

National Indian Health Board



Submitted via email to consultation@ihs.gov

October 21, 2020

RADM Michael D. Weahkee
Director, Indian Health Service
U.S. Department of Health and Human Services
Mail Stop: 08E37A
5600 Fishers Lane
Rockville, MD 20857

Re: Indian Health Service COVID-19 Vaccine Draft Response Plan

Dear Director Weahkee:

On behalf of the National Indian Health Board (NIHB),¹ we write to comment on the agency's COVID-19 Vaccine Draft Response Plan. We believe that this represents an important first step in ensuring that a vaccine is available for Indian Country in a timely manner and that a plan exists to ensure its distribution. We thank the agency for taking the time to put this together. We also thank the agency for holding regional consultations in order to ensure that the opinions of Indian Country are reflected in the final product.

While we are generally supportive of this plan and the steps that it outlines, we do want to make sure that it takes into account the needs of the different Tribal programs across the country. We want to urge the agency to work with each provider and the community they serve in order to ensure that vaccine amounts are enough to adequately vaccinate everyone in the community. We also have concerns around data collection and the capacity of Tribal programs to provide the necessary information with a quick turnaround.

Trust Responsibility

We kindly remind the agency that the United States has a unique legal and political relationship with Tribal governments established through and confirmed by the United States Constitution, treaties, federal statutes, executive orders, and judicial decisions. Central to this relationship is the Federal Government's trust responsibility to protect the interests of Indian Tribes and communities, including the provision of health care to American Indians and Alaska Natives

¹ Established in 1972, the National Indian Health Board (NIHB) is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

(AI/ANs). In recognition of the trust responsibility, Congress has passed numerous Indian-specific laws to provide for Indian health care, including laws establishing the Indian health care system and those providing structure and detail to the delivery of care, such as the Indian Health Care Improvement Act (IHCA).² In the IHCA, Congress reiterated that “Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government’s historical and unique legal relationship with, and resulting responsibility to, the American Indian people.”³ We believe that a trust responsibility is not fulfilled if there is not a plan to ensure that Indian Country has access to the vaccine and that it can be distributed in a timely manner.

Vaccine Distribution

As we are sure you are aware, Indian Country has struggled with vaccine distribution during prior pandemics. In fact, concerns about a repeat of the H1N1 pandemic were voiced during the recent consultation calls. In those instances, Tribes did not have adequate access to a vaccine and were often forced to work with uncooperative state and county governments. There were concerns about the availability of the vaccine in the Tribal communities. In one call, a commenter mentioned an instance where his daughter, who was pregnant, had to go to a neighboring off-reservation county to receive a vaccination. We are happy to see that IHS saw the need for a system wide plan in order to distribute the COVID-19 vaccine, which should minimize the logistical errors that plagued the H1N1 vaccine distribution.

When working with Indian health providers to count the number of beneficiaries who will need access to a vaccine, we ask IHS to consider the individual circumstances of each community. As voiced in one of the consultations, it may be to the benefit of the broader community if IHS allows Indian health providers to vaccinate non-AI/ANs who live on or near Tribal land. This is especially true for Tribes with smaller land bases that are adjacent to areas with high non-AI/AN populations. We also recommend that, as much as legally possible, efforts take into account the need to vaccinate family members who reside in aboriginal areas across the international boundaries of Canada and Mexico. It will be difficult to control the disease if large portions of the community are not vaccinated against it.

We recognize and acknowledge the necessity of a tiered roll out of the vaccine given the reality that, initially, there will not be enough doses of the vaccine to provide a vaccination to every person that seeks one. Because of the small quantities of vaccine that will be available initially, we understand and support a roll out that prioritizes the most vulnerable populations first. For this tiered rollout to effectively mitigate the damage COVID may do, it will be critical for IHS to work closely with each and every Tribal Nation to ensure all of those vulnerable Tribal citizens are accounted for in the first tier of the vaccine roll out. In identifying the vulnerable populations, IHS should provide the highest level of deference to the information provided by Tribal Nations. Tribal Nations are in the best position to understand the needs and risks of their citizens. At the same time, some Tribal Nations may wish for assistance in the process of gathering information to

² 25 U. S. C. § 1601 et seq.

