

Abbreviated Minutes

Health Resources and Services Administration

1st Tribal Advisory Council Meeting

Held Virtually

on

December 1–2, 2021

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Executive Summary

The Health Resources and Services Administration (HRSA) Tribal Advisory Council (TAC) met virtually for its inaugural meeting on December 1 and 2, 2021. Chief Chuck Hoskin Jr., Oklahoma Area Delegate, served as the Acting Chair of the first HRSA TAC. Eighteen tribal leaders and officials participated on the first day and 16 participated on the second day.

To begin Day 1 of the meeting, Aaron Payment, Bemidji Area Delegate, provided an opening blessing. Chuck Hoskin, Natasha Coulouris, Director of HRSA's Office of Intergovernmental and External Affairs (HRSA IEA); and CAPT Carmen "Skip" Clelland, Director of the Office of Tribal Affairs (OTA), then provided opening remarks. Next, Chuck Hoskin, Oklahoma City Area Delegate and Acting TAC Chair, introduced TAC business and housekeeping items. During the business portion, Chuck Hoskin was nominated and elected as HRSA TAC Chair.

The next item on the agenda was a HRSA senior leadership roundtable discussion by each HRSA Office and Bureau, facilitated by Diana Espinosa, then Acting Administrator of HRSA. Next, the Office for the Advancement of Telehealth (OAT) kicked off presentations by select HRSA Bureaus and Offices that continued on Day 2. Chuck Hoskin and Natasha Coulouris provided a recap of the day and next steps, and Chuck Hoskin adjourned Day 1.

Day 2 began with a blessing provided by Selwyn Whiteskunk, Albuquerque Area Delegate. Next, select HRSA Bureaus and Offices presented, followed by a presentation on HRSA's finances and budget. Chuck Hoskin then opened the floor for engagement between the TAC delegates and HRSA leadership. Finally, Chuck Hoskin and Diana Espinosa provided brief closing remarks, Aaron Payment provided a closing blessing, and Chuck Hoskin adjourned the meeting.

Action items from this meeting comprise the following activities:

- Organize the Health Professions Shortage Area (HPSA) Subcommittee.
- Hold a call with the Alaska delegate on Uniform Data System (UDS) issues with regard to the Community Health Aide Program (CHAP).
- Explore Technical Assistance for the TAC.
- Plan the next TAC meeting.

Day 1 Meeting Summary

December 1, 2021

For Day 1 of the inaugural TAC meeting, the TAC delegates and HRSA staff then gathered for the full meeting during which they discussed business and housekeeping items, held a roundtable discussion with HRSA senior leadership, and heard a presentation by OAT.

1:00 pm Opening Blessing, Welcome, and Introductions

Chuck Hoskin, Acting Chair and Oklahoma Area Delegate, opened the meeting. Jennifer Gillissen, Kauffman & Associates, Inc., reviewed the meeting protocol. Aaron Payment, Bemidji Area Delegate, then provided a blessing. Next, Chuck Hoskin turned the floor over to Natasha Coulouris, Director of HRSA's IEA, and Carmen "Skip" Clelland, Director of the OTA, who introduced themselves.

Natasha Coulouris gave opening remarks in which she thanked the TAC delegates and HRSA leadership for taking the time to meet. She affirmed that HRSA honors the trust relationship and special obligations to American Indian and Alaska Native (AI/AN) tribes and is committed to meaningful and ongoing engagement. HRSA IEA serves as the principal agency for intergovernmental and external affairs and partnerships. Within HRSA IEA, [OTA](#) leads HRSA's effort to strengthen their government-to-government relationship with tribes. She explained the purpose of the TAC, as detailed in the TAC Charter, noting that meaningful dialogue is crucial to the development of successful programs in Indian Country. She added that the TAC will also review HRSA's Tribal Consultation Policy and help set the agenda for HRSA's Annual Tribal Consultation.

Carmen Clelland then gave his own opening remarks, sharing about his background and thanking the TAC delegates for their help in setting the meeting agenda. He also recognized HRSA senior leadership and those behind the scenes who helped set up the TAC.

1:20 pm TAC Business and Housekeeping

Chuck Hoskin turned the floor over to Ivy Vedamuthu, OTA Tribal Liaison, to take roll of the TAC delegates. She noted that they made quorum.

Roll Call of Delegates and Alternates

Chief Chuck Hoskin Jr.

Cherokee Nation

Acting Chair, Oklahoma Area Delegate

Councilman Selwyn Whiteskunk

Ute Mountain Ute Tribe

Albuquerque Area Delegate

Rhoda Jensen

Yakutat Tlingit Tribe

Alaska Area Delegate

Chairperson Aaron Payment

Sault Ste. Marie Tribe of Chippewa Indians

Bemidji Area Delegate

Chairman Lee Spoonhunter
Northern Arapaho Tribe
Billings Area Delegate

Kira Norton
Hoopa Valley Tribe of California
California Area Delegate

Chief Cyrus Ben
Mississippi Band of Choctaw Indians
Nashville Area Delegate

Mary Harrison
Nashville Area Alternate

Jill Jim
Navajo Nation Alternate

TAC Roles & Responsibilities

Chuck Hoskin read the HRSA TAC Charter with Federal Advisory Committee Act exemption:

The HRSA TAC Charter complies with an exemption within the Unfunded Mandates Reform Act (UMRA) (P.L. 104-4) to the Federal Advisory Committee Act that promotes free communication between the federal government and tribal governments. In accordance with this exemption, the HRSA TAC facilitates the exchange of views, information, or advice between federal officials and elected officers of tribal governments (or their designated employees with authority to act on their behalf) acting in their official capacities.

