The History, Success, and Future Trajectory of Tribal Self Governance under the ISDEAA P.L. 93-638

Presenters:
Geoff Strommer, JD
Hobbs, Straus, Dean & Walker. LLP
and
Carolyn Crowder, Self Governance Liaison
Norton Sound Health Corporation
The Alaska Self Governance Journey

What we will cover……..

He Huliau Turning Point

I. Self Determination in Alaska
II. The Alaska Tribal Health Compact
III. Statewide Health Services: Role of ANTHC, SCF & ANHB
IV. Contract Support Cost Litigation Impact on Capacity Building
V. National Tribal Health Future Landscape
The Alaska Tribal Health System

I. Self Determination in Alaska
History: Alaska Native Health Service Delivery

- **1900-1970**: Health care for Alaska Natives was provided by the U.S. government.

- **1970-1998**: Alaska Native tribes organized health care organizations under Self-Governance legislation and gradually assumed ownership of health services at regional and tribal levels.

- **1998-Curren**: All Alaska Native health care is provided by Alaska Tribes/Tribal Health Organizations:
  - Represents 229 Tribes
  - Serves 147,000 Alaska Natives/American Indians
  - 586,412 square miles of predominantly road-less land
History: Alaska Tribal Health System

- **Alaska Native Health Board (ANHB)** established (1968) Representing 26 member Tribal Health Orgs & Independent Tribal P. L. 93-638 Compactors & Contractors (Dues Organization)
  - Alaska Tribal Health Directors serve as Technical Advisors
  - Formed Committees to work on Issues: Legislative, CHAP Directors, BH Directors, etc.
  - Forum to address all Statewide Health Issues & present unified voice on Health matters
  - Created & Co-managed Statewide Services i.e. Community Health Aide Program, Sanitation & Safe Water Services
  - Recognized as the Federal & State Health Advocacy Voice for Alaska Natives
  - Health Arm of the Alaska Federation of Natives (AFN)
    - Cultural, economic & political voice of entire Alaska Native Community
Milestones: Alaska Tribal Health System

- 1966 Formation of Alaska Federation of Natives (AFN) to respond to indigenous land rights
- 1968 Formation of the Alaska Native Health Board
- 1970 First regional health organizations (YKHC and NSHC); CHAP program contracted in 1972
- 1975 AFN’s Alaska Native Health Care Policy Statement; Passage of ISDEAA began the self-determination process to contract village and community based services
- 1980s & 1990s Alaska Tribal Health System focused on Tribal Control of IHS Operations
- 1995 Alaska Tribal Health Compact agreement Established; 13 Co-signers to ATHC; all but Anchorage Service Unit and ANMC were operated by Tribal Health Organizations (THOSs)
- 1997 ANTHC authorized by Congress under Section 325 to contract for Statewide Services and to jointly operate ANMC with SCF; new ANMC Hospital Constructed
- 1998 Formation of ANTHC
- 1999 ANMC ownership transferred to ANTHC, & SCF; Joint Operating Board (JOB) created
- 2002 ANHB Statewide Native Health Plan
- 2004 ATHS Memo of Understanding
Alaska Tribal Health System Today

- Shared advocacy lead by Alaska Native Health Board
- One compact with Indian Health Service
- Co-Manage ANTHC statewide services & statewide AK Native Medical Center w/open access to urgent care statewide
- Strong Inter-tribal Health Network
- ATHS organizations collectively spend almost $4 million per day
- ATHS employs over 8,000 full and part-time staff statewide ~ 70% Native Hire
- ATHS expenditures $1.4 billion; $1.7 billion by 2020
- ATHS serves 147,000 people; 160,000 people by 2020 (9% increase)
Alaska Tribal Health Care Delivery System

- Alaska Native Medical Center: tertiary care center
- 6 regional hospitals
- 7 multi-physician health centers
- 25 sub-regional mid-level care centers
- 180 small community primary care centers
- Purchased/Referred Care to private medical providers and other specialty services
II. The Alaska Tribal Health Compact
Evolution of the All-Alaska Compact

- Alaska Tribal Health System proposed SINGLE State-wide Agreement under the Title III of the ISDEAA Tribal Self Governance Demonstration Project & Supported by the Alaska Area Director (1988-early 1990s)

- Alaska Tribal Health Compact was established to support and encourage all Tribal health providers in Alaska to continue to support a statewide, locally controlled, integrated health delivery system (1995)

