on American Indian Education in March 24-26, 2011. The exhibit concentrated on diabetes awareness, mammography, nutrition, high blood pressure, heart health, stroke, and smoking. The conference stressed education and focused on honoring elders, culture, and student growth and advancement. PAS also presented information on Healthy Eating.

The Public Affairs Specialist from ORA Dallas District Office (ORA-DO) hosted a table and attended an event on June 8-10, 2011 in Tulsa, Oklahoma. "Food safety" was the main theme. "FDPIR" "Food Distribution Programs on Indian Reservations" sponsored the event. Some of the tribes participating were Choctaw, Caddo, Cherokee, Arapaho, Potawatomi and Comanche who reside near Tulsa. Representatives of "Northern Tribes" also attended. Materials distributed included "Fight BAC" "Playing it Safe with Eggs" "Eating for a Healthy Heart" and Safe Handling of Raw Produce and Squeezed Fruit and Vegetables and Diabetes.

From August through September 2011, the ORA NWE-DO compiled current literature pertinent to Native American health issues. This information was shared in a 2011 mass mailing to the health clinics or designated health officials with the 12 Indian Tribes within the district. ORA/NWE-DO will follow up with clinic and leadership visits with tribes in February of 2012.

On September 14, 2011 NWEDO shared information during a cable television interview on Leominster Cable Access Television, Ch 8's "City Scape" show. The program was filmed at the station's Leominster studio and gave NWE-DO an opportunity to explain how important educational outreach six states.

In November 2010, CTP met with staff from the National Native Commercial Tobacco Abuse Prevention Network to learn about the organization and discuss the CTP Stakeholder Discussion Series.

## **TRIBAL DELEGATION MEETINGS**

### **Squaxin Island Tribe**

In November 2010, CTP met with members of the Squaxin Island Tribe (Washington State), as representatives of the Tribe and the Tribal-owned tobacco company, Skookum Creek Tobacco Company. The purpose of the meeting was to discuss enforcement of the Family Smoking Prevention and Tobacco Control Act.

### **National Congress of American Indians**

In December 2010, the CTP met with the National Congress of American Indians (NCAI) to exchange information on missions. CTP and the NCAI explored collaborations and discussed the Family Smoking Prevention and Tobacco Control Act. CTP discussed various CTP events that would interest or impact on American Indian and Alaska Natives. CTP staff also discussed the tobacco statute, strategies for outreach to American Indians and Alaska Native Tribes, the proposed FDA Stakeholder Discussion Series and CTP compliance and enforcement initiatives.

### **Seneca Manufacturing Company and Skookum Creek Tobacco Company**

In December 2010, CTP hosted a Stakeholder Discussion session for tobacco product manufacturers and growers. Then representatives from two tribal-owned tobacco product manufacturing companies participated in the discussion – Seneca Manufacturing Company and Skookum Creek Tobacco Company.

### **Cherokee Nation**

In February 2011, the ORA Southwest Region (SWR) Retail Food Specialists responded to a food safety question from the Environmental Health Specialist, Office of Environmental Health, Cherokee Nation. The inquiry focused on using a "self-contained bioreactor" that uses an "organic decomposition product" and water to decompose food waste.

### **Cherokee Nation**

In February 2011 ORA-SWR Retail Food Specialists the Office of Environmental Health, Cherokee Nation and staff to review changes and respond to questions about the 2009 FDA Food Code.

### **Yukon Kuskokwim Health Corporation**

In March 2011, the Center for Device Radiological Health (CDRH) worked with the Yukon Kuskokwim Health Corporation (YKHC) to register an oxygen generator. YKHC is a 501(c) (3) nonprofit tribal health organization operating under Title V of the Indian Self-Determination and Education Act. YKHC operates the Yukon Kuskokwim Delta Regional Hospital (YKDRH), a 50 bed Indian Health Service hospital, in Bethel Alaska. The YKHC service area is located in a rural section of western Alaska. The hospital in Bethel is 500 miles west of Anchorage and is the only hospital in a 75,000 square mile area. Yukon Kuskokwim Health Corporation also provides basic health care at 48 tribally owned clinics at villages throughout their service area. Bethel separated from the Alaska road and rail system by several mountain ranges and is accessible mostly by air.

### **Chickasaw Nation**

In April, 2011, the ORA-SWR Retail Food Specialist responded to a food safety inquiry from the Environmental Health Officer, Chickasaw Nation's Office of Environmental Health and

Engineering. The inquiry focused on out-of-state caterer serving over a 1000 breakfasts meals twice weekly to seniors outside the Windstar Casino.

#### **Chickasaw Nation**

In July 2011 ORA-SWR Retail Food Specialist provided refresher training on the FDA Food Code to the Chickasaw Nation Office of Environmental Health and Engineering, Ada, Oklahoma. The Chickasaw Office Environmental Health and Engineering satisfactorily completed restandardization field training resulting in renewing their FDA Standardized Inspection Officer Certificate.

#### **Chehalis Tribe**

In August 2011, the ORA Pacific Region Office (PRO) Retail Food Specialist met with members of the Chehalis Tribe Gaming Commission (Washington State). The purpose of the meeting was to discuss retail food safety procedures and the Retail Food Program Standards.

#### **Jamestown S'Klallam Tribe**

In September 2011, the ORA-PRO Retail Food Specialist contacted the Jamestown S'Klallam Tribe (Washington State) to offer assistance with Food Code adoption and to orientation to the Retail Food Program Standards.

#### **Squaxin Island Tribe**

The ORA-PRO Retail Food Specialists conducted a Self-Assessment Audit Workshop for Retail Program Standards enrollees in September 2011. A representative of the Squaxin Tribe attended the workshop.

#### **Viejas Tribe**

The ORA-PRO hosted the FDA Voluntary Programs Standards Initiative. Viejas has been enrolled in the Voluntary Program Standards Initiative from 2008 to 2011. The VPSI offers continuous improvements toward best practices for an effective and efficient Food Safety Program. The Tribe participated in a recent two and one-half day Self-Assessment workshop, in September 2011, at the Los Angeles District Office. This workshop is designed to help jurisdictions complete their program self-assessment using the Program Standards.

#### **Chickasaw Nation**

In October 2011, The Office of Regulatory Affairs (ORA) Southwest Region (SWR) Retail Food Specialists responded to food safety questions from the Chickasaw Nation Office of Environmental Health and Engineering about operating bars in casinos.

#### **Squaxin Island Tribe**

Office of Regulatory Affairs, Pacific Regional Office (ORA-PRO) interacted with the Squaxin Island Tribe, Gaming Commission (Washington State). Squaxin Island enrolled in the Voluntary Retail Food Program Standards, (Retail Program Standards) since September 2005. The Tribal Council adopted the 2001 FDA Food Code in June 2005 as their regulatory foundation. The FDA Pacific Region Retail Food Specialist has provided field training to the gaming agent conducting inspections for the tribe along assistance with program assessment.

#### **Crow Agency, Montana**

ORA-PRO Retail Food Specialist worked with the Crow Agency Sanitarian on the Voluntary National Retail Food Regulatory Program Standards. The Crow Agency was the first tribal jurisdiction to enroll in the retail standards.

### **Coeur d'Alene Tribe**

The Coeur d'Alene Tribe enrolled in the Voluntary National Retail Food Regulatory Program Standards. The ORA-PRO Retail Food Specialist met with the tribal sanitarian to enroll in the program, and to begin work on the tribe's self-assessment.

### **Mohegan Tribe**

In 2011, the ORA Northeast Region Office (ORA-NER) Retail Food Specialist provided technical assistance to the Mohegan tribal health department in Connecticut. The technical assistance focused on Food Code interpretation, retail food safety, reduced oxygen packaging of food, food establishment plan review and compliance issues.

### **Mohegan Tribe**

In 2011, ORA-NER continued support for the Mohegan Tribe's improvement of their retail food safety program for implementation of the FDA Voluntary National Retail Food Regulatory Program Standards. The ORA-NER Retail Food Specialist focused on food employee hygiene including dissemination of the FDA Employee Health and Personal Hygiene Handbook and addressing various food safety technical issues.

### **Mashantucket Pequot Tribe**

In 2011, the FDA Northeast Region's Retail Food Specialist provided technical assistance to the Mashantucket Pequot tribal health department located in Connecticut. The technical assistance focused on Food Code interpretation, retail food safety, reduced oxygen packaging of food, food establishment plan review and compliance issues. The Retail Food Specialist also supported the Mashantucket Tribe in their continued participation in the FDA Voluntary National Retail Food Regulatory Program Standards.

### **National Native Commercial Tobacco Abuse Prevention Network**

In March 2011, CTP staff met with staff of the National Native Commercial Tobacco Abuse Prevention Network.

### **Inter-Tribal Council of Arizona, Inc. (ITCA)**

In May 2011, CTP staff met with the health promotions coordinator in the Inter Tribal Council of Arizona to learn more about the ITCA and provide background about the Center.

**Gila River Indian Community** In June 2011, CTP hosted a stakeholder discussion session with American Indian public health officials in the Gila River Indian Community (Chandler, AZ). The Lieutenant Governor of the Gila River Indian Community provided opening remarks.

### **Arizona Department of Health**

In July 2011, CTP staff met with the Program Manager (Tribal Liaison) in the Arizona Department of Health Services' Division of Public Health Services to learn more about their work with the Inter Tribal Council of Arizona.

### **Association of American Indian Physicians (AAIP)**

In August 2011, CTP staff met with the Executive Director and staff from the Association of American Indian Physicians (AAIP) in order to learn about the AAIP's mission and activities as well as provide an overview of the Center.

### **Cherokee Nation Policy Action Institute**

In September 2011, CTP attended the Healthy Communities Tribal Policy Action Institute hosted by the Cherokee Nation. CTP staff met with Health Legislative Officer for the Cherokee Nation, the Tobacco Cessation Coordinator for the Lumbee Tribe (NC) and Tribal affairs staff from the Oklahoma Department of Health.

### **The Seneca Nation of Indians**

In November 2011, CTP staff met with representatives from the Seneca Nation of Indians (New York). The purpose of the meeting was to discuss the enforcement of the Family Smoking Prevention and Tobacco Control Act.

### **Lac du Flambeau Band of Lake Superior Chippewa Tribe**

In 2011, ORA Central regional office (CRO) supported the Lac du Flambeau Tribe's retail food safety program by implementation of the FDA Voluntary National Retail Food Regulatory Program Standards. ORA-CRO's Retail Food Specialist will continue to provide guidance and support as the Tribe moves toward completing their baseline survey on the Occurrence of Foodborne Illness Risk Factors. ORA-CRO efforts also included assistance and guidance to the tribe in their effort toward making improvements to meet Standard No. 3: Inspection Program Based on HACCP Principles.

### **Lac du Flambeau Band of Lake Superior Chippewa Tribe**

The Lac du Flambeau Tribe has participated in the FDA Voluntary Program Standards Initiative since 2008. This voluntary initiative offers continuous improvements toward standards recognized as building blocks for an effective and efficient Food Safety Program. The Tribe completed their Retail Food Program self-assessment in 2009, their baseline survey on the Occurrence of Foodborne Illness Risk Factors in 2011 and is progressing toward meeting and improving upon Standard 3: Inspection Program Based on HACCP Principles.

### **Potawatomi Tribe**

In November 2010, the ORA-CRO's Retail Food Specialist provided technical assistance to the Potawatomi tribal casino food service in Milwaukee, Wisconsin. The two days of technical assistance focused on the state of the art reduced oxygen packaging of food and provided assistance to casino food service staff, State Department of Agriculture regulatory staff as well as the City of Milwaukee Health Department.



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United States Department of Health and Human Services

## Health Resources and Services Administration (HRSA)

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The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, is the primary federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable. Comprising 6 bureaus and 13 offices, HRSA provides leadership and financial support to health care providers in every state and U.S. territory. HRSA grantees provide health care to uninsured people, people living with HIV/AIDS, and pregnant women, mothers and children. They train health professionals and improve systems of care in rural communities. HRSA oversees organ, bone marrow, and cord blood donation. It supports programs that prepare against bioterrorism, compensate individuals harmed by vaccination, and maintains databases that protect against health care malpractice and health care waste, fraud and abuse.

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Tribal Consultation Policy: Yes

## **HIGHLIGHTS OF DIVISION SPECIFIC ACCOMPLISHMENTS/ACTIVITIES TARGETED TOWARD AMERICAN INDIANS/ALASKA NATIVES (AI/AN)**

The Health Resources and Services Administration (HRSA) shares many priorities with American Indian and Alaskan Native populations, including, but not limited to, reducing the burden of disease; increasing health professional workforce development; increasing health information technology investments in Tribal and Urban health facilities; and improving access to funding and grant opportunities. HRSA does this work through a variety of activities and has made significant progress in Federal Fiscal Year 2011.

In order to more fully engage with and support our Tribal partners, HRSA has made efforts to improve our communication with American Indian/Alaskan Native (AI/AN) populations through various means. HRSA meets quarterly with the Indian Health Service (IHS); convenes an internal workgroup on a quarterly basis; and meets with National organizations and Tribal/Urban leaders. Our tribal website provides information on funding opportunities, regional contacts, and technical assistance. And, in an effort to increase our accessibility and respond to any questions and concerns that our Tribal partners may have, we have created an email box [aianhealth@hrsa.gov](mailto:aianhealth@hrsa.gov) to manage all inquires.

HRSA leadership actively participates in the Secretary's Tribal Advisory Committee (STAC) as well as the Interdepartmental Council on Native American Affairs (ICNAA), and the various sub-groups in order to strengthen our relationships with the American Indian/Alaskan Native communities. HRSA Administrator Dr. Wakefield and IHS Director Dr. Roubideaux have written two Dear Tribal Leader Letters (December 2010 and October 2011) and a Dear Title V Urban Indian Program Director letter (April 2010). The Dear Tribal Leader and Dear Title V Urban Indian Program Director letters address concerns raised by our tribal partners including increasing AI/AN representation on HRSA's advisory committees; providing better support for the recruitment and retention of health care providers; increasing access to primary care; and highlighting implementation efforts around the Affordable Care Act and the reauthorization of the Indian Health Care Improvement Act.

## **DIVISION SPECIFIC ACTIVITIES**

With support from the Indian Health Service and Secretary Sebelius, HRSA and IHS have designated all IHS/tribal facilities as National Health Service Corps approved sites. This allows IHS/tribal facilities to recruit and retain primary care providers by utilizing the scholarship and loan repayment incentives offered through the National Health Service Corps program. A welcome letter was sent by Drs. Wakefield and Roubideaux to all site Directors on May 6, 2011 outlining the benefits of becoming a National Health Service Corps approved site. Following the letter, IHS participated at the National Health Service Corps Scholar Orientation and Placement Conference as a speaker and exhibitor, where IHS representatives spoke to National Health Service Corps scholars about the opportunities available at IHS sites throughout the country. The National Health Service Corps and IHS have also developed and distributed joint informational materials. As a second step in the initiative, HRSA and IHS are partnering to designate a Health Professional Shortage Area (HPSA) score for over 300 newly approved IHS/tribal facilities.

HRSA's health center program grantees served over 217,000 American Indians and Alaskan Natives according to the 2010 Uniformed Data System. Currently 25 organizations receive both Health Center Program and Indian Health Service (IHS) funding (18 Tribal organizations and 7



Urban Indian Program organizations). These 25 organizations served approximately 121,000 patients in 2010 and HRSA awarded approximately \$48 million to these dually-funded health centers in Fiscal Year 2011 including \$13 million in Capital Development funding to two tribal health centers, \$100,000 to one tribal health center to improve quality of care and electronic reporting capabilities in Beacon Communities, \$455,000 to 13 centers to achieve recognition as a patient-centered medical home, and \$560,000 to seven tribal organizations through the Health Center Planning Grant Program to assist in the development of a future health centers.

In coordination with the Centers for Medicaid and Medicare Services (CMS), eligibility for Medicaid Meaningful Use incentives has been modified to allow all tribal clinics to be treated as Federally Qualified Health Centers for purposes of qualifying for these incentives. This modification allows tribal clinics to meet the needy individual patient volume threshold, rather than the more stringent Medicaid patient volume threshold, making it easier for tribal clinics to qualify for these incentives.

The Stem Cell Therapeutic and Research Act of 2010 reauthorized the National Cord Blood Inventory. The National Cord Blood Inventory focuses on increasing collections of umbilical cord blood from donor mothers of diverse racial and ethnic groups. The status is pending, but the University of Colorado Cord Blood Bank has set funding targets to collect and store 51 Native American cord blood units.

In calendar year 2010 the Ryan White HIV/AIDS program served a total of 5,264 (duplicated) American Indians/Alaskan Natives living with HIV/AIDS, and trained 1,956 providers who serve American Indian and Alaskan Natives living with HIV/AIDS.

The Emergency Medical Services for Children program is supported by the Maternal and Child Health Bureau and provided support to 84 IHS affiliated EMS programs in 25 States in Fiscal Year 2011. The EMSC program assists with the procurement of ambulance and equipment purchases for the programs and develops and supports pediatric specific training initiatives tailored to the needs of Tribal emergency medical services. In Fiscal Year 2012 HRSA's Emergency Medical Services for Children program intends to solicit applications for a demonstration project that will address the regionalization of care in areas serving American Indian and Alaskan Natives, focused on the pediatric population. Demonstration programs would partner state Emergency Medical Services for Children programs with Indian Territories. It is expected that 3-4 demonstration projects would be funded for 3 years at \$270,000/year.

Through HRSA's Office of Federal Assistance Management, HRSA has been actively seeking tribal grant reviewers. The call for reviewers was also promoted by colleagues at IHS and Intergovernmental and External Affairs. As a result, 47 new American Indian and Alaskan Native individuals have registered in our reviewer database since June 15, 2010, bringing our total of American Indian and Alaskan Native reviewers to 200. Of these 200 reviewers, 49 have participated in application reviews.

The Office of Rural Health Policy continues to provide technical assistance to tribal entities around funding opportunities and grant writing tips. The Office has begun to implement the Rural Health Information Technology Network Development Program; this 3-year pilot program was developed in Fiscal Year 2011 in response to the Secretary's Rural HIT Taskforce and the President's Rural Health Initiative. The purpose of the program is to improve health care and support the adoption of Health Information Technology in rural America by providing targeted

support to rural health networks and assist them in reaching meaningful use. Up to \$300,000 in awards were made to three tribal entities on September 1, 2011.

HRSA's ten Regional Offices have convened a regional workgroup that focuses on the various interactions regional offices have with tribal partners; this group also provides a forum to identify opportunities for HRSA staff to improve support for tribal stakeholders. Throughout the year HRSA's ten Regional Offices have begun to explore ways to partner with IHS Area Offices to better meet the health care needs of American Indians/Alaskan Natives. On September 14, 2011, the Chief Medical Officer and Deputy Director for the Bemidji Area Office provided an overview to the Regional Workgroup on potential opportunities to improve systems of care through HRSA's and IHS' programs.

In continued support of the important role Tribal Colleges and Universities play in their communities HRSA provided \$766,949 in funding to four Tribal Colleges and Universities in Fiscal Year 2011.

Technical assistance to Tribal organizations has been provided on various occasions throughout fiscal year 2011. Over 20 technical assistance activities have had a Tribal/Urban focus.

1. December 16, 2010 – Region X provided an overview of HRSA's resources at the Portland Area IHS sponsored training for tribes in the Northwest.
2. December 16, 2010 - Outreach and technical assistance on the NHSC and open Bureau of Primary Health Care (BPHC) funding opportunities was provided to the Detroit Urban Indian health center.
3. January 6, 2011 – Region V presented an overview of HRSA's programs at the Green Bay, WI Tribal Budget Consultation.
4. January 7, 2011 - HRSA's Bureau of Primary Health Care held a pilot training and webinar for IHS and HRSA grantees on the UDS for RPMS users, seeking to improve the coordination of these two key data sets. The training was held in conjunction with the Alaska Primary Care Association and Aleutian Pribilof Islands Association. It took place on the second day of the UDS training in AK.
5. January 19, 2011 – Region IX provided an overview of HRSA's programs and resources to the California Area Office of IHS and the Tribal Program Directors in Sacramento, CA.
6. January 20 -21, 2011 – Region IX presented to the California Rural Indian Health Board and Rural Tribal Program Directors in Sacramento, CA on HRSA's programs and resources.
7. January 21, 2011 – Region VIII provided technical assistance via teleconference to Sanford's Health Office of Native American Health regarding BPHC's planning grant opportunity and ORHP's rural health outreach and network grant program.
8. March 31, 2011 – The Office of Rural Health Policy provided an overview of its priorities, programs and funding opportunities to Tribal stakeholders in California.
9. April 19, 2011 – HRSA provided an overview of recent funding opportunities offered through the Affordable Care Act at the NIH/Nation Tribal Health Reform Implementation Summit.
10. April 20, 2011 – BPHC provided an overview of FQHCs and Urban Indian Health Programs at the National Council of Urban Indian Health 2011 Leadership Conference.

11. August 16-17, 2011 – ORHP held a workshop in Montana in coordination with the Center for Rural Outreach and Public Service to inform tribal partners on funding opportunities and resources available through ORHP.

### **AFFORDABLE CARE ACT ACTIVITIES SPECIFIC TO TRIBES**

HRSA is responsible for implementing several key provisions of the Affordable Care Act that impact Tribal and Urban American Indian/Alaska Native populations. HRSA has been working with the Indian Health Service and others across the Department of Health and Human Services to do this work.

The Affordable Care Act provides \$11 billion in funding for the operation, expansion and construction of health centers throughout the nation. HRSA awarded approximately \$48 million to 25 dually-funded health centers in fiscal year 2011 including \$13 million in capital development funding to two Tribal health centers; \$100,000 to one tribal health center to improve quality of care and electronic reporting capabilities in Beacon Communities; \$455,000 to 13 centers to achieve recognition as a patient-centered medical home, \$560,000 through the Health Center Planning Grant Program to assist in the development of a future health centers to seven tribal organizations; and \$500,000 was awarded to the Native American Community Academy to support their school-based health center program.

The Affordable Care Act authorizes and appropriates \$1.5 billion for the NHSC through 2015. In Fiscal Year 2011, the Affordable Care Act funded 2,612 new loan repayment awards and 248 scholarships. The Affordable Care Act also:

1. Increases the maximum annual loan repayment award from \$35,000 to up to \$50,000.
2. Establishes permanent half-time service opportunities for NHSC scholars and loan repayers with the creation of 2- and 4-year contracts for the Loan Repayment Program.
3. NHSC participants may now receive up to 20 percent service credit for teaching (and up to 50 percent in future Teaching Health Centers).
4. Allows Indian Health Facilities that serve only Tribal members to qualify as NHSC sites.

In cooperation with the Administration for Children and Families and supported by the Affordable Care Act, \$1.5 billion was made available for the Maternal, Infant, and Early Childhood Home Visiting Program through 2014. Funding for home visiting programs has been made available for states, Tribes and territories that plan to deliver services for early childhood home visitation programs that provide comprehensive services and improve outcomes for families living in at-risk communities. In Fiscal Year 2011 \$10.5 million has been set-aside for Tribal and Urban Indian entities. To date thirteen cooperative agreements were awarded to tribal entities in Fiscal Year 2010 and six cooperative agreements were awarded in Fiscal Year 2011; HRSA anticipates that approximately five to six cooperative agreements will be made to tribal entities in Fiscal Year 2012.

In addition \$600,000 was awarded on September 28, 2011 to support the Tribal Research Center on Early Childhood which will provide leadership and support to promote excellence in community-based participatory research and evaluation of Maternal, Infant, and Early Childhood Home Visiting, Head Start, and Early Head Start initiatives that serve American Indian and Alaskan Native children and families.

Section 7101 of the Affordable Care Act expands participation in the 340B Drug Pricing Program to newly eligible covered entities that include: Sole Community Hospitals, Critical Access Hospitals, Children's Hospitals, Free Standing Cancer Hospitals, and Rural Referral Centers. Twelve hospitals were identified as Tribal on the list of newly-eligible Critical Access Hospitals.

### **AGENCY TRIBAL CONSULTATION POLICY**

Based on feedback received at the 13<sup>th</sup> Annual Budget Consultation, HRSA has begun the process of updating our Tribal Consultation Policy in accordance with the Department of Health and Human Services Consultation Policy. Two meetings were held with Tribal Leaders at the National Indian Health Board (NIHB) and The National Congress of American Indians (NCAI) on September 26, 2011 and October 30, 2011 respectively. These meetings provided an opportunity to receive input and feedback from Tribal Leaders and Tribal partners on HRSA's draft Consultation Policy. Approximately 140 Tribal leaders attended both of these sessions. HRSA staff is currently reviewing all comments and feedback received and expects to have a final draft Consultation Policy for review by February 20, 2012 with an approved policy by March 2012.



United States Department of Health and Human Services

## Indian Health Service (IHS)

The Indian Health Service provides a comprehensive health service delivery system for approximately 1.9 million American Indians and Alaska Natives who are members or descendants of 565 federally recognized Tribes in 35 states. The IHS fiscal year (FY) 2010 appropriation was \$4.05 billion. The IHS has a total of about 15,700 employees, which includes approximately 2,700 nurses, 900 physicians, 700 engineers and sanitarians, 600 pharmacists, and 300 dentists. The IHS system consists of 12 Area offices, which are further divided into 161 Service Units that provide care at the local level. Health services are provided directly by the IHS, through tribally contracted and operated health programs, and through services purchased from private providers. There are over 600 facilities in the Indian health system. The Federal system consists of 31 hospitals, 63 health centers, and 30 health stations. In addition, 34 Urban Indian health programs provide a variety of health and referral services.

The provision of Federal health services to American Indians and Alaska Natives is based on a Government-to-Government relationship between Indian Tribes and the United States, as well as numerous treaties, court decisions, and legislation. The Snyder Act of 1921 provides the basic authority for health services provided by the Federal Government to American Indians and Alaska Natives. The Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA), as amended, allows Tribes to assume the administrative and program direction responsibilities that were previously carried out solely by the Federal Government. Tribes currently administer over one-half of IHS resources through ISDEAA contracts and compacts. The IHS administers the remaining resources and manages facilities where Tribes have elected not to contract or compact their health programs. The Indian Health Care Improvement Act of 1976 (IHCA), as amended, authorizes the provision of health care services by IHS and was reauthorized in 2010 with passage of the Affordable Care Act.

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## HIGHLIGHTS OF DIVISION SPECIFIC ACCOMPLISHMENTS/ACTIVITIES TARGETED TOWARD AMERICAN INDIANS/ALASKA NATIVES (AI/AN)

### **Tribal Consultation**

Tribal consultation was identified as a top division priority in 2011. The four IHS priorities include:

1. To renew and strengthen our partnership with Tribes;
2. To reform the IHS;
3. To improve the quality of and access to care; and
4. To ensure that our work is accountable, transparent, fair and inclusive.

Activities in FY 2011 included comprehensive and wide-ranging activities targeted at improving communication with Tribes, expanding consultation activities on top Tribal priorities, increasing formal written communications with Tribal Leaders, convening a series of listening sessions throughout Indian Country and within each IHS Area, and hosting Tribal delegation meetings.

### **Consultation on Tribal Consultation Process**

IHS continued to implement recommendations on how to improve the IHS Tribal consultation process. In addition to the strategies listed below, the Director's Tribal Advisory Workgroup on Consultation recommended that IHS hold a "summit" that would serve as a "one stop shop" for Tribes to learn about IHS Tribal consultation activities and as a forum for providing input. On July 6-7, 2011, the first IHS Tribal Consultation Summit was convened, which was followed by a half-day educational session on the Affordable Care Act (ACA). Tribal participants actively engaged with the IHS and other Federal agencies during the two-day meeting. The event provided numerous opportunities for Tribes to provide feedback and recommendations on current IHS consultation topics. The Summit also allowed Tribes to participate in workshops and other information sharing on resources to expand Tribal consultation activities. The IHS Director also initiated a consultation in 2011 on the application of the Federal Advisory Committee Act to the current list of IHS advisory groups, workgroups and committees.

### **Tribal Communication Strategies**

The IHS Web site [www.ihs.gov](http://www.ihs.gov) functions as a central portal for updates on important Agency initiatives and operational updates. Redesigned in early 2010, The *Director's Corner*, which is accessed through the site's main page, has proven to be a tremendous success, receiving more than 95,000 individual views during the past year. The *Director's Corner* features press releases, presentations, and links to a host of Agency-relevant activities, including IHS reform initiatives, Tribal Leader letters, and other announcements. The *Director's Corner* also features the *Director's Blog*, which provides timely updates on a variety of topics, photographs from Tribal site visits, and other events effecting Indian Country, along with essential Agency communications. These updates have increased Agency transparency and information sharing with an annual usage of approximately 32,000 users.

### **Tribal Consultation Website**

Developed in response to Tribal recommendations, the Tribal Consultation Web site at <http://www.ihs.gov/PublicAffairs/DirCorner/index.cfm?module=tc> was developed in 2010 to serve as a central location to find information about these vital activities. Site content includes the following: information on all IHS Tribal workgroups, boards, and committees; a repository of



Letters to Tribal Leaders; and, in the near future, postings of current activities, including minutes and meeting summaries.

### **IHS Area Listening Sessions**

The IHS Director initiated Tribal consultations in each of the 12 IHS Areas during FY 2011, with an emphasis on continued improvement in the IHS Tribal consultation process at the national and Area levels. In FY 2011, the IHS Director convened 12 Area listening sessions at each of the 12 IHS Areas by teleconference videoconference or in-person meetings. Tribal Leaders recommended improvements to Tribal consultation processes at the national, Area, and local levels, asked questions on current issue and also presented Tribal priorities on the funding needs.

### **Tribal Delegation Meetings**

During 2011, the IHS Director met with 65 Tribal delegations that represented 339 Tribes. During Tribal delegation meetings, Tribes discussed issues specific to their local health facility and community and IHS provided information, updates and helped determine next steps to resolve issues.

### **Agency Consultations on Tribal Priorities**

Tribal consultation activities in response to priorities established by Tribes in FY 2011 included the following:

#### **Annual IHS Budget Formulation**

The IHS Budget Formulation Workgroup met in February 2011 to review IHS Area budget formulation recommendations and to make national recommendations for the IHS budget. The IHS Director reviewed the workgroup recommendations and incorporated them into the agency budget formulation process.

#### **Annual HHS Tribal Budget and Policy Consultation**

The IHS participated in Tribal Resource Day and the HHS Tribal Budget and Policy Consultation Session held on March 2-4, 2011, in Washington, DC. Two Tribal representatives from the IHS Budget Formulation Workgroup presented oral and written testimony on IHS budget recommendations at the Tribal Consultation Session.

#### **Contract Health Services (CHS)**

Tribal consultation on the CHS program continued throughout FY 2011. In a mailing to Tribal Leaders on January 10, 2010, the IHS Director initiated a formal consultation on how to reform the CHS program, including the establishment of a Federal/Tribal workgroup. The 24-member Director's Workgroup on Improving CHS met several times and developed specific recommendations for improvements. The recommendations included improving how IHS calculates CHS unmet need, improving CHS business practices, evaluating the current CHS formula, and including medical inflation in the IHS budget. An update to Tribal Leaders was provided on February 9, 2011, which outlined the workgroup recommendations, indicated the IHS Director's concurrence, and discussed next steps.

Based on one of the workgroup recommendations, 12 Area work sessions were held throughout the second quarter to review current CHS policies and procedures and make recommendations on changes to improve CHS business practices. These recommendations are currently being used as a framework for revisions to Chapter 3 of the *Indian Health Manual*. A technical sub-committee was formed to evaluate alternatives to calculating current and future CHS need.



## **Consultation on the Affordable Care Act (ACA) and Indian Health Care Improvement Act (IHCIA)**

Formal consultation on the ACA and IHCIA was initiated by the U. S. Department of Health and Human Services (HHS) and the IHS in a jointly signed letter to Tribes dated May 12, 2010. Listening sessions were held with Tribes at several Indian health meetings and with several Tribal workgroups and advisory committees. The IHS Director also updated Tribes on the progress of the implementation efforts during the IHS Tribal Consultation Summit in July 2011. In May, 2011, a letter was sent to Tribes to report on the status of provisions that had deadlines as of the one year anniversary of the Affordable Care Act. In July, 2011, the IHS Director sent a letter to Tribes with an update on implementation of the IHCIA and included a summary table with progress on implementation of each provision. In November, 2011, a letter was sent to Tribes with the IHS Director's decision on the consultation on the formula for distribution of program increases for the Indian Health Care Improvement Fund. While updates to data used in the formula were approved, the formula itself will be kept the same until all programs are funded at a similar level of need, and new provisions in the IHCIA will not be adopted until specific funding is available for their implementation. Consultations were initiated to gather input on two IHCIA provisions: establishment of the agency's first Sexual Assault Policy; and an update to the Memorandum of Agreement with the Department of Interior on Indian alcohol and substance abuse treatment. IHS participated in several listening sessions, HHS and IHS meetings and monthly White House Affordable Care Act Outreach calls to provide updates and answer questions from Tribes on ACA and IHCIA implementation. Updates were also provided on the IHS Director's blog, including updates on the issue of the definitions of Indian in ACA, the Notices of Proposed Rule-Making on the ACA State Exchanges and how they addressed the special provisions for Indians, updates from the Office of Personnel Management on implementation of the Access to Federal Insurance (FEHB) provision, links to documents that were submitted to Congress on behavioral health issues, a draft letter to notify outside providers of new CHS payment policies, a link to a fact sheet on the Affordable Care Act, and a blog on the cost of repeal of the ACA for American Indians and Alaska Natives.

## **Health Information Technology Shares Consultation**

In August, 2010, the IHS Director sent a letter to Tribes to report on the initial recommendations of the Information Systems Advisory Committee (ISAC) and to initiate further consultation activities. The IHS Office of Information Technology (OIT) held 12 listening sessions in 2011 in coordination with the IHS Areas. Listening sessions in each IHS Area provided Tribes with multiple opportunities to discuss the recommendations and current information technology programs, services, functions, and activities. An action plan has been created that summarized the Tribal feedback and recommendations from these events, and the IHS Director plans to provide an update to Tribes in early 2012.

## **Behavioral Health**

Ongoing efforts to address behavioral health issues, including mental health, substance abuse, and suicide, continue as top Tribal priorities. In a letter to Tribes dated November 12, 2010, the IHS Director, Assistant Secretary of Indian Affairs, and Administrator, Substance Abuse and Mental Health Services Administration (SAMHSA), informed Tribal Leaders of a combined effort to hold a national Suicide Awareness Conference and ten Listening Sessions and requested input on the agenda and goals.

On March 8, 2011, the IHS Director initiated a consultation with Tribes on priorities for implementation of the updated Memorandum of Agreement (MOA) with the Department of the





Interior (DOI) on AI/AN alcohol and substance abuse prevention and treatment. Section 703 of the IHCA provides new authorities that permit the DOI and HHS, acting through the IHS, to develop and enter into a MOA, or review and update an existing MOA.

On March 28, 2011, the IHS Director requested a consultation with Tribes on the IHS National Sexual Assault Policy, as required by sections 17 and 25 of the Tribal Law and Order Act of 2010. An update was provided by the IHS Director to Tribes on the progress of Agency behavioral health and suicide prevention strategic plan development on September 2, 2011.

### **Access to Quality Health Care**

Collaborating to strengthen Departmental efforts in support of AI/AN communities in FY 2011, the IHS Director and Health Resources and Services Administration (HRSA) Administrator met to identify priorities common to both agencies, including the following: reducing the burden of disease on the AI/AN population; increasing health professional workforce development; increasing health information technology investments in Tribal and Urban Indian health facilities; and improving access for American Indians and Alaska Natives to funding and grant opportunities. The IHS Director initiated a consultation in 2011 on the distribution of the Special Diabetes Program for Indians renewal through FY 2013. After review of input received from Tribes, the Director decided to continue the same distribution of funding to IHS, Tribes and urban Indian health programs.

### **Contract Support Costs**

IHS initiated a consultation with Tribes to evaluate the 2007 Contract Support Costs Policy. An advisory committee was established with Tribal governmental representatives and the first workgroup meeting is scheduled in January 2012.

### **Other IHS Consultation Activities**

The IHS Director also met with many of the Agency's Tribal advisory workgroups, committees, and boards. The IHS Director attended the White House Tribal Nations Conference in December 2011.

## **DIVISION SPECIFIC ACTIVITIES**

In FY 2011, IHS Areas reported a number of new consultation activities and initiatives that relate to the Agency's partnership with Tribes. The activities that follow have been grouped by IHS Area.

### **Aberdeen Area IHS**

#### **Annual IHS Budget Formulation Consultation**

The Aberdeen Area IHS Budget Formulation Consultation was conducted on December 13, 2010, in Rapid City, South Dakota. The Tribes and the IHS met to discuss the Tribal priorities and make recommendations for the IHS budget.

#### **Contract Health Services (CHS)**

The Aberdeen Area IHS conducted three CHS workgroups with Tribes. Three sessions were held to discuss efforts to reform the CHS program and make overall improvements to the CHS program: March 22, 2011, in Rapid City, South Dakota; April 13, 2011, in Aberdeen, South Dakota; and May 4, 2011, in Chamberlain, South Dakota. Additional topics under discussion included whether or not changes should be made to the existing formula for distribution of new CHS funds and various methods to improve CHS business operations.



### **Affordable Care Act and IHCA**

The Aberdeen Area IHS partnered with the Great Plains Tribal Chairmen's Health Board to conduct two ACA Consultation sessions with Tribes. The first meeting was held on December 14, 2010, in Rapid City, South Dakota and the second meeting was held on January 25-26, 2011, in Bismarck, North Dakota.

### **Commitment to Consultation**

The IHS, in collaboration with Great Plains Tribal Chairmen's Health Board, met with Aberdeen Area Tribal Leaders and staff from each Tribe, governing bodies, and organizations in FY 2011 for consultation to develop a Strategic Plan for the Aberdeen Area IHS. The IHS, along with the Great Plains Tribal Chairmen's Health Board met onsite with 17 Tribes and 2 Urban Indian health organizations. Agency staff participated in the National Indian Health Board Conference, Direct Service Tribes workgroup meetings, and numerous national meetings. The Area also participated in over 20 additional meetings with individual Tribal leaders or representatives. A report to Area Tribes identifying the top five Tribal priorities and Area-specific follow-up actions was provided.

### **Alaska Area IHS**

#### **Improvement and Promotion of CHS Business Practices**

As a part of a national consultation with Tribes on recommendations from the IHS Work Group on Improving CHS, the Alaska Area Director hosted a Tribal Leader session on improvement and promotion of CHS business practices on March 24, 2011.

The Alaska Area IHS is a member of the Alaska Federal Health Care Partnership (AFHCP), a formal, voluntary partnership of Alaska's federally funded health care agencies. On June 8, 2011, the AFHCP's *Home Tele-health Monitoring Program* was named the Outstanding Rural Health Program for 2011 by the National Rural Health Association at its 34th Annual Rural Health Conference in Austin, Texas. Utilizing a 24-hour call center, the program monitors vital signs established by providers and reports red flags back to providers. This early intervention has reduced medical air evacuations, emergency room visits, and hospital stays.

The Alaska Area IHS continues to provide staff consultation and technical support to the Navajo Area IHS for their P.L. 93-638 negotiation activities. In FY 2011, this included assistance with negotiation of new Title V Funding Agreements with the Utah Navajo Health Systems Corporation, Tuba City Regional Health Care Corporation, and the Winslow Indian Health Center.

#### **Alaska Area Consultations**

The Alaska Area IHS conducted the following Tribal consultations: Annual Tribal budget formulation consultation for FY 2012 on November 30, 2010; Suicide Prevention Regional Listening Session (in conjunction with the DOI) on November 30, 2010; semi-annual "Mega-Meetings" with the Alaska Native Health Board and Tribal members from throughout Alaska on February 9, 2011, and August 3, 2011; Area Listening Session with Tribal Leaders on IHS OIT Tribal Shares on March 21, 2011; and Consultation, including comment solicitation and discussion from Alaska Tribal Caucus stakeholders over distribution of FY 2012 Area and Headquarters Tribal shares.

The Alaska Area Director held additional consultation with Tribal organizations at their request, including the following: Tanana Chiefs Conference Annual Convention on March 16, 2011;



Southcentral Foundation's Mat-Su Valley Native Primary Care Clinic ground-breaking ceremony on April 18, 2011; Maniilaq Association's dedication of a Long-Term Care Center on September 14, 2011; and Norton Sound Health Corporation Board of Directors meeting on September 19, 2011.