Approval of Minutes

Chuck Hoskin noted that there were no past meeting minutes to approve, this being the inaugural meeting.

Approval of the Agenda

Chuck Hoskin entertained a motion to approve the meeting agenda. Aaron Payment made the motion. Cyrus Ben, Nashville Area Delegate, seconded the motion. Hearing no objections, Chuck Hoskin said the motion carries.

Presentation of TAC Business Items

Carmen Clelland, TAC Executive Secretariat, facilitated the business items.

HRSA Chair and Co-Chair Nomination for Spring and Fall 2022

Chuck Hoskin motioned to nominate a chair for Calendar Year 2022. Aaron Payment moved to nominate Chuck Hoskin as the chair and Rhoda Jensen, Alaska Area Delegate, as the co-chair. Lee Spoonhunter, Billings Area Delegate, seconded the motion. Hearing no objections, Chuck Hoskin said the motion carries.

HRSA TAC Technical Assistance Considerations

Carmen Clelland said the next item was to consider technical assistance for the TAC to support their work and Chuck Hoskin opened the floor for discussion on the topic. Aaron Payment recommended that HRSA contract with an entity like the National Indian Health Board (NIHB) to provide technical assistance to the TAC. Chuck Hoskin motioned to have HRSA connect with NIHB and provide technical assistance options to the TAC at the next meeting. Aaron Payment

moved to have HRSA explore and present technical assistance options. Cyrus Ben seconded the motion. Hearing no objections, Chuck Hoskin said the motion carries.

HRSA TAC Alternate Delegates

Carmen Clelland said the next item was the alternate delegate selection. Should a delegate be unavailable for a meeting, HRSA would reach out to their alternate to provide them with all necessary materials to attend in the delegate's place. The alternates must be elected tribal leaders or employees of the tribe who are authorized to speak and make commitments on its behalf.

Carmen Clelland offered two options to identify alternates: (1) HRSA could make a list of potential alternates, or (2) if a TAC delegate is unable to attend a meeting, they can identify their own alternate and inform HRSA in writing prior to the meeting. Chuck Hoskin and Rhoda Jensen said they preferred the latter option. Chuck Hoskin entertained a motion to adopt Option 2. Aaron Payment made the motion. Selwyn Whiteskunk, Albuquerque Area Delegate, seconded the motion. Hearing no objections, Chuck Hoskin said the motion carries.

TAC Delegate Terms

Carmen Clelland said the next item was the rotation of this TAC's delegate terms. They need to identify a term limit rotation, so they do not need to recruit every TAC delegate at the same time. Areas will be chosen at random to determine which will rotate out first. He offered two timelines to choose from: (1) half of the TAC would serve 1 year while the other half would serve 2 years, or (2) half of the TAC would serve 2 years while the other half serves 3 years. Aaron Payment recommended the latter option, given challenges with recruitment. Chuck Hoskin entertained a motion to adopt Option 2. Aaron Payment made the motion. Rhoda Jensen seconded the motion. Hearing no objections, Chuck Hoskin said the motion carries.

2:15 pm HRSA Senior Leadership Roundtable Discussion

Chuck Hoskin turned the floor over to Diana Espinosa for the roundtable discussion. Diana Espinosa introduced herself, shared her appreciation for the TAC members, and thanked HRSA leadership for their participation. She highlighted actions she has taken over the past several months that showcase HRSA's commitment to strengthening their relationship with tribal nations. Specifically, she reorganized HRSA to have HRSA IEA and created OTA, dedicated to tribal affairs, within it. She said that this new structure will foster greater collaboration across HRSA and the regions. It also shows that HRSA recognizes relationships with tribal leaders as being equal to other governments. Through the TAC, she hopes that HRSA will be able to act quickly.

Diana Espinosa said HRSA is trying to increase its transparency and foster timely communication. This meeting presents a great opportunity for the TAC to understand the statutory frameworks within which HRSA operates, explore how they can work within those frameworks to expand budgetary and funding opportunities for Indian Country, and learn how HRSA can better tailor their services to best meet the needs of tribal nations. Lastly, she

acknowledged that this meeting does not replace consultation. Rather, she hopes that the TAC will help HRSA hold more meaningful consultations.

Next, Diana Espinosa facilitated the roundtable discussion.

Bureau of Health Workforce

Luis Padilla, MD, Associate Administrator and Director of the National Service Corps, presented for the Bureau of Health Workforce (BHW).

Overall, BHW's mission is to improve the health of underserved communities, which they uphold by strengthening the health workforce and connecting skilled professionals to communities in need. They leverage a continuum in health professionals' education from high school, through post-graduate training, and into community services through various loan and scholarship programs. Across their more than 40 programs, BHW's work focuses on four aims: (1) increasing access to quality, competent care, (2) addressing the supply of providers, (3) addressing the distribution of providers, and (4) ensuring quality education and training. It is important to demonstrate that communities' health outcomes are improving as a result of their health professions programs.

Currently, the Bureau is focused on an equitable response to COVID-19. They are also committed to leveraging current and new programming in two areas: (1) behavioral and mental health, and (2) community health. BHW is using current and new funding to address mental health, particularly substance use disorder (SUD) and opioid use disorder (OUD). Tragically, 100,000 lives have been lost this year to opioid and substance use overdoses—a 40 percent increase over last year—which will be a major driver of their work in years to come.