- Congress Authorized statewide organization: 13 THOs + 2 Unaffiliated Reps designated to manage ANTHC statewide services and co-manage ANMC, through ANTHC Consortium Board of Directors (1998)

- Demonstration project made permanent by Title V Legislation: Open to any Tribe/Tribal Organization eligible for Self Governance; Co-signers to the Alaska Tribal Health Compact; Tribal authority delegated through Authorizing Resolutions (2000)

- Co-signer Funding Agreements are entered into by a Tribe, or Tribal Health Organization on behalf of member Tribes; designed to support local sovereignty (individual funding agreements) while supporting and enhancing statewide Tribal Health Care System (ground rules established for consensus decision making, joint negotiations and common resource distribution recommendations)

- Foundation is Respect for Strong Government-to-Government Relationship
Evolution of the All-Alaska Compact

- Alaska Tribal Caucus Negotiations Structure:
  - All co-signers are members of negotiating team
  - Election of Co-lead negotiators: one Tribal Governance Leader, one Administrative Leader

- Invocation Opening

- Pre-negotiations – 2 days, usually in March; opportunity to bring up new issues & identify new co-signers

- Final Negotiations – 1 week, usually in May

- Common Negotiations – Preserves Tribal Right to Opt out of commonly negotiated items
Evolution of the All-Alaska Compact

- Alaska Tribal Caucus Negotiations Structure:
  - Closed Caucus: Review of Common Open Items Issues & Updates, Tribes may call for Caucuses as needed
  - Open Mike daily
  - Individual Tribal Funding Agreement Negotiations (drawing to determine order)
    - Opportunity to share local concerns and issues
    - Negotiation of Tribal-specific terms, language & issues
  - ANHB serves as facilitator
    - Sets Agenda for Compact Negotiations
    - Facilitates Tribal Caucuses
Alaska Tribal Caucus Cooperative Relationship:

- **Co-signer Common Negotiations Consensus Process**
  - **Tribal Shares Workgroup** makes recommendations on resource distribution to the Tribal Caucus (Open to All Co-signers)
  - **Legal Language Committee** makes recommendations on Compact & Funding Agreement Common Language proposals (Open to All Co-signers & Legal Counsel)
  - Open Tribal Caucus Discussion & Position on National Issues of Importance to Co-signers
  - Open Items List Recorder: All Co-signers Agree on Documentation of Tribal Shares, Legal language, Issues among Co-signers
  - Agreement on Ground Rules; Paramount is consensus decision making
Alaska Tribal Caucus Cooperative Relationship:

- **Decision making Process**
  - Closed Caucus before Pre- & Final-negotiations & as needed
  - Co-signer discussion of IHS Agency Lead Negotiator positions/decisions in other negotiations
  - General Agreement which issues will be considered to be Common Issues among Co-signers
  - Documentation & Agreement on Caucus position on Open Items List of Issues

- **Principles:**
  - Shared Vision for the Greater Good
  - Do No Harm
  - Do Not Made Concessions which has potential to erode Tribal rights to Self Govern

- Consensus Decision-making & Process for Conflict Resolution
- Tribes retain right to opt out of commonly negotiated language during individual negotiations
Health Resources (Tribal Shares) for One Individual or Village may be spread across Several THO’s

Patient visits Village or Subregional System

Patient may be from village or small village consortium that operated Village Health Aide Program independently.

Referred to Regional Corp.

Patient evaluated and Referred to Regional Program for outpatient treatment or purchases care, if available or referred to Regional Hospital or ANMC.

Referred to ANMC

ANMC treats patient or may refer further to Contract Care (PRC) for more complex care
Alaska Tribal Health System Referral Patterns
The Alaska Tribal Health Compact

Funding & Resource Distribution
Key Concepts

**Activities IHS carries out**

- **PSFA**
  - means programs, services, functions, and activities (or portions thereof) that IHS carries out that an Indian Tribe may elect to carry out through a contract or compact

- **Inherent Federal Function**
  - means those governmental functions which only IHS must perform which cannot legally be delegated to Tribes

**Associated funds**

- **Total Tribal Share**
  - means the associated portion of funds used by IHS to carry out the PSFAs to be contracted at all levels. (In this presentation Tribal share is also used to refer only to Area and HQ tribal shares)

- **Residual**
  - means associated portion of funds used by IHS to carry out remaining inherent Federal functions when all other PSFAs are contracted
Total of 3 Levels of Shares are Available

PSFA and associated funds are available for each AK co-signer from all 3 levels of the IHS.