### **Consultation with Senior Government Officials**

The Alaska Area IHS collaborated with or arranged for Alaska Native Tribes to consult with senior Federal officials in the following events: (1) Youth Suicide Round Table, on October 4, 2010, at the invitation of Alaska's Senator Murkowski to address native youth suicide prevention efforts; (2) HHS Region X Tribal Consultation on June 9, 2011, which involved the Director, Region X, and representatives of the Office of the Assistant Secretary of Health, SAMSHA, Administration for Children and Families, Administration on Aging, Centers for Medicare & Medicaid Services (CMS), HRSA, the Alaska Office of Consumer Information and Insurance Oversight, and the Office of the National Coordinator for Health Information Technology; (3) IHS Director's National Tribal Consultation Summit in Washington, DC, which directly addressed the IHS Director's initiative to improve relations with Tribes on July 6-9, 2011; and (4) Discussions on August 9-10, 2011, in Barrow, Alaska, among Alaska's Senator Begich, DOI Secretary Salazar, the Arctic Slope Native Association, and municipal parties about staffing for the Barrow replacement hospital and continuing support to this remote community. These efforts improved United States-Tribal relations and increased awareness among Federal officials of the diverse and unique issues affecting the health of Alaska Natives.

### **IHS Joint Venture Construction Program (JVCP)**

Four Alaskan Tribes were invited to participate in the IHS JVCP. All four Tribes have completed the required planning documents. Two of the Tribes have completed joint venture agreements and are currently in construction. The two remaining applications have submitted and are currently pending review.

### **Barrow Hospital**

The Barrow Hospital is a new \$160 million, 100,000 square-foot 14-bed acute care facility that is being constructed under a P.L. 638 Title V Construction Project Agreement with the Arctic Slope Native Association. The new facility will serve the entire Barrow Service Unit, a population of 5,396, and will replace an existing hospital constructed in 1965. To date, \$82.5 million has been transferred to Arctic Slope Native Association. The June 2013 estimate for completion is based on congressional funding through IHS appropriations.

### **Albuquerque Area IHS 2013 Budget Formulation**

The Albuquerque Area IHS held a kick-off conference call on November 17, 2010, to discuss the FY 2013 Budget Formulation materials with all Service Units. All Service Units met with their local Tribal leadership to develop Tribal submissions. Once received, these submissions were then aggregated into the Albuquerque Area submission. An additional conference call with Service Units and Tribal representatives was held to discuss the Area's submission in January 2011.

### **IHS Regional Performance Measures Meaningful Use Conference**

The Albuquerque Area co-hosted a Performance Measures Meaningful Use Conference on January 19-20, 2011. There were over 200 onsite attendees and the sessions were videotaped for use by other IHS Areas. Topics included State Medicaid Meaningful Use requirements and Electronic Health Record and Improving Patient Care.



### **Area Tribal Consultation Meetings**

The Albuquerque Area IHS held a Tribal consultation with all Albuquerque Area Tribes on March 30-31, 2011. Topics discussed included the following: improving the Albuquerque Area consultation process; feedback on the selection process for Tribal representatives to national workgroups; Area Tribal shares methodologies; and P.L. 638 contracts and reports from current Tribal workgroup representatives. A thumb-drive was developed for distribution at the consultation session, which included copies of all 2010 Tribal Leader Letters, updates, and other correspondence from HHS and other Federal components, and Area IHS consultation policies.

A second Tribal consultation with all Albuquerque Area Tribes was held on August 25-26, 2011. Updates on the CMS Tribal Technical Advisory Group (TTAG), Direct Service Tribal Advisory Committee (DSTAC), and the Director's Workgroup on Improving CHS were presented, along with Veterans' issues, and activities related to the ACA and IHCIA. Albuquerque Area Tribal shares methodologies were presented and discussed.

### **IHS Cyber Security Conference**

In July 2011, the IHS sponsored a Cyber Security Conference that provided information on cyber security, IT management, and reform. There were 210 registered attendees.

### **Department of Veterans Affairs (VA) and IHS Collaboration**

The Albuquerque Area IHS met several times with the administration of the local VA hospital. As a result of these meetings, the Albuquerque Area held two VA eligibility and documentation processing training sessions for IHS Patient Registration/Benefits Coordinators in January 2011. The VA assisted with training on VA eligibility at a Community Health Representative meeting in March. Posters were provided to all Service Units that inform veterans of their eligibility to apply for VA health benefits at IHS/Tribal facilities. The Albuquerque Area partnered with the local VA to host a veterans' symposium on November 15, 2010. The symposium provided information to veterans on locally available services and was attended by over 425 attendees.

### **Jicarilla Service Unit IPC**

The Jicarilla Service Unit (JSU) is an Improving Patient Care (IPC 3) site. The Service Unit has published over 25 articles in the local Tribal newspaper. Delivering health prevention information in various formats, including three radio broadcasts on the local radio station, the JSU is a community resource. By sharing information about the clinic, the Service Unit has partnered with several community programs to work collaboratively in improving services to eligible patients.

### **Tribal Healthy Homes**

The staff at the Albuquerque Area Division of Environmental Health Services (DEHS) created new national partnerships with multiple Environmental Protection Agency (EPA) Regions and HUD Offices. The co-sponsors of two national Tribal Healthy Homes training sessions conducted by Montana State University, the DEHS worked to increase awareness of how housing deficiencies affect health and methods to improve individual and community Tribal housing. Tribes throughout the nation attended the training and attendees from the Albuquerque Area IHS have moved forward with new community housing projects supported by technical assistance from the DEHS staff.



## **Bemidji Area IHS**

### **The Fond du Lac (FDL) Tribal Methamphetamine Prevention and Treatment Initiative**

The Fond du Lac (FDL) Tribal Methamphetamine Prevention and Treatment Initiative is the first program of its kind established in Indian County. The FDL has established several memorandums of agreement with community partners, including county family drug and Driving While Impaired courts; Social Service and Court Services; local hospitals and public health departments; Work Force Center; Salvation Army; and United Way. The initiative led to the establishment of an employer referral network and the integration of FDL Rule 25 Assessors in DWI and family drug courts. The Assessors are trained on current options for assessments and recommendations, billing requirements, and process and regulations within Rule 25. Similarly, a children's mental health case manager was hired to assist with clients' minor children, engage clients, and encourage family members throughout treatment. Staff conducts ongoing learning opportunities, integrated treatment, motivational interviewing, coaching circles, and cultural activities. As a result, there have been over 800 contact hours for telehealth, and 11 youth completed the treatment program.

### **The "White Earth Native Alive Campaign"**

The "White Earth Native Alive Campaign" focuses on AI/AN suicide prevention. The Tribal health program has established partnerships that include ambulance services, a Tribal casino, and County human services programs. The Tribe is developing a fundraising strategy to help sustain and grow the program in the future.

In the first half of FY 2011, there were 35 suicide-related events, with seven completed suicides. The program implemented activities focused on prevention. Specifically, over 100 people received Gathering of Native Americans (GONA) training, which focuses on cultural-based intervention strategies; 76 community members were trained in Safe Talk (expanding capacity); three suicide crisis response teams were actively trained; a community-driven, 24 hour/7 days per week crisis hotline for the Suicide Intervention Team was developed (volunteers provided telephone support to more than 28 callers averaged two calls per month). Cultural diversity training for non-Native professionals was provided and more than 200 presentations were provided at community council meetings throughout the reservation to increase awareness. Tele-Behavioral Health services are under development and expected to provide services in 2012.

### **Efforts to Address Prescription Medication and Illegal Drug Abuse**

Tribal Councils from Leech Lake, Red Lake, and White Earth passed Tribal Proclamations declaring prescription medication and illegal drug abuse to be a public health emergency. Partnering efforts initiated by the White Earth Tribe resulted in a Drug Abuse Prevention Summit cosponsored by the State of Minnesota.

### **Advances in Information Technology Management**

In the mid-1990's, the Bemidji Area IHS, in collaboration with Tribes, redesigned Area services and Tribal shares to enable Tribes to assume a wide range of Agency and Area-specific functions. With advancements in Electronic Health Records implementation and related requirements of other health information technologies, the Area proposed providing additional technical assistance in health information management, VistA imaging, and dental services to support Tribal programs. The Area is also actively working to ensure all Meaningful Use (MU) requirements are met. An Information Management conference in July 2011 attracted more than 100 attendees and focused on all aspects of health care technology.



## **Billings Area IHS** **Budget Formulation**

The Billings Area IHS coordinated the FY 2013 Budget Formulation meeting in December 2010 on the campus of Montana State University-Billings. All Tribes within the Billings Area IHS and representatives from the five Urban Indian health programs attended. Area Tribal representatives also attended the IHS-Wide Budget Formulation meeting in Tempe, Arizona, in February 2011. Once again, with an increase in the overall IHS Budget, CHS was the top priority for Billings Area Tribes.

## **Montana Wyoming Tribal Leaders Council (TLC)**

The TLC is comprised of elected officials from Billings Area Tribes. In addition to the Executive Committee meetings, a Sub-Committee on Health has regularly scheduled meetings throughout the year. All concerns raised are brought forth to the TLC.

The Tribal Leaders Health Conference was held in May 2011 in Billings, Montana. A Tribal Consultation Listening Session on the ACA/IHCIA implementation was also held in conjunction with the event. Conference attendance exceeded 200. The Billings Area IHS will also be contracting with the TLC for future Tribal Consultation sessions in FY 2012.

## **Governing Body Meetings**

The Tribal Councils and Tribal Health Departments have been invited and will continue to be invited to quarterly IHS Governing Body meetings in 2012. Governing Body members include the IHS Area Director, Associate Area Directors, and Service Unit executive staff. This standing invitation improves the communication efforts between the IHS and Tribes on issues related to operational concerns, finances, and customer service. By providing consistent updates, the Area and Tribes share vital information to better educate patients and members of the community.

## **Emergency Task Force**

Several Service Units within the Billings Area IHS were damaged or affected by extensive flooding in 2011. The most affected Service Unit was the Crow Service Unit in Crow Agency, Montana. The Billings Area's performance in coordinating the combined efforts of the Crow Tribe, BIA, National Guard, and Service Unit, assured that access to health care services was restored as quickly as possible and that patient and staff safety was not compromised.

## **Native American Youth Academy**

In July 2011, the Billings Area IHS coordinated and conducted a Native American Youth Academy in Missoula, Montana. The target age group of the Tribal youth program is 11-14 years of age. The primary topics pertained to leadership skills, healthy lifestyles, and related issues. One of the goals is for the students to interface with the local communities and Tribal Governments.

## **California Area IHS**

### **Behavioral Health Activities**

The California Area Office (CAO) partnered with the Toiyabe Health Project and San Manuel Band of Mission Indians for the Methamphetamine/Suicide Prevention Initiative. The Area also partnered with Northern Valley Health Program for the Domestic Violence Prevention Initiative. A total of 27 Tribal Governments are participating in these two ongoing IHS initiatives.



### **Tribal Delegation Meetings**

The CAO Director conducted 43 Tribal Delegation Meetings. Discussions included the following topics: construction of new clinics; emergency medical services; CSC; services for new Tribes; the Indian health care improvement fund; obesity, diabetes, and related complications; behavioral health; amendments to the Contract Health Service Delivery Area (CHSDA); and member Tribes leaving consortiums. The CAO Director provided information and technical guidance to these Tribal governments and Tribal organizations to facilitate informed decisions under P.L. 93-638 compacting/contracting.

### **Budget Formulation Preparation for FY 2014 Budget**

The CAO Director sponsored a WebEx meeting for all California Tribal Government leaders on September 9, 2011. The Webinar provided Tribal Government leadership with a summary of the IHS budget process, Government Performance and Results Act measures, and current assessments of unmet CHS need. California Tribal Government leaders used this information when making budget recommendations and setting health priorities.

### **California Area Tribal Advisory Committee (CATAC)**

The CAO conducted the following CATAC meetings: October 27, 2010, in Sacramento, California; January 4-5, 2011, in Sacramento, California; March 14, 2011, in Coarsegold, California; and June 21, 2011, in Sacramento, California. On January 4-5, 2011, the CATAC finalized the FY 2013 California budget priorities to submit to the national Budget Formulation Workgroup. These included CHS, Indian health care improvement fund, obesity/diabetes and complications, behavioral health, cancer, heart disease, and dental care. In environmental health and engineering, two critical priorities ranked equally: water/sanitation projects and maintenance and improvement funds. Other funding priorities were outpatient/ambulatory construction and injury prevention.

### **Tribal Participation in Youth Regional Treatment Center (YRTC) Site Selection**

On December 16, 2010, two Tribal Leaders on the CATAC participated in a Site Selection and Evaluation Review of proposed properties for the northern California YRTC. Five properties were ranked and rated for the report. Tribal Leaders on the CATAC were invited to visit the second- and third-ranked properties. On November 16, 2011, the CAO Director and Tribal Leaders reviewed and ranked three additional properties.

### **Nashville Area IHS**

#### **2013 Budget Formulation**

Consultation with Nashville Area Tribes on the FY 2013 Budget Submission was completed through the Core Budget Formulation Team (CBFT), which is comprised of both Tribal and Federal representatives. The CBFT held numerous conference calls with the United South and Eastern Tribes (USET) to develop consensus for the FY 2013 budget submission at the Impact Week meeting in February 2011.

#### **Hi-Tech Agreement Supporting Deployment of Electronic Health Record (EHR)**

A Hi-Tech agreement with the USET has created the fundamental framework for EHR deployment and Meaningful Use implementation.

#### **Consultation Session on Centrally Paid Expenses**

The Nashville Area IHS consulted with Tribes on the cost allocation methodology associated with Centrally Paid Expenses, which was held in January 2011 in Nashville, Tennessee. The outcome



of this consultation was agreement on the methodology based on the 2002 National Workgroup. Tribes agreed to pay up-front costs for services they deemed directly beneficial and valuable to them.

### **Consultation Session on Indian Sanitation Facilities Act (P.L. 86-121) Project Funding Agreements**

The Nashville Area IHS consulted with Tribes during USET meetings in 2010 on proposed language for use in P.L. 86-121 Project Funding Agreements, which are used by Self-Governance Tribes for sanitation facility construction contributed funds. During the January 2010 special workshop held in Nashville, Tennessee, a new template agreement was developed that incorporated Tribal input and addressed the majority of their concerns, working in partnership to achieve Government-to-Government needs.

### **New Service Unit Established and Staffed – Mashpee Wampanoag, Massachusetts**

The Nashville Area IHS successfully established a new Federal Service Unit to provide direct services to the Mashpee Wampanoag Tribe in Massachusetts. New facilities were completed, equipped, and occupied in August 2011. Contract Health Services were delivered and staffing increased over 800 percent during 2011, greatly expanding access to health care.

### **Consultations with New Tribe – Shinnecock Indian Nation, New York**

Since Federal recognition of the Shinnecock Indian Nation in 2010, the Nashville Area IHS has worked to establish working relationships, collect data, conduct a needs assessment, and establish a budget request for new funding. The Acting Nashville Area Director led a team that traveled to Southampton, New York, for a first-ever meeting with the Shinnecock Indian Nation in July. The Area established points of contact and developed phased work plans to deliver services. To date, the work by the Area has established credibility, mutual trust, and built a solid foundation for a strong partnership going forward.

### **Tribal Utilities Summit**

The Nashville Area IHS advanced a 2010 MOA partnership with the USET to coordinate support for the operation and maintenance of utility systems for Tribal sanitation facilities. The Nashville Area and the USET collaborated with the EPA and the Poarch Band of Creek Indians to organize a Tribal Utility Sustainability Summit. The event brought together 130 Tribal utility professionals to share best practices and receive training to maintain operator certification.

### **Navajo Area IHS**

#### **Methamphetamine and Suicide Prevention Initiative (MSPI) and Domestic Violence Prevention Initiative (DVPI)**

The majority of the eleven MSPI programs and eight DVPI programs are making successful progress addressing methamphetamine abuse, domestic violence, and suicide prevention education for the Navajo Nation. Each is working to develop partnerships and coordinate with Navajo Nation programs that also address these issues. Currently, the programs are participating in monthly brown bag and other meetings hosted by the IHS to discuss topics such as the National Suicide and Behavioral Health Strategic Plans and how their contributions are helping to sustain national efforts. The DVPI programs started their second program year and the MSPI programs are starting their third and final year of activities to meet the August 2012 target completion date and provide required data to contribute to this national effort.





## **Improvements as the Result of Consultation**

The Navajo Area IHS held meetings, briefed, and discussed National Tribal Consultation issues and related topics with elected and appointed Navajo Nation staff.

## **Improvements to the Navajo Area IHS Tribal Consultation Process**

Several improvements were made to the Navajo Area IHS Tribal Consultation process: Navajo Area IHS Circular 11-01 on Tribal Consultation was signed by the Area Director on August 16, 2011. Three national recommendations from Tribes to improve the Tribal Consultation process were implemented by the Navajo Area IHS, including the following: (1) IHS Navajo Area made funds available to support travel for several elected Tribal leaders to the National Direct Service Tribal consultation meetings; (2) the Navajo Area IHS announced Area consultation sessions in writing to elected Tribal Leaders; and (3) Navajo Area IHS staff were invited and participated in workgroups requested by Navajo Nation leadership on matters under consultation, including Diabetes, the MSPI, DVPI and CHS.

Similarly, the Navajo Area IHS participated in many consultation sessions with the Navajo Nation, including 16 P.L. 93-638 Title I negotiation and reconciliation meetings; 12 Title IV negotiation sessions; 4 Tribal Delegation meetings; 3 meetings with Area Health Board members; 1 Tribal Listening Session held by the IHS Director on June 8, 2011; and 1 OIT Tribal Shares consultation session in April 2011.

## **Oklahoma City Area IHS**

### **Joint Venture Facility Construction Program**

The Oklahoma City Area IHS works regularly in partnership with Tribes on Joint Venture Facility Construction. Current projects include the following: Cherokee Nation Vinita Health Center; Chickasaw Nation Ardmore and Tishomingo Health Centers; and Absentee Shawnee Tribe Little Axe Health Center.

### **Budget Formulation**

Annually, the Oklahoma City Area IHS produces an Area Profile, which provides extensive population, mortality, morbidity, and workload data to support Tribal priority discussions in the annual budget formulation process.

### **Contract Health Services (CHS)**

The CHS Program of the Oklahoma City Area IHS conducted Combined Quarterly Meetings with Federal and Tribal CHS managers. Updates and training are provided on new initiatives, such as Best Practices, Catastrophic Health Emergency Fund Provider Information, Unmet Needs, and Process Improvement. A strong working relationship has been established with the CHS Division, Tribal, and Federal CHS managers. Numerous community and providers meetings have been held to clarify IHS CHS processes.

The Timely Filing Report identifies open purchase orders that have expired according to timeframes established by the Medicare Modernization Act. This automated report easily identifies these documents for cancellation, which decreases staff workload and enhances fiscal integrity. The Oklahoma City Area IHS coordinated development and implementation of this report with Information Technology staff and now makes this format available for use by Tribes and Tribal organizations.



### **Improving Patient Care Initiative (IPC) Implementation**

The Oklahoma City Area IHS IPC Improvement Support Team has developed an “IPC Made Simple” model that embraces the intent of the national model, while simplifying implementation and reporting requirements. One Tribal and one Federal facility are participating in the IPC Made Simple pilot project and several have expressed interest in this valuable program.

### **Pharmacy**

The Claremore Indian Hospital Pharmacy works collaboratively with the Cherokee Nation Public Health Nursing Department to provide a Smoking Cessation Clinic. The Claremore Indian Hospital Pharmacy is currently working with the Chickasaw Nation to collaboratively work within the National IHS Anticoagulation Training Program to offer training to Federal, Tribal, and Urban Indian health care providers on advanced, contemporary anticoagulation management.

### **Wellness Programs**

The White Cloud Health Station has partnered with the Iowa Tribe of Kansas and Nebraska to construct a walking trail with exercise stations placed along the trail. This trail will provide a safe walking environment and promote exercise and wellness programming. The Clinton Health Center developed a boot camp for employees, including nutrition counseling, exercise, and behavioral health counseling. This program has expanded to include employees of the Cheyenne and Arapaho Tribes.

### **WebCident**

The Oklahoma City Area IHS partnered with numerous Tribal health care systems to expand access to WebCident for incident reporting. The IHS developed and deployed nationally a Web-based worker and patient safety adverse event reporting system called WebCident. Worker, visitor, and patient-related errors and adverse events can be reported, analyzed, trended, and reviewed electronically, 24 hours/day, 7 days per week. When an incident report is submitted electronically into WebCident, the system automatically generates graphic table and line-listing output reports for review and evaluation. This information is used proactively by leaders, clinicians, and others at local, regional, and national levels to reduce and prevent risk, errors, and adverse events.

### **Phoenix Area IHS**

#### **Indian Health Board of Nevada (IHBN)**

The Phoenix Area IHS works closely with the IHBN on various health care initiatives and attends quarterly meetings on health care issues that affect Nevada Tribes. The IHBN provided a leadership role in the development of the Nevada Area Office Implementation Plan as required by Congress. The Report was submitted to Congress in March 2011. In support of Nevada Tribes, a Phoenix Area Deputy Director has been established in Nevada.

#### **Inter Tribal Council of Arizona (ITCA)**

The Phoenix Area IHS contracts with the ITCA for a Health Steering Committee that serves as a forum for consultation with the IHS and Phoenix Area Tribal leadership. Quarterly meetings are held to discuss and provide updates on various policy and health care issues that impact Phoenix Area Tribes. The ITCA holds an annual budget consultation and formulation meeting attended by all Phoenix Area Tribes.



### **Indian Health Service/Tribal/Urban (I/T/U) Health Directors Meeting**

This year's I/T/U Health Directors meeting was held in Phoenix, Arizona, on June 21-23, 2011. The Phoenix Area IHS consults with Tribal leaders, Tribes, and Urban Indian health directors on health care policy and issues. Phoenix Area IHS staff and other health care experts attend the meetings.

### **Utah Indian Health Advisory Board (UIHAB)**

The Phoenix Area IHS actively participates on the UIHAB, with representatives from Utah Tribes, Tribal organizations, Urban Indian organizations, and IHS Service Units. The UIHAB facilitates vital linkages to the State and local agencies on American Indian health issues, such as Medicare/Medicaid billing, waivers, electronic health records, and immunization. Meetings are held monthly in Salt Lake City, Utah, and one strategic planning session is held annually.

### **Direct Service Tribes Advisory Committee (DSTAC)**

The Phoenix Area's Office of Self-Determination is represented on the DSTAC as a Federal Liaison and Technical Advisor to provide leadership, advocacy, and policy guidance. This position also provides recommendations to the IHS Director on health care delivery issues with emphasis on policies that impact Direct Service Tribes. Conference calls with the DSTAC are held monthly and coordinated by the IHS Office of Direct Service and Contracting Tribes. There is a national meeting, along with four quarterly meetings that are held at selected sites and locations.

### **Interagency Joint Action Summit for Suicide Prevention**

The Phoenix Area Integrated Behavioral Health program held its eighth annual conference in May 2011. There was joint collaboration between the programs and four other local Phoenix agencies. Phoenix Area IHS staff participated on the planning committee and provided speakers for the IHS, BIA, Bureau of Indian Education (BIE), SAMHSA Action Summit for Suicide Prevention conference held in Scottsdale, Arizona, in August 2011. There were approximately 900 attendees at this conference. Upcoming Phoenix Area-wide workshops are planned for 2012.

### **Domestic Violence Community Awareness Day**

The Whiteriver Social Work program participated in a Domestic Violence Community Awareness Day. The well-attended event was considered quite successful and more than 1,000 White Mountain Apache community members participated.

### **Arizona Health Care Cost Containment System (AHCCCS)**

The AHCCCS held several Tribal consultation meetings, teleconferences, and Webcasts in various locations. Topics included IHS 638 Waiver Exceptions on Eligibility and Benefit Restrictions. The purpose was to improve health care quality and access for eligible Tribal members by enhancing reimbursement from the State of Arizona.

### **Portland Area IHS**

#### **Portland Area IHS Workgroup on Tribal Consultation**

Embracing the Agency's commitment to strengthen partnerships with Tribes, the Portland Area IHS convened a Tribal workgroup to review the Area's consultation program in late 2010. The workgroup recommended succession planning activities to ensure Area Tribal leadership remains knowledgeable and active on health issues, able to interact effectively with other Federal agencies, and prepared to promote Tribal participation in health meetings via expanded use of electronic tools and technology.



Throughout FY 2011, the Portland Area IHS actively addressed the workgroup's recommendations, communicating directly with each Tribe's executive authority to encourage attendance and participation at Health Board meetings and related activities. The Area also provided training opportunities on the IHS and related health issues for Tribal leadership and staff; instituted an Area presence at quarterly State meetings; participated at meetings with other Federal agencies; promoted inter-Agency and inter-departmental cooperation and coordination of Tribal services and programs; and used electronic tools to reduce redundancy of materials sent to Tribal representatives.

### **Ongoing Tribal Consultation Activities**

In FY 2011, the Portland Area's ongoing Tribal consultation activities included assisting IHS Headquarters with the April information technology Tribal shares listening session; working with Tribal leaders and the HHS Regional Director on Region X Tribal consultation issues; facilitating the IHS Director's second Tribal listening session; participating at the Direct Service Tribes annual meeting in August; reporting on Area and Agency budget, finances, and health care programs at meetings of the Affiliated Tribes of Northwest Indians in May and September; and quarterly meetings with the Northwest Portland Area Indian Health Board.

The Chief Medical Officer continued the Area's long-standing practice of hosting and leading semi-annual meetings with IHS clinical directors and Tribal medical directors from throughout the Portland Area. A record number of clinical leaders from (25) IHS and Tribal sites participated in the October meeting. The meetings are part of a forum for facilities to share their approaches to common, local challenges, and serve to strengthen clinical-level relationships between individual programs, Tribes, and the IHS. The Portland Area IHS conducted the FY 2014 Tribal budget consultation in November 2010. Attended by more than 50 Tribal representatives, the second day of the event featured an orientation for Tribal leaders on contracting under P. L. 93-638.

### **Portland Area Special Initiatives, Consultations, and Program Development**

The Portland Area IHS partnered, consulted, and collaborated with specific Tribes on a number initiatives and Tribal concerns, including, but not limited to the following: discussion, review, and assessment of the present condition and future funding of a Tribe's YRTC; assisting a Tribe in responding to a natural disaster that destroyed more than 21 homes in a reservation community; guiding two Tribes in separate efforts to expand their CHSDA; engaging two Title V Tribes in discussions regarding an orthodontic program at a Service Unit; meeting with the Tribal Council of a Direct Service Tribe for a general discussion of Service Unit operation and progress toward a regional referral center; cooperating with a Direct Service Tribe's newly established Joint Health Commission; monitoring and evaluating Area Office, Service Unit, and Tribal health staff interactions; use of the Area's digital network capabilities to provide training on VistA Imaging; meeting with a Tribe to learn more of their need for additional engineering services to plan and manage extensive infrastructure development and a comprehensive utility organization; conducting an Area-wide Meaningful Use conference; working with Tribes on their requests for a MOA to obtain the services of a Public Health Service (PHS) Commissioned Corps member; providing onsite technical assistance, including coordinating meetings and teleconferences involving Tribal leadership and Tribal program staff; engaging numerous Federal partner agencies on behalf of Tribal programs; creating a forum for presenting CHS best practices; and conducting various meetings with individual Tribes regarding language in their annual funding agreements.



### **Engagement with Urban Indian Programs**

The Portland Area IHS has emphasized engagement with its three Urban Indian health programs. Area leadership has met with Urban Indian program leadership, collectively and individually, for program consultation, to discuss budget concerns and priorities, and ensure that Urban Indian program directors participated with Portland and Alaska Areas in meeting with Veterans Administration VISN-20 leadership.

### **Partnership with the Portland Area Facilities Advisory Committee**

The Portland Area IHS continues its partnership with Tribes on the Portland Area Facilities Advisory Committee. This Tribal advisory group provides leadership to the Tribal effort to increase access to specialty and secondary care and alleviate Tribal dependence on CHS funding for services beyond primary care.

### **Tucson Area IHS**

#### **Tribal Consultation Meetings**

Activities in FY 2011 for the Tucson Area IHS included formal consultation to improve the consultation process, implementation of specific activities to improve communication with Tribes, consultations on top Tribal priorities, and regular Tribal meetings.

The Tucson Area IHS participated in 325 consultation meetings and conference calls with Tucson Area Tribes, including 42 general consultations; 65 ISDEAA consultations; collaborations and negotiations; 70 Sanitation Facilities consultations; and 56 Environmental Health-related consultations. The Area hosted the following: IHS Director's Tucson Area Listening Session on January 26, 2011; the IHS OIT Listening Session on March 31, 2011; the CHS Listening Session, Budget Formulation Consultations; and two Direct Service Tribe quarterly meetings.

#### **Engaging Tribal Stakeholders in the Agency Budget Formulation Process**

The Tucson Area IHS actively engaged Area Tribes in the formulation of FY 2011 Health and Budget Priorities. The Area I/T/U budget group worked as a team to develop budget needs and health priorities.

#### **Facilitating Tribal Contracting**

The Tucson Area IHS facilitated the FY 2012 contract and annual funding agreement renewal process for the ISDEAA. The Tucson Area Office of Tribal Self Determination crafted 2012 renewal documents (including an updated Annual Funding Agreement and Buy-Back Agreement documents). The Area's assistance to the Chairman, Pascua Yaqui Tribe, resulted in uninterrupted continuation of the Pascua Yaqui Tribe's contract and annual funding agreement into FY 2012.

#### **Contract Health Services (CHS) Listening Session**

The Tucson Area CHS Listening Session was convened on March 31, 2011. The discussion included the following CHS-specific issues: Catastrophic Health Emergency Fund threshold adjustments; ongoing educational sessions for patients and vendors; the importance of getting patients to apply and reapply for Medicaid, thereby saving CHS dollars for direct care patients; encryption of patient referral information for electronic transfer of referrals to and from provider offices; and promoting a team approach between the IHS and Tribal programs. The Sells Service Unit met with each of the 12 Tohono O'odham Nation Districts' elected officials



and provided basic CHS education sessions to enhance access to care by patients and appropriate utilization of CHS.

### **Consultation on Arizona's Medicaid Program**

The Tucson Area IHS held Tribal consultation meetings with Tribes and Tohono O'odham Nation communities to discuss the initiative by the State of Arizona's Medicaid program (Arizona Health Care Cost Containment System [AHCCCS]) to eliminate Medicaid eligibility for childless adults. Consultation centered around the effects of this policy on services within the Tucson Area, including discussions regarding priority for positions to be retained or eliminated and potential reduction in services. The Tucson Area IHS, Tohono O'odham Nation, and Pascua Yaqui Tribe have submitted waiver letters to the Centers for Medicare & Medicaid Services (CMS) in Baltimore, Maryland, to allow eligible Native Americans who are enrolled in the State childless adult program to retain their eligibility for services. The Tohono O'odham Nation developed a Tribal Resolution on this issue, which they subsequently approved and submitted to the National Congress of American Indians.

### **Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and Medicaid Enrollment Outreach**

The Tucson Area IHS received a \$300,000 grant from CMS for the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) outreach and enrollment in April 2010. Since that time, the Tucson Area IHS has hired two full-time Patient Benefits Coordinators to provide outreach and facility-based Medicaid assistance to the Tohono O'odham Nation. This has resulted in an additional 300 children enrolled in the Arizona AHCCCS program. For FY 2011, third-party revenue also increased by five percent, primarily, as a result of Arizona AHCCCS payments.

The Tucson Area IHS convened a committee of health department members comprised of members of the Tohono O'odham Nation, Pascua Yaqui Tribe, and IHS staff. The group sponsored an Outreach and Education training conference on September 30, 2011, which provided educational presentations by representatives of the AHCCCS, CMS Region IX, and the Social Security Administration (SSA). Approximately 165 IHS and Tribal staff participated in this conference. The Tucson Area IHS is currently marketing and promoting CHIPRA outreach to Area Tribal communities.

### **Other**

IHS consulted with Tribes on the selection of several Area Directors during 2011 in a collaborative process where Tribes participated in the interview process and made recommendations on the candidates for selection. Area Directors were appointed after Tribal consultation for the Albuquerque, Portland, and Phoenix Areas.

## **AMERICAN RECOVERY AND REINVESTMENT ACT ACTIVITIES SPECIFIC TO TRIBES**

In 2010, all IHS ARRA funding was obligated for health facility construction, maintenance and improvements, sanitation facilities construction, health equipment, and health information technology projects. Throughout FY 2011, 84 percent of the American Recovery and Reinvestment Act of 2009 (ARRA) funds were disbursed. The following are examples of activities and accomplishments of the IHS and Tribes working together on this important initiative.



## **Aberdeen Area IHS** **ARRA Projects**

The Aberdeen Area IHS received \$113 million in ARRA funds to implement projects on reservations across the four-state region: maintenance and improvement (\$15.2 million); medical equipment (\$1.286 million); regular sanitation facilities construction (\$6 million); sanitation facilities construction from the EPA (\$6 million); and new health care facilities construction (\$84.5 million).

Many Area Tribes have taken control of their projects and a few have been completed. The Eagle Butte IHS hospital replacement project, which has an overall budget in excess of \$110 million, was nominated as one of the Department's "Best ARRA Projects." The Aberdeen Area IHS met its 2010 goal of obligating all ARRA funds into projects. The refined goals now include project completion and disbursing the funds to the contractors as the work is completed.

### **ARRA Project Funds Obligations and Disbursements**

American Recovery and Reinvestment Act project funds obligations and disbursements in the Aberdeen Area IHS included the following: Maintenance and Improvement Projects for Health Care Facilities (\$15.2 million received, 100 percent obligated, and 75 percent disbursed); Medical Equipment (General) (\$563,000 received, 100 percent obligated, and 91 percent disbursed); Scanners (\$500,000 received, 100 percent obligated, and 100 percent disbursed); Tribal Medical Equipment (\$223,000 received, 100 percent obligated, and 89 percent disbursed); Sanitation Facilities Construction (Regular) (\$6.0 million received, 100 percent obligated, and 66 percent disbursed); Outpatient Care Facility (New Construction) (\$84.5 million received, 100 percent obligated, and 99 percent disbursed); EPA Safe Drinking Water Act (\$2.8 million received, 100 percent obligated, and 69 percent disbursed); and EPA Clean Water Act (\$3.2 million received, 100 percent obligated, and 88 percent disbursed).

### **Tribal Consultation about ARRA Funding**

The Aberdeen Area IHS and Tribes consulted to assign \$113.3 million in ARRA project funds to prioritized projects and has now disbursed \$105.3 million to Tribes and other recipients.

## **Alaska Area IHS**

### **Total ARRA Implementation**

The Alaska Area IHS successfully implemented over \$200 million in ARRA projects, including the following: 14 sanitation facility construction projects (\$14.2 million); Nome hospital construction (\$142.5 million); computed tomography scanner (\$0.7 million); 21 medical equipment projects (\$1 million); and 37 health facility maintenance and improvement projects (\$19.6 million). Also, in collaboration with the EPA, the Alaska Area IHS obligated 11 Safe Drinking Water Act projects (\$8 million), and 19 Clean Water Act projects (\$19.9 million).

### **Nome Hospital**

This new 18-bed acute care hospital is funded with \$142.5 million in ARRA funds and \$25.12 million in IHS and Denali Commission funding. The 150,000 square foot facility is being constructed through a unique partnership between the IHS and the Norton Sound Health Corporation, via a Title V Construction Project Agreement. The new facility replaces the existing hospital built in 1948, servicing over 8,000 people in 20 remote communities. The project is on track for completion in the fall of 2012.



### **ARRA Maintenance and Improvement Projects**

Alaska Area IHS ARRA Maintenance and Improvement projects include roof and window replacement and exterior siding at Mt. Edgecombe Hospital in Sitka, Alaska; renovating the woman's clinic and laboratory at the Anchorage Native Primary Care Center; renovating the electrical distribution system and emergency generator at the hospital in Dillingham, Alaska; and constructing a new birth postpartum center at the Alaska Native Medical Center in Anchorage, Alaska. Projects are conducted via P.L. 638 Title V Construction Contract Agreements with the Alaska Native Tribal Health Consortium and are either completed or scheduled for completion by September 30, 2012.

### **Sanitation Facility Construction**

The Alaska Area IHS has successfully managed 34 projects that received ARRA funding for Sanitation Facilities Construction projects. These were funded by the IHS (\$14.4 million), EPA Clean Water Act (\$19.9 million), and EPA Safe Drinking Water Act (\$7.9 million).

The majority of the ARRA projects are complete or nearing completion with 93 percent (\$13.4 million) of the IHS funds and 81 percent (\$22.5 million) of the EPA funds being expended. The following examples demonstrate the positive impact of ARRA funding on our remote Tribal villages: The sewage collection system failed in Scammon Bay due to shifting ground conditions and the Arctic's extreme seasonal changes. This caused raw sewage to spill out into a densely populated area of the village. The IHS, EPA, Alaska Native Tribal Health Consortium, and the local village collaborated on an ARRA-funded project, which remedied the sewage overflow situation, protecting the residents of the community from direct contact with raw sewage. Due to an outdated water treatment plant, residents of Kwigillingok, Alaska, received a boil water notice, which is issued when contamination is confirmed in the water system. During a notice, all customers must boil their water before consuming it or use bottled water. The ARRA project provided a modern washeteria for laundry facilities and a much needed water treatment plant. While most homes still lack running water services, community residents no longer have to boil water.

### **Medical Equipment Projects**

Twenty-one medical equipment projects, with a combined value of \$1.7 million were awarded ARRA funding within the Alaska Area IHS. All medical equipment projects have been completed.

### **Albuquerque Area IHS**

#### **ARRA Projects**

The Albuquerque Area IHS awarded ARRA maintenance and improvement projects to four Tribes and one equipment project through P.L. 93-638 contracts. All five projects were completed on schedule.

### **ARRA Funding Disbursement**

Sixteen water and wastewater ARRA projects were funded totaling \$8,894,190. Twelve projects have been completed, with 4 projects nearing completion. Funding disbursements are at about 90 percent with the remaining funds scheduled for dispersal by December 2012.

### **Bemidji Area IHS**

The Bemidji Area IHS Office of Environmental Health and Engineering (OEHE) is on target to meet all targeted outlays of ARRA funds. As of September 30, 2011, Sanitation Facilities (IHS and EPA) were 87 percent disbursed; Maintenance and Improvement projects were





92.9 percent disbursed; and Equipment projects were 99.8 percent disbursed, resulting in an overall disbursement rate of 90.7 percent of the funding and obligations. In addition to the OEHE ARRA projects, the Bemidji Area IHS received six ARRA projects, totaling \$480,285, addressing the needs of Tribes utilizing non-RPMS systems for their Electronic Health Records. The projects improved the internal and external interfaces required to transmit data. Awards were granted to five Tribes and one Urban Indian health program in the Bemidji Area.

### **Billings Area IHS**

The Billings Area IHS contracted \$7.4 million in ARRA projects with private sector companies and Tribal Governments in FY 2011. The majority of these projects have been completed.

### **California Area IHS**

#### **Largest EPA and IHS ARRA Project in the United States**

The California Area IHS is managing the largest EPA and IHS ARRA-funded project in the nation, on the Tule River Reservation. The \$8.2 million ARRA project, which is scheduled for completion in November 2013, will serve 371 homes.

#### **Water Treatment Monitoring Equipment**

The California Area IHS installed water treatment monitoring equipment for three remote public water systems on the Yurok Reservation. Compliance with the EPA's Surface Water Treatment Rule was particularly challenging, since no electrical power is available in the three communities. This ARRA project will serve 127 homes.

### **Nashville Area IHS**

The Nashville Area IHS received and managed \$14,062,607 in ARRA funding that supported 42 new projects for sanitation facilities construction, medical equipment, and health care facility improvements. The majority of the ARRA funds (94 percent) were awarded to Area Tribes through P.L. 93-638 contracts or P.L. 86-121 agreements. Thirty-three of 42 projects are fully complete at this time. ARRA funds disbursement currently stands at 86 percent for the Nashville Area IHS.

#### **New Roof, HVAC System, and Computed Tomography (CT) Scanner at Mississippi Band of Choctaw Indians (MBCI) Hospital**

The health center for the Mississippi Band of Choctaw Indians received significant benefits from ARRA funding, which greatly improved facilities and equipment serving 9,258 members. Significant water leaks were addressed by a new roof and repairs were made to the heating, ventilation, and air conditioning system. This substantially decreased energy usage and improved the facility environment. A new CT scanner replaced a non-functional unit, greatly improving access to quality diagnostic services and enhancing timeliness for patients seeking treatment.