Community health encompasses social determinants of health (SDOH), public health, and social determinates of education, which impact underrepresented students entering health professions. Again, BHW is focused on leveraging their current and new funding to bolster community health. Dr. Padilla said, in the early spring of next year, BHW anticipates releasing funding to address community health worker and paraprofessional training. Around the same time, they will also release their public health scholarship program, which will provide \$42 million to support public health students.

BHW does not believe that health equity can be achieved without addressing diversity in the workforce. BHW is proud to say that nearly half of their graduates and program completers come from underrepresented communities and/or disadvantaged backgrounds. Recognizing the importance of provider resiliency for frontline providers, BHW released funding to support provider resiliency and will look at new ways to expand this work.

Across all of BHW's loan and scholarship programs, they have made 533 new and continuation awards, totaling over \$25 million. The number of AI/AN participants in these programs has nearly quadrupled in the last decade, from 56 in 2012 to 214 in 2021. Additionally, BHW has awarded nearly \$10 million across all of their grant programs, several of which have tribal components. Further, nearly 1,200 clinicians are working in Indian Health Service (IHS) or tribal

sites across the country, representing significant growth over the last few years as a result of the additional funding and set-asides that Congress appropriated for IHS and tribal entities.

Discussion

Chuck Hoskin opened up the floor for discussion.

Question from Lee Spoonhunter

Lee Spoonhunter discussed Graduate Medical Education (GME) opportunities, stating that tribes have been advocating for a tribal set-aside for the Teaching Health Center Graduate Medical Education (THCGME) program for years. HRSA denied the two tribes' applications for this program were both denied because HRSA said they operate hospitals rather than outpatient centers, which is inaccurate. The Centers for Medicare & Medicaid Services (CMS) classifies these programs as "tribal hospital-based provider systems," meaning they are tribal hospitals with outpatient health departments. These successful programs could serve as recruitment and retention models for other Indian health care systems, but they are costly to implement and operate.

He asked and made the following questions and comments: (1) why do tribes seem to be unable to gain under HRSA's THCGME program, (2) BHW continues to encourage tribes to apply for existing grant opportunities, though the current funding mechanisms make it nearly impossible for tribes to receive the funding, (3) what can BHW do to help tribal leaders understand how to gain access to this vital funding, and (4) HRSA needs to develop a tribal set-aside within the THCGME program for IHS and tribal medical residency programs.

Response from Dr. Padilla

Dr. Padilla said he is aware of the situation Lee Spoonhunter described, and HRSA has reached out to one of the applicants. The THCGME program currently has two awardees that are tribal entities and continues to encourage tribes to apply. Historically, the program's purpose is to support outpatient, community-based residency programs. BHW is aware that at the time they issued the funding opportunity, they required that eligible entities meet a certain full-time equivalent baseline. He said he understands that facilities in Indian Country are playing a dual role of hospital and outpatient services. BHW wants to find a way to adjust their funding opportunities to make it clear that tribal facilities are eligible and have an opportunity to effectively compete for this funding.

Question from Rhoda Jensen

Rhoda Jensen asked how the \$42 million in public health scholarships will be advertised and if there will be a tribal set-aside.

Response from Dr. Padilla

Dr. Padilla said he does not have authority to include a set-aside for tribal entities for the THCGME program, public health loan repayment program, or community health and paraprofessional training program. However, tribal entities are eligible to apply for all three of these programs. Currently, the public health loan repayment program will be for tribal entities that are providing public health training or have their own health department. The same

applies for the community health worker, though that program applies to any community-based organization. In terms of messaging, BHW has already released notifications of the upcoming funding opportunities. BHW will continue to conduct outreach and work with the regional partners to ensure eligible applicants are applying.

Question from Mary Harrison

Mary Harrison, Nashville Area Alternate, said while tribes are eligible for grants related to rural health, few of those dollars get into Indian Country, though a majority of tribal lands are in rural communities. She requested that, (1) in consultation with tribes, HRSA set aside at least 5 percent of every grant for tribes and Indian health providers and that they do so in a way that poses minimal burden on tribes, (2) that the Federal Office of Rural Health Policy (FORHP) work directly with IHS to address workforce shortages in Indian Country to improve access to health services, and (3) that HRSA designate flagship funding to tribal entities to improve health outcomes.

Response from Dr. Padilla

Dr. Padilla said BHW will continue to work with their partners to address rural needs in Indian Country and workforce needs in tribal communities. They are doing that now through their partnership with the Residency Planning and Development grant and in partnerships with Federally Qualified Health Centers (FQHCs).

Bureau of Primary Health Care

Tonya Bowers, Deputy Associate Administrator, presented for the Bureau of Primary Health Care (BPHC).

BPHC provides HRSA's primary support for the Health Center Program. This program has grown greatly over the last 2 decades in support of the need for primary health care services. It has grown from about \$1 billion in 2000 to about \$5.6 billion in 2021, representing significant investment in underserved communities. Currently, HRSA provides grants to nearly 1,400 health centers, which operate more than 13,500 distinct locations. Through this hub and spoke model, BPHC served almost 29 million patients in 2020. Of those patients, one in three were living in poverty, one in five were uninsured, one in five were rural residents, and nearly 3 million were adults ages 65 or older. Overall, health centers served more than 35,000 AI/AN patients in 2020.

Health centers provide patient-centered, comprehensive, integrated care by offering a range of services, including primary medical, oral, and mental health services, including SUD and medication-assisted treatment services. Health centers also provide enabling services, such as community outreach, case management, health education, interpretation, and transportation.