- **IHS-wide (HQ) Shares**
  AK Portion (about 11% of national total) benefiting AK Tribes

- **Area Level Shares**
  All Alaska Area funding less Residual and Transitional funds

- **Local Level Shares**
  Portion benefiting each Tribe or Tribal Organization plus share for “statewide services” to ANTHC and SCF.

* Restricted somewhat by sec 325 which limits transfer of some statewide tribal shares
## Alaska Tribal Health Funding

### Annual Alaska IHS Tribal Health Funding

<table>
<thead>
<tr>
<th>Sources of Funds</th>
<th>Annual Funding* (in thousands)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area Office (Residual, Transitional and Admin support)</td>
<td>$5,100</td>
<td>0.7%</td>
</tr>
<tr>
<td>IHS Non Recur. and IHS Grants</td>
<td>$8,000</td>
<td>1.1%</td>
</tr>
<tr>
<td>Headquarters Tribal Share</td>
<td>$9,000</td>
<td>1.2%</td>
</tr>
<tr>
<td>Area Tribal Shares</td>
<td>$12,900</td>
<td>1.7%</td>
</tr>
<tr>
<td>M&amp; I and Equipment (formula)</td>
<td>$10,400</td>
<td>1.4%</td>
</tr>
<tr>
<td>Contract Support Costs</td>
<td>$201,800</td>
<td>26.7%</td>
</tr>
<tr>
<td>Purchases and Referred Care (PRC)</td>
<td>$86,400</td>
<td>11.5%</td>
</tr>
<tr>
<td>Recurring Health Services Program Base</td>
<td>$421,800</td>
<td>55.7%</td>
</tr>
<tr>
<td><strong>Total Annual Funding</strong>*</td>
<td><strong>$754,700</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

History of Compact Funding Negotiations with IHS

- Early negotiations (1994-1996) for the Alaska Compact were difficult as many issues were without precedent. Negotiations were time consuming and contentious and often required multiple week long meetings to resolve. These issues included:
  - Negotiation of Headquarters Residual and defining the national TSA formula for Headquarters Tribal share.
  - Negotiation of Area Office Residual (Alaska Area has one of the smallest residuals in the IHS with less than .5% funding and 23 positions devoted to residual functions.)
  - Negotiation of downsizing plan for Alaska Area Office. (Alaska Area reduced itself from over 225 employees to the current level of 35 which includes residual, transitional and buyback service support employees).
Common Factors used in IHS Resource Distribution Formulas

- Historical Recurring Base of Program- (primary driver of many formulas)
- Population- (primary driver of many formulas)
  - IHS active user (used in most IHS formulas)
  - IHS service population (used for Pop Growth only)
- Census- (used by ATHC in Alaska Tribal Share formula)
Factors in IHS Resource Distribution Formulas

- Modifiers for formulas-
  - Size of program (*economies of scale*)
  - Number of Tribes (*used in Alaska TSA formula*)
  - Cost of care (*geographical factor*)
  - Dependency on program (*PRC*)
  - Need (*poverty and mortality or disease incidence rates*)
  - Facility size and condition (*M&I*)
  - Indirect cost rate (*CSC*)
  - Level of existing funding from all sources (*IHCIF-FDI*)

- Alaska formulas for resource distribution rely on similar modifying factors but may combine and weight them differently.
Principles for Resource Distribution in Alaska

- In the initial years of Compact negotiations the Alaska Tribal Caucus developed several principles to guide discussions of resource distribution.
  - Support stable base budgets. Operating Unit funding once distributed is recurring to each co-signer to the maximum extent possible (this now includes all funds except for some directed grant funds and national program formula funding primarily in Facilities categories).
  - Maximize Resources to Alaska - Alaska Tribes (and co-signers) have generally agreed to work together through the Alaska Native Health Board, Alaska Tribal Caucus and other Alaska tribal entities to maximize the total funding to the Alaska Tribal Health System (not a single co-signer).
    - United statewide position – The Alaska Native Health Board in cooperation with the Tribal Caucus develops and supports a statewide unified position on funding priorities.
Principles for Resource Distribution in Alaska (cont’d)

- Alaska internal distributions - Co-signers have agreed the Alaska Tribal Health system has unique needs and requirements for support which are different from IHS national requirements. It has agreed to review all new resource allocation decisions in Alaska in Tribal Caucus once resources reach the Area Office for internal fairness and support of statewide services and objectives.
  - It has agreed to allocate all Headquarters TSA shares and Area tribal shares using a locally approved Alaska Tribal Share Adjustment Formula.
- Transparency - Alaska co-signers have agreed to share all financial information contained in the compact or individual funding agreements.
- Resource distribution decisions continue to be some of the most difficult to manage within the Alaska Tribal Caucus with all participants forced to compromise at times.
Tribal Caucus Resource Distribution Guidelines