#### **New Clinic at Houlton Band of Maliseet Indians (HBMI)**

The Houlton Band of Maliseet Indians (HBMI) in northern Maine received a new clinic as a result of ARRA funding. The existing clinic was undersized, did not meet minimum health care facility standards, and was not economically feasible to renovate. Using ARRA funding and additional resources secured by the Tribe, they were able to design and construct a new, energy efficient, state-of-the-art clinic facility, which will enable them to meet existing and future health care needs for nearly 700 Tribal members.



### **Navajo Area IHS**

Quarterly meetings tracked completion of ARRA funded activities. As of September 2011, P.L. 86-121 project funds were 100 percent obligated and 65 percent disbursed. All of medical equipment dollars (including information technology) were disbursed and equipment had been delivered. Twenty-six out of 27 Maintenance and Improvement projects were completed. The Navajo Area IHS relocated a 16-slice CT scanner to Crownpoint Service Unit from Gallup, New Mexico, after the Gallup Service Unit received \$750,000 in ARRA dollars for a CT Scanner replacement.

### **Oklahoma City Area IHS**

The Kickapoo Tribe of Oklahoma's Frye Road Water Line Extension was an ARRA-funded project in conjunction with the EPA. The goal of the project was to extend the Kickapoo Tribe of Oklahoma's potable water supply line to Tribal residents whose water was found to have high concentrations of radioactive materials.

The Iowa Tribe of Oklahoma's Inlet Pipe Rehab Project was also an ARRA-funded project via the EPA. The project objective was to rehabilitate the existing wastewater lagoon inlet pipe, which had been damaged during construction.

### **Phoenix Area IHS**

Seventy ARRA projects, totaling \$27.4 million were funded in the Phoenix Area IHS. These projects consisted of the following: Maintenance and Improvements, Medical Equipment, Computed Tomography Unit, and Sanitation Facilities Construction. All ARRA funds have been obligated and 73 percent of the funds have been disbursed as of the end of FY 2011.

### **Portland Area IHS**

As of December 1, 2011, 76 of 77 ARRA projects were completed within budget and scope, fully reconciled, and closed out. Thirty-five of Portland Area's 43 Tribes benefited from \$12.2 million in expenditures. Highlights include the following: (1) purchase and installation of digital radiography at three Federal Service Units, allowing better interface with electronic health records, higher quality images, and more timely review of x-rays for improved patient care, allowing these sites to eliminate use of some hazardous materials and reducing the space needed for storage of x-ray film; (2) upgrading a heating, ventilating, and air conditioning system at a YRTC has yielded a 23 percent reduction in energy costs and a 30 percent reduction in energy usage during comparable time periods over the past 3 years; (3) two Tribal water systems are again in compliance with the EPA's allowed level of arsenic; and (4) a \$346,000 project closed a Tribal landfill, that did not qualify for funding under the Agency's Sanitation Deficiency System but met ARRA requirements for funding.

### **Tucson Area IHS**

The Tucson Area IHS met all target goals regarding reporting, funds obligations, equipment installations, and funds disbursements on ARRA projects. All ARRA projects are approximately 80 percent complete and on schedule for completion by the target date.

### **ARRA Funding**

The Tucson Area Division of Environmental Health and Engineering is successfully managing 21 ARRA projects, totaling \$7.33 million in Facilities Management and Sanitation Facilities Construction (SFC). Approximately 72 percent of ARRA funding has been disbursed.



Fourteen projects (all 13 of the Facilities Management projects and one of the SFC projects) are complete with final reports submitted.

The original scope of work has been completed for two SFC projects at a substantial cost savings, and additional work has been added to each project. Five SFC projects use ARRA funds transferred from the EPA to the IHS. Inter-agency coordination has been successful in completing the original scope of work for three of these projects and accomplishing above 90 percent construction completion for one project and 75 percent completion for the other. Project monitoring and reporting has also been successful with 100 percent of ARRA recipients reporting for all M&I and SFC projects. Internal monitoring of project status, including financial status in the UFMS, continues at the Area level on a monthly basis to ensure ARRA goals are being met.

### **Health IT ARRA Activities**

Health IT activities funded by the ARRA included the following: Domain controller equipment installation; Cisco equipment installation in all facilities (with the exception of the San Xavier Health Center); video conferencing equipment was installed and configured; peripheral devices, such as monitors and printers have been deployed as improvements for the inpatient and emergency room. The Tohono O'odham Nation and Pascua Yaqui Tribe have been utilizing video-conferencing equipment since the summer of 2010. The Tohono O'odham Nation Community Health Representative laptops were purchased and are fully operational for the Personal Health Record initiative. The ARRA IT equipment funding was provided to the Area by IHS Headquarters, which handled all ARRA funding and reporting requirements.

### **Repair and Renovations to Health Facilities**

The Pascua Yaqui Tribe completed renovation of existing Tribal health facilities to include a pharmacy, which is currently operational. The Tucson Area IHS was requested by the Tohono O'odham Nation to use ARRA funds to complete repairs and renovations to the health facility. All repairs and renovations have been completed.

## **AFFORDABLE CARE ACT ACTIVITIES SPECIFIC TO TRIBES**

### **Communication of Implementation Activities**

Since May 12, 2010, the Department and IHS have consulted with Tribes on implementation of the ACA and permanent reauthorization of the Indian Health Care Improvement Act (IHCIA). The Department is the lead on ACA implementation and the IHS participates in implementation activities. The IHS, as the IHCIA implementation lead, communicates with Tribes through a variety of means, including correspondence to Tribes, regional and national Tribal Listening Sessions, and the annual budget consultation sessions on the progress of the implementation activities.

At the July 2011 IHS Tribal Consultation Summit, the IHS Director provided an update to Tribal Leaders on IHCIA implementation milestones, timelines, and inter-Agency coordination activities for the past year. During the Consultation Summit, the IHS Director also facilitated a workshop on the ACA to provide opportunities for the HHS and the Office of Personnel Management (OPM) to provide information on ACA and IHCIA implementation of provisions important to improving access to health care for AI/AN communities.



Tribal consultation information and updates were provided on several ACA and IHCIA provisions during the year. In May, 2011, a letter was sent to Tribes to report on the status of provisions that had deadlines as of the one year anniversary of the Affordable Care Act. In July, 2011, the IHS Director sent a letter to Tribes with an update on implementation of the IHCIA and included a summary table with progress on implementation of each provision. In November, 2011, a letter was sent to Tribes with the IHS Director's decision on the consultation on the formula for distribution of program increases for the Indian Health Care Improvement Fund. While updates to data used in the formula were approved, the formula itself will be kept the same until all programs are funded at a similar level of need, and new provisions in the IHCIA will not be adopted until specific funding is available for their implementation.

Consultations were initiated to gather input on two IHCIA provisions: establishment of the agency's first Sexual Assault Policy; and an update to the Memorandum of Agreement with the Department of Interior on Indian alcohol and substance abuse treatment. IHS participated in several listening sessions, HHS and IHS meetings and monthly White House Affordable Care Act Outreach calls to provide updates and answer questions from Tribes on ACA and IHCIA implementation. Updates were also provided on the IHS Director's blog, including updates on the issue of the definitions of Indian in ACA, the Notices of Proposed Rule-Making on the ACA State Exchanges and how they addressed the special provisions for Indians, updates from the Office of Personnel Management on implementation of the Access to Federal Insurance (FEHB) provision, links to documents that were submitted to Congress on behavioral health issues, a draft letter to notify outside providers of new CHS payment policies, a link to a fact sheet on the Affordable Care Act, and a blog on the cost of repeal of the ACA for American Indians and Alaska Natives.

IHS Area Directors met with HHS Regional Directors and discussed collaboration on joint outreach and education activities related to ACA for patients, employees and Tribes. IHS Area Directors also conducted a number of activities related to the implementation of the ACA as listed below.

### **Alaska Area IHS**

Effective October 1, 2011, the Alaska Area IHS negotiated newly authorized provisions of the IHCIA and ACA into the Alaska Tribal Health Compact and the 25 associated funding agreements. The Alaska Area Director assisted Tribal CHS programs by developing a letter to be sent to private-sector providers, which asserts that IHS beneficiaries properly referred by Tribal CHS programs may not be billed directly for services rendered.

### **Albuquerque Area IHS**

Albuquerque Area activities in support of the ACA included the following: (1) the Albuquerque Area Director or his designees have attended all State of New Mexico and Tribal meetings related to the Health Insurance Exchange activities, including meetings with Tribal leaders and Tribal community members; (2) the Area Director and Executive Officer participated in the State and Tribal Medicaid Reform Workgroup; (3) during the August Area Tribal Consultation, a presentation was provided to Tribal leadership, with an update on activities related to the ACA and IHCIA and informed Tribes that the Department was conducting national consultation sessions on proposed rule-making by HHS and the Internal Revenue Service; and (4) the Area Director attended the HHS Regional session in Denver, Colorado, on September 7, 2011.



## **Bemidji Area IHS**

### **Outreach and Area Tribal Liaison**

An ACA overview was provided by the Region V HHS Director at the consultation session in January 2011. An update was provided during the Regional/Area quarterly consultation follow-up call in June. Based upon feedback from the Area Tribal Advisory Board, the Bemidji Area will advertise and hire a temporary employee to provide outreach, serve as area liaison to Tribes and States, and provide education and assistance. In addition, one day of the annual Area meeting will be on the ACA and how to work with States on issues affecting AI/AN people.

### **Inclusion of IHClA Provisions in Tribal Contract and Compacts**

The Bemidji Area IHS has included IHClA provisions to Tribal contracts and compacts, as appropriate and requested. Information regarding the provisions for Veteran's Health and Federal Employee Health Benefits was shared as available.

## **Billings Area IHS**

### **Montana Wyoming Tribal Leaders Council**

The base contract with the Montana Wyoming Tribal Leaders includes a requirement to conduct meetings with Tribal Leaders and Tribal Health Departments when disseminating information to Tribes about health concerns. The Billings Area IHS has contracted with the Montana Wyoming Tribal Leaders Council (\$100,000) for services associated with the ACA and the IHClA. Communication and outreach services to Tribes and Tribal Health Departments through consultation, dissemination of information, and education sessions will be provided.

## **California Area IHS**

### **Letters to Tribes**

The California Area IHS Director sent eleven letters to Tribal Leaders and Program Directors discussing various aspects of the ACA, including letters and announcements from the Department, IHS Director, and OPM.

### **ACA Consultation**

The California Area IHS Director participated in a HHS Regional Tribal consultation on the ACA Insurance Exchanges, Notice of Proposed Rule-making and other ACA provisions on September 7, 2011, in Denver, Colorado.

### **FY 2011 Annual Tribal Leaders' Consultation Conference**

The California Area IHS hosted the Annual Tribal Leaders' Consultation Conference on March 15-17, 2011, in Coarsegold, California, on the Picayune Rancheria. There were 225 conferees, including 40 Tribal Leaders in attendance. The California Area Tribal Advisory Committee developed the final agenda with input from the Tribal leaders. The Area Director's 90-minute presentation was designed to address issues and concerns identified during last year's meeting.

## **Nashville Area IHS**

### **ACA Implementation**

The Nashville Area IHS implemented the majority of the IHClA provisions in FY 2010 during P.L.93-638 negotiations. However, due to multi-year agreements, some Tribes did not seek the opportunity to negotiate until FY 2011. In FY 2011, the Nashville Area IHS conducted negotiations with seven Tribes, which will incorporate between 5 and 12 provisions of the IHClA. These provisions include, but are not limited to, medical transportation costs, mental health



workers licensing requirements, payment liability, continuing education for Tribal employees, and traditional AI/AN health care practices.

### **HHS Regional (I, II, IV, VI) Consultation Sessions**

Regional Tribal Consultation sessions were held in March 2011 with HHS Regions I, II, and IV. Nashville Area senior leadership attended these sessions and facilitated follow-up activities. These sessions highlighted the following issues: allowing health care providers to practice medicine on Tribal lands in emergencies; identification of SAMHSA liaisons for each HHS Regional office; the Secretary's Tribal Advisory Council; Tribal-State relationship challenges and successes; ACA implementation; difficulties faced by smaller Tribes in securing HHS grants and other Federal funds; co-pay requirements under HHS regulations; data access and sharing; and networking among various HHS departments, including Medicaid.

### **Outreach and Education**

The Nashville Area transferred \$100,000 to the USET to fund outreach and education about the ACA and IHCA.

### **Navajo Area IHS**

A Navajo Area Budget Formulation session was held with Tribal Leaders on December 14-15, 2010, where recommendations from prior year Area-wide sessions were reviewed against appropriation increases for 2009-2010. Formal recommendations were adopted for the IHS FY 2013 budget and Tribal representatives were selected for IHS budget formulation meetings held on May 20, 2011.

### **Phoenix Area IHS**

#### **Outreach and Education**

The Phoenix Area worked closely with Tribes to increase understanding and implementation of the ACA. Information was shared with the Inter-Tribal Council of Arizona (ITCA) in an Area-wide consultation meeting and other routine meetings and during an IHS/Tribal/Urban consultation meeting. The Phoenix Area also effectively negotiated ACA provisions into ISDEAA Title I and Title V agreements. Finally, train-the-trainer contracts were awarded to the Indian Health Board of Nevada and the ITCA, to enable trainers for Indian communities and Tribal leaders to utilize the ACA.

#### **Implementation of Meaningful Use**

The Phoenix Area also is implementing Meaningful Use in compliance with the ACA. The Area Office upgraded IHS and tribal servers with certified Electronic Health Record Meaningful Use software, installed and tested with each state HIPAA 5010 transmission software, provided orientation to all sites regarding ICD-10 implementation, provided on-site technical assistance to each IHS and Tribal site in the implementation of the MU EHR, provided continuous monitoring and problem mitigation of IT security systems, supported end-user training, prepared each database the national health information exchange, and assured compliance with Computerized Physician Order Entry to reduce medication errors and increase efficiency in the clinics.

### **Portland Area IHS**

As ACA information was released, the Portland Area shared it with Tribes. The Portland Area IHS met with senior VA leadership of the Veterans Administration VISN-20 to begin planning implementation of the VA/IHS MOU. The Portland Area participated in HHS Region X Tribal consultation and in HHS ACA Tribal consultation on the following: (1) Eligibility expansion



under the ACA; (2) Affordable insurance exchanges; and (3) Section 139D of the IRS Revenue Code. The Portland Area worked with State organizations developing exchanges and has kept Tribes informed of progress by the OPM in implementing Tribal access to the Federal Employees Health Benefits Plan.

### **Tucson Area IHS**

Tucson Area IHS and the Tucson Veterans' Hospital (VA) have engaged in collaborative meetings to implement the services and cost-sharing provisions contained in the ACA under a memorandum of understanding between the IHS and the VA.

## **TRIBAL DELEGATION MEETINGS**

Tribal Leaders and representatives frequently request high-level consultations with the IHS Director on a host of topics affecting AI/AN health policy and program management issues. In accordance with IHS Circular No. 91-3 (1991), Tribal Delegation Meetings with the IHS Director follow a formal process that includes coordinated briefings to ensure that IHS staff are prepared to respond to questions and requests. In addition, issues requiring follow-up are identified and addressed in a timely manner. In 2011, IHS held 65 meetings with Tribal delegations representing 339 Tribes at IHS headquarters and at various Indian health meetings throughout the year.

## **AGENCY TRIBAL TECHNICAL ADVISORY GROUP**

IHS has several advisory groups, committees and workgroups that provide input and advice to the IHS Director on a variety of topics that relate to current consultations or ongoing priority issues. Updates on groups active in 2011 are included below.

### **Director's Tribal Advisory Workgroup on Consultation**

The Director's Tribal Advisory Workgroup on Consultation consists of 24 elected or appointed Tribal officials from each of the 12 IHS Areas. The charge of the workgroup is to recommend improvements to make the Tribal Consultation process more meaningful, effective, and accountable.

The Director's Tribal Advisory Workgroup on Consultation met by phone in May, 2011 to plan the agency's first Tribal Consultation Summit, which was designed, based on the workgroup's recommendation, to be a "one stop shop" for Tribal leaders to hear updates and provide input on current consultation activities. The workgroup provided an update on their activities and held a breakout session to provide Tribal leaders an opportunity to provide input on workgroup activities.

### **Tribal Self-Governance Advisory Committee (TSGAC)**

Comprised of Tribal leaders from each IHS Area, the IHS TSGAC provides advice to the IHS Director and assistance on issues and concerns pertaining to Tribal Self-Governance and the implementation of ISDEAA Self-Governance activities within the IHS. On a quarterly basis, the TSGAC meets to confer, discuss, and reach consensus on specific Self Governance issues. The TSGAC is supported by a technical workgroup, which is available to conduct further research and review to address policy issues. In 2011, the IHS TSGAC and the IHS Director met quarterly and discussed several issues, including implementation of ACA and the permanent reauthorization of the IHCA, the IHS budget and its formulation process, contract health services, contract support costs, Self-Governance expansion in HHS, and the Self-



Governance strategic plan. The Annual Self-Governance Conference was held in May, 2011 and a joint Federal/Tribal Self-Governance training session was held in August, 2011.

### **Direct Service Tribes Advisory Committee (DSTAC)**

The IHS DSTAC was established in FY 2005 to provide leadership, advocacy, and policy guidance on behalf of Tribes receiving health care services directly from the IHS. The DSTAC is comprised of elected and appointed Tribal Leaders from 10 IHS Areas with Direct Service Tribes (DST). Technical assistance for the DSTAC is provided by IHS Headquarters and Area level staff. The DSTAC met quarterly in FY 2011 and held monthly conference calls. During the spring of 2011, the DSTAC participated in the IHS budget formulation process by developing priorities for the FY 2013 budget and presenting testimony at the IHS National Budget Formulation Work Session. The DSTAC also participated in the Agency's first Tribal Consultation Summit during the summer of 2011 and provided an overview of their membership, goals, and accomplishments. The Eighth Annual Direct Service Tribes National meeting was held in Nashville, Tennessee, with strong support from Federal and Tribal representatives.

### **Tribal Leaders Diabetes Committee (TLDC)**

The IHS TLDC was created by the IHS Director in 1998 and continues to hold quarterly meetings. The TLDC recommends a process for distributing congressionally mandated Special Diabetes Program for Indians (SDPI) funding to the IHS Director. The TLDC also provides the IHS and Tribal leadership with an ongoing forum to discuss all matters related to diabetes and the impact of other chronic diseases on AI/AN communities. The SDPI, now in its fourteenth year, provides funding for diabetes treatment and prevention services at 404 I/T/U health programs, serving nearly all federally recognized Tribes. The TLDC made recommendations for the distribution of the reauthorization of SDPI funding through FY 2013 and the IHS Director concurred with their recommendations to keep the distribution the same and to transition from a competitive to a continuation application process.

### **Information Systems Advisory Committee (ISAC)**

The ISAC, an advisory body to the IHS Director that represents the Indian health system customer base, was established to guide the development of co-owned, progressive, and innovative Indian health information technologies. During 2011, the ISAC conducted four committee meetings, including their bi-annual meeting held at the Regional Office in Seattle, Washington, and three audio and Web conference meetings. In 2011, the ISAC addressed issues that included the establishment of the IHS IT strategic planning framework and the IT Tribal Shares Improvement Project recommendations to the IHS Director. The ISAC also participated in the first IHS Tribal Consultation Summit held on July 6, 2011.

### **Information Technology Investment Review Board (ITIRB)**

As required by the Clinger-Cohen Act of 1996, the IHS created an IT Investment Review Board. Comprised of 9 permanent members, including 5 Federal representatives, 4 Tribal representatives, 2 rotating members, and an Ex-Officio member, the ITIRB is the official IHS review body for IT investment, including all major initiatives, funding, and expenditures. The ITIRB ensures that IT resources support the IHS mission, promote the life cycle management of IT systems as "capital investments," and assure IT system project approvals are based on established selection criteria.





### **National Tribal Advisory Committee (NTAC) on Behavioral Health**

The IHS established the NTAC to enhance the Government-to-Government relationship and direct the efforts of the IHS Division of Behavioral Health to improve service delivery within Indian Country. The NTAC helps guide the development and support for behavioral health throughout the I/T/U health system. The committee 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, providing guidance and recommendations regarding behavioral health programmatic issues that affect the delivery of behavioral health care to eligible beneficiaries. The NTAC membership is made up of elected Tribal Leaders from each of the IHS Areas. The NTAC met on December 9, 2010, in Ontario, California, to finalize their recommendations to the IHS Director on the National Behavioral Health and Suicide Prevention Strategic Plans. The NTAC also met in Scottsdale, Arizona, at the IHS/BIA/BIE/SAMHSA Action Summit for Suicide Prevention on August 1, 2011. The goal of the summit was to identify priorities related to the behavioral health and suicide prevention strategic plans. The NTAC also periodically reviews progress of the Agency's Methamphetamine and Suicide Prevention Initiative and the Domestic Violence Prevention Initiative.

### **Behavioral Health Workgroup (BHWG)**

The IHS BHWG was established as a technical advisory group of subject matter experts charged with providing guidance to the IHS in the development of programs and services for behavioral health for AI/AN communities. The BHWG currently functions as a technical advisory group providing advice through the NTAC. The BHWG is composed of Tribal and Urban representatives who are providers and experts in the field of behavioral health or substance abuse representing each IHS Area. The NTAC held a joint meeting with the BHWG on December 9, 2010, in Ontario, California, to finalize their recommendations to the IHS Director on the National Behavioral Health and Suicide Prevention Strategic Plans.

### **Government Performance and Results Act (GPRA) Measures Steering Committee**

The IHS GPRA Steering Committee meets to review IHS GPRA measures plans. The IHS convened the 2012 GPRA evaluation meeting and 2013 planning session on June 29-30, 2010, in San Diego, California, in conjunction with the IHS budget formulation workgroup. While the meeting was primarily focused on the budget, a new document was distributed that provided a history of each clinical measure and included annual targets, results, and a graph of historical results for each measure. In November 2010, the IHS convened the 2010 GPRA Coordinators Conference in Sacramento, California, to discuss and plan improvement for IHS and tribally operated GPRA measures, targets, and outcomes.

### **Scholarship Standing Advisory Board**

The IHS Scholarship Standing Advisory Board provides advice and consultation related to the IHS Scholarship Program to the Chief of the IHS Scholarship Program. This advisory board is comprised of 10 Tribal members. This board meets if requested by the IHS Director or IHS Scholarship Program.

### **Budget Formulation Workgroup**

Tribes, Tribal organizations, Urban Indian health programs, and other key stakeholders are actively involved in the budget formulation process to ensure that the IHS budget reflects the evolving health needs of AI/AN people and communities. The IHS Tribal Consultation policy



describes the charge and activities of the IHS Budget Formulation Workgroup. This workgroup develops annual budget recommendations starting with 12 Area IHS budget sessions, a national budget meeting, a Departmental meeting, and an evaluation meeting. Budget Formulation Workgroup meetings were held in FY 2011 to develop and complete the FY 2013 budget cycle including the HHS Budget Consultation Session and Tribal Resource Day on March 2-4, 2011, in Washington, DC. The Agency also convened the FY 2013 budget formulation evaluation meeting and 2014 budget formulation planning session on May 10-11, 2011, in Albuquerque, New Mexico. Budget formulation workgroup members assist with Area budget formulation sessions each year. Tribal priorities from the Tribal budget formulation workgroup are reviewed and incorporated into the IHS budget formulation process each year.

### **Contract Support Costs (CSC) Workgroup**

On October 11, 2011, the Director wrote to Tribal Leaders announcing a formal Tribal Consultation on the IHS 2007 CSC Policy. A CSC workgroup will be developed and convened. Two Tribal leaders from each IHS Area will serve on the CSC Workgroup to review, evaluate and make recommendations regarding the 2007 CSC Policy (IHS Indian Health Manual Part 6, Chapter 3). The IHS plans to convene the workgroup in January 2012. All recommendations submitted by the workgroup will be shared with all Tribes for review and comment before implementation.

### **IHS and Tribal Institutional Review Board Chairs Workgroup**

The IHS and Tribal Institutional Review Board Chairs Workgroup is composed of approximately 20 individuals who review research proposals that need national institutional review board (IRB) review. The members are drawn from the I/T/U and academic organizations. Area IHS and Tribal IRBs convene conference calls to discuss issues related to the protection of human subjects in research activities conducted in I/T/U settings. All human participant research conducted in IHS facilities or with IHS staff or resources must be approved by an IHS IRB. This also includes all research in tribally managed or Urban Indian health facilities.

## **AGENCY TRIBAL CONSULTATION POLICY**

The IHS has a Government-to-Government relationship with AI/AN Tribal Governments and is committed to regular and meaningful consultation and collaboration with eligible Tribes. Consultation is considered an essential element for a sound and productive relationship with Tribes. Tribal consultation has been affirmed by Executive Order in 2000 and through Presidential Memoranda in 1994, 2004, and 2009. The IHS Tribal Consultation Policy can be referenced at IHS Circular No. 2006-01 and was the first Tribal consultation policy implemented in HHS over 10 years ago. The recent consultation on the IHS Tribal consultation process resulted in recommendations from Tribes to keep the policy the same but to improve its implementation. The Director's Tribal Advisory Workgroup on Consultation developed 6 pages of recommendations for improvements in the Tribal consultation process and implementation of those recommendations continues. They focus mainly on the process for consultation, including timely notification, clear communication of the purpose of the consultation, clear plans and deadlines, better distribution of consultation notices, development of a Tribal consultation website, and more specific outcomes. The Director's Tribal Advisory Workgroup on Consultation will review the updated HHS Tribal Consultation Policy and will determine if changes to the IHS Tribal Consultation Policy are needed.





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United States Department of Health and Human Services

## National Institutes of Health (NIH)

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The mission of the National Institutes of Health (NIH) is to seek fundamental knowledge about the nature and behavior of living systems and to apply that knowledge to enhance health, lengthen life, and reduce the burdens of illness and disability. The NIH works towards this mission by conducting and supporting research in: 1) the causes, diagnosis, prevention, and cure of human diseases; 2) the processes of human growth and development; 3) the biological effects of environmental contaminants; 4) in the understanding of mental, addictive and physical disorders; and 5) directing programs for the collection, dissemination, and exchange of information in medicine and health, including the development and support of medical libraries and the training of medical librarians and other health information specialists.

The prevention, diagnosis, and treatment of diseases and conditions that disproportionately affect American Indian, Alaska Native, and Native American (AI/AN/NA) communities are a priority for the NIH. Toward this end, the NIH promotes research and capacity-building programs and conducts and supports health promotion education and the translation of research findings into programs, educational/informational tools and materials for dissemination into the AI/AN/NA community. Expanding the pool of scientists, researchers, and health professionals within the AI/AN/NA community is also essential in dealing with the many variables associated with improving the health of the AI/AN community. The NIH also recognizes partnerships and consultation as a fundamental strategy to reach the community.

This report highlights several programs and specific activities the NIH supported or participated in during 2010 in the areas of research, capacity-building and health education that are relevant to AI/AN/NA communities. These programs, aim to address disparities in health experienced by AI/AN/NA communities. This report serves as a resource and a basis of discussion to enhance agency support for Indian Country. Tribal Consultation Policy: NIH currently uses the guidance of the OS policy.

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## HIGHLIGHTS OF DIVISION SPECIFIC ACCOMPLISHMENTS/ACTIVITIES

### **Annual Patty Iron Cloud National Native American Youth Initiative (NNAYI)**

NIA and NIMH supported NNAYI, coordinated by NIMHD. NNAYI is designed to prepare AI/NA high school students to continue their education and pursue a career in the health professions and/or biomedical research. The students spend one week in Washington, DC and come to the NIH campus for two days, touring NIH laboratories and attending lectures by NIH staff.

### **Building Bridges: Advancing American Indian/Alaska Native Substance Abuse Research: A State of the Science and Grant Development Workshop**

This meeting, which was lead by NIDA and co-funded by NCI, NIAAA, NIDA, and OBBSR, convened leading AI/AN substance abuse researchers, junior investigators, and community members. The meeting showcased state-of-the-science AI/AN substance abuse research, identified future research needs, and provided both training and technical assistance to academic and tribal partners in NIH grant writing and partnership development. Scientific reports presented at the meeting are being prepared for a special edition of the American Journal of Drug and Alcohol Abuse.

### **Montana-Wyoming Tribal Leaders Council Native Youth Academy**

NIAID's Rocky Mountain Laboratories (RML) hosted the Native Youth Academy of the Montana-Wyoming Tribal Leadership Council. This NIAID activity also had participation from the NIH Office of the Director (NIH OD), the Institutes and Centers of NIH (ICs), and the Indian Health Service. More than 50 American Indian (AI) youth ranging in age from 11 to 14 attended the 5-day academy. Students participated in laboratory activities while adults participated in listening sessions and learned about NIH educational, outreach, training, and employment programs.

### **Native American Research Centers for Health (NARCH)**

In collaboration with IHS, NARCH supports partnerships between AI/AN tribes or tribally-based organizations and institutions that conduct intensive academic-level biomedical, behavioral, and health services research. This collaboration is designed to enhance and expand the capacity and skills of tribal organizations and NA researchers to conduct high-quality biomedical and behavioral health research and to apply successfully for competitive research grants. There are 18 active NARCH Centers, with representation from more than 450 AI/AN/NA tribes. Many AI/AN/NA junior faculty have started their first grant-funded research with NARCH funds and half of the NARCH Centers have already progressed to receiving direct NIH grants.

### **Native American Research Centers for Health (NARCH) Initiative**

NIDA is the second largest financial contributor to NARCH Initiatives among the NIH ICs. The NARCH Initiative is unique in its potential to support both substance abuse science and investigator training. Through NARCH, NIDA continued its support of twelve ongoing programs, including studies of: 1) Pain rehabilitation for AIs with chronic pain, 2) The process of CBPR, 3) The prevention of intentional injury, 4) The improvement of health research skills for trainees, 5) Factors related to methamphetamine abuse, 6) Physical activity and drug use, 7) Family-based alcohol and drug-prevention interventions, 8) Substance abuse at TCUs, 9) Maternal substance abuse, and 10) Oral histories of sobriety and abstinence.

### **Native American Short-Term Research Education Program in Children's Health**

A 10-week summer program is being offered to support the scientific development of undergraduate Native American (NA) students by giving them the opportunity to participate in



basic and clinical research, educational courses, clinical shadowing, mentoring activities, and community health outreach in the fields of cardiology, pulmonology, and hematology. The partners in the project are the Navajo, Arapahoe, and Hopi Tribes and the University of Utah. Three students participated during Summer 2011 and will return in Summer 2012 along with a new cohort of students. The grant funds five summer internships or 40 students. The cycle of recruitment, enrollment, program implementation, and evaluation is ongoing. Progress of students will be tracked for 7-10 years post-program experience.

### **Research to Improve Preconception Health of Adolescent Women**

The Oglala Sioux Tribe, in partnership with Stanford Research/University of South Dakota School of Medicine and the Oglala Lakota College, will be addressing priority health issues identified by the Tribe. They will also support and expand the research capacity and infrastructure already developed over the past decade. This initiative will help to train more NA researchers and biomedical professionals, leading to an increase in the research capacity and infrastructure at Tribal Colleges and Universities (TCUs).

### **Trans-NIH American Indian and Alaska Native Health Communications and Information Work Group**

This workgroup, led by NIAMS, coordinates efforts to develop and disseminate health information targeting AI/AN communities. It partners with IHS to disseminate quarterly NIH information kits to approximately 1600 community health representatives. Since the inception of the project in January 2008, NIH has sent more than 8000 information kits to community health representatives in the areas of arthritis, bone health, cancer diagnosis and treatment, diabetes, drug abuse prevention, heart health, physical activity, stroke, and SIDS.

## **DIVISION SPECIFIC ACTIVITIES**

### **National Cancer Institute**

#### **Partnership for Native American Cancer Prevention (NACP)**

This project started in 2002, partners the Arizona Cancer Center (AZCC) and Northern Arizona University (NAU) with the following objectives:

- 1) Initiation of a robust cancer research at NAU, e.g., enhances faculty career development and train students in cancer research;
- 2) Creation of a stable, long-term cancer research, education, and outreach collaboration; and
- 3) Improvement of institutional efficacy in impacting the disparity in cancer in AIs of the Southwest -- especially among the Navajo, Hopi, and the Tohono O'odham Tribes. In FY 2011, the NACP continued its successful program supporting the training and career development of NA faculty at NAU, training students in cancer research and education, as well as developing cancer research capacity at NAU.

#### **Regional Native American Community Networks Program (RNACNP)**

This research, outreach, and training project is designed to contribute directly to improved cancer health outcomes and quality of life for AI/AN populations, who experience dramatic health inequities. The central strategy is to capitalize on opportunities and leverage existing resources to pursue an integrated, multifaceted research program that is catalyzed by tight partnerships with Native communities. The project addresses cancer health issues ranging from prevention and clinical trials to survivorship. The long-term goal is to generate findings that can be translated into practices and policies that will reduce AI/AN cancer health disparities.



### **Alaska Native Tumor Registry**

NCI's Surveillance, Epidemiology, and End Results (SEER) Program continued to include the Alaska Native Tumor Registry (ANTR) as a full member through an interagency agreement with the Alaska Native Tribal Consortium. In 1999, the ANTR completed its first survival analysis, which was distributed statewide to medical providers, tribal health board members, and key tribal personnel. The ANTR published "Cancer in Alaska Natives 1969–2003: 35-Year Report" in 2006. ANTR currently submits data annually to SEER in November.

### **Cherokee Nation Cancer Registry (CNCR)**

NCI's Surveillance Research Program is partnering with the Cherokee Nation of Oklahoma to fund a pilot cancer registry that conforms to SEER standards in case finding, patient follow-up, data processing, data reporting, and quality assurance. The target population includes all AIs residing in the Cherokee Nation's 14-county tribal jurisdictional service area in Oklahoma. CNCR data were used to obtain funding from the Centers for Disease Control and Prevention (CDC) for the Cherokee Nation Comprehensive Cancer Control Program.

### **Northwest Portland Tribal Registry Project**

The Northwest Portland Area Indian Health Board is a tribal organization governed by the 43 federally recognized tribes of Idaho, Oregon, and Washington. The Northwest Tribal Registry (NTR) Project was formed by the Board to increase the quality of surveillance data on AIs/ANs through record linkage studies. NTR is maintained and regularly updated through NCI support. Some subpopulations of AIs/ANs who have not accessed care through IHS are under-represented in the registry, most notably those living in urban areas.

### **Native American Research Centers for Health (NARCH)**

The NCI is committed to reducing cancer health disparities among AI/AN through the NARCH initiative. Research projects funded through this initiative will increase research capacity of AI/AN research institutions and provide much needed outreach to address observed cancer health disparities in the AI/AN communities. NARCH continues to carry out research projects that are relevant to the needs of specific tribes in the AI/AN communities to increase awareness about cancer screening, diagnosis, and treatment in order to reduce cancer health disparities among AI/AN.

### **Oklahoma NARCH Student Development Project**

This NARCH student development program recruits undergraduate students from Cherokee, Chickasaw, Choctaw, Creek, and Seminole tribes in Oklahoma, and students enter into the Summer Undergraduate Research Program at the University of Oklahoma Health Sciences Center (OUHSC). The goal of this project is to increase the number of AI undergraduate students exposed to biomedical research opportunities at research intensive institutions.

### **NARCH VI Administrative Core-Lakota Center for Health Research**

The major goals of the proposed administrative core is to coordinate the activities of NARCH VI, including monitoring the training of students and research projects, programmatic decisions, data analysis, and planning/review over a wide geographical range and multiple institutions. To accomplish these goals, the Black Hills Center for American Indian Health (BHCAIH) will partner with the South Dakota School of Mines and Technology (SDSMT) to carry out three research projects and one student development training project. These efforts will help in developing a cadre of AI/ANs actively engaged in environment-related health inequities research.



### **Northern Plains NARCH Program: HPV Self-Sampling to Improve Cervical Cancer Screening in AI Communities**

Studies have shown that the overall survival and mortality rates of cervical cancer patients may significantly improve (up to 92%) if the cancer is diagnosed at the preneoplastic or early neoplastic lesion stage. CRCHD maintains funding of this high impact study involving cervical cancer screening in AI communities. This study will entail human papillomavirus self-sampling to improve cervical cancer screening in AI communities in the Aberdeen area of South Dakota. This study has potential to lead to increased early detection of cervical cancer, which may improve patient management and reduce cervical cancer mortality in this population.

### **University of Arizona and Northern Arizona Partnership - Study of Uranium as an Environmental Risk Factor for Cancer among the Navajo**

This joint project of the University of Arizona and Northern Arizona University seeks to: 1) Identify organic uranium complexes and determine uranium isotope ratios in unregulated water sources, 2) Measure the extent of uranium contamination of soils from the abandoned mines in remediation areas of Navajo lands, and 3) Test the bioavailability and mutagenicity of natural uranium using model systems. Although the scientific link between uranium and human health is unclear, the perception of the Navajo people is that uranium has poisoned many in their community. These studies are a critical first step in an interdisciplinary approach aimed at empowering NAs to address their concerns over environmental exposure to uranium.

### **Southwest American Indian Collaborative Network (SAICN)**

The NCI provided support for the Inter Tribal Council of Arizona, Inc. (ITCA) to establish the Southwest American Indian Collaborative Network (SAICN) to eliminate cancer health disparities among AIs. This has been a collaborative program with the Hopi Department of Health. The collaborative project involves three primary partners: ITCA, the Arizona Cancer Center (AZCC), and the Phoenix Indian Medical Center (PIMC). This partnership is enhanced through input from the communities, three Arizona universities, and genomics researchers from the Translational Genomics Institute (TGen). SAICN supported CBPR and the development of partnerships among communities, cancer prevention/care delivery systems, and research discovery/development systems.

### **The Northwest Tribal Cancer Navigation Program (NTCNP)**

The project is a patient navigation research program that is administered through the Northwest Portland Area Indian Health Board (NPAIHB). NTCNP implemented a research and outreach model of patient navigation that used lay or nurse-navigators and was culturally responsive to the needs of each of the tribal groups that it served. Each tribe's local health board and the NPAIHB advisors provided advice and oversight of local activities.

### **The University of Oklahoma Community Networks Program (OUCNP)**

The OUCNP is a recently completed partnership among the University of Oklahoma Cancer Center, the Oklahoma State Department of Health, the Cherokee Nation, and the Choctaw Nation of Oklahoma in order to reduce the burden of cancer among tribal members. Activities included: 1) Capacity-building among partners through CBPR, education, and training; 2) Building a clinical trials database; 3) CBPR and training programs involving these partners to reduce cancer health disparities; and 4) a patient navigator program among community partners.

### **Center for Native Population Health Disparities (CNPHD)**

In FY 2011, the NCI awarded a 5-year research cooperative agreement to the University of



Washington (UW) and Black Hills Center for American Indian Health (BHCAIH) in support of a Center for Native Population Health Disparities (CNPHD). The aim is to contribute directly to improved cancer health outcomes and quality of life for AI/AN populations—populations that experience dramatic health inequities.

### **Spirit of EAGLES Community Network Program II (SoE-CNP II)**

Translational research, outreach efforts, clinical trials, CBPR, and training conducted by the Mayo Clinic and the Alaska Native Tribal Health Consortium at the Alaska Native Medical Center in Anchorage is pursued in order to investigate the effects of tobacco exposure on pregnant AN – in essence, how substances in tobacco can cause cancer and at what levels the substances are found in the baby born to those women. Assisting in this national research effort are the South-Central Foundation, University of California San Francisco; the University of Minnesota; the CDC; and the University of Toronto.

### **The Walking Forward Program**

Since FY 2002, the NCI has supported access to health services through The Walking Forward Program at the Rapid City Regional Hospital (RCRH) as one of the six Cancer Disparity Research Partnership (CDRP) grantees. The ongoing goal of this project is to increase the access and enrollment of minority/underserved populations onto NCI cancer clinical trials.

### **National Center for Research Resources**

#### **Science Education Partnership Award (SEPA): Building Bridges – Health Science Education in Native American Communities**

The goals of this SEPA-funded project at the University of Nebraska Medical Center are to: 1) Promote student interest in the sciences by hands on science lessons, fostering a more science literate public, 2) Increase the number of NAs entering health and science careers, 3) Improve science instruction in the classrooms serving NA partners, and 4) Increase awareness of health and science professions among NA populations and help to bridge the significant gap in health and education disparities. Student engagement will be enhanced through summer experiences at science camps for middle school to extended laboratory research projects for select high schools students.