Under the HRSA grant, health centers must be private nonprofit or public agencies that are governed by a patient-majority community board, serve high-need communities or populations, and provide comprehensive primary care and enabling services. They must also make their services available to everyone in their communities so no one is turned away and adjust service

fees based on a person or family's ability to pay. Further, they must collaborate with community partners to maximize resources and efficiencies in service delivery. Finally, they must meet performance requirements.

Currently, HRSA provides grants to 35 tribal and urban Indian health centers that receive funding under the Health Center Program and IHS. These health centers are referred to as being dually-funded. In 2020, these health centers served nearly 189,000 patients and received over \$87 million in ongoing health center funding, \$60 million from the American Rescue Plan (ARP) Act for COVID-19 response and to enhance their health services and infrastructure, and nearly \$18 million in capital funding to support improvements to health care infrastructure. BPHC will continue to explore opportunities to target resources to tribes and tribal organizations in Indian Country.

Discussion

Chuck Hoskin opened up the floor for discussion.

Question from Lee Spoonhunter

Lee Spoonhunter said tribes want Congress to enact legislation that would expand self-governance programs within the U.S. Department of Health and Human Services (HHS) by expanding Title VI of the Indian Self-Determination and Education Assistance Act. Specifically, the proposed legislation would expand self-governance and programs in HHS, beyond IHS, by authorizing a 5-year tribal self-governance demonstration project that would ultimately show the effectiveness of tribally operated programs overseen by various HHS agencies and programs, including HRSA's community health center grants. This legislation includes expanding self-governance to HRSA's Health Center Program.

Since the Indian Self-Determination and Education Assistance Act was enacted, the growth of self-governance has significantly improved health outcomes and the daily lives of AI/ANs. However, the current patchwork system of funds for tribes does not fulfill the federal government's trust responsibility to tribal nations. Patient outcomes are better when tribes are empowered to authorize their own programs. He asked if HRSA can commit to working collaboratively with tribes in advancing this proposal.

Response from Tonya Bowers

Tonya Bowers said she appreciated the comment, and should Congress enact that legislation, BPHC would work with the tribes and tribal programs to implement it.

Question from Rhoda Jensen

Rhoda Jensen discussed the \$18 million in capital funding, which provided a blanket distribution of \$500,000 to all health centers that receive HRSA funds. While grateful for this funding, it is hard to build anything with that amount of money. They need real capital dollars to build health centers for Indian Country. Noting that the Infrastructure Bill passed, she asked if any capital dollars will come from it. She also asked how they can secure more capital funding.

Response from Tonya Bowers

Tonya Bowers acknowledged that capital dollars are scarce but valuable in improving the health of communities. HRSA provided the \$18 million in capital funding to support health centers' COVID-19 response. To get those funds out quickly, they made distributions based on a formula. She hopes there will be access to a significant amount of resources to support capital construction activities in the near future, which will require larger grants. On a related note, HRSA also administers a loan guarantee program for commercially acquired loans, which can result in lower rates for construction activities.

Federal Office of Rural Health Policy

Megan Meacham, Director of the Rural Strategic Initiatives Division, presented for FORHP.

FORHP consists of a number of community-based and state-based grants, a Rural Communities Opioid Response Program (RCORP), and policy and research activities. FORHP also advises the Secretary of HHS on rural health care issues and their programs range from grassroots programs to service delivery and implementation programs within rural communities. FORHP programs cover a range of rural health topics and priority areas. Many of their programs include flexibilities to allow communities to define their particular needs within the larger purpose of the program under which they operate. FORHP is aware of the challenge of getting funding to tribal communities, and they look forward to further discussion in future TAC meetings.

Through the RCORP program, FORHP has awarded a number of tribal and tribal-serving grantees to enable them to provide lifesaving OUD and SUD services, including medication-assisted treatment. For example, Wabanaki Public Health and Wellness was able to use \$200,000 to plan and \$1 million to establish their lodge for tribal members in SUD recovery through RCORP grants.

Tribal hospitals participate in FORHP's Small Rural Hospital Improvement Program. In addition to this annual funding, these hospitals also received two rounds of COVID-19 response funding, with about \$80,000 received through the Coronavirus Aid, Relief, and Economic Security (CARES) Act in 2020 and \$250,000 received through the ARP Act in 2021. Also, through the CARES Act in 2020, FORHP provided \$26.3 million to 57 tribes and tribal health providers for COVID-19 response through the Rural Tribal COVID-19 Response program. Further, a number of FORHP's non-tribal grantees include tribal members within their service areas. So, while these funds do not go directly to the tribes, FORHP does encourage grantees to serve any underserved populations within their service areas.

Tribes are eligible to apply for nearly all programs. FORHP currently has two open opportunities, which can be found on [grants.gov](https://www.grants.gov) or the grants tab of HRSA's website ([hrsa.gov](https://www.hrsa.gov)). Through RCORP, FORHP will make another round of implementation awards, providing \$1 million per award. **Applications are due January 13, 2022.** There is also a Rural Health

Network Development Planning program, providing up to \$100,000 per award. **Applications are due January 28, 2022.**

Additionally, FORHP has two upcoming opportunities. RCORP anticipates funding a Behavioral Health Support program and HRSA anticipates funding the Expanding Public Health Workforce Capacity grant program. For the latter program, HRSA will award approximately \$45 million to 30 grantees to expand public health capacity to support health care job development training and placement in rural and tribal communities. That program comprises four tracks: (1) community health support, (2) health IT and/or telehealth support, (3) paramedicine, and (4) case management, staff, or respiratory therapist.

Discussion

Chuck Hoskin opened up the floor for discussion.