- The Caucus adopted some principles to use when adopting internal Alaska resource distribution formulas.
- The variables used for proxy measures should be:
  - Non Biased (*collected by a third party*)
  - Reliable (*replicable from year to year and across regions*)
  - Valid (*measure intended funding need*)
- Distributions normally are recurring except in rare cases where the tribal caucus agrees to make non-recurring.
Alaska Adjustments to Funding Distribution in Compact

- The Alaska Tribal caucus commonly modifies national funding formulas to reflect the characteristics of the Alaska Tribal Health System
- The tribal caucus normally reviews program increases and recommends allocations that reflect the unique characteristics of the Alaska Tribal Health System.
- The Tribal Caucus normally reserves a portion of most increases (normally about 25%) to support ANMC which is not included in many national allocation formulas and the Alaska Tribal Share Formula.
Alaska Tribal Health Compact Impact on Alaska Area Office:

- Alaska paved the way for Tribes to assume Area Office Assume non-residual programs, functions, services and activities (PFSAs)

- Transfer of Area PFSAs to ANTHC radically changed relationship with Alaska Area Office

- Role of Alaska Area Office shifted to processing compacts/contracts & assisting with Self Governance in AK & Nationally
Statewide Services

- Statewide Services from the ANTHC (formerly provided by the Alaska Area Office) include:
  - Area Business Office Support
  - Community Health Program Support Services
  - CHAP Program Coordination. Certification and Training
  - Contract Health Coordination (from Area Office)
  - Information Technology (transferred to ANMC)
  - Professional Recruitment and Training Support
  - Regional Supply Service Center
  - Environmental Health and Engineering (includes sanitation and facilities support services)
III. Statewide Health Services: Role of ANTHC, SCF & ANHB
Role of ANTHC

- Co-Manages ANMC w/SouthCentral Foundation
  - Inpatient & specialty care
  - Level II Trauma Center (earned in 1999)
  - Provides care management for patients referred into ANMC & Purchased/referred care
- Manages all Statewide Health Services incl. seeking grants which provided service statewide
- Responsible for most former Area Office Functions incl. Area Director’s reserve
- Annual Report to Tribes (Early Dec. in ANC)
- Board oversight of policies, strategic plans incl. master campus plan, and budget (Tribal Health Organizations have a representative seat)
- Participates as equal compact Tribe in ANHB and Alaska Tribal Health Compact
Role of Southcentral Foundation (SCF)

- Co-Manages ANMC through Jt. Operating Board (JOB)
- Care Coordination of rural Anchorage Service Unit (ASU) Primary Care Centralized Services incl. referrals to SCF specialty care and ANMC, village pharmacy
- Regular Reports to ASU Tribes through Independent Rural Anchorage Service Unit Tribal Health Council (ASUTHC) & SCF Village Services Management Team (VSMT)
- Participates in Board oversight of policies, strategic plans incl. master campus plan, and budget
- Participates as equal compact Tribe in ANHB and Alaska Tribal Health Compact under Tribal authority granted to CIRI, Inc.
Role of ANHB

- Leads Tribal Health Advocacy for AK Tribes
- Leads Strategic Planning for Alaska Tribal Health System
- Facilitates bi-annual Mega meetings with Tribes, IHS Alaska Area and State of Alaska Department of Health & Social Services
- Facilitates all Tribal Health Caucuses & Communication to AK Tribes
- Staffs Alaska Tribal Health Directors meetings & various committees
- Legislative Committee develops Health Advocacy Priorities for Board Approval on Federal & State issues
- Facilitates Annual Budget Formulation Activities
- Facilitates Tribal Consultation in AK & with the IHS/HHS Region X & State of Alaska
- ANHB Board elects/appoints Tribal representatives to IHS, State and other committees & workgroups
- Participates in AFN, State and Federal committees & workgroups
IV. Contract Support Cost
Litigation & Impact
What is CSC?

→ 106(a)(1) funds – (Secretarial Amount)

→ 106(a)(2) funds (CSC)
THE WIN for Tribes on Contract Support Costs.