#### **Science Education Partnerships Award (SEPA): Environmental Health Science Education for Rural Youth**

Through the SEPA program, NCRR provides funding to improve life science literacy throughout the nation's institutions of higher education, including TCUs. This SEPA-funded project at the University of Montana has the following goals: 1) Offer innovative training experiences and career development opportunities in biomedical science; 2) Increase enrollment in post-secondary science education; and 3) Improve science literacy by making information and materials culturally appropriate and comprehensible to a broad audience, including NAs, rural residents, and groups most affected by environmental health problems and disparities in health outcomes.

#### **University of Iowa's Institute for Clinical and Translational Science: Streptococcus Mutans and Dental Caries in Native American Children**

The Clinical and Translational Science Award (CTSA) program is a national consortium of medical research institutions transforming clinical and translational research across the nation. The CTSA at the University of Iowa is supporting a study to identify risk factors for ECC among AI/AN infants and toddlers and to determine if Streptococcus Mutans (SM) alone, or in combination with environmental and behavioral factors, increases risk of caries in AI/AN





children.

### **Institutional Development Award (IDeA) Network of Biomedical Research Excellence (INBRE)**

The INBRE program partners with educational institutions in Alaska, New Mexico, Oklahoma, Montana, Nebraska, and North Dakota to support biomedical workforce training and education in AI communities through a variety of mechanisms. This training begins in high schools located in rural communities and remote AN villages in order to promote success in college and encourage graduate study. The program includes a variety of strategies to: 1) Conduct integrated outreach; 2) Support research projects and student participation; and 3) Increase student recruitment, retention, and placement strategies.

### **National Eye Institute**

#### **The Tohono O’odham Vision Screening Program**

Results from this project indicate that astigmatism is common among preschool Tohono O’odham children. But preschool children can be quickly and effectively screened for astigmatism with a keratometer, a device that can be used by non-medical personnel. Because of this project, three major recommendations can be made to assure proper care for children with astigmatism: 1) Every child should be screened for visual disorders by age 3-years; 2) A child with astigmatism should receive an eye examination to determine if eyeglasses are needed; and 3) Arrangements need to be made for the child to receive eyeglasses, if they are needed. Native Research Network (NRN) and the Association of American Indian Physicians (AAIP) meetings.

### **National Human Genome Research Institute**

#### **Alaska Biomedical Partnership for the Research and Education Pipeline (BioPREP)**

The Alaska BioPREP seeks to engage students in cutting-edge scientific research while they are still in high school in order to prepare them for the rigor of university-level scientific inquiry. The program reaches out to rural and AN students who may not receive the same research opportunities as their counterparts in urban high schools. In the summer of 2011, NHGRI provided presentations highlighting current research being conducted within the NHGRI Intramural Research Program and presented information on careers in genomics.

### **Population Architecture of Genes and Environment (PAGE)**

PAGE is a collaborative study examining well-phenotyped, population-based, and ethnically diverse cohorts involving >80,000 participants. The study aimed to: 1) Assess generalizability across diverse ethnic groups, 2) Examine associations across important phenotypes, and 3) Identify genetic and environmental modifiers. The 7,000 participants were from 13 AI tribes: Apache, Caddo, Comanche, Delaware, Fort Sill Apache, Kiowa, Wichita, Gila River and Salt River Pima/Maricopa, Akchin Pima/Papago, Oglala Sioux, Cheyenne River Sioux, and Spirit Lake Communities. Additionally, 388 AI/AN participants were from the Women’s Health Initiative.

### **Web-Based Genomics Research Resource for American Indian and Alaska Native Communities**

This collaborative project was launched with the National Congress of American Indians Policy Research Center, in order to create a web-based genomics resource guide about genetics research for AI/AN individuals and communities. The aims of the resource are to: 1) Provide



AI/AN individuals and communities with basic information related to genomic technologies and genetics and genomics research studies, 2) Assist AI/AN individuals and communities in making informed decisions about participation in genetics and genomics research studies, and 3) Equip AI/AN communities as partners in genetics and genomics research studies.

### **National Heart, Lung, and Blood Institute**

#### **Arsenic Exposure, Cardiovascular Disease, and Diabetes in Native Americans**

The objective of this project is to evaluate the association of inorganic arsenic exposure and arsenic biotransformation on the risk of cardiovascular disease and diabetes in 4,549 NAs who participated in the Strong Heart Study. An initial analysis showed low-to-moderate inorganic arsenic exposure and confirmed long-term constancy in arsenic exposure and urine excretion patterns in AIs from three US regions over a 10-year period. Further analysis of 600 samples is in progress to correlate arsenic exposure and cardiovascular and pulmonary health and health status.

#### **Oral Flora, Periodontitis, and Vascular Dysfunction in Young Native Americans**

The overall goal of this project is to examine the possible relationship between periodontal disease and vascular disease in AI/AN 21-40 year-olds. Cardiac disease is the leading cause of mortality in adult AIs/ANs, and these studies are investigating the links between cardiac disease and prevalent periodontal disease.

#### **Summer Research Training Institute for AI/AN Health Professionals**

The overall goal of this Institute is to develop a cadre of highly trained AI/AN biomedical and health researchers who are sensitive to the culture and specific concerns of AI communities, and who can bring the benefits of academic research to these communities to reduce health disparities. The Institute offers up-to date classes on a variety of relevant topics on career advancement in AI/AN health-related research.

#### **The Prevalence of Congenital Heart Disease in Native Americans in Wisconsin**

Congenital heart disease is the most common birth defect encountered in Wisconsin and there is evidence that the incidence may be nearly twice the expected rate in NA. This pilot project began in FY 2010 and aims to determine the actual rate of congenital heart disease in NAs in Wisconsin and to identify possible risk factors.

#### **Tribal College Faculty and Tribal Health Professionals Development Project**

The purpose of this study is to increase the capacity in basic epidemiology research among TCU faculty and tribal health professionals. The primary objective is to develop and conduct skill-building workshops to enhance research capacity. These skills will be applicable immediately to their current positions in the health field. The aim of this project is to build capacity among the tribal college faculty and tribal health professionals working in health research and other health fields. The project helps to foster relationships between academic institutions and tribal communities by providing a forum for collaboration.

### **National Institute on Aging**

#### **National Institute on Aging (NIA) Native Elder Research Center (NERC) Program of the Resource Centers on Minority Aging Research (RCMAR)**

The University of Colorado at Denver and Health Sciences Center's Native Elder Research Center is one of NIA's Resource Centers on Minority Aging Research (RCMARs). Its aims include: 1) Expanding partnerships with AI/AN/NA communities to ensure continuous access and involvement of Native elders, their families, and local systems of care in the process of age



research; and 2) Preparing AI/AN/NA investigators for research careers at the interface of aging, health, and culture and for reducing differentials in health status.

### **National Institute on Alcohol Abuse and Alcoholism**

#### **Invited Plenary Speech at the 23<sup>rd</sup> Annual Native Health Research Conference**

This conference was held June 27-30 in Niagara Falls, New York. Individuals who were involved with, and use, health research in NA tribal communities attended the conference. The conference enhanced the collective ability to advance biomedical, behavioral, and health services research for their benefit. The NIAAA presented an invited plenary talk entitled, "Building a Culturally-Supportive Framework for the Indigenous Research Community: Engaging Future Generations of Alcohol Researchers."

#### **Preventing Underage Drinking by Southwest California Indians**

The goal of this project is to reduce underage drinking among NA reservation dwelling youth. The community-based environmental prevention program will focus on: 1) Reducing underage access to alcohol, 2) Preventing underage drinking and driving through enhanced enforcement, and 3) Individual-level interventions including screening and brief interventions.

#### **Prevention Trial in the Cherokee Nation: Interactive Effects of Environment & Screening and Brief Intervention**

The goal of this project is to conduct and evaluate a community-level intervention to prevent underage drinking and negative consequences among AI and white youth in rural, high-risk communities in Northeastern Oklahoma. This prevention study utilizes community environmental change, brief intervention, and referral approaches, which will be evaluated alone and in combination.

#### **Risk Factors for Alcoholism in Native Americans**

These studies are aimed at identifying risk and protective factors related to alcohol dependence in reservation-dwelling Mission Indians. The purpose is to elucidate the genetic, clinical, and neurobehavioral factors related to alcohol abuse. Findings suggest that Mission Indians have a distinct cluster of biological and behavioral risk factors, and the initiation of alcohol use during adolescence is particularly malignant for this population. The identification of factors associated with risk for alcohol dependence should guide the development of tailored intervention programs.

### **National Institute of Allergies and Infection Disease**

#### **Intramural NIAID Research Opportunities (INRO)**

INRO is an exploratory program aimed at recruiting research trainees from populations underrepresented in biomedical research. Targeted outreach includes direct communications and tailored e-mails to AI/AN intermediaries, such as the American Indian Graduate Center and the National Indian Education Association; tailored print ads (SACNAS, Winds of Change, and Tribal College Journal); a feature article in the Winds of Change; presence at key conferences (SACNAS and American Indian Science and Engineering Society); and ongoing relations with AI collegiate partners.

#### **Viral Host Interactions in Hepatitis C**

This is a long-term study of the clinical outcomes of HCV infection in a large cohort of AIs/ANs. The objective of this study is to correlate HCV disease with duration of infection and HCV genotype in populations that are relatively genetically homo-geneous. The presence of type 2 diabetes mellitus, steatosis, and duration of HCV infection were independent predictors of



advanced fibrosis (see Livingston et al., “Factors associated with the progression of fibrosis on liver biopsy in AI/AN persons with chronic hepatitis C” Canadian Journal of Gastroenterology, Vol 24(7), pages 445-451).

### **National Institute of Arthritis and Musculoskeletal and Skin Diseases**

#### **The National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) Multicultural Outreach Initiative**

The goal of this initiative is to address disparities in accessing information about bone, joint, muscle, and skin diseases, including improving availability of research-based information and emphasizing that better health relies on research. Since the project’s inception, NIAMS has established workgroups to guide development and dissemination of messages. The group addressing NA needs includes members who are affiliated with the Navajo Nation, Sioux, Klamath Tribes of Oregon, Laguna Tribe in New Mexico, and AN communities. Current activities include developing and field testing a health planner targeting AI, AN, and Native Hawaiians in two pilot sites.

#### **Understanding Rheumatic Disease in Oklahoma Tribal Members**

As part of IHS’ NARCH, NIAMS supports efforts by the Chickasaw Nation Health System to improve the health of NA with rheumatic diseases. Researchers are establishing the prevalence of rheumatic diseases in Oklahoma tribal communities, defining the features of rheumatic diseases in tribal members (compared with Americans of European or African descent) to improve diagnosis and clinical care, and providing medical care.

### **National Institute on Drug Abuse**

#### **AI/AN Webinar program**

NIDA began a series of web-based training focused on AI/AN substance abuse research. The first in this series of webinars, Alternatives to Randomized Clinical Trials for American Indian and Alaska Native Populations, addressed the importance of employing experimental designs that are appropriate to community needs and to a new generation of preventive interventions. Webinar presenters also highlighted other research designs that can be employed to evaluate interventions with scientific rigor (March, 2011).

#### **Association of American Indian Physicians (AAIP): NIDA Mentoring Meeting**

The NIDA American Indian and Alaska Native Scholars group convened a one-day workshop at the Association of American Indian Physicians (AAIP). The purpose of the meeting was to address questions related to developing and implementing research projects related to substance abuse in Indian Country (August, 2011).

#### **Behavior Health Center of Excellence: First Annual Behavioral Health Conference**

NIDA provided support to the Aberdeen Area Tribal Chairmen’s Health Board to support a meeting focused in part on best practices and research in substance abuse and suicide prevention in persons of the Great Plains Region. This meeting was co-sponsored by the Great Plains Tribal Chairmen’s Health Board, Substance Abuse and Mental Health Services Administration (SAMHSA), and the IHS Meth and Suicide Prevention Initiative (February, 2011).

#### **Drug Use among AI/AN: Epidemiology & Prediction**

NIDA supports several studies to assess culturally distinct health promotion and risk factors for substance abuse among AI/AN/NA including: 1) A 30-year surveillance project assessing substance use among AI adolescents attending reservation schools; 2) The exploration of contextual risk factors for substance use in reservation-dwelling AIs; 3) Exploratory and pilot



studies of methamphetamine use and co-occurring disorders in diverse NA communities; and 4) Three projects led by Native investigators on oral histories of sobriety, drug use at tribal colleges, and maternal health.

### **Mentoring and Supporting Native Student Development**

NIDA supports several mentoring and development programs including: 1) A partnership with Harvard Medical School to improve the opportunity for NA high school students to engage in science education and pursue undergraduate and graduate training in biomedical sciences and medicine; and 2) A program at the University of Washington led by an AI investigator to increase the pool and career development of researchers investigating behavioral aspects of HIV research within ethnic and sexual minority populations, with an emphasis on Native HIV research, including HIV preventive interventions.

### **National Action Alliance for Suicide Prevention: AI/AN Task Force**

NIDA serves on the National Action Alliance for Suicide Prevention AI/AN Task Force. Goals of this effort include increasing research in this area as well as increasing the focus on the intersection between suicide and substance abuse. NIDA staff participated in the Alliance meeting. NIDA staff also made presentations on methamphetamine and other substance abuse among AI/AN communities at the conference that followed (August 2011).

### **Partnership for Public Health Research in the Oglala Sioux Tribe**

The Oglala Sioux Tribe faces numerous health challenges, many stemming from behaviors that emerge during childhood and adolescence. The goal of this collaborative project is to facilitate research infrastructure development within the Tribe, focusing on prevention among the Tribe's youth. Researchers and community members are working together to develop a research agenda and implement a research program.

### **Prevention Research among AI/AN**

NIDA supports several prevention research projects in AI/AN communities. These include a community-level prevention trial in Cherokee Nation led by a Native investigator, an efficacy trial for preventing inhalant use in Alaska that integrates community participation and cultural heritage, a school-based brief motivational intervention (MI) for substance-using NA high school students, and a home-visiting intervention for teen mothers.

### **Substance Abuse Treatment Research**

NIDA supports several projects focused on advancing treatment strategies for AI/AN communities. These include work on the use and dissemination of Evidence-Based Practices (EBPs) in substance abuse treatment programs serving AI/AN communities, tobacco cessation treatment for AN youth, and motivational interviewing and community reinforcement strategies with the Zuni pueblo led by a Native investigator.

### **Support for Student Participation and Staff Presentations at Meetings/ Institutes/ Conferences**

NIDA provided support, via staff participation and funding for student travel and participation, for several professional conferences/meetings/institutes. For example, NIDA provided support for junior scholars to attend the Native Children's Research Exchange meeting (September 2011) and students to participate in the NWPAlHB Summer Research Training Institute for American Indian/Alaska Native (AI/AN) Health Professionals (August 2011), American Psychological Association Conference (June 2011), NRN (June 2011), and AAIP (August 2011). NIDA Staff



provided plenary talks at the Native Research Network (NRN) and the Association of American Indian Physicians (AAIP) meetings.

### **Web and Computer-Based Drug Prevention and Treatment Intervention for AI/AN**

NIDA supports two projects that are designed to develop, evaluate, and assess web and computer-based interventions for AI/AN populations. These projects address the need for evidence-based, culturally relevant drug prevention and treatment interventions that are accessible and engaging to NA youth and adults in remote locations.

### **National Institute of Dental and Craniofacial Research**

**Periodontal Disease Prevention and Control in American Indian and Alaska Native Adolescents**  
This study is focused on characterizing the status of periodontal health in adolescents with type 2 diabetes. Both of these associated diseases are increased in AI/AN populations. The study participants are urban-dwelling AI/AN adolescents living in Denver, Colorado who are at high risk for Type 2 diabetes and periodontitis.

### **Preventing Caries in Preschoolers: American Indian Head Start Programs**

This trial will determine whether or not an oral health promotion program delivered by community oral health workers in the Head Start setting is effective at preventing ECC. In addition to evaluating the impact on ECC, the study will examine family changes in oral health knowledge, attitudes, and behaviors. This study team is from the Center for Native Oral Health Research at the University of Colorado, Denver.

### **Promoting Behavioral Change in American Indian Mothers and Children**

The Center for Native Oral Health Research at the University of Colorado, Denver is studying several aspects of Early Childhood Caries (ECC), which develops in a disproportionately high number of AI children. A recently launched randomized trial is investigating the cost and efficacy of a behavioral intervention (motivational interviewing) on the prevention of ECC in a Northern Plains tribe. The intervention is being conducted in collaboration with the AI community to assure the development of culturally appropriate educational and health promotional materials that emphasize the value of family oral health at all stages of development, from prenatal to adulthood.

### **Streptococcus Mutans and Dental Caries in Native American Children**

This prospective cohort study is targeted at establishing the risk factors for the development of ECC in infants and toddlers of a Northern Plains Tribe to determine if the caries-causing bacteria, *Streptococcus mutans*, alone or in combination with environmental factors, increase the risk of ECC. Investigators will determine the incidence of ECC through age 36-months and consider issues that may contribute to ECC such as the transmission of *Streptococcus mutans* from mother to child; bacterial virulence factors; and behavioral, dietary, and nutritional risk factors.

### **National Institute of Diabetes and Digestive and Kidney Diseases**

#### **A Targeted Approach to Increasing American Indian Tissue and Organ Donation**

In this project, investigators will mount a multi-pronged program on ESRD and organ donation at seven TCUs in the Pacific Northwest and Northern Plains. These states are primarily rural, contain medically underserved areas, and have large populations of AIs. Because students are among those most likely to donate organs, TCUs offer the possibility of reaching a younger population of AIs.



### **Diabetic Nephropathy**

NIDDK has a substantial portfolio of clinical investigations of diabetic nephropathy in AIs, supported through the intramural program. In addition to the portfolio of laboratory interventions, NIDDK also supports studies evaluating factors that affect therapeutic response, enzyme inhibitors, the renin-angiotensin system, angiotensin-converting enzyme inhibitors, and variables responsible for the development and progression of diabetic kidney disease.

### **Genetic Determinants of Obesity in Pima Indians**

The Pima Indians of AZ have the highest prevalence of Type 2 diabetes mellitus of any population in the world. Obesity is also extremely common, and data indicates that obesity in this population has major genetic determinants. In 2009, a genome-wide association study using over 500,000 single nucleotide polymorphisms was conducted and completed on approximately 1500 members of the Pima Indian population of the Gila River Indian Community in AZ. Analyses are being conducted currently to identify regions of the genome that are associated with obesity.

### **Genetics of Obesity in Yup'ik Eskimos**

The investigators extended their current data set of over 800 interrelated Yup'ik Eskimos to 1000 family members in order to: 1) Identify single nucleotide polymorphisms (SNPs) in the seven candidate genes, 2) Test these genes for association with obesity phenotypes, and 3) Test for gene-environment and gene-gene interactions. The discovery of gene-environment interactions gained from this study will further the understanding of obesity and will be relevant to future studies aimed at developing and testing interventions and novel therapeutic targets for obesity.

### **Hepatitis Beta Research Network Clinical Center in Pacific Northwest/Alaska**

This Clinical Center is being established as a part of the Hepatitis B Clinical Research Network (HB-CRN). It will consist of three collaborating institutions in the Washington and Alaska. The goal is to establish a data base, a natural history study, and a bio repository of patients with chronic hepatitis B virus (HBV) infection from the Pacific Northwest and Alaska. The Clinical Center will bring together patients, investigators, and resources from a variety of health centers as well as a number of affiliated community and outreach clinics.

### **Neural Correlates of Food Reward in American Indian Women**

Despite the disproportionate obesity burden among AIs, this will be the first study in this underrepresented population that uses functional magnetic resonance imaging (fMRI) and an opioid antagonist. Our results will provide important data about brain activation in response to high-calorie foods that will inform dietary interventions aimed at preventing and treating obesity and may identify a promising pharmacologic treatment for obesity and overeating in AIs.

### **NIDDK National Diabetes Education Program (NDEP) Multicultural Campaigns**

The NIDDK launched the NDEP with the Centers for Disease Control in 1997 to change the way diabetes is treated. Since its inception, NDEP has taken a multicultural approach to address its goals of improving diabetes management, approaches, community-based interventions, health system changes, and an inclusive partnership network. The project provides ideas and encourages creation of activities in AI communities regarding education about diabetes prevention and treatment.



### **Prevention and Control of Type 2 Diabetes in the Pima Indians of Arizona**

NIDDK, community leaders, and community members have developed and produced several health education materials to promote the message that diabetes can be prevented. These materials include two videos, "Close to the Heart: Breastfeeding Our Children and Honoring Our Values," which encourages breastfeeding to prevent obesity and Type 2 diabetes, and "Message of Hope: We Can Prevent Diabetes in Native American Communities." Members of the Gila River Indian Tribe participated in this effort.

### **Research on Type 2 Diabetes Mellitus-Gila River Indian Reservation**

This agreement employs local or area personnel to serve as coordinators, recruiters, interpreters, clerks, receptionists, technicians, and medical personnel to assist NIDDK personnel in the conduct of a comprehensive study of the causes and complications of type 2 diabetes mellitus in the Pima Indian population on the Gila River Indian Reservation, other Indian reservations in the Phoenix Area office jurisdiction, and the Phoenix Indian Medical Center (PIMC).

### **National Institute of Environmental Health Sciences**

#### **Protecting the Health of Future Generations: Assessing and Preventing Exposures**

This CBPR project investigates exposures to two classes of emerging endocrine-disrupting chemicals (EDCs) with the Yupik people of St. Lawrence Island (SLI) in the Alaskan Arctic. The purpose of this project is to initiate research partnerships that work in collaboration with the two Yupik villages of SLI to assess multiple exposure routes of two emerging EDCs-polybrominated diphenyl ethers (PBDEs) and perfluorinated compounds (PFCs). The project will assess exposures to PBDEs and PFCs in surface waters through analyses of contaminant levels and biomarkers for xenobiotic chemicals in the threespine stickleback fish. The research team will also analyze household dust for PBDEs and PFCs.

#### **Air Pollution Outreach, Education, and Research Capacity-Building in Alaska Natives**

In collaboration with the Alaska Native Tribal Health Consortium (ANTHC), researchers will implement the Air Toxics Under the Big Sky program in seven AN villages to educate the communities on the importance of good indoor air quality. As the program evolves, it will support the communities to identify community-specific air pollution issues of importance and to characterize respiratory disease within the communities. In the future, intervention type strategies will be identified and implemented within each of the communities to mitigate the identified air pollution problems and improve respiratory health among the AN populations.

#### **Applying Toxicogenomics and Biomolecular Technologies to Environmental Monitoring, Risk Assessment, and Bioremediation (University of San Diego Superfund Research Center)**

Biomarkers developed by UCSD Superfund Research Program scientists are being evaluated, in partnership with tribal labs, for environmental monitoring of water quality. Biomarkers can be used as effective tools for detecting Superfund toxicants in contaminated watersheds. Important gaps persist in tribal institutional capacity to access the most effective technologies to protect the environment and human health. Working in close partnership with the 29 Palms Band of Mission Indians, the UCSD Research Translation Core completed the transfer of a tried-and-true biomolecular assay for dioxin-screening. This effort serves as an effective model for building the institutional capacity of tribes to utilize cutting-edge molecular assays developed by UCSD Superfund Research.





### **Environmental Health and Justice in Norton Sound, Alaska**

The purpose of this project is to work in partnership with fifteen communities in the Norton Sound region of Alaska to find effective means to limit the release of, and mitigate the human health effects of, contaminants in the natural environment. The majority of the residents of these villages are Inupiat and Yupik, indigenous people who depend on the harvest of wild foods to sustain them and their ways of life. The collaborative work includes constructing a database of information regarding formerly used defense sites (FUDS) in the region and the contaminants found at these sites. Researchers are working with village leaders to provide training to oversee FUDS clean-up work and establish independent monitoring programs for contaminants.

### **Hazardous Waste Worker Training Program**

During the FY 2011 grant year, 991 members of NA tribes and public safety agencies were trained directly by JSCC instructors in 40 grant-funded classes, for a total of 8,664 contact hours of direct training. In addition, 25 courses conducted by NA peer trainers who trained 452 workers at public safety facilities and NA tribal settings for a total of 5,833 hours of secondary training. In all, 1,443 trainees attended 65 classes for a total of 14,497 contact hours of grant-funded direct and secondary training.

### **Health Research Advisory Council Superfund Research Program: Tribal-University Collaboration to Address Tribal Exposures to PAHs and Improve Community Health**

The CTUIR and many other US tribes are engaged in traditional and cultural practices that may result in increased risk of disease due to cumulative PAH exposures from traditionally-smoked foods, air exposure from traditional smoking of foods, and ambient air pollution. This Outreach Core builds on strengths and resources within the tribal community and is facilitating the tribal communities' abilities to evaluate their PAH exposures and design risk reduction strategies. The Outreach Core held a symposium focused on conducting research with tribal communities, including tribal legal issues, research ethics, concepts in indigenous and western science, and integration of sociocultural health indicators in tribal risk research.

### **Navajo Uranium Assessment and Kidney Health Project and the Diné Network for Environmental Health Project**

Projects address the health impact of past uranium mining at more than 1,000 mining and milling sites, with special focus on chronic kidney disease and contamination of drinking water from unregulated sources. The aim of this project is to develop acceptable safe alternative water sources as well as to calculate risks for kidney disease from contaminated water.

### **National Institute of Mental Health**

#### **23<sup>rd</sup> Annual Native Health Research Conference, "Peace, Good Mind & Strength: Indigenous Principles of Health Disparities Research and Training for the Seven Generations"**

NIMH participated in this conference, held June 27-30, 2011 in Niagara Falls, New York. The goal of the conference was to promote indigenous cultural strengths in research and health workforce development. NIMH staff participated in a mentorship breakout session and general session. As a result of the conference, NIMH identified and selected the United South and Eastern Tribes, Inc. and the Salish Kootenai College as new participants for the Mentorship in Mental Health Program.

### **Developing Community-Based Interventions for American Indian Mental Health**

This career development award is designed to provide comprehensive mentored research



training in community-based mental health services for AI adolescents (age 12-16), with a focus on Navajo youth and their families. The training includes coursework, mentoring, and applied research related to the development and implementation of tailored mental health services.

### **Indigenous HIV/AIDS Research Training (IHART) Program**

I-HART was developed to increase the number of AI/AN health researchers who successfully garner major grants for tribal priority health issues. The I-HART program will target junior and mid-career AI/AN community/tribal-based researchers and AI/AN university-based researchers to hone their competitive grant making skills for mental health and HIV/AIDS research grant acquisition.

### **Mental Health and Diabetes among Ojibwe Adults**

This project aims to identify and understand culturally-specific mental health and substance use issues comorbid with type 2 diabetes (T2D). The overall goal is to investigate further the impact of such comorbidity on treatment compliance and health behaviors among Ojibwe adults by way of CBPR.

### **The Mentorship in Mental Health Research Program**

This program develops TCU faculty who conduct high quality, culturally appropriate, and community-supported mental health research among AI/AN/NA communities. Current mentorship projects include projects between the University of Nebraska at Lincoln, Nebraska and the Sinte Gleska University, Antelope, South Dakota; between the University of Washington, Salish Kootenai College and the Tribal College and University of The Confederated Salish and Kootenai Tribes; and between Vanderbilt University and the United South and Eastern Tribes, Inc. (USET).

### **National Alliance for Suicide Prevention American Indian/Alaska Native Task Force**

The NIMH participated in the American Indian/Alaska Native Task Force (AI/AN TF) of the National Action Alliance for Suicide Prevention, a public-private partnership guiding the implementation of the goals and objectives in the National Strategy for Suicide Prevention. The AI/AN TF, in partnership with tribes, aims to implement suicide prevention strategies to reduce the rate of suicide in AI/AN communities. Along with IHS, the Bureau of Indian Affairs, and the Bureau of Indian Education, the AI/AN TF hosted the National Suicide Prevention Summit and Alaska Suicide Prevention Summit for AI/AN communities, leaders, service providers, educators, and law enforcement.

### **Resilience through the High School Years**

This project is a longitudinal study of cultural and individual factors which influence risk and resilience for mental, emotional, and behavioral disorders in Ojibwe participants. The prospective study follows children through high school – a period of increased risk for emotional, behavioral, and substance use problems. This study will show the progression of mental health and substance use disorders among a large sample of indigenous adolescents.

### **National Institute of Minority Health and Health Disparities**

#### **American Summer Research Internship in Maternal/Child Health**

This project is an innovative program for AI undergraduates at the University of Utah. The Internship combines basic and clinical research experiences with didactic educational sessions devoted to research design and ethics. Participants also engage in complementary learning experiences, including opportunities to develop test-taking and writing skills, participate in health-related community outreach, and shadow health professionals and educators. When



students complete the Internship, they will have gained basic and clinical research experience, built a network of support, developed a clearer understanding of the career opportunities in science and medicine, and obtained valuable life experiences essential to career development in any field.

### **The Roadmap to Healthy Communities: Understanding Indian Health**

The goal of this project is to develop, implement, and evaluate a series of four annual conferences that will contribute to capacity building within AI tribes and urban AI communities of New Mexico to address their common and specific health care needs. The primary objectives for the conferences are to bring together tribal leaders and other key tribal members for a series of leadership and educational sessions. The conferences are designed to build health policy capacity within the tribes, create partnerships between tribes and with the University of New Mexico Robert Wood Johnson Foundation Center for Native American Health Policy, and address shared and unique tribal health and health care issues. The conferences will be divided into four key components: 1) Understanding needs, 2) Building capacity, 3) Understanding health policy, and 4) Navigating tribes into the future.

### **National Institute of Neurological Disorders and Stroke Alaska Native Stroke Registry**

The Alaska Native Stroke Registry (ANSR) has developed a state-wide surveillance system to determine the incidence of stroke in the NA population. ARRA-funded supplements were provided for urban sampling and rural door-to-door case ascertainment to understand attitudes and beliefs about vascular risk factors. The investigators developed a survey instrument to assess stroke and myocardial infarction, vascular risk factors, medication adherence, social health networks, community social organization, health-illness beliefs, explanatory models of disease, health locus of control, and barriers to physical activity. This project is guiding development of a stroke prevention intervention culturally tailored for the AN population.

### **Outreach at Annual Meetings for Medical and Scientific Societies Representing American Indians and Native Americans**

NINDS program staff members attend annual meetings for the Association of American Indian Physicians (AAIP) and the Society for Advancing Chicanos and Native Americans in Science (SACNAS) to provide information to students on education and training opportunities. NINDS-sponsored scientific sessions focus on the latest cutting-edge neuroscience, bringing exposure to Native students and access to role model neuroscientists.

### **Specialized Neuroscience Research Program**

The Specialized Neuroscience Research Program cooperative agreement at the University of Alaska, Fairbanks supports infrastructure development and promotes recruitment and retention of AN and other underrepresented students to improve their success rates in biomedical career paths. The program now has 12 faculty members, is well integrated into the university community, and educates students at all levels from high school to post-doctorate.

### **National Institute of Nursing Research**

#### **Uranium in Food Grown in an American Indian Community**

This study explores the health risks of uranium exposure from harvested animals and plants on AIs from the Diné (formerly Navajo) reservation in northwestern New Mexico. This study examines dietary behaviors, compares uranium levels in food d and from high versus low contamination areas, and disseminates findings to the Navajo leadership and community.



## **National Library of Medicine**

### **National Library of Medicine (NLM) Environmental Health Information Partnership (EnHIP)**

EnHIP strengthens institutional capacity to reduce health disparities through the use of information technology and environmental health information. The program includes 3 Tribal Colleges [Oglala Lakota College (South Dakota), Diné College (Arizona), and Haskell Indian Nations University (Kansas)]; the University of Alaska, Anchorage, serving a large population of Alaska Natives; 14 HBCUs; and 3 Hispanic-Serving Institutions. This program has helped TCUs incorporate NLM resources in their curricula and community outreach projects.

### **NLM Chickasaw Health Information Center (CHIC)**

CHIC (<http://chicresources.net>) is a public-private project jointly supported by NLM, the Chickasaw Nation, and Computercraft, a Chickasaw-owned science and technology company. CHIC is a consumer health information center in the Carl Albert Indian Health Facility in Ada, OK. Computercraft developed and hosts the CHIC website and also developed a mobile kiosk. NLM trains staff and health care providers, and NLM provides instruction and guidance about effective information provision practices.

### **NLM Native American Information Fellowship Program**

This program teaches representatives from AI tribes, NA villages, and the Native Hawaiian community about NLM. It also improves access to health information and technology for their communities. Fellows have participated from the Mandan, Hidatsa and Arikara Nations (Three Affiliated Tribes); Ft. Berthold Reservation, North Dakota; the Nez Perce Tribe, Lapwai, Idaho; the Navajo Nation from Tuba City, Arizona; urban AIs; and three Native Hawaiians.

## **Office of Behavioral and Social Sciences Research**

### **Native American Research Centers for Health (NARCH) V Program at the National Congress of American Indians Policy Research Center (NCAIPRC), University of New Mexico and University of Washington**

This NARCH V program focuses on promoters and barriers to CBPR in AI/AN communities. The research study aims to: 1) Identify best practices, tools, and measurement instruments for use by partnerships nationwide; 2) Assess relationships between larger contexts, partnering relationships, and intermediate CBPR outcomes (e.g., community capacities, policy/practice changes, and sustainable/ culturally-centered interventions); and 3) Identify variability of CBPR projects within diverse underserved communities. This multi-method study conducted through 2013 is jointly funded by NIH and IHS.

## **TRIBAL DELEGATION MEETINGS**

### **Collaboration between the Cherokee Nation and the Oklahoma Department of Health to Implement We Can! (Ways to Enhance Children's Activity & Nutrition)**

To tackle the burden of obesity, the Cherokee Nation will develop local media strategies to: 1) Promote healthy food and beverage choices; 2) Limit unhealthy food and beverage availability in schools; 3) Implement farm-to-school programs; 4) Adopt quality physical education in schools; 5) Increase safe, attractive, and accessible places for physical activity; 6) Adopt procurement and purchasing policies to reduce the price of healthy foods; 7) Develop prompts for healthy food and beverage items and implement menu labeling; 8) Reduce the cost of recreation services; and 9) Expand activity groups in workplaces, community gathering places, parks, and neighborhoods. NHLBI We Can! program staff successfully planned and conducted a We Can! Parent Program webinar training session for Cherokee Healthy Nation staff and Oklahoma State Health Department staff, with a total of 11 participants taking part in the



webinar. The intent of training participants was for them to explore potential opportunities to integrate parent-focused activities into their programming.

### **Consultation with Tribal Leaders at the National Congress of American Indians**

At the mid-year conference of the National Congress of American Indians (NCAI) at Milwaukee, WI, June 13-16, 2011, the NCI organized a tribal consultation for this then-proposed funding announcement. Input was requested from NA communities, and tribal leaders provided feedback on time-line, tribal participation, and methods for funding. These comments were incorporated into the final version of the FOA.

### **Eighth National Conference on Changing Patterns of Cancer in Native Communities: "Strength through Tradition and Science"**

NCI supported this conference which occurred in September, 2011 at The Westin Hotel in Seattle, WA. The conference was convened by the Spirit of Eagles, a research program based at the Mayo Clinic, and funded by NCI. The intended audience for this conference included community members and leaders, survivors, advocates, researchers, health care providers, policy makers, and others working with Native populations.

### **The 23<sup>rd</sup> Annual Native Health Research Conference**

NCI provided support for this conference entitled "Peace, Good Mind, & Strength: Indigenous Principles of Health Disparities Research and Training for the Seven Generations" on June 26-30, 2011 in Seneca Falls, NY. NCI conducted a workshop at the conference on CBPR. Conference participants included researchers, health care providers, administrators, educators, Tribal Review Board (TRB) members, indigenous students in training, policy-makers, and tribal leaders. The purpose was to advance biomedical, behavioral, and health services research for the benefit of Native communities, as well as to showcase recent health research projects and efforts undertaken in Indian Country.

### **Honoring the Gift of Heart Health (HGHH) Materials Development Workgroup**

The HGHH Materials Development Workgroup members are serving as field reviewers and advisors in the revision of two documents: the Alaska Native Easy-to-Read booklet and the HGHH manuals for American Indians and Alaska Natives. Partners within this workgroup also provide valuable guidance in the development of materials that support planning and development of project activities. Revisions of the two documents have continued in FY 2011 and should be completed by December 2011. The Members/Attendees were NHLBI-Division for the Application of Research Discoveries (DARD), IHS-Nutrition, IHS-Health Promotion/Disease Prevention, IHS-Native Cardiology, IHS-Diabetes Program Confederated Tribes of Warm Springs, Sonoma County Indian Health Clinic, Alaska Native Medical Center, and SouthEast Regional Health Consortium. These meetings were conducted through teleconferences and e-mails.

### **Honoring the Gift of Heart Health (HGHH)**

The NHLBI, in collaboration with the IHS Health Promotion and Disease Prevention Program, funded a total of 10 pilot projects. Each of the pilot projects included planning, implementation, and program and evaluation activities using a community-based approach. This approach integrated the use of community health workers and community health educators to conduct education and outreach activities in order to prevent and control CVD risk factors. In FY 2011, final project reports and associated data from the pilot projects were submitted. NHLBI has begun to synthesize and analyze submitted data and is in the process of developing summary reports.



### **We Can! (Ways to Enhance Children's Activity & Nutrition) Alaska Regional Training**

A total of 91 participants from all Alaska regions participated in this training, including representatives from 28 tribal-affiliated entities serving a primarily AN population. Attendees included health care providers and staff; public school staff and administrators; coordinators and instructors of after-school programs; public health program coordinators; academic researchers; health insurers; and nutrition educators. Participants received hands-on training on We Can! curricula for parents and youth and heard innovative ideas to help launch and strengthen the program. NHLBI We Can! program staff will continue to provide technical assistance to programs that implement We Can! programming into their communities and will work closely with the **Alaska Native Tribal Health Consortium** and the Alaska Physical Therapy Assistant Health and Wellness Committee as they plan to host a second regional training.

### **We Can! (Ways to Enhance Children's Activity & Nutrition) Partnership with Cherokee Nation**

We Can! is a national public education program from the NIH to help prevent obesity among youth ages 8-13. We Can! reaches parents and caregivers in home and community settings with educational materials and activities to encourage healthy eating, increase physical activity, and reduce screen time. The NHLBI We Can! program staff continued to provide technical assistance to the Cherokee Nation Healthy Nation program by guiding tribal staff to We Can! web-based resources and providing hardcopy materials and resources as needed. The Cherokee Healthy Nation program continues to be a part of the We Can! network and is privy to messages that are sent to all members of the We Can! network. NHLBI We Can! staff will continue to explore additional partnership activities with the Cherokee Healthy Nation program.

### **AGENCY TRIBAL CONSULTATION POLICY**

The NIH adheres to the US Department of Health and Human Services (HHS) Tribal Consultation Policy signed by the HHS Secretary Kathleen Sebelius on December 14, 2010. This policy may be accessed in its entirety at [www.hhs.gov/intergovernmental/tribal/index.html](http://www.hhs.gov/intergovernmental/tribal/index.html). NIH has developed a draft document entitled NIH Guidance on the Implementation of the HHS Tribal Consultation Policy (hereafter, NIH Guidance). The purpose of the NIH Guidance is the provision of more specific direction to the NIH ICs on their implementation of the HHS Tribal Consultation Policy. On November 10, 2011, NIH began the process of consulting with tribes/tribal leaders for their input on the draft NIH Guidance. It is anticipated that structured forums will continue to be utilized during FY 2012 to present tribal representatives with the NIH Guidance and seek their feedback. The agency will incorporate feedback from the tribal consultations to prepare a final NIH Guidance document. Nothing in the NIH Guidance will supersede the HHS Tribal Consultation Policy.





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United States Department of Health and Human Services  
**Office of the Assistant Secretary for Health**

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The Office of the Assistant Secretary for Health oversees 14 core public health offices — including the Office of the Surgeon General and the US Public Health Service Corps — as well as 10 regional health offices across the nation and 10 Presidential and Secretarial advisory committees.

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**Intradepartmental Council on Native  
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## **HIGHLIGHTS OF DIVISION SPECIFIC ACCOMPLISHMENTS/ACTIVITIES TARGETED TOWARD AMERICAN INDIANS/ALASKA NATIVES (AI/AN)**

### **Health Promotion and Disease Prevention**

In September 2010 (year one of a three-year program), the National Indian Women's Health Resource Center was funded at a level of \$257,090 through the MCHP competitive grant process. The grantee provided HIV/AIDS- related services to 528 participants in FY2011; 02 Year award was made in September 2011.