³ Id. § 1601(1)

inform their decision making. In this case, if a Tribal Nation requires staffing or technical assistance to assess their need, IHS should be standing ready to provide that help. Additionally, the agency must work with Tribes to ensure that their entire community has access to a safe and effective vaccine, in the subsequent tiers of rollout. That involves working with the Tribes to get an accurate count of the number of people in their community.

We know from the H1N1 experience that essential lines of communication can often be frayed or non-existent. This was true of Tribal- federal communications, and especially of Tribal- state/local communications in many instances. We must ensure that mistakes from the H1N1 experience are not repeated, and that other challenges and obstacles are anticipated and accounted for so that they can be avoided or addressed immediately. For this reason, a continuous communication structure will be needed, along with a commitment to transparency of information. This will allow Tribes to have real time information as they require it, and a complete picture so they have the highest levels of situational awareness possible.

Although, in some places states work well with Tribes, in many jurisdictions, states or counties do not share information or resources freely with their Tribes. Likewise, in many of those same jurisdictions, states or counties may place burdensome requirements on Tribes looking to access information or resources. For this reason, it is important that the agency takes whatever steps are necessary to minimize the need for Tribes to work with state and local officials, if that is a Tribe's request, while providing assistance to Tribes seeking information or other support.

During a recent consultation call, it was mentioned that the agency's distributor, McKesson is often unresponsive and slow to deliver supplies. During a global pandemic, this is completely unacceptable and we need a way to ensure that a speedy resolution is reached when issues arise. We urge the agency to separately set up a portal so providers can report issues with the distributor so the agency can respond and ensure that they are addressed in a timely manner. We urge the agency to include a tracker in the portal so providers know that their complaint has been received and is being investigated.

Data Management

We also want to ensure that all Indian health providers are able to remain in compliance with any data reporting requirements that may be imposed upon them by the agency. We acknowledge that this section of the draft has not yet outlined specific requirements and that many of these decisions are still yet to be made. However, we urge the agency to consider requirements that minimize the necessary paperwork and even offer flexible deadlines that allow providers to focus their energy on providing the vaccine to patients. As I am sure you are well aware, Tribes were hard hit economically by the COVID-19 pandemic. Many Tribes are short staffed and the agency should take this into account when formulating reporting requirements. This is already a chaotic and busy time and we do not want burdensome paperwork requirements that add to the confusion.

As the agency is conducting its gap analysis, we ask that the agency reach out to Tribes who do not have access to the Resource and Patient Management System (RPMS) in order to ensure that they have the resources necessary to report any required information. We ask that any centralized reporting platform be configured in such a way that it takes into account the different levels of

access to technologies that different providers may have. We appreciate that the agency is already exploring the use of contingency plans in some of the information technology (IT) changes that they have identified are not implemented. However, we ask that the agency work to ensure that any reporting platform is accessible to all providers, regardless of their technological capabilities.

We also ask that the agency provide technical assistance to Tribal programs as they are navigating paperwork requirements. For many of them, these are going to be unfamiliar and depending on the staffing situation of the Tribe, it may even be handled by a person who has never handled anything of this magnitude before. In order to ensure accuracy, IHS must work with Tribes to ensure that they have the necessary support to complete the forms and supply the necessary data.

Additional Consultation Will Be Needed

In addition to ensuring a real time, assessable, and transparent communications platform and process exists between IHS and the Tribes, we believe that the agency must plan for regular formal Tribal consultation during the development of the IHS plan and the vaccine rollout. We understand that the nature of this crisis presents many unknowns, and that, as a result, plans are necessarily working drafts. These working drafts must be examined and evaluated as new information comes in, and Tribes must be given the opportunity to make changes to the plans if the situation requires.

Conclusion

We want to thank the agency for the steps taken in this draft guidance. We believe that this represents an important first step in ensuring access to a safe and effective vaccine as soon as one is available. It is an important beginning to the conversation on how to make sure that it is effectively distributed throughout Indian Country. We urge the agency to take additional steps that ensure that everyone in a Tribal community is vaccinated, including non-AI/ANs. We also urge the agency to ensure that any data reporting requirements are not overly burdensome on providers and that they have the resources needed to complete them. Thank you in advance for your consideration of our comments.

Sincerely,

A handwritten signature in black ink, appearing to read "Stacy A. Bohlen". The signature is fluid and cursive, with a long horizontal stroke at the end.

Stacy A. Bohlen
CEO
National Indian Health Board