Question from Lee Spoonhunter

Lee Spoonhunter reiterated the fact that few rural health program dollars get into Indian Country. He requested that HRSA set aside 5 percent of every grant for tribes and Indian health providers, and that they do so in a way that places minimal burden on tribes.

Question from Mary Harrison

Mary Harrison said she appreciates what HRSA has done for funding, especially in her tribal area. However, tribes should not have to compete against other tribes and non-tribal entities. She requested that: (1) grants are not overly restrictive and allow tribes to provide services they believe will serve their communities, (2) allocation and distribution mechanisms allow for all federally recognized tribes to get funding through a formula derived through tribal consultation, and (3) HRSA create a tribal set-aside in all funding opportunities, make them noncompetitive, streamline the application process, and reduce reporting requirements to reduce the administrative burden on tribes.

Health Systems Bureau

Onyeka Anaedozie, Deputy Associate Administrator, presented for the Health Systems Bureau (HSB).

HSB runs five programs: (1) the Organ Donation and Transplantation program, (2) the C.W. Bill Young Cell Transplantation Program, (3) the National Hansen's Disease (Leprosy) Program, (4) the National Vaccine Injury Compensation Program, and (5) the Countermeasures Injury Compensation Program. Traditionally, they do their work through contracts.

The Organ Donation and Transplantation program ensures equitable allocation and distribution of solid organs, bone marrow, and cord blood units. To date, 165 million people have registered to become organ donors, and 23 million people have registered to be blood stem cell donors. In 2020, HRSA's transplantation programs facilitated nearly 40,000 organ transplants and nearly 6,200 bone marrow and cord blood transplants.

The Hansen's Disease Program is responsible for providing diagnosis, medical care, and rehabilitative treatment for patients who have Hansen's Disease. It conducts and promotes the coordination of research related to the treatment, control, and prevention of the disease and it conducts trainings on the diagnosis and related complications of the disease.

The two injury compensation programs (the National Vaccine Injury Compensation Program and the Countermeasures Injury Compensation Program) provide compensation to individuals who are injured or adversely affected by vaccinations. They have programs for regularly administered vaccines (e.g., the flu vaccine) and a program for vaccines like those for COVID-19.

The Hill Burton program is a smaller program. It ensures any hospitals, nursing facilities, or other health facilities that received grants and loans from the federal government between 1946 and 1997 provided uncompensated services and care. Since 1980, this program has been responsible for providing more than \$6 billion in uncompensated services.

HSB's newest initiative is the Community-Based Outreach Program, which began in June 2021 to support COVID-19 vaccination and increase vaccine confidence. This program provided \$120 million to 14 nonprofit private and public organizations to reach underserved communities through a community-based workforce. In July 2020, HSB provided an additional \$120 million to expand and sustain community-based COVID-19 vaccination efforts.

In November, HSB released \$77 million to nine community-based organizations to build on their progress. Further, a funding opportunity that closed on December 10 will award another \$77 million to up to nine additional community-based organizations to continue to mobilize COVID-19 vaccination efforts. Though not tribal-specific, some current awardees do work with tribes.

Discussion

Chuck Hoskin opened up the floor for discussion. There were no comments.

HIV/AIDS Bureau

Chrissy Abrahms, Director of the Division of Metropolitan HIV/AIDS Programs, presented for the HIV/AIDS Bureau (HAB).

HAB administers the Ryan White HIV/AIDS program, which is the only discretionary grant program that funds a comprehensive system of care and treatment for people with HIV. The program follows a dynamic public health care approach to ensure that people with HIV are diagnosed, receive and remain in medical care, are prescribed antiretroviral therapy, and achieve viral suppression. Grantees include states, cities, counties, and local community-based organizations that serve hard-to-reach populations and people without sufficient health care coverage or financial resources.

More than half of the people with diagnosed HIV in the United States (more than half a million people) receive services through this program each year, making it the largest federal program for care and treatment services for people with HIV. In 2021, the program was funded at \$2.21 billion. In 2019, 88.1 percent of the program's clients (and 87.8 percent of the program's AI/AN

clients) were virally suppressed, exceeding the national average of 64.7 percent and showing an increase from 69.5 percent of program's clients in 2010. Of the program's clients, 73.4 percent are from racial/ethnic minority populations, with nearly 3,100 clients (.5 percent) identifying as AI/AN.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 facilitated engagement with AI/AN clients and HIV care by enabling IHS-operated clinics to apply directly for funding under Parts C and D of the Ryan White program. It also exempted them from the payer-of-last-resort restrictions under Parts A, B, and C of the program. These changes have helped increase access to HIV services at IHS clinics.

HAB works collaboratively with IHS to raise awareness of the Ryan White program and to support the HIV care and treatment needs of AI/ANs. HAB also provides training, technical assistance, and culturally tailored resources for tribes and health care providers. In 2021, HAB invested in five AIDS Treatment Centers, which receive HRSA funding and Minority AIDS Initiative funding to work with minority populations, including AI/AN populations, to assess their training needs and provide culturally responsive, needs-based training programs.

Discussion

Chuck Hoskin opened up the floor for discussion. There were no comments.

Maternal and Child Health Bureau

Laura Kavanagh, Deputy Associate Administrator, presented for the Maternal and Child Health Bureau (MCHB).

MCHB is the only federal bureau with the mission of improving the health and well-being of America's mothers, children, and families. Programs address behavioral health, women's health (including before, during, and after pregnancy), and infant health to help reduce racial and ethnic disparities. MCHB also supports children and youth with special health care needs and their families, and its Pediatric Mental Health Care Access Program promotes behavioral health integration into pediatric primary care. In August 2021, HRSA awarded approximately \$10.7 million in ARP Act funding to 24 new pediatric mental health care access programs, including two tribal entities (Chickasaw Nation and Red Lake Band of Chippewa Indians).