In September 2010 (year one of a five-year program), the Alaska Native Tribal Health Consortium was funded at a level of \$225,000 through the National Umbrella Cooperative Agreement Program competitive grant process. The grantee provided services to 237 individuals in FY2011; the 02 Year award was made in September 2011.

In September 2010, the Indian Health Care Resource Center of Tulsa received a three-year grant at a level of \$485,000 per year through the PAC competitive grant process. In FY 2011 a total of 2,522 individuals received services through this project. This includes 229 providers who received training during the first year of the project. The 02 Year award was made in September 2011.

In September 2010, the AATCHB received a five-year grant at a level of \$250,000 per year through the NUCA Program competitive grant process. In FY 2011 a total of 45 individuals representing 6 tribes and 4 tribal colleges participated in the Mapping Pathways project. The 02 Year award was made in September 2011.

The Indigenous Peoples Task Force implements the Native CHAT project. During FY 2011 the grantee's CHAT Facebook sites (Native CHAT, and Ikidowin IPTF) had 345 friends and 95 fans. To date, the youth have created 32 video clips and posted them on YouTube; over 2,000 views during FY 2011. The Native CHAT Film Festival was completed at the end of June 2011, and the video clips posted as a result of the Film Festival had 953 total views. The Indigenous Peoples Task Force, Minneapolis, MN, received its Year 03 (of three) award (\$244,134) in September 2011.

During of FY 2011 Long Island Association for AIDS Care (LIAAC) provided services to more than 1,200 ex-offenders (includes Native American in target population). In September 2011 LIAAC received its Year 03 (of three) award in the amount of \$250,000.

In September 2010, the MAIC received a five-year grant at a level of \$250,000 per year through the NUCA Program competitive grant process. The grantee provided services to 458 individuals in FY2011 and received 02 Year funding in September 2011.

In September 2010, the SIHB received a five-year grant at a level of \$250,000 per year through the NUCA Program competitive grant process. The grantee finalized and distributed a literature review regarding evidence-based interventions for CVD prevention and treatment in an Environmental Scan titled "*Progress Towards Health Equity: Efforts to address Cardiovascular Disease Among American Indian and Alaska Native*" to 484 individuals. The review was also posted on their website [www.uihi.org/project/healy-equity](http://www.uihi.org/project/healy-equity), and distributed through the Office on Women's Health Region X listserv and the Native American Rehabilitation Association of the Northwest. The grantee also finalized and distributed to urban Indian health organizations the capacity report titled "*Culture, Service, and Success: A Profile of Urban Indian Health Organization Programming to Address Cardiovascular Disease*" to the same sources. A total of



208 unique visitors have visited the project website with links to CVD resources. The grantee's 02 award was made in September 2011.

### **Health Professions Recruitment**

During FY 2011 the six AI/AN Health Disparities grantees made progress toward achieving the original objectives proposed at the beginning of the five year project period. During the 04 Year the Albuquerque Area Indian Health Board analyzed preliminary data on 176 middle schools and 132 high schools that is now available on the 2009 Southwest Tribal Youth Project Youth Risk and Resiliency Survey. The survey covers the states of New Mexico, Colorado and Texas. This grantee also received approval of a proposal presented at the National Center for Health Statistics to conduct a population-based analysis of access to healthcare utilization for urban AI/AN in addition to delivering a data literacy training to 31 participants in Albuquerque, NM. The Alaska Native Tribal Health Consortium implemented focus groups to obtain community feedback regarding their prenatal care and delivery experiences; two nurses were trained to assist with analysis of the findings. The Inter Tribal Council of Arizona, Inc. delivered a Tribal Motor Vehicle Code Training course to the Apache and Hualapai Tribes in Arizona, in addition to conducting a safety checkpoint and inspecting 33 child restraint systems. The Great Plains Tribal Chairmen's Health Board presented results of a cancer gap analysis among AI/AN communities study at the National Cancer Institute, NIH, in April 2011; the Oklahoma City Area Inter-Tribal Health Board created a cultural competency manual and guide for non-native healthcare providers. The six grantees received the 05 Year awards in September 2011.

## **DIVISION SPECIFIC ACTIVITIES**

### **Office of Adolescent Health**

The 2010 Consolidated Appropriations Act (Public Law 111-117) provides funding for the Teen Pregnancy Prevention Program which supports Tier 1 (evidence-based) and Tier 2 (research and demonstration) grant programs. On September 30, 2010, Tier 1 funding competitively awarded \$75 million in grants across 75 grantees in 32 States and Washington, D.C. to implement programs that have been proven effective through rigorous evaluation to reduce teen pregnancy, behavioral risk factors underlying teen pregnancy, or other associated risk factors. Grantees are currently in their second year of implementation in this five year grant program. They are replicating a range of identified evidence-based program models. The Tier 1 grantee that is working with the youth Tribal population is Rural America Initiatives of Rapid City, South Dakota, (funding amount \$599,621). The Hawaii Youth Services Network is working with middle-school aged adolescents, primarily Pacific Islander, and Filipino youth (funding amount \$999,999).

Tier 2 funding competitively awarded \$15.2 million to 19 grantees in 14 states and Washington, D.C., to support research and demonstration programs that will develop, replicate, refine, and test additional models and innovative strategies for preventing teenage pregnancy. These grantees are also in their second year of implementation in this five year grant program. The Tier 2 grantees who are working with Tribal populations to prevent teen pregnancy are as follows:

1. the University of Denver Colorado in Aurora, Colorado, is working with 13-15 year olds enrolled in after-school programs at Native Boys and Girls clubs located in rural tribal reservation areas in North Dakota and South Dakota (funding amount \$924,543);
2. the National Indian Youth Leadership Project (NIYLP) in Gallup, New Mexico, is working with Native American youth ages 12-17 in rural McKinley County (funding amount \$555,706); and

3. Rural America Initiatives of Rapid City, South Dakota, is working with Lakota American Indian youth, ages 11-14 (funding amount \$599,581).

The grantee that is working with Alaskan youth is the State of Alaska, Division of Public Health, Section of Women's, Children's & Family Health in Anchorage, Alaska, which focuses on youth ages 11-19 in Anchorage, the Matanuska-Susitna Valley, the Kenai Peninsula Borough, Kotzebue, and Bethel (funding amount \$599,985).

### **Office of Minority Health**

OMHRC has been working with the Native American Community providing capacity building and technical assistance to Tribes and Native serving HIV/AIDS organizations and agencies to strengthen programs in Indian Country.

#### General Capacity Building Activities:

- OMHRC's TIHA was represented and/or presented information at: IHS HIV summit, a National Native HIV/AIDS Awareness day event, Urban Indian Health Summit, AAIP conference, Women and Girls HIV Summit, United States Conference on AIDS, National Rural Health Conference, Multiracial and Multicultural Conference and American Public Health Association.
- Assists more than 10 Tribes and American Indian organizations throughout the United States. Each tribe and organization received some type of technical assistance or capacity building to assist programming efforts around HIV.
- Viral Hepatitis and HIV/STI Project: OMHRC and IHS collaborated with the UIHIs to address the need for integrated education and prevention efforts. The Viral Hepatitis and STI Prevention project provides free technical assistance to urban Indian health organizations (UIHO) nationwide to address these health issues, and develop culturally appropriate health promotion materials. The project hosts several webinars throughout the project year.
- Facing AIDS in Native Communities Video: OMHRC and IHS are collaborating to further develop and utilize excess footage from the film, "Facing AIDS in Native Communities." The videos will be utilized by area service units as well as community clinics to further educate and reduce stigma associated with HIV/AIDS and its co-morbidities. Each video will be available on the IHS/HHS web site as well.

#### Minority AIDS Initiative Projects:

- OMHRC awarded mini-grants for Tribes and Tribal programs to further develop HIV/AIDS programs or continue HIV/AIDS programs. Mini-grants were awarded to the Red Circle Project, Shoshone-Bannock Tribe, Navajo AIDS Network, Sacred Spirits, Tucson Indian Center, and Native American Interfaith Ministries.
- Evaluated 2 HIV/AIDS Curricula: The curricula evaluated have the potential to be further developed and adapted in other Native communities. Each evaluation benefited the community and organization to make improvements and seek additional funding for expansion.
- Curricula Adaptation to multimedia format and Internet: Currently developing HIV/AIDS multi-media curriculum for Native youth to access in schools and via the internet. The curriculum that has been identified is culturally and age appropriate and has shown success in preliminary evaluation studies.

## **Grantee Meetings**

TIHA's FY11 grantee meeting was held on November 15-16, 2010 in Albuquerque, NM. TIHA had a variety of presenters and discussion topics including:

- Native specific HIV/AIDS Curricula, curricula adaptation, clinical practice guideline structures and workgroups were presented on from National Native American AIDS Prevention Center, First Nations Community Health Source, and AIDS Project Los Angeles.
- Tommy Chesbro, Director, Planned Parenthood Oklahoma address stigma, anti-stigma campaigns and the AI/AN community. Mr. Chesbro conducted a Lesbian, Gay, Bi-sexual, and Transgender Two-Spirited panel on stigma and its impacts in the community.
- Angela Barajas-Fallon, Director of Public Health Nursing Sells Service Unit, discussed Tribal responses to HIV/AIDS, and the HIV/AIDS/STD efforts in the Sells Service Unit areas.
- The Indian Health Service STD Program discussed STD/HIV screenings and youth adapted curricula and campaigns.
- Niki Graham, Director of Prevention Task Force Salish Kootenai College, presented a workshop on HIV Basics and Updates, and gave a presentation on promotion strategies and testing in Montana.
- TIHA facilitated a series of webinars for grantees and the public with an average attendance of 90 persons per webinar. The webinars hosted were titled: Fundamentals of Social Marketing, Nutrition and HIV, Social Media and HIV, and Working with Active Drug Users.

## **Next Steps**

The OMHRC's TIHA will schedule a series of webinars for grantees starting in January 2012. The series will include social marketing evaluation, HIV co-occurring diseases, case management and other topics specified by grantees at the past meetings. TIHA will also continue current programs, capacity building, and technical assistance.

## **Office of Women's Health**

In October 2010, as part of the OWH Coalition for a Healthier Community Grant Initiative, the Utah Department of Health conducted two hands-on foot exam trainings for American Indians medical professionals (medical assistants, nurses and other medical staff). These trainings involved hands-on learning techniques for conducting proper foot exams for patients with diabetes. Thirty-two participants, representing six tribes, attended one of the two trainings, in either Salt Lake City, Utah, or Page, Arizona.

As part of the OWH Coalition for a Healthier Community Grant Initiative, the Utah Navajo Health System, Inc (UNHS) collaborated with its Sweet Success Program in partnership with Utah Women's Health Information Network-UWIN.

## **AFFORDABLE CARE ACT ACTIVITIES SPECIFIC TO TRIBES**

The Affordable Care Act (Public Law 111-148) provides funding for the Pregnancy Assistance Fund (PAF) to support pregnant and parenting teens and women in States and Tribes across the country. On September 29, 2010, PAF awards were awarded competitively to 17 States and Tribes to develop and implement activities to support pregnant and parenting teens and women. The PAF grantees are currently in their second year of implementation of this three year grant program.

Grantees are using their grant funds to carry out any or all of the following activities:

- Supporting pregnant and parenting student services at institutions of higher education
- Supporting pregnant and parenting teens at high schools and community service centers
- Improving services for pregnant women who are victims of domestic violence, sexual violence, sexual assault, and stalking
- Increasing public awareness and education

The two PAF grantees who are currently implementing programs in tribal areas are:

- The Inter-Tribal Council of Michigan, Inc. in Sault Sainte Marie, Michigan, (funding amount \$500,000) is providing support, assessment, education, and referral services to pregnant and parenting AI teens at Community Service Centers across 20 counties, including two major urban areas in Michigan.
- The Choctaw Nation of Oklahoma in Durant, Oklahoma, (funding amount \$900,000) is directly serving 600 pregnant and parenting youth through community service centers and public awareness and education efforts. In-depth descriptions about all projects of the aforementioned Teen Pregnancy Prevention Program and the PAF grantees can be found on the Office of Adolescent Health website at <http://www.hhs.gov/ash/oah/oah-initiatives>.

#### **AGENCY TRIBAL TECHNICAL ADVISORY GROUP**

The HHS AI/AN Health Research Advisory Council (HRAC) was established to provide HHS a vehicle for consulting with Tribes about health research priorities and needs in AI/AN communities, and collaborative approaches in addressing these issues and needs. The HRAC is comprised of elected Tribal officials from each of the 12 Indian Health Service areas, and four National At-Large Members. Federal partners participate in Council activities by providing input and support, and linkages with HHS's operating and staff divisions.

The HRAC held a face-to-face meeting on October 7, 2010, in Albuquerque, New Mexico. The first annual HRAC Research Roundtable was held October 21, 2010, on the National Institutes of Health campus in Bethesda, Maryland. The HRAC held teleconference calls with Tribal delegates and Federal partners on January 18, 2011 and May 12, 2011. The second HRAC meeting was held on June 27, 2011, in Niagara Falls, New York, in conjunction with the Annual Native Health Research Conference.

The HRAC provided the Secretary's Tribal Advisory Council with an overview of HRAC and its priorities during the March 2, 2011, meeting and then presented testimony at the 13<sup>th</sup> Annual National Tribal Budget Consultation on March 3-4, 2011. HRAC members participated in the Annual Native Health Research Conference as well as the Indian Health Service Roundtable in Niagara Falls, New York. The HRAC was also represented during a panel presentation at the National Indian Health Board's Annual Consumer Conference in Anchorage, Alaska in September 2011. These outreach opportunities allow the HRAC to receive feedback on research priorities and issues that the HRAC can utilize as it provides recommendations to HHS.

The HRAC developed an Annual HRAC Report, which provides a summary of HRAC's activities and priorities for the year. In addition, the HRAC produced an Annual Health Research Report, a compilation of findings from HHS related to important health research topics in AI/AN communities as well as programs that have been established by Federal agencies to serve AI/ANs or minority populations.

The HRAC submitted recommendations to HHS Secretary Kathleen Sebelius on research issues including:

- The National Institutes of Health will develop a single Tribal consultation policy;
- National Children's Study oversample AI/AN populations and fund additional cohorts in Indian Country;
- HHS Data Council adopt an HHS wide Research Policy for Indian Country;
- HHS adopt agency wide minimum standards and requirements for a Tribal data sharing agreement; and
- research priorities on quantification of chronic disease prevalence, mental health/suicide prevention, methamphetamine and other drugs prevalence and prevention, intentional and unintentional injuries, hypertension, stroke prevalence/prevention, auto immune disorders, health services, and evaluation of emerging technology.

The HRAC Co-Chairs met with the NIH Director, Dr. Francis Collins, to discuss the HRAC recommendations and then followed up discussions with the National Institute on Minority Health and Health Disparities Director, Dr. John Ruffin.

The HRAC has tentatively scheduled a face-to-face meeting on July 16, 2012 in Seattle, WA in conjunction with the Annual Native Health Research Conference and an HRAC Research Roundtable on November 15, 2012 in Bethesda, MD.



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United States Department of Health and Human Services

## Substance Abuse and Mental Health Services (SAMHSA)

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The Substance Abuse and Mental Health Services Administration (SAMHSA) has established a clear vision for its work—a life in the community for everyone. To realize this vision, the Agency has sharply focused its mission on building resilience and facilitating recovery for people with or at risk for mental or substance use disorders. Prevention Works ... Treatment is Effective... People Recover.

**Mission:** To reduce the impact of substance abuse and mental illness on America's communities. To achieve this mission SAMHSA has 8 Strategic Initiatives that will guide the agency's work. They are:

1. Prevention of Substance Abuse and Mental Illness
2. Trauma & Justice
3. Military Families – Active, Guard, Reserve, and Veteran
4. Health Reform
5. Recovery Support
6. Health Information Technology for Behavioral Health Providers
7. Data, Outcomes, and Quality-Demonstrating Results
8. Public Awareness and Support

### Organization

SAMHSA's core functions are to administer discretionary, formula, and block grant programs; and provide up-to-date information on behavioral health issues and prevention and treatment approaches. This work is achieved through the following Centers:

1. Center for Behavioral Health Statistics and Quality (CBHSQ)
2. Center for Mental Health Services (CMHS)
3. Center for Substance Abuse Prevention (CSAP)
4. Center for Substance Abuse Treatment (CSAT)

### Contact Information:

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### Intradepartmental Council on Native American Affairs Liaison:

Sheila K. Cooper  
Senior Advisor for Tribal Affairs

Tribal Consultation Policy: Yes

## **HIGHLIGHTS OF DIVISION SPECIFIC ACCOMPLISHMENTS/ACTIVITIES**

### **Behavioral Health – Tribal Prevention Grant (BH-TPG)**

The Administration's budget proposal for FY 2012 includes the Behavioral Health - Tribal Prevention Grant (BH-TPG) administered by SAMHSA. The proposal for the BH-TPG emerged from SAMHSA's participation in HHS national and regional Tribal consultation, in SAMHSA-specific Tribal consultation sessions, and from Tribal leaders' identifying services and resources that would improve behavioral health in Indian Country. The BH-TPG represents a significant advance in the Nation's approach to substance abuse and suicide prevention, based in recognition of behavioral health as a part of overall health. The program will focus on the prevention of alcohol abuse, substance abuse and suicides in the 565 federally-recognized Tribes. Recognizing the Federal obligation to help Tribes deal with physical and behavioral health issues, SAMHSA will work in consultation with Tribes, establishing a single coordinated mental health and substance abuse program for all federally-recognized Tribes. BH-TPG would be non-competitive funding to prevent substance abuse and suicide for every federally-recognized Tribe. SAMHSA consulted with Tribes on the design of the program and on a distribution formula for funds available beyond a base award of \$50,000. The program would provide flexibility to appropriately allow for Tribal self-governance. The final program requirements would be determined based on additional Tribal consultation.

### **Tribal Law and Order Act (TLOA) Implementation**

The Tribal Law and Order Act (TLOA) was signed into law on July 29, 2010 and included several important provisions to improve public safety and address behavioral health issues. As a result, the Secretary of Health and Human Services, the Secretary of the Interior, and the Attorney General, recently signed a MOA to, among other things:

1. Determine the scope of the alcohol and substance abuse problems faced by American Indians and Alaska Natives;
2. Identify the resources and programs of each agency that would be relevant to a coordinated effort to combat alcohol and substance abuse among American Indians and Alaska Natives; and
3. Coordinate existing agency programs with those established under the Act.

To accomplish the above stated goals, SAMHSA sought to establish an Indian Alcohol and Substance Abuse Interdepartmental Coordinating Committee (IASA Committee) to include key agency representation from SAMHSA, Indian Health Service (IHS), Office of Justice Programs, Office of Tribal Justice, Bureau of Indian Affairs, Bureau of Indian Education, and the Department of Education. To date, the IASA Committee is also represented by the Administration on Aging and Administration for Children and Families within HHS. The IASA Committee has created an organizational structure to include workgroups to carry out its work. TLOA created within SAMHSA an Office of Indian Alcohol and Substance Abuse to improve coordination among Federal agencies carrying out the Indian Alcohol and Substance Abuse Prevention and Treatment Act and a framework for interagency and Tribal coordination was developed that established the roles and responsibilities of the Federal agencies and sets the foundation for further implementation of the TLOA. The work of the new Office of Indian Alcohol and Substance Abuse will help inform the Administration's National Drug Control Strategy as overseen and coordinated by the White House Office of National Drug Control Policy.

### **Office of Indian Alcohol and Substance Abuse (OIASA)**

SAMHSA established the OIASA in the Center for Substance Abuse Prevention, to take the lead in coordinating Federal agencies and departments in leveraging their expertise, programs,

services, and resources addressing substance abuse in Indian country, as required under the Tribal Law and Order Act. During the period October 1, 2010 through September 30, 2011, OIASA worked with TLOA partner agencies in creating an organizational structure under a Memorandum of Agreement (MOA) to guide their collaborations under TLOA; established five workgroups to address key TLOA activities including guidance for Tribal Action Plans, an inventory of federal resources for Indian country, and a newsletter through which to communicate with AI/AN communities; and established a Web site ([www.samhsa.gov/tloa/](http://www.samhsa.gov/tloa/)) as a central source for information on Federal resources and information for AI/AN substance abuse prevention and treatment issues. SAMHSA joined other TLOA partner agencies in preparing and mailing a Deal Tribal Leader letter, including hard copies of the MOA and the relevant sections of the TLOA, to all Federally recognized Tribes on August 4, 2011. The OIASA staff and TLOA partners conducted 14 outreach presentations to keep Indian country and the prevention field informed of TLOA progress, and participated in several tribal consultations and listening sessions in preparation for these TLOA responsibilities:

- a. Attended, presented and participated in several consultation/listening sessions in partnership with BIA, OJP, OTJ and IHS as well as at the Tribal Justice Safety Wellness sessions (TJSW): between September and December 2010
- b. Formal consultation on MOA and TAP: December 8, 2010
- c. Formal consultation on Detention Planning (DOJ/DOI) and other TLOA activities: May 8, 2011

### **Uniform Block Grant Application**

On July 26, SAMHSA announced a new application process for its major block grant programs--the Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant (MHBG). The change is designed to provide States greater flexibility to allocate resources for substance abuse and mental illness prevention, treatment and recovery services in their communities. One of the key changes to the block grant application is the expectation that States will provide a description of their tribal consultation activities. Specifically, the new application's planning sections note that States with federally-recognized Tribal governments or Tribal lands within their borders will be expected to show evidence of Tribal consultation as part of their Block Grant planning processes. However, Tribal governments shall not be required to waive sovereign immunity as a condition of receiving Block Grant funds or services. Included within the MHBG application SAMHSA notes that States should identify strategies for the MHBG that reflect the priorities identified from the needs assessment process. Goals that are focused on emotional health and the prevention of mental illnesses should be consistent with the IOM Report on Preventing Mental, Emotional, and Behavioral Disorders. More specifically, they also should include Strategies that implement suicide prevention activities to identify youth at risk of suicide and improve the effectiveness of services and support available to them, including educating frontline workers in emergency, health and other social services settings about mental health and suicide prevention. Finally, the uniform application requests that States attach to the Block Grant application(s) the most recent copy of the State's suicide prevention plan. It notes that if the State does not have a suicide prevention plan or if it has not been updated in the past 3 years, the State should describe when it will create or update its plan.

### **The SAMHSA Military Families Strategic Initiative**

The Service System's Development Program hosted a Tribal Partnership Summit, September 21-22, 2011, in Salt Lake City, Utah. The Summit was designed to provide technical assistance



and support to States collaborating with Tribes and Tribal communities in their efforts to strengthening the behavioral health systems serving Service Members, Veterans, and their Families (SMVF). The Summit included 51 participants from six States including, Arizona, California, North Carolina, Oklahoma, Utah, and Washington. State Team Leaders identified State teams of six delegates comprised of three Tribal participants who influence behavioral health policy for SMVF, as well as three State team members. State delegations included department heads from mental health, substance abuse, children and families, Indian services, and Veterans Affairs as well as leaders/liaisons from several Tribal nations including the Lumbee, Chickasaw, Cherokee, Suquamish, Spokane, and Quileute. The goals of the Tribal Summit were to provide TA focusing on:

4. Developing practical strategies for promoting State behavioral health system partnerships with Tribal communities in supporting the recovery, resiliency, and readiness of SMVF.
5. Linking Tribal leaders with State resources for improving outreach and engagement for Tribal SMVF.
6. Implementing promising, best, and evidence-based practices among military, civilian, and Tribal entities for strengthening behavioral health systems.

The Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) Tribal technical assistance specialist worked with the New Mexico State-level leadership to help them successfully connect with a number of Tribes and pueblos in order to increase the use of social/emotional and developmental screenings for young children. These partnerships led to trainings and the distribution of screening materials within several Tribal communities.

### **Tribal Portfolio**

American Indian/Alaska Native youth experience disproportionately high rates of violent victimization; substance abuse and dependence; and suicide. Recognizing these serious issues, SAMHSA administers a variety of programs that serve Tribal youth. In FY 2010, SAMHSA granted 104 awards to Tribes and Tribal Organizations for a total of \$68,120,563. In FY 2011, SAMHSA granted 103 awards to Tribes and Tribal Organizations for a total of \$71,065,895.

### **Regional Staff**

For the first time in its history, SAMHSA now has a presence in each of the 10 HHS Regional Offices. This new configuration of SAMHSA staff will help ensure that a voice for behavioral health is present in the regions along with all of the other HHS operating divisions. The Regional Administrators will help SAMHSA reach out to and provide information for States, Territories, Tribes, providers, communities and other stakeholders about funding opportunities, Federal policies affecting them, or disaster preparedness and response. They will also make it easier for SAMHSA to collaborate with other HHS colleagues in the regional offices and be better informed about behavioral health needs throughout the country. This staff configuration will help SAMHSA be more effective in accomplishing its mission of reducing the impact of substance abuse and mental illness on America's communities.

### **National Action Alliance for Suicide Prevention**

On September 10, 2010, the National Action Alliance for Suicide Prevention (NAASP) was launched by the U.S. Department of Health and Human Services Secretary, Kathleen Sebelius, and former Defense Secretary, Robert Gates. The NAASP has a private sector Co-Chair, former U.S. Senator Gordon Smith (R-OR), and a public sector Co-Chair, Army Secretary John McHugh. Members of the NAASP include, but are not limited to, the Surgeon General, Regina

Benjamin; the SAMHSA Administrator, Pamela S. Hyde; Department of Interior Assistant Secretary of Indian Affairs, Larry Echo Hawk; HHS Assistant Secretary for Health, Dr. Howard Koh; and National Indian Youth Leadership Project Executive Director, McClellan Hall. In addition, the IHS Director, Dr. Yvette Roubideaux, serves as an *ex officio* Member of NAASP. Mr. Echo Hawk, Mr. Hall and Dr. Roubideaux serve as the leaders of the NAASP AI/AN Task Force which will establish specific priorities for Tribal youth regarding suicide prevention, intervention, and postvention strategies, including positive youth development. The Task Force also helped develop the agenda and strategy for the National Suicide Prevention Summit and will also do so for the Alaska Suicide Prevention Summit for AI/AN communities, leaders, service providers, educators, and law enforcement.

### **Action Summits for Suicide Prevention**

Between November 2010 and February 2011, SAMHSA, IHS, and the Department of the Interior jointly conducted a series of ten Tribal listening sessions across Indian Country on suicide prevention to gather information on Tribal needs. The input shaped the theme and agenda for two Action Summits for Suicide Prevention. The first Action Summit was held in Phoenix and the second was held in Anchorage. The Action Summits emphasized an action oriented approach and brought together nationally recognized speakers, behavioral health providers, Tribal leaders, health care providers, first responders, and many others to develop and strengthen new or existing collaborations, gather information on best and promising practices, collect information on the most up-to-date research on suicide and substance abuse prevention, intervention, and aftercare, and share personal experiences in addressing suicide and substance abuse in Indian Country. The Action Summit themes focused on the importance of collaboration among Tribal, Federal, State, and community- and program-level leadership to promote AI/AN behavioral health. Compiled feedback from the Action Summits will form the next steps for future agency collaboration.

### **Using Art to Raise Awareness Around Behavioral Health**

On March 8, SAMHSA unveiled a painting by artist Sam English, Turtle Mountain Band and Red Lake Band of Chippewa Indians, which was commissioned to help raise awareness about the roles of families and the community in mental and substance use disorder prevention. Mr. English was specifically chosen for this work because of his familiarity with the prevention and recovery populations. During the unveiling ceremony, Mr. English shared his history with alcohol and his 30 years of sobriety and how he uses art as a healing process. The art work hangs in the main foyer, 8<sup>th</sup> floor, of the SAMHSA Building.

## **TRIBAL DELEGATION MEETINGS**

### **HHS Annual Tribal Budget, HHS Regional and SAMHSA Specific Consultation**

The goal of SAMHSA's participation in Tribal Consultation includes, but is not limited to, eliminating behavioral health disparities of Indians, ensuring that access to critical behavioral health resources and services is maximized, and to advance or enhance the social, physical, and economic status of Indians. To achieve this goal, and to the extent practicable and permitted by law, it is essential that federally-recognized Indian Tribes and SAMHSA engage in open, continuous, and meaningful consultation. In addition to Administrator Hyde, SAMHSA senior leadership participated in Tribal consultation sessions. The BH-TPG and the TLOA Memorandum of Agreement (MOA) and TLOA Tribal Action Plans were consultation items discussed at each Regional Consultation session. In August, the signed MOA and supporting documents were mailed to all 565 Tribal Leaders.

## **SAMHSA Meetings**

### **Tribal Justice, Safety and Wellness Sessions (TJSW)**

In response to Tribal Leaders, Tribal Representatives and Tribal Organizations request, SAMHSA and DOJ have partnered with other Federal agencies to address cross-cutting issues and to continue joint Federal efforts to conduct consultation, training, and technical assistance sessions to help address issues of concern facing AI/AN communities. The sessions bring together elected Tribal leaders and key policy decision makers, Tribal administrators, executive directors, finance and grant administration officers, Tribal planners, grant writers, justice and law enforcement personnel, Tribal program project coordinators, and grantee officers. TJSW sessions were held at Palm Springs in December and at Phoenix in May.

### **Navajo Disaster Behavioral Health Plan**

The SAMHSA Disaster Technical Assistance Center (DTAC) is planning a 2-day meeting for the Navajo Nation Emergency Mutual Aid Compact (NNEMAC) Work Group. The DTAC will facilitate the discussion on drafting the Navajo Nation Disaster Behavioral Health (DBH) Plan. During the October meeting, the director of the Navajo Department of Behavioral Health (DBH), behavioral health staff, including spiritual leaders and traditional healers, will draft the DBH plan for the Navajo Nation. The NNEMAC work group includes Navajo Nation professionals, emergency first responders, division directors, managers, and elected officials who are developing a Navajo Nation-wide emergency management framework that enables all response partners to prepare for and provide a unified response to disasters and emergencies. During the 2-day meeting, the NNEMAC workgroup will discuss the Navajo Nation Response Framework and will also hold a workgroup session to discuss the DBH planning process. DTAC will be assisting in facilitating pre-meeting conference calls, facilitation during the 2-day meeting, and assessing for possible training needs of behavioral health and emergency management staff. The October session is a result of a DTAC presentation in June to the Inter Tribal Council of Arizona in conjunction with the NNEMAC. In addition, DTAC has been exploring data collection with several Tribal communities and there is favorable Tribal interest in SAMHSA conducting a disaster behavioral health needs assessment.

## **AGENCY TRIBAL TECHNICAL ADVISORY GROUP**

### **TTAC Meeting, March 23, Rockville, MD.**

SAMHSA has six standing committees and on March 22, for the first time, all six committees, including the TTAC, came together for a Joint Committees Meeting. The Joint Committees Meeting provides an opportunity for the committee members to meet, share their committee involvement and find common ground. It also gives SAMHSA an opportunity to present information to all committees with an immediate ability to address questions and clarify information. The Joint Committees Meeting includes presentations on the Federal budget (current and future), progress on SAMHSA's Strategic Initiatives, and on special topics such as women's issues, defining recovery, or quality data collection. The TTAC membership held their committee meeting the day following the Joint Committees meeting which provided an opportunity to discuss the topics presented the previous day and the relevance or impact to Tribes. A new chair, Julia Davis-Wheeler, Nez Perce Tribe and co-chair, Andy Joseph Jr, Confederated Tribes of the Colville Reservation were elected during this meeting.

### **TTAC Meeting, August 15, Rockville, MD.**

The TTAC met prior to the Joint Committees Meeting and the meeting served as an orientation session since several new members had joined within the past year.

## **AGENCY TRIBAL CONSULTATION POLICY**

The SAMHSA Tribal Consultation Policy was last updated on March 2, 2007. The SAMHSA TCP has been re-written to reflect and align with the 2010 HHS TCP and will be available for public comment by the end of 2011



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United States Department of Health and Human Services

## **Intrdepartmental Council on Native American Affairs (ICNAA)**

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The Intrdepartmental Council on Native American Affairs (ICNAA), authorized by the Native American Programs Act of 1974 (42USC2991), as amended, serves as the focal point within the Department of Health and Human Services (HHS) for coordination and consultation on health and human services issues affecting the American Indian, Alaska Native and Native American (AI/AN/NA) population, which includes more than 560 federally recognized tribes, approximately 60 tribes that are state recognized or seeking federal recognition, Indian organizations, Native Hawaiian communities, and Native American Pacific Islanders, including Native Samoans.

It brings together HHS leadership to ensure consistency on policy affecting American Indians, Alaska Natives and Native Americans, and to maximize limited resources. The major functions of the ICNAA are to:

- Develop & promote HHS policy that provides greater access;
- Assist in the Tribal Consultation process;
- Develop both short term & long term strategic plans;
- Promote self-sufficiency and self-determination;
- Develop legislative, administrative, and regulatory proposals to benefit Native Americans; and
- Promote the Government-to-Government relationship as reaffirmed by the President

### **Membership**

The ICNAA membership consists of each of the HHS Operating Divisions heads, Staff Division heads, the Director, Office of Intergovernmental and External Affairs, the Director, Center for Faith-Based and Community Initiatives, the Executive Secretary to the Department, and two HHS regional representatives.

### **Direction and Oversight**

The ICNAA is located in the Office of Intergovernmental and External Affairs (IEA), Immediate Office of the Secretary and provides executive direction and coordination with the Council Chairperson on all Council activities

The Commissioner, Administration for Native Americans (ANA), is the Chairperson and the Director, Indian Health Service (IHS) is the Vice-Chairperson. The Chairperson is charged with the overall direction of the Council and shall preside over all Council activities, including Council meetings and Executive Committee meetings.

The Executive Committee, comprised of the Chairperson and Vice-Chairperson, the Assistant Secretaries for Children and Families, Aging, Health, and Resource and Technology and the IEA Director, is authorized to act on behalf of the Council, and is responsible for overseeing Council functions and recommending subjects and actions for consideration by the full Council.

### **Management and Administration**

IEA's Principal Advisor on Tribal Affairs serves as the principal management officer for all Council functions, including management and administration of Council activities, the administration of funds provided for Council activities, and in consultation with the Executive Committee, preparation of agendas for Council meetings, and maintaining records of Council business, including minutes from Council meetings. The Principal Advisor is the primary liaison between Council members, and other Federal agencies, and reports directly to the Council Chairperson and Vice-Chairperson. The Council meets no less than twice a year. At least one Council tribal liaison has been appointed by each ICNAA member to work with IEA on special projects, and on the implementation of Secretarial initiatives and policies affecting AI/AN/NAs.

A key element of the Office of Intergovernmental and External Affairs (IEA) mission is to facilitate communication regarding health and human services (HHS) initiatives as they relate to state, local, and tribal governments. The Office of Tribal Affairs within IEA coordinates and manages IEA's tribal and native policy issues, assists tribes in navigating through HHS programs and services, and coordinates the Secretary's policy development for tribes and national native organizations. The ten Regional Offices housed in IEA are one of the key components in the ongoing relationship building HHS has with all the federally recognized tribes in the United States.

The ten Regional Offices (ORD) are the lead organizers of the annual regional tribal consultations. In this responsibility the ORD in conjunction with the tribal leaders in their respective region plan, coordinate, and conduct consultation meetings. At these meetings the tribal leaders meet with HHS Regional Operating Division staff as well as HHS headquarters leadership to discuss policy changes that impact their respective tribal community. This true government-to-government conversation reaffirms and promotes the sustaining relationships the ORD has with the tribal leaders.

Throughout the year, the ORD continues these exchanges and addresses all the ICNAA priorities. ORD bi-monthly report document this activity, but the constant and consistent interaction the ORD has with the tribal leaders cannot be overlooked. The meetings, phone calls, and emails, though too numerous to list; represent the groundwork of the relationship that the ORD has with the tribes. The ORD and the work of ICNAA go hand in hand. The tribal consultations and the daily connections with tribal leaders allow the ORD to deepen the connections with Indian Country.

### **Status and Activities**

Tribal consultation activities across HHS, is an ICNAA priority and is required by Presidential Order 13175. The annual two day HHS Tribal Budget Consultation sessions as well as the regional HHS Tribal consultations have proven to be very successful in assuring that AI/AN

communities have an opportunity to communicate their health and human services needs and priorities to high level HHS officials.

Although, the Indian Health Service serves as the main conduit for the provision of federally supported health care for federally recognized tribal nations, this responsibility is shared with all HHS agencies because of the overarching government to government relationship between the federal government and the 565 tribal nations. ICNAA serves to support this relationship across all of HHS which fosters a more meaningful provision of health and human services for AI/AN/NA communities.

Accomplishments are expected to continue in order that more HHS resources are made available to AI/AN/NAs communities by analyzing and instituting the next level of recommendations of the Barriers Study; to continue to support HHS-wide tribal consultation; support new initiatives and to continue to serve as the HHS focal point for Native American health and human services.

**The 2011 priorities of the Council were:**

1. Access and Availability
2. Outreach and Technical Assistance
3. Grants Eligibility Review
4. Expansion of Services (Self Governance Expansion)

Access and Availability

The ICNAA worked to develop, implement, and evaluate a comprehensive initiative to increase Tribal accessibility to HHS Federal Financial Assistance Programs. The following activities were completed to increase access and availability:

- The Grants Forecast Tool has been updated to highlight Tribal eligibility where it is explicitly known. There are specifically 55 records that show Native American / Tribal Organizations as eligible entities. The ICNAA will send out notices to each of the program offices alerting the broader community and encouraging them to continue to make these opportunities explicitly state where Tribes are eligible. We will also ask them to continue to work with their respective OGC where their statue is silent, in light of the ICNAA's activities.
- An awareness training was conducted on December 6th, 2011 to HHS OPDIV grants and program officials to offer ways to improve Tribal access. The "Supporting Tribal Access to Grants" workshop was held and included strategies for partnering with the Office of Grants Policy Oversight, and Evaluation to assist in bridging barriers to obtaining maximum grant funding opportunities for Tribal governments. This training aimed to increase the Tribes' ability to complete the life cycle of a grant. 200 grants and program officials from across the Department attended the training. Evaluations were given following the training and follow up evaluations will be conducted at the six month and one year marks.

Outreach and Technical Assistance

The ICNAA worked to address outreach and technical assistance issues. The following activities were completed to improve outreach and technical assistance throughout the Department:

- In order to formulate next steps to improve our outreach to Native Americans, the ICNAA needed to first understand the extent and depth of the technical assistance that HHS currently provides. The ICNAA developed a survey document to query each of the operating divisions within the Department on whether or not they provide technical

assistance to potential applicants and grantees and the kind of technical assistance they provide. The survey consisted of approximately 20 questions. Results were analyzed and next steps are being determined.

### Grants Eligibility Review

The ICNAA worked to determine the funding opportunities, for which Tribes are eligible, so Tribes and HHS can identify priorities for technical assistance on application processes. In this process the ICNAA will also determine the funding opportunities, for which Tribes are not eligible, identify the nature of the barrier, so that HHS and Tribes can identify priorities and develop options to reduce them.

- Each operating division has identified funding opportunities for which Tribes are eligible or ineligible
- Where Tribes have been determined as ineligible, the nature of the barrier (law, regulations, policy/program instruction, other) has been identified
- Next steps include gathering feedback from the Secretary's Tribal Advisory Committee on determining priorities for policy or regulation change

### Expansion of Services and Pilot Development (Self Governance Expansion)

The ICNAA worked to determine what self governance expansion would look like at the Department of Health and Human Services. Activities in 2011 included:

- Reviewed the previously completed HHS feasibility study on the expansion of Tribal Self governance to other parts of HHS. We then posed two questions: 1) Did any HHS programs have existing legislative or regulatory authority that would allow for a demonstration project as proposed by the feasibility study under Title VI of the Indian Self Determination and Educational Assistance Act (ISDEAA)?; and 2) If not, does any existing program have authority to permit a demonstration project that would allow tribes more flexibility and authority over their decision-making?
- Held a series of detailed conversations to solicit the thoughts and feedback of Tribal Leaders and self governance experts
- Developed a list of questions to help HHS move forward with understanding from the Tribes more about expansion of services. In late October, the department sent Tribal leaders a letter regarding the status of Self Governance within HHS, to request Tribal input on self-governance expansion, announce two education sessions, as well as to solicit nominations for a Tribal Federal Workgroup
- The first education session was held November 30<sup>th</sup> in Washington, DC and the second was held on December 13<sup>th</sup> in Minneapolis, Minnesota. Nominations for the Tribal Federal Workgroup were received and members were selected and notified of their selection
- The first meeting of the Tribal Federal Workgroup is set to occur on February 2, 2012

### **Plans for 2012**

The Council met in December 2011 to address the Council activities and plans for this upcoming year. The ICNAA Leadership charged HHS to continue progressing with the priorities identified in 2011. In addition to continuing the work on the priorities of 2011, improving Tribal/State relations has been included as a new initiative of focus for the ICNAA.