- CSC Are Mandatory: “There shall be added” to the Secretarial amount direct and indirect CSC.
- Must Be Paid in Full: Salazar v. Ramah Navajo Chapter (2012)
- Are Appropriated in a Separate, Indefinite Account: “such sums as may be necessary”
- Are Critical to Support Health Programs: $800 million for IHS, up $82 million from FY 2016 estimate
Past-Year CSC Claims

- Over 25 years of litigation
- Two U.S. Supreme Court decisions
  - Salazar v. Ramah Navajo Chapter (2012)
- Ramah class action on BIA side
- Individual litigation and settlement on IHS side
Looking Ahead: IHS Contract Support Cost Policy Revision

- Revision needed to reflect full-funding mandate
  - Current policy revolves around distribution of insufficient funding during years Congress “capped” CSC spending
- Draft policy developed collaboratively by CSC Workgroup
  - Product of months of intensive negotiations
  - Reflects many compromises by both tribal and federal sides
- Consultation Process
  - 60-day consultation period ended June 10
  - Tribal-Federal Workgroup to meet to consider comments
  - Goal is final approval of policy before end of year
Tribal SG Opportunities

- Provides fiscal incentive for Tribes who are interested in Contracting or Compacting their Health programs
- Review internal Administrative Infrastructure unfunded needs which potentially are eligible for reimbursement under CSC
- Evaluate program/service pass-through opportunities with member Tribes for Economic local benefit to community
- Perform cost allocation analysis to ensure Tribes are maximizing reimbursement under CSC
Serving Tribal Communities through Self governance

- **Tribal Council(s) Direct Authority (Resolution) & Accountability (Board Appointments)**
- **Tribal Leadership engaged in community health planning & annual priorities with Focus on Cultural, Holistic Health: mind, body, spirit**
- **Dynamic Economic Impact: jobs, workforce development, economic opportunities for Tribes**
- **Creating a Vision for Future Generations: drawing a roadmap to achieve healthy Tribal communities considering all influences & resources i.e. education, socio-economic factors, changing environmental factors, socially accepted norms, health status, Tribal culture**
- **Tribal owners will demand quality, appropriate care**
- **Patient-Focused Care Coordination Team includes patients, family & community**
- **Tribal Collaborations provides forums to share evidenced-based best practices**
- **Flexible, responsive, accountable, Tribally-inclusive services & programs**
Self-Governance in a Changing Political Era

V. National Tribal Health Future Landscape
Federal Landscape

- Present Administration made significant strides in Tribal Consultation & Relationship building; need a strategy to continue this with a new Administration
- Present Administration working hard to finish some important initiatives (i.e. Tribal Medicaid reimbursement State Plan Amendments) and to build ways to sustain recent gains (i.e. White House Council on Native American Affairs, annual White House Tribal Nations Summit)
- Possible changes in Congressional majority may change current bi-partisan support for Tribes
- Need to educate new staff & Congress in DC and by inviting to Tribal Communities
- Partnership with Tribal Organizations will be important (NIHB/ANHB, TSGAC, & NCAI)
- Active engagement & awareness of national issues will be key including pushing Tribal Consultation agenda
- It is expected that funding priorities will be dramatically different depending on who gets in office
- IHS Senior Staff positions still vacant and filled with acting positions; Director recruitment is uncertain until after a new President is elected
Potential Outcomes: Great Plains Crisis

Congressional holds oversight hearings & push through pending IHS Reform bills:

- **Senate Bill S.2953**: Sen. John Barrasso (R-WY), chairman of the Senate Committee on Indian Affairs, and Sen. John Thune (R-SD) introduced the Indian Health Service Accountability Act of 2016. The act will improve transparency and accountability at the IHS by:
  - Expanding removal and discipline authorities for problem employees at the agency;
  - Providing direct hiring and other authorities to avoid long delays in the traditional hiring process;
  - Requiring tribal consultation prior to hiring area directors, hospital CEOs and other key positions;
  - Commissioning Government Accountability Office reports on staffing and professional housing needs;
  - Improving protections for employees who report violations of patient safety requirements;
  - Mandating that the secretary of HHS provide timely IHS spending reports to Congress; and
  - Ensuring the Inspector General of HHS investigates all patient deaths in which the IHS is alleged to be involved by act or omission.

- The act also addresses staff recruitment and retention shortfalls at IHS by:
  - Addressing gaps in IHS personnel by giving the secretary flexibility to create competitive pay scales and provide temporary housing assistance for medical professionals;
  - Improving patient-provider relationships & continuity of care by providing incentives to employees; and
  - Giving the secretary of HHS the ability to reward employees for good performance & finding innovative ways to improve patient care, promote patient safety, and eliminate fraud, waste, and abuse.