MCHB's Healthy Start program supports grants to advance community-based approaches to improve health outcomes before, during, and after pregnancy and to reduce racial and ethnic disparities in rates of infant deaths and other adverse perinatal outcomes. In Fiscal Year (FY) 2021, this program awarded approximately \$2.2 million to two grantees that serve AI/ANs (the Great Plains Tribal Chairmen's Health Board and the Inter-Tribal Council of Michigan).

MCHB's Family-to-Family Health Information Center grant program provides funding to support social determinants of health (SDOH). In FY 2021, this program awarded \$580,500 to six grantees, which serve tribes, Native Hawaiians, and Pacific Islanders.

MCHB's Maternal, Infant, and Early Childhood Home Visiting program, in partnership with the Administration for Children and Families (ACF), supports tribal programs to help prevent child abuse and neglect, support positive parenting, improve maternal and child health, and promote child development and school readiness. In FY 2021, approximately \$12 million supported 23 tribal grantees. The Tribal Maternal, Infant, and Early Childhood Home Visiting program has started planning a tribal summit tentatively scheduled for June 2022.

Discussion

Chuck Hoskin opened up the floor for discussion. There were no comments.

Provider Relief Bureau

Danita Hunter, Associate Administrator, presented for the Provider Relief Bureau (PRB).

PRB ensures resiliency of the nation's health care systems and infrastructure by providing support for COVID-19 response. PRB reimburses health care providers for health care-related expenses or lost revenues attributable to COVID-19 and provides claims reimbursement to health care entities for COVID-19 testing and treatment for uninsured individuals. PRB administers the Provider Relief Fund, which has provided direct payments to health care providers experiencing changes to operating revenues and increases in expenses during the pandemic. HRSA released funds through general and targeted distributions, and HRSA has made over \$674 million in payments to tribal entities. HRSA allocated more than \$513 million to tribal-targeted distribution payments to approximately 437 IHS and tribal providers, including tribal hospitals, clinics, and urban Indian health care centers.

The PRB also administers a rural-specific program made possible by an \$8.5 million investment from the ARP Act, and announced the first round of ARP payments in November. In the upcoming weeks, the PRB also plans to roll out additional payments. Further, the PRB oversees two claims reimbursement programs: (1) HRSA COVID-19 Uninsured Program, and (2) the COVID-19 Coverage Assistance Fund. The programs provide reimbursements for under-insured and uninsured populations.

Discussion

Chuck Hoskin opened up the floor for discussion. There were no comments.

Office for the Advancement of Telehealth

CDR Heather Dimeris, Director, consolidated her presentation with the Office's primary presentation scheduled for later in the day on Day 1.

Office of Special Health Initiatives

RADM Krista Pedley, Director, presented for the Office of Special Health Initiatives (OSHI).

OSHI provides a focal point for HRSA to deliver on population health and secretarial priorities. OSHI oversees HRSA's global-health and drug-pricing programs and provides agency-wide coordination on behavioral and oral health. OSHI has two main offices: (1) the Office of Pharmacy Affairs (OPA) and (2) the Office of Global Health (OGH).

OPA implements the Drug Pricing Program to reduce the cost of outpatient drugs. Over 22 entities, including tribal programs, participate in the Drug Pricing Program. These safety-net organizations receive 25-50 percent discounts on what they would have otherwise paid for the program, which helps stretch their federal dollars to provide more comprehensive services in the communities. Over 600 manufacturers and over 13,200 entities participate in the program. Last year, the program facilitated close to \$40 million in drug purchases at those discounted prices.

OGH implements the U.S. President's Emergency Plan for AIDS Relief, and partners with seven federal departments and agencies to implement the program to control the global HIV/AIDS epidemic. Since the program's inception in 2003, the U.S. government has invested over \$85 billion in the global HIV/AIDS response, saving over 20 million lives.

HRSA leverages its domestic work in HIV/AIDS and primary care to address barriers to care to help optimize HIV/AIDS service delivery in 20 of the 50 countries that the President's Emergency Plan for AIDS Relief supports. OGH also represents HRSA in bilateral and multilateral engagements, facilitating the sharing of promising and best practices with other countries to improve health outcomes globally. They also coordinate across the agency to develop strategies to advance health and mitigate disease at the U.S.-Mexico border.

For behavioral and oral health, OSHI works across HRSA to coordinate and advise on behavioral and oral health policies and initiatives with the primary intent to facilitate a cross-agency approach to improve health outcomes for the populations that HRSA serves. Lastly, OSHI coordinates other emerging health priorities for HHS, including coordinating the strategic planning work across HHS around climate change and environmental justice.

Discussion

Chuck Hoskin opened up the floor for discussion. There were no comments.

Office of Women's Health

Stephen Hayes, Public Health Analyst, and Nancy Mautone-Smith, Director, presented for the Office of Women's Health (OWH).

OWH coordinates efforts across HRSA to advance the lifelong health and wellness of women. Specifically, they highlighted their work on intimate partner and interpersonal violence, as a disproportionate and alarming number of AI/AN women experience this type of violence. HRSA is committed to addressing this issue and committed to action. OWH is the only federal agency with an agency-wide strategy to address this health issue.

Additionally, OWH coordinates with entities outside of HRSA, such as (1) the National Council of Indian Affairs Working Group on Missing and Murdered Indigenous Women, organized through the Administration for Native Americans within ACF, (2) the HHS Steering Committee on Violence Against Women, and (3) the Veterans Affairs' Intimate Partner Violence Assistance Program.