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United States Department of Health and Human Services

## **APPENDICES**

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**U.S. Department of Health & Human Services  
2011 Annual Tribal Consultation Report**

**APPENDIX I**

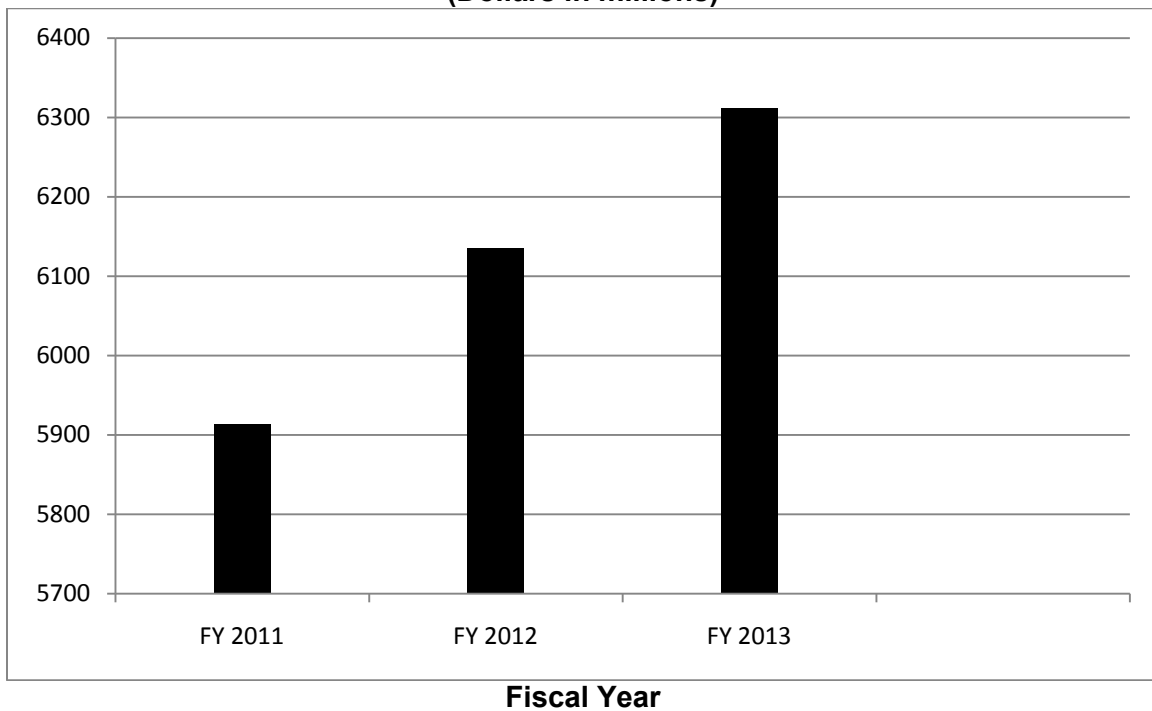
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**HHS TRIBAL BUDGET**

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**HHS Tribal Resource Trends  
FY 2011 – 2013**

(Dollars in millions)



**FY 2011-2013 HHS FUNDING  
FOR AMERICAN INDIANS AND ALASKA NATIVES  
(dollars in millions)**

Program	FY 2011	FY 2012	FY 2013	+/- FY 2012
			President's Budget	
<b>Indian Health Service: 1/.....</b>	<b>5,140.2</b>	<b>5,385.7</b>	<b>5,501.7</b>	<b>+115.9</b>
<b>Administration For Children and Families (ACF):</b>				
Native American Programs.....	48.7	48.6	48.6	--
Head Start.....	214.9	224.6	225.9	+1.3
Low-Income Home Energy Assistance Program.....	53.4	38.5	31.4	-7.1
Child Care & Development Block Grant.....	44.5	45.6	46.1	+0.5
Child Care Entitlement.....	58.3	58.3	68.3	+10.0
Family Violence/Grants for Battered Women's Shelters ACF-2/	13.0	13.0	13.5	+0.5
Developmental Disabilities.....	0.2	0.2	0.2	--
Community Services Block Grant .....	4.9	2.5		-2.5
Community-Based Child Abuse Prevention.....	0.4	0.4	0.4	--
Promoting Safe and Stable Families .....	11.7	12.0	12.0	--
Tribal TANF Grants.....	181.7	181.0	181.0	--
TANF Healthy Marriage Promotion and Responsible Fatherhood (Tribal TANF- Child Welfare Coordination)	1.5	1.5	1.5	--
Tribal Work Programs.....	7.6	7.6	7.6	--
Tribal Child Support.....	42.0	35.0	42.0	+7.0
Child Welfare Services (IV-B).....	6.2	5.1	2.2	-2.9
Foster Care (Title IV-E).....	7.6	6.0	19.0	+13.0
<b>Subtotal, ACF.....</b>	<b>696.6</b>	<b>679.9</b>	<b>699.7</b>	<b>+20</b>
<b>Health Resources and Services Administration:</b>				
Health Centers - Native HI Program	14.2	14.2	14.2	--
Centers of Excellence.....	1.2	1.1	1.1	--
Health Careers Opportunity Program.....	0.9	0.6	--	-0.6
Patient Navigator and Chronic Disease Prevention.....	5.0	--	--	--

Program	FY 2011	FY 2012	FY 2013	
			President's Budget	+/- FY 2012
<b>Subtotal, HRSA.....</b>	<b>21.3</b>	<b>15.9</b>	<b>15.3</b>	<b>-0.6</b>
<b>Administration on Aging:</b>				
Native American Caregiver Support Program.....	6.4	6.4	6.4	--
NSIP (Title VI).....	3.2	3.2	3.2	--
Native American Elder Rights (APS).....	--	--	1.0	+1.0
National Resource Centers on Native Americans.....	0.7	0.7	0.7	--
National Minority Aging Organizations: Native Americans	0.1	0.1	0.1	--
Native American Nutrition and Supportive Services...	<u>27.7</u>	<u>27.6</u>	<u>27.6</u>	<u>--</u>
<b>Subtotal, AoA.....</b>	<b>38.0</b>	<b>38.0</b>	<b>39.0</b>	<b>+1.0</b>
<b>Centers For Disease Control and Prevention:</b>				
Preventive Health and Health Services Block Grant...	0.1	--	--	--
Local STD screening and treatment.....	<u>1.6</u>	<u>1.6</u>	<u>1.6</u>	<u>--</u>
<b>Subtotal, CDC.....</b>	<b>1.7</b>	<b>1.6</b>	<b>1.6</b>	<b>--</b>
<b>Substance Abuse &amp; Mental Health Services Administration (SAMHSA):</b>				
Mental Health				
Programs of Regional and National Significance.....	5.9	5.1	5.1	--
Children's Mental Health Services.....	8.9	8.2	8.2	--
Protection and Advocacy.....	0.2	0.2	0.2	--
Health Surveillance and Program Support				--
Behavioral Health - Tribal Prevention Grant.....	--	--	40.0	+40.0
Substance Abuse Treatment				--
Substance Abuse Block Grant.....	<u>0.6</u>	<u>0.5</u>	<u>0.5</u>	<u>--</u>
<b>Subtotal, SAMHSA.....</b>	<b>15.6</b>	<b>14.0</b>	<b>54.0</b>	<b>+40.0</b>
HHS TOTAL (excluding IHS).....	773.2	749.4	809.6	+60.2
<b>HHS TOTAL.....</b>	<b>5,913.4</b>	<b>6,135.1</b>	<b>6,311.3</b>	<b>+176.2</b>

\*1/ Includes insurance collections, rental of staff quarters and mandatory diabetes funding.



**U.S. Department of Health & Human Services  
2011 Annual Tribal Consultation Report**

**APPENDIX II**

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**UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES  
TRIBAL CONSULTATION POLICY**

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**U. S DEPARTMENT OF HEALTH AND HUMAN SERVICES  
TRIBAL CONSULTATION POLICY**

1. Purpose
2. Background
3. Tribal Sovereignty
4. Policy
5. Philosophy
6. Objectives
7. Consultation Participants and Roles
8. Tribal Consultation Process
9. Consultation Procedures and Responsibilities
10. Establishment Of Joint Tribal/Federal Workgroups And/Or Taskforces
11. Health and Human Services Budget Formulation
12. Tribal Consultation Performance And Accountability
13. Evaluation, Recording Of Meetings And Reporting
14. Conflict Resolution
15. Tribal Waiver
16. Effective Date
17. Definitions
18. Acronyms

**4. PURPOSE**

The U. S. Department of Health and Human Services (HHS) and Indian Tribes share the goal to establish clear policies to further the government-to-government relationship between the Federal Government and Indian Tribes. True and effective consultation shall result in information exchange, mutual understanding, and informed decision-making on behalf of the Tribal governments involved and the Federal Government. The importance of consultation with Indian Tribes was affirmed through Presidential Memoranda in 1994, 2004 and 2009, and an Executive Order (EO) in 2000.

The goal of this policy includes, but is not limited to, eliminating health and human service disparities of Indians, ensuring that access to critical health and human services is maximized, and to advance or enhance the social, physical, and economic status of Indians. To achieve this goal, and to the extent practicable and permitted by law, it is essential that Federally-recognized Indian Tribes and the HHS engage in open, continuous, and meaningful consultation.

This policy applies to all Divisions of the Department and shall serve as a guide for Tribes to participate in all Department and Division policy development to the greatest extent practicable and permitted by law.

## **5. BACKGROUND**

Since the formation of the Union, the United States (U.S.) has recognized Indian Tribes as sovereign nations. A unique government-to-government relationship exists between Indian Tribes and the Federal Government. This relationship is grounded in the U.S. Constitution, numerous treaties, statutes, Federal case law, regulations and executive orders that establish and define a trust relationship with Indian Tribes. This relationship is derived from the political and legal relationship that Indian Tribes have with the Federal Government and is not based upon race.

An integral element of this government-to-government relationship is that consultation occurs with Indian Tribes. The Executive Memorandum titled “Tribal Consultation” reaffirmed this government-to-government relationship with Indian Tribes on November 5, 2009. The implementation of this policy is in recognition of this special relationship.

This special relationship is affirmed in statutes and various Presidential Executive Orders including, but not limited to:

- Older Americans Act, P.L. 89-73, as amended;
- Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended;
- Native American Programs Act, P.L. 93-644, as amended;
- Indian Health Care Improvement Act, P.L. 94-437, as amended;
- Personal Responsibility and Work Opportunity Reconciliation Act of 1996, P.L.104-193;
- Presidential Executive Memorandum to the Heads of Executive Departments dated April 29, 1994;
- 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
- Presidential Memorandum, Tribal Consultation, November 5, 2009
- American Recovery and Reinvestment Act of 2009, P.L. 111-5, 123 Stat. 115 (Feb. 17, 2009).
- Children's Health Insurance Program Reauthorization Act of 2009, P.L. 111-3, 123 Stat. 8 (Feb. 4, 2009).
- Patient Protection and Affordable Care Act of 2010, P.L. 111-148, 124 Stat. 119 (Mar. 23, 2010).

## 6. TRIBAL SOVEREIGNTY

This policy does not waive any Tribal Governmental rights and authority, including treaty rights, sovereign immunities or jurisdiction. Additionally, this policy does not diminish any rights or protections afforded other American Indians or Alaskan Natives (AI/AN) or entities under Federal law.

The special government-to-government relationship between the Federal Government and Indian Tribes, established in 1787, is based on the Constitution, and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders, and reaffirms the right of Indian Tribes to self-government and self-determination. Indian Tribes exercise inherent sovereign powers over their citizens and territory. The U.S. shall continue to work with Indian Tribes on a government-to-government basis to address issues concerning Tribal self-government, Tribal trust resources, Tribal treaties and other rights.

Tribal self-government has been demonstrated to improve and perpetuate the government-to-government relationship and strengthen Tribal control over Federal funding that it receives, and its internal program management. Indian Tribes participation in the development of public health and human services policy ensures locally relevant and culturally appropriate approaches to public issues.

## 7. POLICY

Before any action is taken that will significantly affect Indian Tribes it is the HHS policy that, to the extent practicable and permitted by law, consultation with Indian Tribes will occur. Such actions refer to policies that:

1. Have Tribal implications, and
2. Have substantial direct effects on one or more Indian Tribes, or
3. On the relationship between the Federal Government and Indian Tribes, or
4. On the distribution of power and responsibilities between the Federal Government and Indian Tribes.

Nothing in this policy waives the Government's deliberative process privilege. Examples of the government's deliberative process privilege are as follows:

1. The Department 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.
2. In specified instances Congress requires the Department to work with Indian Tribes on the development of recommendations that may require legislation, such reports, recommendations or other products are developed independent of a Department position, the development of which is governed by Office of Management and Budget (OMB) Circular A-19.

- A. Each HHS Operating and Staff Division (Division) shall have an accountable process as defined in Sections 8 and 9 of this policy to ensure meaningful and timely input by Indian Tribes in the development of policies that have Tribal implications. If Divisions require technical assistance in implementing these sections, the Office of Intergovernmental Affairs (IGA) can provide and/or coordinate assistance.
- B. To the extent practicable and permitted by law, no Division shall promulgate any regulation that has Tribal implications, or that imposes substantial direct compliance costs on Indian Tribes, or that is not required by statute, unless:
  - 1. Funds necessary to pay the direct costs incurred by the Indian Tribe in complying with the regulation are provided by the Federal Government; or
  - 2. The Division, prior to the formal promulgation of the regulation,
    - a. Consulted with Indian Tribes throughout all stages of the process of developing the proposed regulation;
    - b. Provided a Tribal summary impact statement in a separately identified portion of the preamble to the regulation as it is to be issued in the Federal Register (FR), which consists of a description of the extent of the Division's prior consultation with Indian Tribes, a summary of the nature of their concerns and the Division'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. Made available to the Secretary and to the Director of OMB any written communications submitted to the Division by Tribal officials.
- C. To the extent practicable and permitted by law, no Division shall promulgate any regulation that has Tribal implications and that preempts Tribal law unless the Division, prior to the formal promulgation of the regulation,
  - 1. Consulted with Tribal officials throughout all stages of the process of developing the proposed regulation;
  - 2. Provided a Tribal summary impact statement in a separately identified portion of the preamble to the regulation as it is to be issued in the FR, which consists of a description of the extent of the Division's prior consultation with Tribal officials, a summary of the nature of their concerns and the Division'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. Made available to the Secretary any written communications submitted to the Division by Tribal officials.
- D. On issues relating to Tribal self-governance, Tribal self-determination, Tribal trust resources, or Tribal treaty and other rights, each Division shall make all practicable attempts where appropriate to use consensual mechanisms for developing regulations, including negotiated rulemaking.



## 5. PHILOSOPHY

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

HHS has a long-standing commitment to working on a government-to-government basis with Indian Tribes and to work in partnership with AI/ANs. Also, HHS is committed to enhancing the collaboration among its Divisions to address Tribal issues and promoting the principle that each Division bears responsibility for addressing Tribal issues within the context of their mission.

IGA is identified as the responsible HHS entity, located in the Immediate Office of the Secretary (IOS) for monitoring compliance with EO 13175 and the Department Tribal Consultation Policy. In addition, the Secretary has charged the Intradepartmental Council on Native American Affairs (ICNAA) to meet regularly and no less than 2 times a year and to provide advice on all HHS policies that relate to Indian Tribes as well as instances where HHS activities relate to Native Americans. Regional consultation sessions have been developed as a systematic method to regularly consult with Indian Tribes on HHS programs at field locations. The goal of these efforts is to focus HHS on Tribal issues, to continue to enhance the government-to-government relationship between Indian Tribes and the U.S., as well as to make resources of HHS more readily available to Indian Tribes.

## 6. OBJECTIVES

4. To formalize the Administration's policy that HHS seek consultation and the participation of Indian Tribes in the development of policies and program activities that impact Indian Tribes.
5. To establish a minimum set of requirements and expectations with respect to consultation and participation throughout HHS management, the Office of the Secretary (OS) Division, and Regional levels.
6. The need to consult may be identified by the Department or by an Indian Tribe(s). Any time the Tribe(s) or the Department identifies a critical event the Department may initiate any necessary consultation in accordance with this policy.
7. To identify events and partnerships that HHS would participate with Indian Tribe(s) and Tribal/Indian Organizations that establish and foster partnerships with HHS which complement and enhance consultation with Indian Tribes.
8. To promote and develop innovative consultation methods with Indian Tribes in the development of HHS policy and regulatory processes.
9. To uphold the responsibility of HHS to consult with Indian Tribes on new and existing health and human service policies, programs, functions, services and activities that have Tribal implications.
10. To charge and hold accountable each of the HHS Operating Division Heads for the implementation of this policy.
11. To be responsive to requests by an Indian Tribe(s) request for consultation and technical assistance in obtaining HHS resources.
12. To charge the HHS Operating Divisions with the responsibility for enhancing partnerships with Indian Tribes which will include, requests for technical

assistance, access to programs and resources, as well as collaborating with Tribal subject matter expertise.

13. To provide a single point of contact within HHS and its Operating Divisions for Indian Tribes at the highest level which would have access to the IOS, the Deputy Secretary, and Operating Division Heads. The Principal Advisor for Tribal Affairs and the Division Tribal points of contact will be responsible for compliance with this policy and ensuring timeframes identified in section 9 are met.

## 7. CONSULTATION PARTICIPANTS AND ROLES

7. **Indian Tribes:** The government-to-government relationship between the U.S. and Federally recognized Indian Tribes dictates that the principal focus for HHS consultation is Indian Tribes, individually or collectively.
8. **Indian Organizations:** At times it is useful that the HHS communicate with Indian organizations to solicit Indian Tribe(s) advice and recommendations. The government does not participate in government-to-government consultations with these entities; rather these organizations represent the interest of Indian Tribes when authorized by those Tribes. These organizations by the sheer nature of their business serve and advocate Indian Tribes issues and concerns that might be negatively affected if these organizations were excluded from the process.
9. **Office of Intergovernmental Affairs (IGA):** IGA is responsible for Department-wide implementation and monitoring of EO 13175 for HHS Tribal consultation. IGA serves as the Department's point of contact in accessing department-wide information. The single point of contact within the IGA for Indian Tribes and other Tribal/Indian organizations, at a level with access to all HHS Divisions, is the Principal Advisor for Tribal Affairs. As a part of the IOS, IGA's mission is to facilitate communication regarding HHS initiatives as they relate to Tribal, State, and local governments. IGA is the Departmental liaison to States and Indian Tribes, and serves the dual role of representing the States and Tribal perspective in the Federal policymaking process, as well as, clarifying the Federal perspective to States and Indian Tribes, including Tribal consultation.
10. **Assistant Secretary for Finance and Resources (ASFR):** ASFR is the lead office for budget consultation for the overall departmental budget request.
11. **HHS Divisions:** The Department has numerous Staff Divisions and Operating Divisions under its purview. Each of these Divisions share in the Department-wide responsibility to coordinate, communicate and consult with Indian Tribes on issues that affect these governments. All Operating Divisions shall establish a Tribal consultation policy to comply with the HHS Policy. All Divisions are responsible for conducting Tribal consultation to the extent practicable and permitted by law on policies that have Tribal implications.
12. **Intradepartmental Council on Native American Affairs(ICNAA):** The ICNAA is charged with: (1) develop and promote an HHS policy to provide greater access and quality services for AI/AN/NA throughout the Department; (2) promote implementation of HHS policy and Division plans on consultation with Indian Tribes in accordance with statutes and EOs; (3) promote an effective, meaningful AI/AN/NA policy to improve health and human services for AI/AN/NA; (4) develop a comprehensive Departmental strategy that promotes self-sufficiency and self-determination for all Indian Tribes and AI/AN/NA people; (5) promote the Tribal/Federal Government-to-government relationship on an HHS-wide basis in accordance with EO 13175; and (6) operate in accordance

with policy and timeframes identified within ICNAA charter and as directed by the Secretary and the ICNAA Executive Leadership.

13. **Regional Offices:** The ten (10) HHS Regional Offices share in the Department-wide responsibility to consult, coordinate and communicate with Indian Tribes on issues that affect Indian Tribes and HHS programs, services and resources available to Indian Tribes through States. The Regional Directors are the Secretary's immediate representatives in the field for the HHS. Each of the Regional Office(s) shall conduct an annual regional Tribal consultation meeting with Indian Tribes in their respective regions. Additional meetings may be conducted if requested by the Regional Director or an Indian Tribe(s) within the Region. Further, the Regional Directors will work closely with the respective Indian Tribes and State Governments to assure continuous coordination and communication between Tribes and States. The Regional Office Directors will promote and comply with this policy and its timeframes identified in Section 9.

## 8. TRIBAL CONSULTATION PROCESS

An effective consultation between HHS and Indian Tribes requires trust between all parties which is an indispensable element in establishing a good consultative relationship. The degree and extent of consultation will depend on the identified critical event. A critical event may be identified by HHS and/or an Indian Tribe(s). Upon identification of an event significantly affecting one or more Indian Tribe(s), HHS will initiate consultation regarding the event. In order to initiate and conduct consultation, the following serves as a guideline to be utilized by HHS and Indian Tribes:

5. Identify the Critical Event: Complexity, implications, time constraints, and issue(s) (including policy, funding/budget development, programs, services, functions and activities).
  6. Identify affected/potentially affected Indian Tribe(s)
  7. Determine Consultation Mechanism – The most useful and appropriate consultation mechanisms can be determined by HHS and/or Indian Tribe(s) after considering the critical event and Indian Tribe(s) affected/potentially affected. Consultation mechanisms include but are not limited to one or more of the following:
    - a. Mailings
    - b. Teleconference
    - c. Face-to-Face Meetings at the Local, Regional and National levels between the HHS and Indian Tribes.
    - d. Roundtables
    - e. Annual HHS Tribal Budget and Policy Consultation Sessions.
    - f. Other regular or special HHS Division or program level consultation sessions.
- A. Communication Methods:** The determination of the critical event and the level of consultation mechanism to be used shall be communicated to affected/potentially affected Indian Tribe(s) using all appropriate methods and with as much advance notice as practicable. These methods include but are not limited to the following:
12. **Correspondence:** Written communications shall be issued within 30 calendar days of an identified critical event. The communication should clearly provide

affected/potentially affected Indian Tribe(s) with detail of the critical event, the manner and timeframe in which to provide comment. The HHS frequently uses a “Dear Tribal Leader Letter” (DTLL) format to notify individual Indian Tribes of consultation activities. Divisions should work closely with the Principal Advisor for Tribal Affairs, IOS/IGA if technical assistance is required for proper format and protocols, current mailing lists, and content.

13. **Official Notification:** Within 30 calendar days, and upon the determination the consultation mechanism, proper notice of the critical event and the consultation mechanism utilized shall be communicated to affected/potentially affected Indian Tribe(s) using all appropriate methods including mailing, broadcast e-mail, FR, and other outlets. The FR is the most formal HHS form of notice used for consultation.
  14. **Meeting(s):** The Division shall convene a meeting, within 60 calendar days of official notification, with affected/potentially affected Indian Tribe(s) to discuss all pertinent issues in a national, regional, and/or local forum, or as appropriate, to the extent practicable and permitted by law, when the critical event is determined to have substantial impact.
  15. **Receipt of Tribal Comment(s):** The Division shall develop and use all appropriate methods to communicate clear and explicit instructions on the means and time frames for Indian Tribe(s) to submit comments on the critical event, whether in person, by teleconference, and/or in writing and shall solicit the advice and assistance of the Principal Advisor for Tribal Affairs, IOS/IGA.
  16. **Reporting of Outcome:** The Division shall report on the outcomes of the consultation within 90 calendar days of final consultation. For ongoing issues identified during the consultation, the Division shall provide status reports throughout the year to IOS/IGA and Indian Tribe(s).
- A. HHS Response to Official Tribal Correspondence:** Official correspondence from an Indian Tribe may come in various forms, but a resolution is the most formal declaration of an Indian Tribe’s position for the purpose of Tribal consultation. In some instances, Indian Tribes will submit official correspondence from the highest elected and/or appointed official(s) of the Tribe. HHS will give equal consideration to these types of correspondence. Once HHS receives an official Indian Tribe correspondence and/or resolution, the Secretary/Deputy Secretary and/or their designee should respond appropriately. The process for official correspondence to Indian Tribes is described below:
5. Correspondence submitted by Indian Tribes to HHS shall be officially entered into HHS correspondence control tracking system and referred to the appropriate Division(s).
  6. Acknowledgement of Correspondence: HHS and/or Divisions shall provide acknowledgement to Indian Tribes within 15 working days of receipt.
  7. Official Response to an identified critical event: HHS shall provide an official response to Indian Tribes that includes: the Division head responsible for follow up, the process for resolution of the critical event and timeline for resolution.

- a. If an identified critical event is national in scope the Department shall to the extent practicable respond to the request within 60 working days or less.
- b. If a critical event is specific to a single Indian Tribe the Department shall to the extent practicable respond to the request within 45 working days or less.

**B. Policy Development through Tribal Consultation Process:** The need to consult on the development or revision of a policy may be identified from within HHS, an HHS Division or may be identified by Indian Tribes. This need may result from external forces such as Executive, Judicial, or Legislative Branch actions or otherwise. Once the need to consult on development or revision of a policy is identified the consultation process must begin in accordance with critical events and consultation mechanisms described above. HHS Divisions may request technical assistance from IGA for the Tribal consultation process.

**C. Schedule for Consultation:** Divisions must establish and adhere to a formal schedule of meetings to consult with Indian Tribes and their representatives concerning the planning, conduct, and administration of applicable activities. Divisions must involve Tribal representatives in meetings at every practicable opportunity. Divisions are encouraged to establish additional forums for Tribal consultation and participation, and for information sharing with Tribal leadership. Consultation schedules should be coordinated with IGA to avoid duplications or conflicts with other national Tribal events. HHS Divisions should make every effort to schedule their consultations in conjunction with the Annual Regional Tribal Consultation Sessions.

## 9. CONSULTATION PROCEDURES AND RESPONSIBILITIES

The HHS Tribal consultative process shall consist of direct communications with Indian Tribes, and Indian organizations as applicable, in various ways:

- B. Consultation Parties and Mechanisms- Consultation Occurs:**
1. When the HHS Secretary/Deputy Secretary, or their designee, meets and/or exchanges written correspondence with a Tribal President/Chair/Governor/Chief/Principal Chief and/or elected/appointed Indian Tribal Leader, or their designee to discuss issues concerning either party.
  2. When an HHS Division Head, or their designee, meets or exchanges written correspondence with an Indian Tribal representative designated by an elected/appointed Tribal leader to discuss issues or concerns of either party.
  3. When an HHS Regional Director, who is the Secretary's representative in the field, meets or exchanges written correspondence with an elected/appointed Indian Tribal Leader, or their designee to discuss issues or concerns of either party.
  4. When the Secretary/Deputy Secretary/HHS Division Head, or their designee, meets or exchanges written correspondence with a Tribal representative designated by an elected/appointed Indian Tribal leader to discuss issues or concern of either party.

## B. Consultation Procedures

1. **Tribal:** Specific consultation mechanisms that will be used to consult with an Indian Tribe(s) include but are not limited to mailings, meetings, teleconference and roundtables.
  - a. An Indian Tribe(s) has the ability to initiate consultation, i.e. meet one-on-one with an HHS Division Head or designated representative to consult on issues specific to that Indian Tribe.
  - b. HHS Division Heads will initiate consultation to solicit official Indian Tribe(s)' comments and recommendations on policy and budget matters affecting Indian Tribe(s). These sessions at roundtables, forums and meetings will provide the opportunity for meaningful dialogue and effective participation by Indian Tribe(s).
  - c. National/Regional Inter-Tribal Forums: Other types of meetings and/or conferences occur which may not be considered consultation sessions, but these meetings may provide opportunities to share information, conduct workshops, and provide technical assistance to Indian Tribes.
2. **HHS:** Consultation mechanisms that will be used to consult with Indian Tribe(s) include but are not limited to mailings, meetings, teleconferences and roundtables. HHS has various organizational avenues in which Tribal issues and concerns are addressed. These avenues include the OS, the ICNAA, Regional Offices, and Divisions.

1. **Office of the Secretary**

- a. The HHS National Tribal Consultation Sessions are designed to solicit Indian Tribes' health and human services priorities and program needs. The Sessions provide an opportunity for Indian Tribes to articulate their recommendations on budgets, regulations, policies and legislation.
  - i. Upon completion of consultation, HHS will document and notify Indian Tribes on the proceedings, noting positions and following-up on all issues raised that would benefit from ongoing consultation with Indian Tribe(s) within 90 calendar days.

2. **ICNAA**

- a. The ICNAA represents the internal HHS team providing consistent direction across the Divisions for AI/AN/NA issues. One of the primary responsibilities of ICNAA is to solicit Tribal input in establishing Tribal policy and budget priorities and recommendations for Divisions.

The health and human service priorities established by Indian Tribes are used to inform the development of the Divisions' annual performance goals and measures for improving health and human services, which are linked to their budget requests.

3. **Regional Offices**

- a. Regional Offices will work with the Indian Tribes and Indian organizations within their respective regional area in facilitating the

Tribal perspective with HHS programs, services, functions, activities and planning Tribal regional consultation sessions. HHS Divisions have various geographic coverage, however all HHS Divisions, regardless of geographic location, are intended to serve Indian Tribe(s) in their respective locations.

- b. Regional Offices/Directors will work collaboratively with the HHS Division lead regional representative in communicating and coordinating on issues and concerns of Indian Tribes in those respective regions or areas.
  - c. Regional Offices/Directors will work collaboratively to facilitate Tribal-State relations as they affect Indian Tribes in the delivery of HHS programs and services.
  - d. Regional Tribal Consultation Sessions are held to solicit Indian Tribe(s)' priorities and needs on health and human services. The sessions also provide Indian Tribes with a regional perspective and shall be held, at least but not limited to, annually with status reports to Indian Tribe(s) as appropriate throughout the year, or at least biannually.
9. Regional Consultations will occur between February and April of every year.
  10. Regional Consultations shall be utilized as a venue for Divisions to coordinate their consultation responsibilities in a manner that is feasible and convenient for Indian Tribes.
  11. Regional Offices/Directors will contact Indian Tribes and Indian Organizations in their respective regions to assist in the planning of the session. This will ensure inclusion of all perspectives and issues for the session.
  12. Protocol will ensure that the highest ranking official present from each respective Indian Tribe is given the opportunity to address the session first, followed by other elected officials, those designated by official letter to represent their respective Indian Tribe and representatives of Indian Organizations.
    - a. Official letter from the Indian Tribe designating a representative must be presented to Regional Director before the session begins.
  13. Regional Offices/Directors will seek the assistance of Tribal Leaders to assist with moderating the annual regional consultation session.
  14. The official record of every regional session will be left open for 30 calendar days after the conclusion of the session for submission of additional comments/materials from Indian Tribe(s)
  15. Regional Offices/Directors will provide a summary no later than 45 calendar days after the consultation of the session.
4. **HHS Divisions**
- a. Divisions will work collaboratively with the Indian Tribes on the development of consultation meetings, one-on-one meetings, roundtables, teleconferences and annual sessions.

- b. Divisions will work collaboratively with Indian Tribes on developing and implementing their respective Tribal Consultation Policy or Plan.
  - c. Divisions will coordinate with IGA on their respective consultation activities in order to ensure that HHS and its Divisions are conducting Tribal consultation coordinating in a manner that is feasible and conducive to the needs of Indian Tribes.
  - d. Divisions will participate in both the Annual Tribal Budget and Policy Consultation Session and Annual Regional Tribal Consultations with Indian Tribes.
  - e. Divisions will work collaboratively to facilitate Tribal-State relations as they affect Indian Tribes and AI/ANs in the delivery of HHS programs and services.
3. **States:** In some instances the authority and program funding for HHS programs is administered by the States on behalf of Indian Tribes. The Divisions will consult with the Office of the General Counsel to determine whether these arrangements are based on statutes, regulations, or policy decisions. If there is no clear regulatory or statutory basis mandating that States administer the program on behalf of the Tribe(s), the Division will consult with the affected Indian Tribe(s) as soon as practicable to review alternate options.

If there is a statutory basis mandating that the State administer the program and associated funding on behalf of the Indian Tribe(s) the Division will examine the permissibility of encouraging or mandating a term requiring tribal consultation as a condition of the State's receipt of program funds. If such a term may be mandated regarding State administered programs affecting Indian Tribes it should be incorporated. If it is not permissible, the Division shall facilitate consultation between the State and affected Tribe(s).

In addition, whenever practicable and permitted by law, the Division shall notify Indian Tribes of funds administered by the State that the Division believes should be allocated to Indian Tribes.

The Division shall also encourage the State to recognize that Indian Tribal members are entitled to benefits provided to all State citizens and should be provided the same access to State administered or funded services since Tribal members are citizens of the State(s). To the extent possible, data shall be collected and reported about the number of Tribal members served by the State with federal resources.

#### **10. ESTABLISHMENT OF JOINT TRIBAL/FEDERAL WORKGROUPS AND/OR TASKFORCES CONSULTATION PROCEDURES AND RESPONSIBILITIES**

The need to develop or revise a policy may be identified from within the Division or by an Indian Tribe(s). When new or revised national policy, regulations or legislation affects an Indian Tribe(s), an Indian Tribe(s) or HHS may recommend the establishment of a workgroup and/or task force. In response, HHS may establish such a workgroup and/or task force to develop recommendations on various technical,



legal, regulatory, or policy issues. In such cases, see ADDENDUM 1 which outlines the process for establishing such aforementioned workgroups and/or task forces.

#### **14. HHS BUDGET FORMULATION**

HHS shall consult with Indian Tribes throughout the development of the HHS Budget formulation process to the greatest extent practicable and permitted by law. The Secretary shall require the Divisions to include a process in their Tribal Consultation Policy/Plan that assures Tribal priorities and needs and requests are identified and considered in the formulation of the HHS budget.

- A. HHS Annual Tribal Budget and Policy Consultation Session (ATBPCS):** A Department-wide Tribal budget and policy consultation session will be conducted annually to give Indian Tribes the opportunity to present their budget and policy priorities and recommendations to the Department as HHS prepares to receive the budget requests of its Divisions. The session is convened in March of each year as a means for final input in the development of the Department's budget submission to OMB.
1. At a minimum, HHS conducts annually one ATBPCS to ensure the active participation of Indian Tribes in the formulation of the HHS performance budget request as it pertains to Indian Tribes, which will be held at the HHS Headquarters in Washington, DC no later than March each year.
  2. HHS will notify Tribes of the date of the consultation no later than 90 days prior to the session.
  3. The session will not exceed two days.
  4. Each Operating Division Head/Deputy and budget officer will attend their agency's appropriate session(s).
  5. Each Operating Division Head/Deputy will participate in other portions of the ATBPCS that affect their respective division.
  6. IGA/ASFR will provide a summary of the session to Indian Tribes no later than 30 calendar days after the session has concluded.
  7. Within 90 calendar days IGA shall post the transcript of the ATBPCS with a summary of the Indian Tribes' issues/concerns presented at the session.
  8. HHS will seek the assistance of Indian Tribal Leaders to assist with moderating the ATBPCS. HHS will also contact Indian Organizations in the planning of the session in order to ensure inclusion of all perspectives and issues.
  9. Presentation protocol will ensure that the highest ranking official from each respective Tribe is given the opportunity to address the session first, followed by other elected officials, those designated by their elected official to represent their respective Indian Tribes and representatives of Indian/Tribal Organizations.
    - i. Official letter from the Indian Tribe designating a representative must be presented to IGA before the session begins.
- B. Performance Budget Formulation:** HHS IGA will ensure the active participation of Indian Tribes and Indian Organizations in the formulation and throughout the HHS performance budget request as it pertains to Indian Tribes to the greatest extent practicable and permitted by law.

- C. Budget Information Disclosure: HHS provides Indian Tribes the HHS budget related information on an annual basis: appropriations, allocation, expenditures, and funding levels for programs, services, functions, and activities.

## **15. TRIBAL CONSULTATION PERFORMANCE AND ACCOUNTABILITY**

HHS and its Divisions will measure and report results and outcomes of their Tribal consultation performance to fulfill the government-to-government relationship with Indian Tribes.

Parts of the HHS mission and performance objectives are designed to address the health and well-being of AI/ANs by providing for effective health and human services and by fostering strong, sustained advances in the sciences underlying medicine, public health and social services.

The Divisions shall utilize the Tribal Consultation Policy to address HHS's mission and performance objectives with respect to AI/ANs. HHS and its Divisions will follow the goals and objectives of the seated Secretary and Administration.

Divisions and Indian Tribes will also promote a collaborative atmosphere to gather, share, and collect data and other information to demonstrate the effective use of Federal resources in a manner that is consistent with OMB performance measures and requirements. Divisions shall consult, to the greatest extent practicable and permitted by law, with Indian Tribes before taking actions that substantially affect Indian Tribes, including regulatory practices on Federal matters and unfunded mandates.

## **16. EVALUATION, RECORDING OF MEETINGS AND REPORTING**

The consultation process and activities conducted within the policy should result in a meaningful outcome for the Department and for the affected Indian Tribes. To effectively evaluate the results of a particular consultation activity and the Department's ability to incorporate Indian Tribes' consultation input, the Department should measure, on an annual basis, the level of satisfaction of the Indian Tribes.

1. Divisions should develop and utilize appropriate evaluation measures to assess Indian Tribes' responses to Department consultation conducted during a specific period to determine if the intended purpose of the consultation was achieved and to receive recommendations to improve the consultation process.
  - a. The Divisions will maintain a record of the consultation, evaluate whether the intended results were achieved, and report back to the affected Indian tribe(s) on the status or outcome, including, but not limited to, the annual sessions conducted below.
2. At a minimum, HHS Regional Directors will conduct an Annual Regional Tribal Consultation to consult with Indian Tribes.
  - d. These sessions shall provide an opportunity to receive the Indian Tribe's priorities for budget, regulation, legislation, and other policy matters.
  - e. Consultation Sessions shall include evaluation components for receipt of verbal and written comments from participating Indian Tribes, HHS Divisions,

- and other invited participants to obtain immediate feedback on the consultation process for the session conducted.
- f. The Divisions and the Regional Directors will report at each regional Tribal consultation session regarding what substantive and procedural actions were taken as a result of the previous Tribal consultation session and describe how HHS addressed the consultation evaluation comments provided received by participants.
  - g. All national and regional consultation meetings and recommended actions shall be formally recorded and made available to Indian Tribes.
  - h. Once the consultation process is complete, and any policy decision is finalized, all recommended follow-up actions adopted shall be implemented and tracked by the appropriate Regions and/or Divisions and reported to the Indian Tribes in the IGA Annual Tribal Consultation Report.
  - i. Unless otherwise specified, the IGA Annual Consultation Report shall provide an annual reporting mechanism for this purpose and all HHS Divisions are required to participate in providing information for this report.
3. IGA will seek Tribal feedback to assist in measuring and evaluating the implementation and effectiveness of this Policy. IGA will assess the Department Tribal Consultation Policy on an ongoing basis and utilize comments from Indian Tribes and Federal participants to determine whether amendment to the Policy may be required. If amendment is needed, IGA will convene a Tribal-Federal workgroup.
  7. Divisions are required to submit to IGA their fiscal year Tribal consultation information within 90 calendar days from the end of the fiscal year. IGA shall compile the Division submissions, and publish and distribute the information to the Indian Tribes within 60 calendar days from receipt of the Division reports. The IGA, Regional Directors and Divisions shall also report the Department's views on the level of attendance and response from Tribal leaders during the Annual Tribal Budget and Policy Consultation Session and the Annual Regional Tribal Consultation Sessions, including evaluative comments, and provide advice and recommendations regarding the Tribal consultation process. The IGA shall post on the HHS website, the IGA Annual Tribal Consultation Report, including the evaluation results.