- **House Bill H.R.5406**: Helping Ensure Accountability, Leadership, and Transparency in Tribal Healthcare Act (HEALTTH Act), which offers comprehensive reforms to the crisis-stricken Indian Health Service (IHS)

  - Rep. Kristi Noem (R-SD) introduced a bill to address IHS’ ability to secure long-term contracts for hospitals in emergency conditions, address recruitment with tax-free loan & other incentives, reform the purchased/referred care program, create tribal led boards that control IHS hospitals. Noem says the boards will improve retention, reduce wait times and update the service’s funding formula.
Potential Outcomes From Great Plains Crisis

- **FY2017 Appropriations:** IHS receiving largest increases, compared to other federal agencies, in both House and Senate versions of the appropriations bills; bills move to free conference. House bill increase is 6% or $5.1 billion; the Senate version is $80 million less but still has increases:
  - $4M increase for DV
  - $3.6M increase - Zero Suicide Initiative
  - $21.4M increase for integrated BH Care to address mental health and substance abuse care coordination (example: NUKA model)
  - $16.4M for Alcohol & Substance Abuse
  - $10M for Small Ambulatory Clinics (Gambell & Savoonga clinics mentioned)
  - $11M for Clinic Leases

“We cannot continue to starve the Indian Health System and expect different results.”

National Tribal Budget Formulation Workgroup
Testimony on the FY2018 Tribal Budget Recommendations
June 20, 2016
Potential Outcomes: Great Plains Crisis

- IHS Principal Deputy Director Mary Smith’s Priorities:
  - Reforming How IHS Does Business at GP and all of IHS
    - assessing quality of care and work quickly to make any needed improvements
    - transforming the way these hospitals deliver care as best practices
    - strengthening our Area management & recruitment
    - bringing experts in health care quality to support these direct service facilities
    - And most importantly, doing this work hand-in-hand with the Tribes and local organizations that are valuable sources of expertise and partnership.
  - Consultation on Quality Framework Initiatives
  - Medicaid Enrollment & Purchase of Insurance for Tribal members in DST facilities
  - Workforce issues:
    - Consultation on creating a national CHAP program (incl. CHAP, BHA, DHAT)
    - Contract out Hospital Services in Great Plains (where does money come from?)
    - Staff Housing
    - Telemedicine
    - BH Expansion: Gen-I and Zero Suicide funding & initiatives
Evolving Roles of National Organizations

- Should the roles of Area Tribal Health Boards & NIHB be reformed?
- How can we better collaborate within all national organizations: NIHB, TSGAC, DST & NCUIH and NCAI
- How should we guide the agendas for the new WH Council on Native American Affairs & Secretary’s Tribal Advisory Committee?
- How can we better capitalize on recent reform issues?
- Are we maximizing benefit of Tribal Consultations within HHS, IHS and other agencies?
- Are we maximizing political/advocacy benefits of the national conferences and meetings?
- How might we reform the Tribal Budget Formulation Process & advance Title VI to achieve full funding for IHS?
- What can we do to support the national committees & their efforts?
- Other Questions?
What's Next?

- Title V I Expansion
- Renewed Government-to-Government Collaboration & Partnership
- Fulfillment of Federal Trust Obligations 100%
- Strong Tribal Nations creating own destiny

Determining Our Future
One Tribe at a Time
Lessons Learned:

- Ataquin akun - “We are One”, keeping the connection, unity, pride, collaboration, community “Together We are Stronger!”
- Honor Sovereignty
- Agreement on Clear Common Vision & Values: Dream Big!
- Design Organizational Structure w/ clear roles & accountabilities
- Set up strong technical support; use committees to tackle hard issues
- Develop Strong Advocacy Role - short & long term strategies, bring other key political stakeholders to the table
- Develop Inter-Tribal relationships with respectful ground rules
- Create safe caucus space to resolve differences - bring back to “why we are here”
- Develop annual legislative priorities & monitor results, changing strategies as necessary
- Provide opportunities to share unique issues, best practices & celebrations to increase knowledge & accelerate outcomes
You Don’t have to be an Eagle
to be “Sexy”
.....the Self Governance Journey Continues.....

American Indians and Alaska Natives WILL BE the healthiest people in the world!

Igamsiqanaghalek!  Quyana!  Taikuu!
Questions?