Between January 2017 and December 2020, OWH completed HRSA's first strategy to address intimate partner violence (IPV), which included 27 activities ranging from training for supervisory staff within HRSA to ambitious screening goals for grantees. OWH has awarded a contract to support a new strategy that, building on the sustainable successes of the first strategy, will expand the program's focus to include intersecting forms of IPV and to identify opportunities to focus on prevention.

OWH hopes to collaborate with stakeholders to identify promising practices and emerging opportunities to break the cycles that perpetuate IPV. One item from this strategy is the development of the national IPV training and technical assistance partnership, which has resources available for different communities. They also fund the Strong Hearts Native Helpline in collaboration with ACF. Last, in December 2020, they released the toolkit, [Caring for Women with OUD](#).

Discussion

Chuck Hoskin opened up the floor for discussion. There were no comments.

Office of Health Equity

Christina Ramey, Deputy Director, presented for the Office of Health Equity (OHE).

OHE serves as the principal advisor across HRSA in matters related to health inequities, priority population health, and health literacy by providing expertise for short- and long-term objectives and research. The Office increases the visibility of data and policies that may impact health equity and partner with governmental and non-governmental stakeholders to increase the visibility of health disparities and health equity issues nationally.

In FY 2021, OHE authored three publications on maternal mortality and life expectancy and released the 2019–2020 HRSA Health Equity Report. The Office also presents at educational events, including the virtual National Minority Health Month event, Vaccine Ready. Further, it helps facilitate the Roots of Health Inequity course for HRSA staff.

OHE provides technical assistance and guidance to HRSA's Bureaus and Offices on SDOH, virtual and onsite training on health literacy, and research into unmet needs and critical care that affects Indian Country. OHE plans to increase its outreach to governmental and academic stakeholders who are committed to addressing barriers to accessing health care.

Discussion

Chuck Hoskin opened up the floor for discussion. There were no comments.

Office of Planning, Analysis and Evaluation

Susan Monarez, Director, presented for the Office of Planning, Analysis and Evaluation (OPAE).

OPAE's mission is to drive organizational improvement, which it does through numerous collaborative activities across HRSA's Bureaus and Offices. It facilitates the use of performance and quality measurements to demonstrate program effectiveness, promote transparency and

accountability, and drive performance improvement. This evaluation informs HRSA's decision-making and strategic direction, shows what is working, and shows where there is opportunity for improvement. OPAE also manages the regulatory and legislative activities for HRSA, such as those related to the Government Accountability Office and the Office of the Inspector General.

OPAE provides leadership on cross-cutting health policy analysis with a focus on health care financing and regulation. It also leads the integration and elevation of HRSA's innovation efforts, and uses Susanville Indian Rancheria's ATI Government Solutions for this work.

Discussion

Chuck Hoskin opened up the floor for discussion on any of the roundtable items presented.

Question from Rhoda Jensen

Rhoda Jensen asked how Uniform Data System (UDS) data is collected. She said, in her opinion, HRSA is missing out on a lot of encounters regarding the actual work happening in Indian Country because tribes cannot show all of the work under the current UDS tabulations. For example, community health aides are identified under the *other* category, so many encounters are not included.

Response from Tonya Bowers

Tonya Bowers said program experts will be available on Day 2 to address UDS questions.

Presentations of Select HRSA Bureaus and Offices

4:10 pm Office for the Advancement of Telehealth

CDR Dimeris, Director, presented for OAT.

HRSA's first telehealth program began in 1988 through the Office of Rural Health Policy, predecessor to the FORHP. In 2006, HRSA established the Telehealth Resource Center program. In 2017, HRSA created a Telehealth Workgroup. Then, in 2020, COVID-19 changed the telehealth landscape, and in 2021, OAT became a stand-alone office that reports directly to the Immediate Office of the Administrator. While OAT does not focus specifically on rural health, it does still emphasize rural, frontier, and tribal communities in their work, alongside other geographic areas.

OAT coordinates with key federal partners to improve access to telehealth, enhance health outcomes, and support clinicians and patients. They also promote telehealth for health care delivery, distance learning, and health information services. Further, OAT provides funding for direct services, research, and technical assistance for telehealth.

A newer investment with the Alaska Native Tribal Health Consortium, through the National Telehealth Technology Assessment Resource Center, is overseeing a pilot to address whether the mapping of broadband in four states and select rural communities really targets the needs and the bandwidth for telehealth video appointments. Throughout the pandemic, many areas

relied on audio-only telehealth, but video services can be helpful for some situations and applications. This pilot is the first HRSA investment in broadband.

OAT has an annual budget of \$34 million for FY 2021 (Table 1), alongside the one-time funding received through the CARES Act.