## **17. CONFLICT RESOLUTION**

The intent of this policy is to promote partnership with Indian Tribes that enhance the Department's ability to address issues, needs and problem resolution. Agencies shall consult with Indian Tribes to establish a clearly defined conflict resolution process under which Indian Tribes bring forward concerns which have a substantial direct effect. However, Indian Tribes and HHS may not always agree and inherent in the government-to-government relationship, Indian Tribes may elevate an issue of importance to a higher or separate decision-making authority.

Nothing in the Policy creates a right of action against the Department for failure to comply with this Policy.

## 18. TRIBAL WAIVER

Divisions shall review and streamline the processes under which Indian Tribe may apply for waivers of statutory, regulatory, policy, or procedural requirements. Each Division shall, to the extent practicable and permitted by law, consider any application by an Indian Tribe for a waiver with a general view toward increasing opportunities for utilizing flexible approaches at the Indian Tribal level when the proposed waiver is consistent with the applicable Federal policy objectives and is otherwise appropriate. Each Division shall, to the extent practicable and permitted by law, render a decision upon a complete application for a waiver within 120 calendar days of receipt, or as otherwise provided by law or regulation. If the application for waiver is not granted, the Division shall provide the applicant with timely written notice of the decision and the reasons therefore. Waiver requests for statutory or regulatory requirements apply only to statutory or regulatory requirements that are discretionary and subject to waiver by the Division.

## 19. EFFECTIVE DATE

This policy is effective on the date of the signature by the Secretary of Health and Human Services.

This policy replaces the Tribal Consultation Policy signed on February 1, 2008, and it applies to all Operating Divisions and Staff Divisions. Operating Divisions shall complete necessary revisions to their existing Division consultation policy/plan to conform to the revised Department Tribal Consultation Policy. Operating Divisions without a consultation policy shall utilize the guidance of the OS policy until the development of their respective policy.

## 20. DEFINITIONS

1. **Agency** – Any authority of the United States that is an “agency” under 44 USC 3502(1) other than those considered to be independent regulatory agencies, as defined in 44 USC 3502 (5).
2. **Communication** – The exchange of ideas, messages, or information, by speech, signals, writing, or other means.
3. **Consultation** – An enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.
4. **Coordination and Collaboration** – Working and communicating together in a meaningful government-to-government effort to create a positive outcome.
5. **Critical Events** – Planned or an unplanned event that has or may have a substantial impact on Indian Tribe(s), e.g., issues, policies, or budgets which may come from any level within HHS.

6. **Deliberative Process Privilege** – Is a privilege exempting the government from disclosure of government agency materials containing opinions, recommendations, and other communications that are part of the decision-making process within the agency.
7. **Executive Order** – An order issued by the Government’s executive on the basis of authority specifically granted to the executive branch (as by the U.S. Constitution or a Congressional Act).
8. **Federally Recognized Tribal governments** – Indian Tribes with whom the Federal Government maintains an official government-to-government relationship; usually established by a Federal treaty, statute, executive order, court order, or a Federal Administrative Action. The Bureau of Indian Affairs (BIA) maintains and regularly publishes the list of Federally recognized Indian Tribes.
9. **HHS Tribal Liaisons** – HHS staff designated by the head of an HHS Division that are knowledgeable about the Division’s programs and budgets, and have ready access to senior HHS Division leadership, and are empowered to speak on behalf of that Division for AI/AN/NA programs, services, issues, and concerns.
10. **Indian** – Indian means a person who is a member of an Indian tribe as defined in 25 U.S.C. 479a. Throughout this policy, Indian is synonymous with American Indian/Alaska Native.
11. **Indian Organizations:** 1). Those Federally recognized tribally constituted entities that have been designated by their governing body to facilitate DHHS communications and consultation activities. 2). Any regional or national organizations whose board is comprised of Federally recognized Tribes and elected/appointed Tribal leaders. The government does not participate in government-to-government consultation with these entities; rather these organizations represent the interests of Tribes when authorized by those Tribes.
12. **Indian Tribe** – an Indian or Alaska Native tribe, band, nation, pueblo, village, or community that the Secretary of the Interior acknowledges to exist as an Indian tribe pursuant to the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a.”
13. **Intradepartmental Council on Native American Affairs (ICNAA)** – Authorized by the Native American Programs Act of 1974 (NAPA), as amended. The ICNAA serves primarily to perform functions and develop recommendations for short, intermediate, or long-term solutions to improve AI/AN/NA policies and programs as well as provide recommendations on how HHS should be organized to administer services to the AI/AN/NA population.
14. **Joint Tribal/Federal Workgroups and or/Task Forces** – A group composed of individuals who are elected Tribal officials, appointed by Federally recognized Tribal governments and/or Federal agencies to represent their interests while working on a particular policy, practice, issue and/or concern.

15. **Native American (NA)** – Broadly describes the people considered indigenous to North America.
16. **Policies with Tribal Implications** – Refers to regulations, statutes, legislation, and other policy statements or actions that have substantial direct effects on one or more Indian Tribes, 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.
17. **Self Government** – Government in which the people who are most directly affected by the decisions make decisions.
18. **Sovereignty** – The ultimate source of political power from which all specific political powers are derived.
19. **Substantial Direct Compliance Costs** – Those costs incurred directly from implementation of changes necessary to meet the requirements of a Federal regulation. Because of the large variation in Tribes, “substantial costs” is also variable by Indian Tribe. Each Indian Tribe and the Secretary shall mutually determine the level of costs that represent “substantial costs” in the context of the Indian Tribe’s resource base.
20. **To the Extent Practicable and Permitted by Law** – Refers to situations where the opportunity for consultation is limited because of constraints of time, budget, legal authority, etc.
21. **Treaty** – A legally binding and written agreement that affirms the government-to-government relationship between two or more nations.
22. **Tribal Government** – An American Indian or Alaska Native Tribe, Band, Nation, Pueblo, Village or Community that the Secretary of the Interior acknowledges to exist as an Indian Tribe pursuant to the Federally Recognized Indian Tribe List Act of 1994, 25 USC 479a.
23. **Tribal Officials** – Elected or duly appointed officials of Indian Tribes or authorized inter-Tribal organizations.
24. **Tribal Organization** – The recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities: Provided, That in any case where a contract is let or grant made to an organization to perform services benefiting more than one Indian tribe, the approval of each such Indian tribe shall be a prerequisite to the letting or making of such contract or grant.
25. **Tribal Resolution** – A formal expression of the opinion or will of an official Tribal governing body which is adopted by vote of the Tribal governing body.

26. **Tribal Self–Governance** – The governmental actions of Tribes exercising self-government and self-determination.

## 21. ACRONYMS

<b>AI/AN:</b>	American Indian/Alaska Native
<b>AI/AN/NA:</b>	American Indian/Alaska Native/Native American
<b>ASFR:</b>	Assistant Secretary for Finance and Resources
<b>BIA:</b>	Bureau of Indian Affairs
<b>Division:</b>	Staff Division and/or Operating Division
<b>EO:</b>	Executive Order
<b>FACA:</b>	Federal Advisory Committee Act
<b>FR:</b>	Federal Register
<b>HHS:</b>	U.S. Department of Health and Human Services
<b>ICNAA:</b>	Intradepartmental Council on Native American Affairs
<b>IGA:</b>	Office of Intergovernmental Affairs
<b>IOS:</b>	Immediate Office of the Secretary
<b>NPRM:</b>	Notice of Proposed Rule Making
<b>OMB:</b>	Office of Management and Budget
<b>OS:</b>	Office of the Secretary
<b>U.S.:</b>	United States
<b>U.S.C.:</b>	United States Code

**/S/ Kathleen Sebelius  
2010**

**December 14,**

**Secretary**

**U.S. Department of Health and Human Services**

## ADDENDUM 1

### **Establishing 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 HHS to establish Joint Tribal/Federal Workgroups and/or Task Forces to complete work needed to develop new policies, practices, issues, and/or concerns and/or modify existing policies, practices, issues, and/or concerns. These Joint Tribal/Federal Workgroups and/or Task Forces do not take the place of Tribal consultation, but offer an enhancement by gathering individuals with extensive knowledge of a particular policy, practice, issue and/or concern to work collaboratively and offer recommendations for consideration by Federally recognized Indian Tribes and Federal agencies. The subsequent work products and/or outcomes developed by the Joint Tribal/Federal Workgroup and/or Task Forces will be handled in accordance with this policy. These Workgroups will be Federal Advisory Committee Act (FACA) compliant unless exempt.

1. Meeting Notices: The purpose, preliminary charge, time frame, and other specific tasks shall be clearly identified in the notice. All meetings should be open and widely publicized ideally through IGA or the Division initiating the policy.

2. Workgroups: membership should be selected based on the responses received from prospective HHS Regions/Indian Health Service Areas as a result of the notice, and if possible, should represent a cross-section of affected parties. HHS staff may serve in a technical advisory capacity.
- E. Participation:
1. Membership Notices: HHS shall seek nominations from Indian Tribes to participate in taskforces and/or workgroups. The Secretary shall select workgroup members that represent various regions and/or views of Indian Country. Membership of these workgroups shall be in compliance with FACA unless the workgroup is exempt
  2. Appointment of Alternates: Each primary representative may appoint an alternate by written notification. In cases where an elected Tribal Leader (primary representative) appoints an alternate who is not an elected official, and the primary member can not attend a workgroup meeting, the alternate is permitted to represent the primary member and will have the same voting rights as the primary member.
  3. Attendance at Meetings: Workgroup members must make a good faith effort to attend all meetings. Other individuals may accompany workgroup members, as that member believes is appropriate to represent his/her interest, however FACA requirements will be adhered to at meetings unless exempt
- F. Workgroup Protocols: The workgroup may establish protocols to govern the meetings. Such protocols will include, but are not limited to the following:
2. Selection of workgroup co-chairs, if applicable
  3. Role of workgroup members
  4. Process for decision-making (consensus based or otherwise)
  5. Developing a Workgroup Charge. Prior to the workgroup formulation, the HHS will develop an initial workgroup charge in enough detail to define the policy concept. The workgroup may develop recommendations for the final workgroup charge for the approval of the HHS Secretary, the IGA Director or the Division head.
- G. Process for Workgroup Final Products: Once a final draft of the work product has been created by the workgroup the following process will be used to facilitate Tribal consultation on the draft work product:
1. Upon completion, the draft documents will be distributed informally to Indian Tribes and Indian Organizations for review and comment and to allow for maximum possible informal review.
  2. Comments will be returned to the workgroup, which will meet in a timely manner to discuss the comments and determine the next course of action.
  3. At the point that the proposed draft policy is considered to be substantially complete as written, the workgroup will forward the draft document to the HHS Secretary as final recommendation for consideration.
  4. The workgroup will also recognize any contrary comment(s) in its final report and explain the reasoning for not accepting the comment(s).



5. If it is determined that the policy should be rewritten, the workgroup will rewrite and begin informal consultation again at the initial step above.
  6. If the proposed policy is generally acceptable to the HHS Secretary, final processing of the policy by the workgroup will be accomplished.
- H. Recommendations and Policy Implementation: All final recommendations made by the workgroup should be presented to the Secretary. Before any final policy decisions are adopted within HHS, the proposed policy shall be widely publicized and circulated for review and comment to Indian Tribes, Indian Organizations, and within HHS. Once the consultation process is complete and a proposed policy is approved and issued, the final policy shall be broadly distributed to all Indian Tribes.



**U.S. Department of Health & Human Services  
2011 Annual Tribal Consultation Report**

**APPENDIX III**

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**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
ADMINISTRATION FOR CHILDREN AND FAMILIES  
Tribal Consultation Policy**

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- 1.INTRODUCTION
- 2.PURPOSE
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- 6.CONSULTATION PRINCIPLES
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**1. INTRODUCTION**

On November 5, 2009, President Obama signed an Executive Memorandum reaffirming the government-to-government relationship between Indian tribes and the Federal Government, and directing each executive department and agency to consult with tribal governments prior to taking actions that affect this population. The importance of consultation with Indian tribes was affirmed through Presidential Memoranda in 1994, 2004, and 2009, and Executive Order 13175 in 2000.

The U.S. Department of Health and Human Services (HHS) and Indian tribes share the goal of eliminating health and human service disparities of American Indians and Alaska Natives (AI/AN) and ensuring that access to critical health and human services is maximized.

## **2. PURPOSE**

The Administration for Children and Families (ACF), as an Operating Division within HHS, hereby establishes a consultation policy with federally recognized Indian tribes. The purpose of the ACF Tribal Consultation Policy is to build meaningful relationships with federally recognized tribes by engaging in open, continuous, and meaningful consultation. True consultation leads to information exchange, mutual understanding, and informed decision-making.

ACF is bound by the HHS Tribal Consultation Policy in full. Nothing in the ACF Tribal Consultation Policy shall be construed as diminishing or waiving the HHS Tribal Consultation Policy. The ACF Tribal Consultation Policy shall not conflict with the HHS Tribal Consultation Policy and applies to all offices of ACF.

This ACF Tribal Consultation Policy document was developed based upon:

1. Executive Memorandum "Tribal Consultation," November 5, 2009;
2. Executive Order 13175, reaffirmed in 2009;
3. HHS Tribal Consultation Policy (established in 2005, and amended in 2010);
4. Input from an ACF Tribal Federal Workgroup (TFWG) convened to develop the draft ACF Consultation Policy;
5. Input from tribes to ensure a consultation policy that reflects the goals of all partners involved; and
6. Input of all of the programs and regions within ACF, many of which already consult with AI/ANs.

## **3. BACKGROUND**

Since the formation of the Union, the United States (U.S.) has recognized Indian tribes as sovereign nations. A unique government-to-government relationship exists between AI/AN Indian tribes and the Federal Government. This relationship is grounded in the U.S. Constitution, numerous treaties, statutes, Federal case law, regulations and executive orders, as well as political, legal, moral, and ethical principles. This relationship is derived from the political relationship that Indian tribes have with the Federal Government.

An integral element of this government-to-government relationship is that consultation occurs with Indian tribes. ACF program offices shall provide an opportunity for meaningful consultation between tribes and ACF in policy development, as set forth in this policy. The Executive Memorandum titled "Tribal Consultation" reaffirmed this government-to-government relationship with Indian tribes on November 5, 2009. The implementation of this policy is in recognition of this special relationship.

This special relationship is affirmed in statutes and various Presidential Executive Orders including, but not limited to:

- Older Americans Act, Public Law 89-73, as amended (42 U.S.C. 3001 *et seq.*);
- Indian Self-Determination and Education Assistance Act, Public Law 93-638, as amended (25 U.S.C. 450 *et seq.*);
- Native American Programs Act, Public Law 93-644, as amended (42 U.S.C. 2991 *et seq.*);

- Indian Health Care Improvement Act, Public Law 94-437, as amended (25 U.S.C. 1601 *et seq.*);
- Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193 (42 U.S.C. 1305 *et seq.*);
- **Head Start for School Readiness Act of 2007**, Public Law 110-134, as amended (42 U.S.C. 9801 *et seq.*);
- Patient Protection and Affordable Care Act (ACA), Public Law 111-148 (42 U.S.C. 18001 *et seq.*);
- Fostering Connections to Success and Increasing Adoptions Act of 2008, Public Law 110-351 (42 U.S.C. 1305 *et seq.*);
- Presidential Executive Memorandum to the Heads of Executive Departments dated April 29, 1994;
- Presidential Executive Order 13175, Consultation and Coordination With Indian Tribal Governments, November 6, 2000; and
- Presidential Memoranda, Government-to-Government Relationship with Tribal Governments, September 23, 2004; and Tribal Consultation, November 5, 2009.

#### **4. TRIBAL SOVEREIGNTY**

This policy does not waive or diminish 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 persons or entities under Federal law.

Our Nation, under the law of the U.S. and in accordance with treaties, statutes, Executive Orders, and judicial decisions, has recognized the right of Indian tribes to self-government and self-determination. Indian tribes exercise inherent sovereign powers over their members and territory. The U.S. continues to work with Indian tribes on a government-to-government basis to address issues concerning tribal self-government, tribal trust resources, tribal treaties, and other rights.

The 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. Self-determination and meaningful involvement for Indian tribes in Federal decision-making through consultation in matters that affect Indian tribes have been shown to result in improved program performance and positive outcomes for tribal communities. 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 strengthen tribal control over Federal funding that it receives, and its internal program management.

#### **5. BACKGROUND ON ACF**

ACF provides national leadership and direction to plan, manage, and coordinate the nationwide administration of comprehensive and supportive programs for vulnerable and at-risk children and families. ACF oversees and finances a broad range of programs for children and families, including Native Americans, persons with developmental disabilities, refugees, and legal immigrants, to help them develop and grow toward a more independent, self-reliant life. These programs, carried out by State, county, city, and tribal governments, and public and private local

agencies, are designed to promote stability, economic security, responsibility, and self-sufficiency.

ACF coordinates development and implementation of family-centered strategies, policies, and linkages among its programs, and with other Federal, tribal, and State programs serving children and families. ACF's programs assist families in financial crisis, emphasizing short-term financial assistance, and education, training, and employment for the long term. Its programs for children and youth focus on those children and youth with special problems, including children of low-income families, abused and neglected children, those in institutions or requiring adoption or foster family services, runaway youth, children with disabilities, migrant children, and Native American children. ACF promotes the development of comprehensive and integrated community and home-based modes of service delivery where possible. The following offices are located in ACF:

- Administration on Children, Youth and Families (ACYF)
  - Children's Bureau (CB)
  - Family and Youth Services Bureau (FYSB)
- Office of the Deputy Assistant Secretary for Early Childhood Development
- Administration on Developmental Disabilities (ADD)
  - President's Committee for People with Intellectual Disabilities (PCPID), an advisory Committee to the President of the United States and Health and Human Services Secretary
- Administration for Native Americans (ANA)
- Office of Administration
- Office of Community Services (OCS)
- Office of Child Care (OCC)
- Office of Child Support Enforcement (OCSE)
- Office of Family Assistance (OFA)
  - Temporary Assistance for Needy Families Bureau (TANF)
- Office of Head Start (OHS)
- Office of Human Services Emergency Preparedness and Response (OHSEPR)
- Office of Legislative Affairs and Budget (OLAB)
- Office of Planning, Research and Evaluation (OPRE)
- Office of Refugee Resettlement (ORR)
- Office of Regional Operations (ORO).

In June 2010, ACF established the Native American Affairs Advisory Council (NAAAC). This Council will function as an internal agency workgroup to support the Assistant Secretary for Children and Families, the Commissioner of ANA, and all ACF program and Regional Offices that provide services to Native Americans. On behalf of the Assistant Secretary, Administration for Children and Families, the Commissioner of ANA is the Chair of the NAAAC and ANA is the lead office to coordinate the activities.

One of the responsibilities of NAAAC is to facilitate the development of the ACF Tribal Consultation Policy, in conjunction with the Office of the Assistant Secretary for Children and Families and in consultation with tribes.

The members of NAAAC are the ACF program and Regional Offices that have Native American constituents or work with Native American communities. These offices include the Administration on Children, Youth and Families (Children's Bureau, and the Family and Youth Services Bureau); the Administration on Developmental Disabilities; the Administration for

Native Americans; the Office of Child Care; the Office of Child Support Enforcement; the Office of Community Services; the Office of Family Assistance (Tribal Temporary Assistance for Needy Families (Tribal TANF)); the Office of Head Start; the Office of Planning, Research and Evaluation; and the Office of Regional Operations. The following Regions will be represented: Region I, Region II, Region IV, Region V, Region VI, Region VII, Region VIII, Region IX, and Region X.

## **6. CONSULTATION PRINCIPLES**

Consultation is an enhanced form of communication that emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues. ACF will consult, as defined in this document and as practicable and permitted by law, with Indian tribes before taking action that will significantly affect Indian tribes.

The ACF policy is to conduct timely, respectful, meaningful, and effective two-way communication and consultation with tribes wherein elected officials and other authorized representatives of the tribal governments provide input prior to any action that either ACF or one or more tribes determines has or may have significantly affected one or more Indian tribes, and before any such action or further action is taken. An action that triggers consultation is any legislative proposal, new rule adoption, or other policy change that either ACF or a tribe determines may significantly affect Indian tribes. ACF or a tribe may determine that an action may significantly affect one or more Indian tribes and by appropriate communication initiate tribal consultation. An action is considered to significantly affect tribes if there exists a reasonable presumption that it has or may have substantial direct effects on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, on the amount or duration of ACF program funding, on the delivery of ACF program services to one or more tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes.

## **7. CONSULTATION PARTIES**

Consultation parties are:

- A. The ACF Assistant Secretary, ACF Deputy Assistant Secretaries, ACF Central Office Principals, or their designee; and
- B. Tribal President, Tribal Chair or Tribal Governor, or an elected or appointed Tribal Leader, or their authorized representative(s).

Each party will identify their authorized representatives with delegated authorities to negotiate on their behalf.

## **8. CONSULTATION PROCESS**

A. A consultation is initiated:

1. When either ACF or one or more tribes makes a written request for a consultation.
  - a. Either ACF or a tribe may determine an action significantly affects or may affect one or more Indian tribes.
  - b. An action that triggers consultation is any legislative proposal, new rule adoption, or policy change that either ACF or a tribe determines may significantly affect Indian tribes.

2. An action is considered to significantly affect tribes if there exists a reasonable presumption that it has or may have substantial direct effects on:
  - a. One or more Indian tribes;
  - b. The amount or duration of ACF program funding for one or more tribes;
  - c. The delivery of ACF program services to one or more tribes;
  - d. The relationship between the Federal Government and Indian tribes; or
  - e. The distribution of power and responsibilities between the Federal Government and Indian tribes.
- B. A consultation request by ACF or tribe(s) should:
  1. Identify the subject issue(s) for resolution.
  2. Identify the applicable program(s), policy, rule, regulation, statute, and authorizing legislation.
  3. Identify the related concerns such as State-tribal relations, related programs, complexity, time constraints, funding and budget implications.
  4. Identify the affected and potentially affected Indian tribe(s).
- C. ACF will acknowledge receipt of the tribal consultation request within 14 calendar days after receipt of the request.
- D. ACF shall have an accountable process to ensure meaningful and timely input by tribal officials in the development of policies that have tribal implications.
- E. To the extent practicable and permitted by law, ACF shall not promulgate any regulation that has tribal implications, that imposes substantial direct compliance costs on Indian tribes, or that is not required by statute, unless:
  1. Funds necessary to pay the direct costs incurred by the Indian tribe in complying with the action are provided by the Federal Government; or
  2. ACF, prior to the formal promulgation of the regulation,
    - a. Consulted with tribal officials early and throughout the process of developing the proposed regulation;
    - b. Provided a tribal summary impact statement in a separately identified portion of the preamble to the regulation as it is to be issued in the *Federal Register* (FR), which consists of a description of the extent of ACF's prior consultation with tribal officials, a summary of the nature of their concerns and ACF'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. Made available to the Assistant Secretary any written communications submitted to ACF by tribal officials.
- F. To the extent practicable and permitted by law, ACF shall not promulgate any regulation that has tribal implications and that preempts tribal law unless ACF, prior to the formal promulgation of the regulation:
  1. Consulted with tribal officials early and throughout the process of developing the proposed regulation;
  2. Provided a tribal summary impact statement in a separately identified portion of the preamble to the regulation as it is to be issued in the FR, which consists of a description of the extent of ACF's prior consultation with tribal officials, a summary of the nature of their concerns and ACF'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. Made available to the Assistant Secretary any written communications submitted to ACF by tribal officials.
- G. Proper notice of the tribal consultation and the level of consultation shall be communicated to all affected and all potentially affected Indian tribes within 45 calendar

days after receipt of the tribal request. Appropriate forms of notice include a “Dear Tribal Leader Letter” signed by the Assistant Secretary, broadcast e-mail, FR, and other outlets. The notice will provide at least 30 days notice of subject, location, date, and time.

- H. Consultation will occur through a combination of one or more methods, and will include additional actions and participants as determined by the parties. The following are examples of methods of consultation:
1. Meeting(s): One or more meetings for consultation with affected and potentially affected Indian tribes to discuss all pertinent issues related to the legislative proposal, new rule adoption, or other policy change that may significantly affect the tribe(s) using a single purpose meeting, or a national or regional forum, if appropriate, when the consultation is determined to include all tribes. Meetings can be face-to-face, by teleconference call, and other forms of new technologies.
  2. Correspondence: Written communications for consultation exchanged between ACF and the Indian tribe(s) provide affected and potentially affected Indian tribes an opportunity to identify concerns, potential impacts, proposed alternatives or flexibilities, and provide ACF with the opportunity to identify resources and other considerations relevant to the issue(s) raised. All correspondence will identify the manner in which tribal comments will be solicited.
  3. *Federal Register* (FR): When one or more meetings are not practicable, notices in the FR may be used as the method of consultation to solicit comment from tribes about broad-based issues including concerns, potential impacts, proposed alternatives or flexibilities. Such notices will include clear and explicit instructions for the submission of comments that provide adequate time, a minimum of 45 days, for tribal responses. The FR will not be used as a sole method of communication for consultation.
- I. Reporting of Outcome: All national and regional consultation meetings and recommended actions shall be recorded and made available to Indian tribes.

ACF program offices will provide a detailed report on their consultation sessions, which summarizes the discussions, specific recommendations, and responses, and solicits tribal feedback on the consultation process, within 45 calendar days of the conclusion of the consultation process. The ACF report will be available on the program offices’ websites.

Once the consultation process is complete and a proposed policy is approved and issued, the final policy must be broadly distributed to all Indian tribes and it will be independently posted on the ACF webpage and also linked to several appropriate tribal and inter-tribal organization websites.

- J. Meaningful Outcomes: The consultation process and activities conducted within the scope of the ACF policy should result in a meaningful outcome for both ACF and tribes. Before any final policy decisions are adopted that significantly affect Indian tribes, the proposed outcome of a consultation shall be widely publicized and circulated for review and comment to affected Indian tribes, inter-tribal organizations, and within HHS, when appropriate, practicable and permitted by law.

Good faith implementation of ACF programs and a cooperative working relationship with tribes in support of ACF programs is the primary meaningful outcome. ACF will work with States to emphasize the importance of working cooperatively with tribes.



ACF shall facilitate meaningful consultations and outcomes between tribe(s) and one or more States administering ACF programs, shall report the outcome of its efforts to affected tribes, and shall make a good faith effort to ensure all parties fully comply with ACF program requirements.

- K. Waivers: The intent of this policy is to provide increased ability to address issues impacting Indian tribes. ACF will, consistent with HHS Tribal Consultation Policy and as practicable and permitted by law, utilize flexible approaches to enable tribes to achieve established ACF program objectives, including consideration of waivers of statutory and regulatory requirements and other alternatives that preserve the prerogatives and authority of Indian tribes.
- L. Elevation of Issues: Indian tribes may elevate an issue of importance to a higher or separate decision-making authority, detailed in Section 11. ACF-Tribal Conflict Resolution.

## **9. ACF CONSULTATION AND COMMUNICATION RESPONSIBILITIES**

ACF will conduct an annual agency-wide tribal consultation each year, in addition to the tribal consultations required by several ACF program offices. The following will guide ACF's coordination of the various sessions. NAAAC will work with the program offices to coordinate ACF required consultations, on required topics and in required regions, to maximize the time and resources of Indian tribes and program offices.

### **A. ACF Annual Tribal Consultation Session**

1. ACF will hold, at a minimum, an agency-wide annual tribal consultation session to discuss ACF budget, programs and policies impacting tribal programs. ANA, working through NAAAC, will be the lead agency to coordinate the annual tribal consultation session.
2. Every ACF program office Principal, or their designee, will be required to participate in the annual ACF tribal consultation.
3. NAAAC will coordinate with the program offices to prepare and disseminate a written report within 45 calendar days of the conclusion of the annual ACF tribal consultation.
4. ACF will post this report on its website within 7 days of the final report completion.
5. The annual ACF tribal consultation session will not supplant any tribal consultation sessions that are required by law to be conducted by ACF program offices.

### **B. Special Statutory Consultation Requirements**

1. The following ACF Offices have programs that require consultation with Indian tribes in accordance with their authorizing statutes.
  - Office of Head Start
  - Children's Bureau
  - Family and Youth Services Bureau
2. ACF program offices will conduct tribal consultation sessions that are required by law, including in conjunction with the Annual ACF Tribal Consultation Session.

### **C. Individual Program Consultation Responsibilities**

1. Each individual program office will meet with Indian tribes and AI/AN grantees regarding programmatic concerns at the request of the Indian tribe or AI/AN grantee.
2. An official staff contact will be designated as responsible for the initial coordination and facilitation of the program office interaction with tribes and Native American organizations and to serve as the program single point of contact for interaction with offices and workgroups within HHS on AI/AN issues. This contact will be kept current on the ACF website.
3. ACF program offices will acknowledge requests for consultation within 14 calendar days of receipt of the request.
4. ACF program offices will acknowledge and report on unresolved issues with the tribe in a timely manner. ACF program offices will acknowledge issues within 14 calendar days after the conclusion of the consultation.
5. Feedback will be provided by ACF program offices to tribes on the resolution of issues for which consultation has been requested within 45 calendar days of the conclusion of the consultation.
6. ACF program offices will ensure intra-agency coordination with Regional Offices to facilitate communication and outreach on consultations held in the Region. Regional Offices will facilitate State participation as appropriate.
7. ACF program offices and Regional Offices will provide assistance in efforts to resolve tribal-State issues.
8. ACF program offices will provide a written report on the consultations, which summarizes the discussions, recommendations, and responses, within 45 calendar days after the conclusion of the last consultation.

D. **HHS Tribal Consultations:** ACF will participate in the Annual Budget Consultation Session and Annual Regional Tribal Consultations.

## **10. ACF PERFORMANCE AND ACCOUNTABILITY**

- A. Implementation of this policy shall be made part of the Annual Performance Plan for ACF Senior Management as a critical performance element in those offices where there are specific tribal activities.
- B. ACF program offices will design indicators to ensure accountability among program managers, and central office and Regional Office staff in carrying out the HHS and ACF tribal consultation policies.
- C. ACF will ensure that all personnel working with Indian tribes receive appropriate training on consultation, this policy, and working with tribal governments.
- D. As part of the Department's annual measurement of the level of satisfaction of Indian tribes with the consultation process and the activities conducted under this policy, Indian tribes' satisfaction with ACF will be recorded and evaluated to determine whether the intended results were achieved and to solicit recommendations for improvement from tribes.

## **11. ACF-TRIBAL CONFLICT RESOLUTION**

- A. Should an impasse arise between ACF and a tribe(s) concerning ACF compliance with the consultation policy or outcome of consultation, a tribe may invoke the conflict resolution process by filing a written notice of conflict resolution and any action that is the subject of an impasse will be stayed until the conflict resolution process with ACF is complete to the extent practicable and permitted by law. Authorized tribal representatives shall have the opportunity to meet with the Assistant Secretary for Children and Families, and/or a Deputy Assistant Secretary, and/or the Commissioner

for the Administration for Native Americans, and/or the ACF Regional Administrator(s) for the Regional Offices that provide services to the affected tribes. The goal is to accomplish the following:

1. Clarify all aspects of the issue(s) at an impasse;
  2. Explore the alternative position(s) available to resolve the impasse;
  3. Clearly state the issue(s) that the parties can accept on the record;
  4. Form acceptance of recommended actions; and
  5. Facilitate coordination of resolution(s) for parties.
- B. In cases where a tribe(s) is not satisfied with the resolution of an issue or issues after consultation with ACF, a tribe(s), consistent with the government-to-government relationship, may elevate an issue of importance to the Secretary of the Department of Health and Human Services, through the Office of Intergovernmental Affairs (IGA), for decision.

## **12. WORKGROUPS AND ADVISORY COMMITTEES**

- A. To maximize the expertise and knowledge of individuals working in tribal communities, ACF will convene TFWGs, subject to available funding, to develop and discuss agency-wide policies that impact Indian tribes, prior to formal tribal consultation sessions on the policies.

The TFWG will work in accordance with the HHS policy on tribal workgroups and will follow procedures to ensure compliance with the Federal Advisory Committee Act (FACA). See the HHS Tribal Consultation Policy, Addendum 1, for further explanation of TFWG.

- B. ACF has a standing internal working group made up of staff representatives from each ACF program office. This Native American Affairs Workgroup meets once a month to work on tribal issues at the program, ACF, and HHS level.
- C. ACF retains the right to meet with various representatives of organizations on an individual basis.
- D. For policies that impact more than federally recognized Indian tribes<sup>1</sup>, ACF will develop forums to provide opportunities for input and dialogue for State-recognized tribes; Native American organizations, including Native Hawaiians and Native American Pacific Islanders; urban Indian centers; tribally controlled community colleges and universities; Alaska Region Corporations; and others as defined in program office guidance.
- E. Program offices may still convene their individual working groups to work on program specific policies. Program offices will ensure that these working groups operate within the FACA guidelines and requirements.
- F. ACF does not participate in government-to-government consultation with entities described in Section 12., A-E, and these meetings do not take the place of tribal consultation.

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<sup>1</sup> These groups, while not federally recognized tribes, are eligible to receive funding under certain ACF programs in the same manner as federally recognized tribes. ACF will make every effort to seek the input of these groups when changes to policy impact these groups as well.

### 13. DEFINITIONS

- A. Action – Any legislative proposal, new rule adoption, or policy change that either ACF or a tribe(s) determines may significantly affect an Indian tribe(s).
- B. Agency – Any authority of the United States that is an “agency” under 44 U.S.C. 3502(1) other than those considered to be independent regulatory agencies, as defined in 44 U.S.C. 3502 (5).
- C. Administration for Children and Families (ACF) – All the offices that make up the organization of ACF. The acronyms “ACF” and “ACF program offices” are used interchangeably.
- D. Communication – The exchange of ideas, messages, or information by speech, signals, writing, or other means.
- E. Consortia of tribes – Two or more federally recognized Indian tribes.
- F. Consultation – An enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.
- G. Coordination and Collaboration – Working and communicating together in a meaningful government-to-government effort to create a positive outcome.
- H. Critical Event – Planned or unplanned event that has or may have a substantial impact on Indian tribe(s), e.g. issues, policies, or budgets which may come from any level within HHS.
- I. Deliberative Process Privilege – Privilege exempting the government from disclosure of government-agency materials containing opinions, recommendations, and other communications that are part of the decision-making process within the agency.
- J. Executive Order – An order issued by the government’s executive on the basis of authority specifically granted to the Executive Branch (as by the U.S. Constitution or a Congressional Act).
- K. Federally recognized tribal governments – Indian tribes with whom the Federal Government maintains an official government-to-government relationship, usually established by a Federal treaty, statute, executive order, court order, or a Federal Administrative Action. The Bureau of Indian Affairs (BIA) maintains and regularly publishes the list of federally recognized Indian tribes.
- L. Indian – A person who is a member of an Indian tribe (25 U.S.C. 450b(d)). Throughout this policy, Indian is synonymous with American Indian/Alaska Native.
- M. Indian Organization – 1) Those federally recognized, tribally constituted entities that have been designated by their governing body to facilitate HHS communications and consultation activities. 2) Any regional or national organizations whose board is comprised of federally recognized tribes and elected/appointed tribal leaders. The Government does not participate in government-to-government consultation with these entities; rather, these organizations represent the interests of tribes when authorized by those tribes.
- N. Indian tribe – An 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) (43 U.S.C. 1601 et seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians (25 U.S.C. 450b(e)).

- O. Joint Tribal Federal Workgroups and/or Task Forces – A group composed of individuals who are elected tribal officials, appointed by federally recognized tribal governments and/or Federal agencies to represent their interests while working on a particular policy, practice, issue, and/or concern.
- P. Native American (NA) – Broadly describes the people considered indigenous to North America.
- Q. Native American Affairs Advisory Council (NAAAC) – An internal agency work group established to support the Assistant Secretary for Children and Families, the Commissioner of the Administration for Native Americans, and all ACF program and Regional Offices that provide services to Native Americans.
- R. Native Hawaiian – Any individual whose ancestors were natives of the area, which consists of the Hawaiian Islands prior to 1778 (42 U.S.C. 3057k).
- S. Policies that have tribal implications – Refers to regulations, legislation, and other policy statements or actions that have substantial direct effects on one or more Indian tribes, 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.
- T. Sovereignty – The ultimate source of political power from which all specific political powers are derived.
- U. State recognized tribes – Tribes that maintain a special relationship with the State government and whose lands and rights are usually recognized by the State. State recognized tribes may or may not be federally recognized.
- V. Substantial Direct Compliance Costs – Those costs incurred directly from implementation of changes necessary to meet the requirements of a Federal regulation. Because of the large variation in tribes, “substantial costs” is also variable by Indian tribe. Each Indian tribe and the Assistant Secretary shall mutually determine the level of costs that represent “substantial costs” in the context of the Indian tribe’s resource base.
- W. To the Extent Practicable and Permitted by Law – Refers to situations where the opportunity for consultation is limited because of constraints of time, budget, legal authority, etc.
- X. Treaty – A legally binding and written agreement that affirms the government-to-government relationship between two or more nations.
- Y. Tribal Government – An American Indian or Alaska Native tribe, band, nation, pueblo, village, or community that the Secretary of the Interior acknowledges to exist as an Indian tribe pursuant to the Federally Recognized Indian Tribe List Act of 1994, (25 U.S.C. 479a).
- Z. Tribal Officials – Elected or duly appointed officials of Indian tribes or authorized Indian organizations.
- AA. Tribal Organization – The recognized governing body of any Indian tribe; any legally established organization of American Indians and Alaska Natives which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the community to be served by such organization and which includes the maximum participation of Indian tribe members in all phases of its activities (25 U.S.C. 450b).

#### 14. ACRONYMS

<b>ACF</b>	Administration for Children and Families
<b>AI/AN</b>	American Indian/Alaska Native
<b>AI/AN/NA</b>	American Indian/Alaska Native/Native American

<b>ANA</b>	Administration for Native Americans
<b>BIA</b>	Bureau of Indian Affairs
<b>Division</b>	Staff Division and/or Operating Division
<b>EO</b>	Executive Order
<b>FACA</b>	Federal Advisory Committee Act
<b>FR</b>	<i>Federal Register</i>
<b>HHS</b>	U.S. Department of Health and Human Services
<b>NAAAC</b>	Native American Affairs Advisory Council
<b>OPDIV</b>	Operating Divisions of HHS
<b>SPOC</b>	Single Point of Contact
<b>TFWG</b>	Tribal/Federal Workgroup
<b>U.S.</b>	United States
<b>U.S.C.</b>	United States Code

## **15. POLICY REVIEW**

ACF shall review and, if necessary, revise its Tribal Consultation Policy no less than every 2 years. Should ACF determine that the policy requires revision, the TFWG will be convened to develop the revisions.

## **16. RETENTION OF EXECUTIVE BRANCH AUTHORITIES**

Nothing in this policy waives the Government's deliberative process privilege, including when the Department is specifically requested by Members of Congress to respond to or report on proposed legislation. The development of such responses and related policy documents is a part of the deliberative process by the Executive Branch and should remain confidential.

Nothing in the Policy creates a right of action against the Department for failure to comply with this Policy nor creates any right, substantive or procedural, enforceable at law by a party against the United States, its agencies, or any individual.

## **17. EFFECTIVE DATE**

This policy is effective on the date of signature by the Assistant Secretary for Children and Families and shall apply to all ACF program offices.

        /s/ George H. Sheldon          
George H. Sheldon  
Acting Assistant Secretary  
for Children and Families

        August 18, 2011          
Date



**U.S. Department of Health & Human Services  
2011 Annual Tribal Consultation Report**

**APPENDIX IV**

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**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE AND MEDICAID SERVICES  
Tribal Consultation Policy**

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**1. INTRODUCTION**

On November 5, 2009, President Obama signed an Executive Memorandum reaffirming the government to government relationship between the Indian Tribes and the Federal Government, and directing each executive department and agency to engage in regular and meaningful consultation and collaboration with Tribal officials in the development of Federal policies that have Tribal implications and a substantial direct effect on Indian Tribes. The importance of consultation with Indian Tribes was affirmed through Presidential Memoranda in 1994, 2004 and 2009, and Executive Order (EO) 13175 in 2000.

**2. BACKGROUND**

Since the formation of the Union, the United States (U.S.) has recognized Indian Tribes as sovereign nations. A unique government-to-government relationship exists between Indian Tribes and the Federal Government and this relationship is grounded in the U.S. Constitution, numerous treaties, statutes, Federal case law, regulations and executive orders that establish and define a trust relationship with Indian Tribes. This relationship is derived from the political and legal relationship that Indian Tribes have with the Federal Government and is not based upon race. This special relationship is affirmed in statutes and various Presidential Executive Orders including, but not limited to:

- Older Americans Act of 1965, Pub. L. 89-73, as amended;
- Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended
- The Indian Health Care Improvement Act, Pub. L. 94-437, as amended;
- Native Americans Programs Act of 1974, Pub. L. 93-644, as amended
- Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104-193
- Presidential Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, November 6, 2000;
- Presidential Memorandum, Government-to-Government Relationship with Tribal Governments, September 23, 2004;

- Presidential Memorandum, Tribal Consultation, November 5, 2009;
- American Recovery and Reinvestment Act of 2009, Pub. L. 111-5, 123 Stat. 115 (Feb. 17, 2009);
- Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. 111-3, 123 Stat. 8 (Feb. 4, 2009);
- Patient Protection and Affordable Care Act of 2010, Pub. L. 111-148, 124 Stat. 119 (Mar. 23, 2010).

### **3. PURPOSE**

An integral element of the government to government relationship is that consultation occurs with Indian Tribes. In recognition of this special relationship, the Department of Health and Human Services (HHS) revised its Tribal Consultation Policy on December 14, 2010. Under the HHS Consultation Policy every operating Division of HHS shares the Department-wide responsibility to consult with Indian Tribes. The Centers for Medicare & Medicaid Services (CMS) Tribal Consultation policy hereby incorporates and fully adheres to the HHS Policy as revised on December 14, 2010. The purpose of the CMS Tribal Consultation policy is to build meaningful relationships with Indian Tribes and to establish a clear, concise and mutually acceptable process through which consultation can take place between CMS and Tribes.

The CMS Tribal Consultation Policy was developed based upon:

- Presidential Executive Order 13175 (2000) and Executive Memorandum on Tribal Consultation (November 5, 2009)
- HHS Tribal Consultation Policy (December 14, 2010)
- Input from the CMS Tribal Technical Advisory Group (CMS TTAG)
- Input from Tribes to ensure a consultation policy that reflects the goals of all partners involved
- Input from the CMS components and CMS regional offices

### **4. OBJECTIVES**

In order to fully effectuate this Consultation Policy, CMS will:

- Formalize CMS' policy to seek consultation and the participation of Indian Tribes in the development of policies and program activities that impact Indian Tribes;
- Create opportunities for Indian Tribes to raise issues with CMS and for CMS to seek consultation with Indian Tribes and communication with the TTAG and Indian organizations when new issues arise;
- Establish a minimum set of requirements and expectations with respect to consultation and participation for the levels of CMS management;
- Conduct Tribal consultation regarding CMS's policies and actions that have tribal implications;
- Establish improved communication channels with Indian Tribes, TTAG, and Indian organizations to increase knowledge and understanding of CMS' programs;
- Coordinate with IHS and other Divisions of HHS on issues of mutual concern;
- Coordinate among CMS Regional Offices and Central Office to assure consistent policy interpretations and interactions of all levels of CMS with Indian Tribes;



- Enhance partnerships with Indian tribes that will include technical assistance and access to CMS programs and resources.

## 5. TRIBAL CONSULTATION PRINCIPLES

CMS and Indian Tribes share the goals of eliminating health disparities for American Indians and Alaska Natives (AI/AN) and of ensuring that access to Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and Exchanges is maximized. To achieve these goals, and to the extent practicable and permitted by law, it is essential that CMS and Indian Tribes engage in open, continuous and meaningful consultation.

Consultation is an enhanced form of communication that emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues and better outcomes.

To establish and maintain a positive government to government relationship, communication and consultation must occur on an ongoing basis so that Indian Tribes have an opportunity to provide meaningful and timely input on issues that may have a substantial direct effect on Indian Tribes. Consultation with Tribal Governments is especially important in the context of CMS programs because Indian Tribes serve many roles in their tribal communities:

- Tribal members are beneficiaries of services provided by the Indian Health Services (IHS), by tribal health programs operating under the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended, and by urban Indian health programs operating under Title V of the Indian Health Care Improvement Act.
- Tribal members are also eligible to enroll in Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and Exchanges.
- Tribal governments operate businesses, are employers, and are health care providers, through administration of hospitals, clinics, and other health programs.

In 1976, Congress recognized the need for AI/ANs to have access to Medicare and Medicaid services in IHS and Tribal facilities located in Tribal communities and amended titles XVIII and XIX of the Social Security Act to authorize the IHS and Tribal health programs to bill Medicare and Medicaid for services provided in these facilities. Many of the IHS and Tribal facilities are located in remote and isolated locations, experience difficulty in recruitment and retention of health professionals, and endure challenging socio-economic conditions. The involvement of Indian Tribes in the development of CMS policy is crucial for mutual understanding and development of culturally appropriate approaches to improve greater access to CMS programs for AI/ANs, to enhance health care payment and resources to IHS and Tribal health providers, and to contribute to overall improved health outcomes for Indian people.

An action that triggers consultation is any policy that will significantly affect Indian Tribes. Although determined on a case by case basis, such issues could arise in any policy area for which the CMS has responsibility, such as program eligibility standards, changes in provider payment and reimbursement methodologies, or changes in services covered by CMS programs.

To the extent practicable and permitted by law, CMS shall not promulgate any regulation that has Tribal implications, or that imposes substantial direct compliance costs on Indian Tribe(s), or that is not required by statute, unless:

- Funds necessary to pay the direct costs incurred by the Indian Tribe or Indian health provider in complying with the regulation are provided by the Federal Government; or
- CMS, prior to the formal promulgation of the regulation,

- Consulted with Indian Tribes throughout all stages of the process of developing the proposed regulation;
- Made available to the Administrator any written communications submitted to CMS by Tribal officials and Indian health providers;
- Provided a Tribal summary impact statement in a separately identified portion of the preamble to the regulation as it is to be issued in the *Federal Register* (FR), which consists of a description of the extent of CMS's prior consultation with Indian Tribes, a summary of the nature of their concerns and CMS'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

To the extent practicable and permitted by law, CMS shall not promulgate any regulation that has Tribal implications and that preempts Tribal law, unless CMS, prior to the formal promulgation of the regulation,

- Consulted with Tribal officials throughout all stages of the process of developing the proposed regulation;
- Made available to the Administrator any written communications submitted to CMS by Tribal officials.
- Provided a Tribal summary impact statement in a separately identified portion of the preamble to the regulation as it is to be issued in the FR, which consists of a description of the extent of CMS's prior consultation with Tribal officials, a summary of the nature of their concerns and CMS'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.

Nothing in this policy waives the Government's deliberative process privilege.

## 6. ROLES

The government-to-government relationship between the U.S. and Federally recognized Indian Tribes dictates that the principal focus for consultation by CMS is with Indian Tribes, individually or collectively. Consultation parties are:

- Indian Tribes represented by the Tribal President, Tribal Chair, or Tribal Governor, or an elected or appointed Tribal Leader, or their authorized representative (s).
- CMS Administrator, CMS Deputy Administrator, CMS Regional Administrators, or their designee.

Each party will identify his/her authorized representatives with delegated authorities to negotiate on his/her behalf.

**CMS Central Office:** All of the components at CMS Central Office play a major role in the Department-wide responsibility to consult, coordinate and communicate with Indian Tribes on issues that affect Indian Tribes and CMS programs, services and resources available to Indian Tribes. Within CMS Central, the Tribal Affairs Group, Office of Public Engagement, advises the CMS Administrator, senior staff, and other CMS components on matters affecting American Indian and Alaska Native health, including tribal consultation. The Tribal Affairs Group is the point of contact for compliance with the CMS tribal consultation policy and serves as a resource to assist CMS components and the Administrator in determining whether a new or proposed change in policy or regulations could significantly affect Indian Tribes. The Tribal Affairs Group will assist in coordination of consultation between Indian tribes and various CMS components, including the Office of Strategic Operations and Regulatory Affairs.

**CMS Regional Offices:** The ten (10) CMS Regional Offices share in the Department-wide responsibility to consult, coordinate and communicate with Indian Tribes on issues that affect Indian Tribes and HHS programs, services and resources available to Indian Tribes through States. Through Regional Offices, CMS assists Indian Tribes by establishing or maintaining regular communication regarding Medicare, Medicaid, CHIP and Exchanges, policy development and implementation and operational issues, including eligibility, scope of covered services and providers, billing and reimbursement, adequacy of resources, effect of the program on improving health status, and other issues. Further, the CMS Regional Administrators work closely with the respective Indian Tribes and State Governments to ensure continuous coordination and communication between Tribes and States.

While not a substitute for Tribal Consultation, the following entities play an integral role in the identification of policies with substantial direct effect and in providing advice and input on complex technical issues that could assist CMS in determining and understanding the impact and scope of the critical event and the extent of and format for Tribal Consultation.

**Tribal Organizations:** Pursuant to the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended, Indian Tribes have the authority to delegate their right to carry out programs of the Indian Health Service to a Tribal organization. To the extent this has occurred, as practicable and permitted by law, CMS may provide such Tribal organizations an opportunity to fully participate in Tribal consultation under this policy. Such participation will not substitute for direct consultation with Indian Tribes, but shall occur in addition to consultation with Indian Tribes.

**Indian Organizations:** At times it is useful that CMS communicate with Indian organizations to solicit Indian Tribe(s) advice and recommendations. These organizations represent the interest of Indian Tribes when authorized by those Tribes. These organizations by the sheer nature of their business serve and advocate Indian Tribal issues and concerns that might be negatively affected if these organizations were excluded from the process. Even though some of the organizations do not represent federally recognized Indian Tribe(s), CMS may communicate with these groups as part of the consultation process. While communication and interaction with Indian organizations is critical, it does not substitute for tribal consultation.

**Urban Indian Organizations:** Urban Indian organizations are funded under Title V of the Indian Health Care Improvement Act to provide health services to eligible Indians living in urban areas. As health care providers these organizations advocate for and provide services (directly and through referral) to urban Indians. Urban Indian organizations are represented on the TTAG. While communication with Urban Indian organizations is critical, it does not substitute for tribal consultation.

**Tribal Technical Advisory Group: (TTAG):** The TTAG serves as an advisory body to CMS, providing expertise on policies, guidelines, and programmatic issues affecting the delivery of health care for AI/ANs served through programs funded in whole or part by CMS. Interaction by CMS with the TTAG does not substitute for Tribal consultation, but assists CMS to make consultation more effective including advising on the type of consultation needed on particular issues. The TTAG plays an integral role in the CMS consultation process by providing technical assistance on complex issues faced by Tribal Governments.

## **7. CMS TRIBAL CONSULTATION PROCESS**

Upon identification of a policy that has tribal implications and a substantial direct effect on Indian Tribes or on the relationship between Tribes and the Federal Government, CMS will initiate

consultation regarding the policy. In order to initiate and conduct consultation, the following serves as a guideline to be utilized by CMS and Indian Tribes:

- Identify the applicable program, policy, rule, regulation, statute and authorizing legislation;
- Identify how the policy has Tribal implications and a substantial direct effect on one or more Indian Tribes or on the relationship between Tribes and the Federal Government or on the distribution of power and responsibilities between the Federal Government and Indian Tribes.
  
- Identify affected/potentially affected Indian Tribe(s).

Determine Consultation Mechanism – Upon determination by CMS that consultation is required, CMS will evaluate the nature of the critical event that may have a substantial impact on Indian Tribes to determine the appropriate level of and mechanism for consultation. Such evaluation should include, but is not limited to, a review of the complexity, implications, and time constraints at issue that may impact on policy, funding and/or budget development, programs, services, functions and activities. Consultation mechanisms include but are not limited to one or more of the following:

- Mailings;
- Teleconferences;
- Face-to-face meetings at the local, regional and national levels between the CMS and Indian Tribes;
- Roundtables
- Annual HHS Tribal Budget and Policy Consultation Sessions.
- Other regular or special program level consultation sessions.

**Communication Methods:** The determination of the critical event and the level of consultation mechanism to be used shall be communicated to affected or potentially affected Indian Tribe(s) using methods appropriate to the issue and with as much advance notice as practicable. These methods include but are not limited to the following:

*Correspondence:* Written communications exchanged between CMS and Indian Tribes that clearly provide affected/potentially affected Indian Tribe(s) with details of the critical event, and the manner and timeframe in which to identify concerns and potential impacts, and an opportunity to propose alternatives and other comments.

*Meeting(s):* CMS shall convene a meeting, which may occur by teleconference, webinar, or face-to-face, with affected/potentially affected Indian Tribe(s) to discuss all pertinent issues in a national, regional, and/or local forum, or as appropriate, to the extent practicable and permitted by law, when the critical event is determined to have substantial impact.

*Official Notification:* Upon the determination of the consultation mechanism, proper notice of the critical event and the consultation mechanism utilized shall be communicated to affected/potentially affected Indian Tribe(s) using all appropriate methods including mailing, broadcast e-mail, Federal Register, and other outlets as appropriate. The FR is the most formal CMS form of notice used for consultation.

*Receipt of Tribal Comment(s):* The CMS shall develop and use all appropriate methods to communicate clear and explicit instructions on the means and time frames for Indian Tribe(s) to submit comments on the critical event, whether in person, by teleconference, and/or in writing.

*Reporting of Outcome:* CMS shall report on the outcomes of the consultation within 90 calendar days of final consultation. Once the consultation process is complete and a proposed policy is approved and issued, the final policy must be broadly disseminated to Indian Tribes, posted on the CMS AI/AN webpage, and linked to appropriate Indian organization websites.

## **8. BUDGET FORMULATION**

HHS conducts an annual, Department-wide Tribal budget consultation session to give Indian Tribes the opportunity to present their budget recommendations to the Department to ensure Tribal priorities are addressed. CMS will comply with section 11 of the HHS Tribal Consultation Policy regarding Budget Formulation.

CMS will fully consider all recommendations for funding priorities and amounts established by the TTAG in its annual plan. The TTAG develops and updates an American Indian and Alaska Native Strategic Plan which focuses on specific policy and annual budget priorities.

## **9. TRIBAL CONSULTATION PERFORMANCE EVALUATION**

CMS is responsible for evaluating its performance under this Tribal Consultation Policy. To effectively evaluate the results of the consultation process and the ability of CMS to incorporate Tribal recommendations, CMS will assess its performance on an annual basis based on the reporting requirements outlined in Section 12 of the HHS consultation policy. CMS will include the Tribes and TTAG in this annual review process.

## **10. MEETING RECORDS AND ADDITIONAL REPORTING.**

*Meeting Records.* CMS is responsible for making and keeping records of its Tribal consultation activity. All such records shall be made readily available to Tribes through the Annual HHS consultation report. CMS shall make and keep records of all TTAG proceedings and recommendations and will have these records readily available.

*Reports to Tribes.* CMS will comply with HHS annual reporting requirements as outlined in section 13 of the HHS Consultation Policy.

## **11. CONFLICT RESOLUTION.**

The intent of this policy is to promote a partnership with Indian Tribes that enhances CMS' ability to address issues, needs and problem resolution. Nothing in this Policy shall be construed to preclude Indian Tribes from raising issues to responsible officials outside of the consultation process. Nothing in the Policy creates a right of action against CMS or the Department of Health and Human Services for failure to comply with this Policy.

## **12. TRIBAL SOVEREIGNTY**

CMS will fully comply with Section 3 of the HHS Tribal Consultation Policy on Tribal Sovereignty. This policy does not waive any Tribal Governmental rights and authority, including treaty rights, sovereign immunities or jurisdiction. Additionally, this policy does not diminish any rights or protections afforded other American Indians or Alaskan Natives (AI/AN) or entities under Federal law.

## **13. TRIBAL WAIVER.**

CMS will fully comply with Section 15 of the HHS Tribal Consultation Policy on Tribal waivers and process all requests routinely received for waivers under existing program authorities with the statutorily set timeframes.

## **14. EFFECTIVE DATE.**

This Policy is effective on the date of signature by the CMS Administrator.

## **15. DEFINITIONS**

Agency - Any authority of the United States that is an "agency" under 44 USC 3502(1) other than those considered to be independent regulatory agencies, as defined in 44 USC 3502 (5).

Communication – The exchange of ideas, messages, or information, by speech, signals, writing, or other means.

Consultation – An enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

Coordination and Collaboration – Working and communicating together in a meaningful government-to-government effort to create a positive outcome.

Critical Events – Planned or an unplanned event that has or may have a substantial impact on Indian Tribe(s), e.g., issues, policies, or budgets which may originate within CMS.

Deliberative Process Privilege – Privilege exempting the government from disclosure of government agency materials containing opinions, recommendations, and other communications that are part of the decision-making process within the agency.

Executive Order – An order issued by the Government's executive on the basis of authority specifically granted to the executive branch (as by the U.S. Constitution or a Congressional Act).

Federally Recognized Tribal governments – Indian Tribes with whom the Federal Government maintains an official government-to-government relationship; usually established by a Federal treaty, statute, executive order, court order, or a Federal Administrative Action. The Bureau of Indian Affairs (BIA) maintains and regularly publishes the list of Federally recognized Indian Tribes.

Indian – Indian means a person who is a member of an Indian Tribe as defined in 25 U.S.C. 479a. Throughout this policy, Indian is synonymous with American Indian/Alaska Native.

Indian Organizations -Those Federally recognized tribally constituted entities that have been designated by their governing body to facilitate CMS communications and consultation activities. Any regional or national organizations whose board is comprised of Federally recognized Tribes and elected/appointed Tribal leaders. The government does not participate in government-to-government consultation with these entities; rather these organizations represent the interests of Tribes when authorized by those Tribes.

Indian Tribe –an Indian or Alaska Native Tribe, Band, Nation, Pueblo, Village or Community that the Secretary of the Interior acknowledges to exist as an Indian Tribe pursuant to the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a.

Policies with Tribal Implications - Refers to regulations, statutes, legislation, and other policy statements or actions that have substantial direct effects on one or more Indian Tribes, 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.

Self-Government – Government in which the people who are most directly affected by the decisions make decisions, including Indian Tribes exercising self-determination and self-governance pursuant to the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended.

Sovereignty – The ultimate source of political power from which all specific political powers are derived.

Substantial Direct Compliance Costs – Those costs incurred directly from implementation of

changes necessary to meet the requirements of a Federal regulation. Because of the large variation in Tribes, “substantial costs” is also variable by Indian Tribe. Each Indian Tribe and CMS, working through HHS, shall mutually determine the level of costs that represent “substantial costs” in the context of the Indian Tribe’s resource base.

To the Extent Practicable and Permitted by Law – Refers to situations where the opportunity for consultation is limited because of constraints of time, budget, legal authority, etc.

Treaty – A legally binding and written agreement that affirms the government-to-government relationship between two or more nations.

Tribal Government – An American Indian or Alaska Native Tribe, Band, Nation, Pueblo, Village or Community that the Secretary of the Interior acknowledges to exist as an Indian Tribe pursuant to the Federally Recognized Indian Tribe List Act of 1994, 25 USC 479a.

Tribal Officials – Elected or duly appointed officials of Indian Tribes or Tribal organizations.

Tribal Organization – The recognized governing body of any Indian Tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities: Provided, That in any case where a contract is let or grant made to an organization to perform services benefiting more than one Indian Tribe, the approval of each such Indian Tribe shall be a prerequisite to the letting or making of such contract or grant.

Tribal Resolution – A formal expression of the opinion or will of an official Tribal governing body which is adopted by vote of the Tribal governing body.

Tribal Technical Advisory Group – An advisory group comprised of individuals who are elected Tribal officials (and/or Tribal employees acting on their behalf), who provide advice and input on policies, guidelines, and programmatic issues affecting the delivery of health care for AI/ANs served by titles XVIII, XIX, and XXI of the Social Security Act or any other health program funded by CMS.

Urban Indian Organization – A program funded under title V of the Indian Health Care Improvement Act.

/s/

11/17/2011

\_\_\_\_\_  
Donald M. Berwick, M.D.  
Administrator  
Centers for Medicare & Medicaid Services

\_\_\_\_\_  
Date



**U.S. Department of Health & Human Services  
2011 Annual Tribal Consultation Report**

**APPENDIX V**

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**DEAR GOVERNOR LETTER: TRIBAL STATE RELATIONS**

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THE SECRETARY OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D.C. 20201

September 14, 2011

Dear Governor:

Over the last two years, the Department of Health and Human Services (HHS) has taken a number of steps to strengthen our partnership with American Indian and Alaska Native Tribal Nations. We take seriously the federal government's obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by the Department.

However, improving the health and well-being of Tribal nations is contingent upon understanding the specific needs of Tribal communities. Tribal consultation is an essential tool in understanding these unique needs and ensuring government to government relations. I am writing to you today to encourage you to consult with Tribes as you administer health and human services programs that are supported with federal funding.

HHS has made significant progress in strengthening our partnership with Tribes, and Tribal consultation is one piece of our efforts to fulfill our responsibility to represent the best interests of Tribes. Since President Obama signed an Executive Order on Tribal Consultation in 2009, HHS has also updated its formal Tribal consultation policy. The updated policy includes the responsibility of states to consult with Tribes when HHS has transferred the authority and funding for programs to states that are intended to benefit Tribes. States must consult with Tribes to ensure the programs that they administer with federal funding meet the needs of the Tribes in that state. Tribes should be considered full partners by states during the design and implementation of programs that are administered by states with HHS funding. The requirement of states to consult with Tribes in the development of the Affordable Insurance Exchanges is an example of how states can proactively include and partner with Tribes during the planning stages of a program that has the potential to benefit Tribal members greatly. Consultations can identify strengths and barriers to Tribes accessing these services and ensure that Tribes have the opportunity for greater health care coverage for their members and employees.

I believe we share a vision of the future where our nation is strong and where every individual and every community has the opportunity to reach their full potential. We can continue to strengthen our partnership with Tribes and improve health and human service opportunities for all. Together, we have the opportunity to build something great.

Sincerely,

/Kathleen Sebelius/  
Kathleen Sebelius



U.S. Department of Health & Human Services  
2011 Annual Tribal Consultation Report

## APPENDIX VI

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### FREQUENTLY USED ACRONYMS

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4 A's	Alaskan Aids Assistance Association
AAIHS	Albuquerque Area Indian Health Service
AATCHB	Aberdeen Area Tribal Chairmen's Health Board
AC	Action Community
ACA	Affordable Care Act
ACF	Administration for Children and Families
ACLSU	Acoma, Canoncito, and Laguna Service Unit
ACMT	American College of Medical Toxicology
ACTS	Automated Collection and Tracking System
ACYF	Administration on Children, Youth and Families
ADA	American Diabetes Association
ADD	Administration on Developmental Disabilities
AETC	AIDS Education and Training Centers
AFA	Annual Funding Agreement (IHS)
AFCARS	Adoption and Foster Care Analysis and Reporting System
AFDC	Aid to Families with Dependent Children
AFI	Assets for Independence
AHCCCS	Arizona Health Care Cost Containment System
AHEC	Area Health Education Center
AHRQ	Agency for Healthcare Research and Quality
AI/AN	American Indian and Alaska Native
AIC	American Indian Council
AIDS	Acquired Immunodeficiency Syndrome
AIP	Arctic Investigations Program
AIR	All-Inclusive-Rate
ANA	Administration for Native Americans
ANTHC	Alaska Native Tribal Health Consortium
APD	Advance Planning Document
APHA	American Public Health Association
ARRA	American Recovery and Reinvestment Act of 2009
ASPR	Assistant Secretary for Preparedness and Response
ASTHO	Association of State and Territorial Health Officers
ATSDR	Agency for Toxic Substances and Disease Registry Agency for Toxic Substances and Disease Registries

AZDHS	Arizona Department of Health Services
BHPr	Bureau of Health Professions
BIA	Bureau of Indian Affairs (DOI)
BIE	Bureau of Indian Education
BPHC	Bureau of Primary Health Care
CAB	Capacity Building Assistance
CAO	California Area Office (IHS)
CAP	Community Action Plan
CARF	Commission on Accreditation of Rehabilitation Facilities
CATAC	California Area Tribal Advisory Committee
CB	Children's Bureau
CBO	Community-Based Organization
CBPR	Community Based Participatory Research
CBRN	Chemical, Biological, Radiological, and Nuclear
CCDF	Child Care and Development Fund
CDA	Child Development Associate Coeur d'Alene Tribe
CDC	Centers for Disease Control and Prevention
CDIB	Certificate of Degree of Indian Blood
CEO	Chief Executive Officers
CFCIP	Chafee Foster Care Independence Program
CFSR	Child and Family Services Review
CFDA	Catalog of Federal Domestic Assistance
CHA	Community Health Aide
CHC	Community Health Center
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CHP	Community Health Practitioners
CHR	Community Health Representative (IHS)
CHS	Contract Health Services
CHSDA	Contract Health Services Delivery Area
CKD	Chronic Kidney Disease
CLASS	Classroom Assessment Scoring System
CMCS	Centers for Medicaid, CHIP and Survey & Certification
CME	Continuing Medical Education
CMS	Centers for Medicare & Medicaid Services
COBRE	Centers of Biomedical Research Excellence
COE	Center of Excellence
CPPW	Communities Putting People to Work
CRCCP	Colorectal Cancer Control Program
CRCS	Comprehensive Risk Counseling and Services
CRIHB	California Regional Indian Health Board California Rural Indian Health Board
CSBG	Community Services Block Grant
CSC	Contract Support Costs (IHS)
CSE	Child Support Enforcement
CSPS	Comprehensive STD Prevention Services
CTR	Counseling, Testing and Referral
CVD	Cardiovascular Disease

DASH	Division of Adolescent and School Health
DD	Developmental Disabilities
DEA	Drug Enforcement Administration
DEHS	Division of Environmental Health Services (IHS)
DETS	Diabetes Education in Tribal Schools
DFS	Division of Federal Systems
DHS	Department of Health Services
DMCHO	Division of Medicaid and Children's Health Operations
DMHPO	Division of Medicare Health Plan Operations
DOH	Department of Health
DOE	Department of Energy
DOEH	Department of Occupational and Environmental Health
DOI	Department of Interior
DOJ	Department of Justice
DP	Division of Policy
DPRE	Division of Planning, Research, and Evaluation
DSA	Division of State Assistance
DSH	Disproportionate Share Hospital
DSHS	Department of Social and Health Services
DSNS	Division of Strategic National Stockpile
DSLS	Division of Student Loans and Scholarships
DSTS	Division of State and Tribal Systems
DTTM	Division of Tribal TANF Management
DVBD	Division of Vector Born Diseases
DVPI	Domestic Violence Prevention Initiative (IHS)
EBI	Evidence-based Behavioral Intervention
ECC	Early Childhood Caries
ECE	Early Childhood Education
ED	Department of Education
EH	Environmental Health
EHR	Electronic Health Record
EHS	Early Head Start
EIS	Early Intervention Services
	Epidemiologic Intelligence Officer
EJ	Environmental Justice
EMS	Emergency Medical Service
EMSC	Emergency Medical Services for Children
EMTALA	Emergency Medical Treatment and Active Labor Act
ENIPC	Eight Northern Indian Pueblo Council
EPA	U.S. Environmental Protection Agency
ESRD	End Stage Renal Disease
ETV	Education and Training Vouchers
EWIDS	Early Warning Infectious Disease Surveillance
FACA	Federal Advisory Committee Acct
FASD	Fetal Alcohol Spectrum Disorders
FBI	Federal Bureau of Investigation
FEHB	Federal Employees Health Benefits

FEMA	Federal Emergency Management Agency
FFS	Fee-for-Service
FIC	John E. Fogarty International Center for Advanced Study in the Health Sciences
FMAP	Federal Medical Assistance Percentage
FOA	Funding Opportunity Announcement
FQHC	Federally Qualified Health Center
FUDS	Formerly Used Defense Sites
FVPSA	Family Violence Prevention and Services Act Program
FY	Fiscal Year
FYSB	Family and Youth Services Bureau
GPRA	Government Performance and Results Act
GPTCHB	Great Plains Tribal Chairmen's Health Board
GYT	Get Yourself Talking
HAIC	Heart of America Indian Center
HCBS	Home and Community Based Services
HD	Health Department
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health
HIV	Human Immunodeficiency Virus
HPDP	Health Promotion and Disease Prevention
HPP	Hospital Preparedness Program
HPSA	Health Profession Shortage Area
HRAC	Health Research Advisory Council
HRSA	Health Resources and Services Administration
HS	Head Start
HTAC	Healthy Traditions Advisory Council
HUD	U.S. Department of Housing and Urban Development
I/T/U	Indian Health Service/Tribal/Urban Programs
IAA	Inter AIDS Association
	Inter-Agency Agreement
IC	Institutes and Centers of the NIH
ICNAA	Intrdepartmental Council on Native American Affairs
ICWA	Indian Child Welfare Act
IDA	Individual Development Account
IDC	Indirect Cost
IDeA	Institutional Development Award
IEA	Intergovernmental and External Affairs
IEP	Individualized Education Plan
IFSP	Individualized Family Services Plan
IH	Industrialized Health
IHCIA	Indian Health Care Improvement Act
IHS	Indian Health Service
IJ	Immediate Jeopardy
IM	Information Memorandum
IMMP	Infant Mortality Prevention Program

IORA	Immediate Office of the Regional Administrator
IPA	Intergovernmental Personnel Agreement
IPC	Improving Patient Care Initiative (IHS)
IPP	Infertility Prevention Projects
IRS	Internal Revenue Service
ISDEAA	Indian Self-Determination and Education Assistance Act
IT	Information Technology
ITU	Indian, Tribal and Urban
IWGIA	Interagency Working Group on Indian Affairs
JAN	Jicarilla Apache Nation
JVCP	Joint Venture Construction Program (IHS)
KHPA	Kansas Health Policy Authority
LCMV	Lymphocytic Choriomeningitis Virus
LCTHC	Lake County Tribal Health
LIHEAP	Low Income Home Energy Assistance Program
LLP	Lifetime Legacy Plan
M&I	Maintenance & Improvement (IHS)
MAAC	Medical Assistance Advisory Council
MAC	Medicare Administrative Contractors
MAPPS	Media, Access, Pint of Purchase/Promotion, Price and Social Support Svc
MAT	Mescalero Apache Tribe
MCH	Maternal and Child Health
MCO	Managed Care Organizations
MCP	Mentoring Children of Prisoners
MDHFS	Minneapolis Department of Health and Family Support
MFFP	Minority Faculty Fellowship Program
MIC	Missoula Indian Center
MLR	Medicare-Like Rates
MORE	Minority Opportunities in Research
MOU	Memorandum of Understanding
MSHS	Migrant and Seasonal Head Start
MSI	Minority Serving Institution
MSPI	Methamphetamine and Suicide Prevention Initiative (IHS)
MTS	Model Tribal System
MU	Meaningful Use
MUP	Medically Underserved Population
NAAAC	Native American Affairs Advisory Council
NABI	Native Asset Building Initiative
NAC	Native American Contract
NACA	Native Americans for Community Action
NACCHO	National Association of City and County Health Officials
NACR	Native American Cancer Research Corporation
NADLC	Native American Disability Law Center, Inc.
NAFFA	Native Americans Fathers and Families Association
NAIHS	Navajo Area Indian Health Service
NARCH	Native American Research Centers on Health

NARTC	Native American Research and Training Center
NAU	Northern Arizona University
NAVAHCS	Northern Arizona Veterans Affairs Health Care System
NBCCEDP	National Breast and Cervical Cancer Early Detection Program
NCBDDD	National Center on Birth Defects and Developmental Disabilities
NCCAM	National Center for Complimentary and Alternative Medicine
NCCCP	National Comprehensive Cancer Control Program
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCEH	National Center for Environmental Health
NCEZID	National Center for Emerging and Zoonotic Infectious Diseases
NCFY	National Clearinghouse on Families and Youth
NCHHSTP	National Center for HIV, Hepatitis, STD and Tuberculosis Prevention
NCHS	National Center for Health Statistics
NCI	National Cancer Institute
NCIPC	National Center for Injury Prevention and Control
NCIRD	National Center for Immunization and Respiratory Diseases
NCRCCP	National Colorectal Cancer Control Program
NCRR	National Center for Research Resources
NCUIH	National Council of Urban Indian Health
NDEP	National Diabetes Education Program
NDWP	Native Diabetes Wellness Program
NEI	National Eye Institute
NEW	Native Employment Works
NHANES	National Health and Nutrition Examination Survey
NHGRI	National Human Genome Research Institute
NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corp
NHSFLC	National Head Start Family Literacy Center
NHSS	National Health Security Strategy
NIA	National Institute on Aging
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIAID	National Institute of Allergy and Infectious Diseases
NIAMS	National Institute of Arthritis and Musculoskeletal and Skin Diseases
NIBIB	National Institute of Biomedical Imaging and Bioengineering
NICCA	National Indian Child Care Association
NICHD	Eunice Kennedy Shriver National Institute of Child Health and Human Development
NIDCD	National Institute on Deafness and Other Communication Disorders
NIDCR	National Institute of Dental and Craniofacial Research
NIDDK	National Institute of Diabetes and Digestive and Kidney Diseases
NIDA	National Institute on Drug Abuse
NIEHS	National Institute of Environmental Health Sciences
NIGMS	National Institute of General Medical Sciences
NIH	National Institutes of Health
NIH-OD	NIH Office of the Director
NIHB	National Indian Health Board
NIMH	National Institute of Mental Health
NIMHD	National Institute of Minority Health and Health Disparities
NINDS	National Institute of Neurological Disorders and Stroke
NINR	National Institute of Nursing Research
NIOSH	National Institute for Occupational Safety and Health

NIWRC	National Indigenous Women’s Resource Center
NLM	National Library of Medicine
NMDOH	New Mexico Department of Health
NN	Navajo Nation
NPAIHB	Northwest Portland Area Indian Health Board
NPCCCP	Northern Plains Comprehensive Cancer Control Program
NPCR	The National Program of Cancer Registries
NPHII	National Public Health Infrastructure Initiative
NPHPSP	National Public Health Performance Standards Program
NPIRS	National Patient Information and Reporting System
NRC	National Resource Center
NSRTC	New Sunrise Regional Treatment Center
NTEC	Northwest Tribal Epidemiology Center
NTEH	National Tribal Environmental Health Think Tank
NTTPN	National Tribal Tobacco Prevention Network
OCA	Oklahoma City Area (IHS)
OCC	Office of Child Care
OCH	Occupational Safety and Health
OCR	Office for Civil Rights
OCS	Office of Community Services
OCSE	Office of Child Support Enforcement
OD/OBSSR	NIH Office of the Director, Office of Behavioral and Social Sciences Research
OD/ORWH	NIH Office of the Director, Office of Research on Women’s Health
OEABS	Office of External Affairs and Beneficiary Services
OEHE	Office of Environmental Health and Engineering (IHS)
OESS	Office of E-Health Standards and Services (CMS)
OFA	Office of Family Assistance
OHCA	Oklahoma Health Care Authority
OHS	Office of Head Start
OID	Office of Infectious Diseases
OIT	Office of Information Technology (IHS)
OLDC	Online Data Collection
OMB	Office of Management and Budget
OMHD	Office of Minority Health and Health Disparities
ONDIEH	Office of Non-Communicable Diseases, Injury and Environmental Health
OPDIV	Operating Divisions (of HHS)
ORHP	Office of Rural Health Policy
ORO	Office of Regional Operations
OS	Office of the Secretary
OSH	Occupational Safety and Health
OST	Oglala Sioux Tribe
OSTLTS	Office for State, Tribal, Local and Territorial Support
OTA	Office of Tribal Affairs (CDC)
OVW	Office of Violence Against Women
P&A	Protection and Advocacy Systems
PADD	Protection and Advocacy Systems – Developmental Disabilities
PAFAC	Portland Area Facilities Advisory Committee (IHS)
PAK	Physical Activity Kit



PBP	Prairie Band Potawatomi Nation
PCIP	Pre-Existing Insurance Plan
PCMH	Patient Centered Medical Home
PCV	Pneumococcal Conjugate Vaccine
PGO	Program and Grants Office
PHEP	Public Health Emergency Preparedness
PHHS	Preventive Health and Health Services
PHLP	Public Health Law Program
PHN	Public Health Nursing
PHPS	Public Health Prevention Services
PHR	Patient Health Record
PIR	Program Information Reports
PNS	Projects of National Significance
PPMNS	Planned Parenthood of Minnesota, North Dakota and South Dakota
PRAMS	Pregnancy Risk Assessment Monitoring System
PREP	Personal Responsibility Education Program
PSPC	Patient Safety and Clinical Pharmacy Services Collaborative
PYT	Pascua Yaqui Tribe
QI	Division of Quality Improvement
QTEM	Quarterly Tribal Epidemiology Meeting
RCMI	Research Centers for Minority Institutions
REACH US	Racial and Ethnic Approaches to Community Health
RHY	Runaway and Homeless Youth Programs
RHYTTAC	Runaway and Homeless Youth Programs Training and Technical Assistance Contractor
RISE	Research Initiative for Scientific Enhancement
RMSP	Rocky Mountain Spotted Fever
RO	Regional Office
RPM	Regional Program Manager
RPMS	Resource and Patient Management System
RTHP	Return to a Healthy Past
SAH	Strategic Alliance for Health
SAMHSA	Substance Abuse and Mental Health Services Administration
SANACPT	Shawnee Area Native American Child Protection Team
SCF	Southcentral Foundation
	Strengthening Communities Fund
SCTCA	Southern California Tribal Chairman's Association
SDS	Sanitation Deficiency System (IHS)
SEARHC	Southeast Alaska Regional Health Consortium
SEDS	Social and Economic Development Strategies
SEER	Surveillance, Epidemiology, and End Results
SEIOB	Surveillance, Epidemiology and Outbreak Investigations Branch
SEM	Socio-Ecological Model
SFC	Sanitation Facilities Construction (IHS)
SF-PPR	Standard Form-Performance Progress Report
SIDS	Sudden Infant Death Syndrome
SIP	Special Interest Project
SIPI	Southwestern Indian Polytechnic Institute

SHIP	State Health Insurance Assistance Program
SKC	Salish Kootenia College
SLT	Spirit Lake Tribe
SMD	State Medicaid Director
SORH	State Office of Rural Health
SPA	State Plan Amendments
SPARC	Strengthening Partnerships and Resources in Communities for Literacy
SPIEC	Southern Plains Inter Tribal Epicenter
SRS	Department of Social & Rehabilitation Services
SRST	Standing Rock Sioux Tribe
SSA	Social Security updates by a Social Security Administration
SSM	Sault Ste Marie Tribe of Chippewa Indians
SSU	Sells Service Unit (IHS)
STAFFDIV	Staff Divisions
STAND	Students Against Negative Decisions
STD	Sexually Transmitted Disease
	Sexually Transmitted Infection
SUIT	Southern Ute Indian Tribe
SWAT	Students Working Against Tobacco
T/TA	Training and Technical Assistance
TA	Technical Assistance
TAC	Tribal Advisory Committee
TAG	Tribal Affairs Group
TANF	Temporary Assistance for Needy Families
TAO	Tucson Area Office (IHS)
TB	Tuberculosis
TBH	TeleBehavioral Health (IHS)
TCAC	Tribal Consultation Advisory Committee
TCP	Tribal Consultation Policy
TCU	Tribal Colleges and Universities
TDM	Tribal Delegation Meeting (IHS)
TEC	Tribal Epidemiology Centers
TECC	Tribal Epi Center Consortium
THO	Tribal Health Organization
TIPS	Training, Information, and Practical Strategies
TJSA	Tribal Jurisdictional Service Area
TLDC	IHS Tribal Leaders Diabetes Committee
TMIECHV	Tribal Maternal, Infant and Early Childhood Home Visiting
TON	Tohono O'odham Nation
TriTAC	Tribal Technical Assistance Center
TTAG	Tribal Technical Advisory Group
TTANF	Tribal Temporary Assistance for Needy Families
TT-CW	Tribal TANF-Child Welfare Coordination
TVIS	Title V Information System
UCEDD	University Centers for Excellence in Developmental Disabilities, Education, Research and Service
UDB	Unified Database Project
UDS	Uniform Data System
UFMS	United Financial Management System

UNM	University of New Mexico
USDA	United States Department of Agriculture
USET	United Southern and Eastern Tribes
VA	U.S. Department of Veterans Affairs
VIHSTA	Visionary and Innovative Health Sciences Training in Arizona
VITA	Volunteer Income Tax Assistance
WISEWOMAN	Well-Integrated Screening/Evaluation for Women across the Nation
WRIR	Wind River Indian Reservation
YRBS	Youth Risk Behavior Survey
YRTC	Youth Regional Treatment Center (IHS)
YST	Yankton Sioux Tribe