Table 1. OAT FY 2021 Annual Budget

OAT Program	Awardees	FY 2021
Telehealth Network Grant Program This program focuses on tele-emergency services.	30	\$8.9M
Evidence-Based Telehealth Network Program This program focuses on direct-to-consumer activities and data collection to build the evidence base for nationwide models of direct-to-consumer telehealth technologies.	11	\$3.8M
Telehealth Resource Centers There are 12 regional centers and two national centers—one for policy and one for technology.	14	\$4.6M
Licensure Portability Grant Program Through CARES Act funding, the two Licensure Portability Grant Program grantees were able to create the following resources: <ul style="list-style-type: none"> • Provider Bridge – This website assists physicians with cross-state licensure applications. • Multi-Discipline Licensure Resource Project – This website assists other health care providers with cross-state licensure applications. 	2	\$0.3M
Telehealth-Focused Rural Health Research Centers These centers aim to build the evidence base on telehealth by analyzing the effectiveness of in-person health care compared to telehealth services. Since the onset of the pandemic, they have been looking at the comparison of in-person services to a hybrid of telehealth and in-person services.	2	\$2.0M
Telehealth Centers of Excellence There are two Telehealth Centers of Excellence—in Mississippi and South Carolina. These centers focus on understanding emerging areas of telehealth.	2	\$6.5M
Telehealth Technology-Enabled Learning Program This program can include Extension for Community Health Outcomes programs and other distance learning programs to establish provider telehealth training and tele-mentoring. Several of these programs include tribal grantees.	9	\$4.2M
Other	—	\$3.7M
TOTAL	70	\$34M

OAT collaborates on (1) the Telehealth Interagency Policy Council with the HHS Telehealth Workgroup, (2) the Federal Telehealth Workgroup, (3) the Rural Telehealth Initiative Memorandum of Understanding (MOU) with HHS, the Federal Communications Commission, and the U.S. Department of Agriculture, and (4) the American Broadband Initiative with the National Telecommunications and Information Administration. Currently, 3,876 awards include a telehealth component. FORHP, which does include OAT in this instance, has 239 of these awards, and the target population includes tribal communities.

In September 2021, OAT and HHS held a listening session with panels of telehealth and broadband experts across the federal government to discuss the latest information and resources. OAT is planning a second listening session early in 2022.

Discussion

Chuck Hoskin opened up the floor for discussion.

Question from Rhoda Jensen

Rhoda Jensen noted the importance of telehealth for tribal communities, which are largely rural. She recommended, to the maximum extent possible, that HRSA make telehealth infrastructure available to tribes through non-competitive grant processes and dedicated set-asides. HRSA should also seek more input from tribes and provide more technical assistance as this field evolves.

Response from CDR Dimeris

CDR Dimeris noted that tribal input will be valuable in informing the MOU.

Question from Mary Harrison

Mary Harrison asked how OAT will work with IHS and other agencies to advance telehealth. IHS' electronic health record system is very outdated, which limits the availability of datasets required by HRSA. Additionally, she asked how the HRSA TAC and tribal leaders work with OAT to advance telehealth and broadband connectivity access, the need for which increased during the pandemic.

Response from CDR Dimeris

CDR Dimeris said, under the current administration, OAT has strong collaboration with IHS through the Telehealth Interagency Policy Council. The equivalent of 10 years of growth occurred within 1 year, and OAT is really trying to catch up and address challenges. Additionally, the feedback they have already received through the MOU and the listening session, as well as the feedback they hope to receive through the upcoming listening session, will be of great assistance in addressing the disparity.

Question from Aaron Payment

Aaron Payment noted that many tribes in Oklahoma have checkerboard reservations in rural communities. During the pandemic, the importance of telemedicine and tele-behavioral health became very apparent. While grant dollars are available to help address telehealth needs, many tribes lack the capacity to complete competitive applications. He hopes that a big chunk

of the Infrastructure Bill, maybe \$1 billion of it, goes toward filling the unmet need from the original funding distribution, and another big chunk is pushed out to determine needs for tribes and develop archetypes to fill that need. Further, rural areas have trouble getting providers in their areas, and telehealth helps fill that gap, but it cannot happen until the infrastructure is in place. He asked that OAT press upon the need to hold listening sessions to ensure that funding distributions account for tribal needs.

Response from CDR Dimeris

CDR Dimeris said OAT will continue to use its partnerships to inform agencies of tribal needs and hold listening sessions. Regarding tele-behavioral health, she is excited to learn how the data will be analyzed regarding the effectiveness of telehealth for those with special health care needs. Even before the pandemic, she believed there was a strong evidence base of health outcomes for tele-behavioral health. For specialty care, they are seeing great promise through their Telehealth Technology-Enabled Learning Program.

5:00 pm Recap of the Day and Next Steps

Chuck Hoskin turned the floor over to Natasha Coulouris for a brief recap of Day 1. Natasha Coulouris provided the following summary:

- Expanding quality health care to Indian Country is a shared goal.
- TAC delegates expressed interest in HRSA providing TAC technical assistance support.
- HRSA is reaching out to tribes deemed ineligible for the THCGME.
- HRSA will explore the request for 5 percent set-aside within its statutory authority.
- Tribes would like to collaborate with HRSA to advance the proposal to expand self-governance within Title VI beyond IHS funding to include HRSA funding.
- TAC delegates expressed hope for additional capital improvement funding.
- HRSA will continue outreach to ensure it has eligible applicants from Indian Country.
- The TAC would like HRSA to reduce the burden of grant application/reporting process.
- UDS data collection is important to show health provision within Indian Country.
- It is important that OAT continue to collaborate with other federal agencies and aid in enhancing telehealth infrastructure/broadband. Specialty telehealth services (such as tele-behavioral health) would help address workforce shortages in rural areas.
- The TAC would like FORHP to work with IHS to address workforce shortages.

Chuck Hoskin announced that TAC chose not to hold a tribal caucus on Day 2.

5:30 pm Day 1 Adjournment

Chuck Hoskin adjourned Day 1 of the meeting.

Day 2 Meeting Summary

December 2, 2021

Chuck Hoskin, TAC Chair and Oklahoma Area Delegate, was unable to attend the first half of Day 2 of the TAC meeting, so Rhoda Jensen, Co-Chair and Alaska Area Delegate, stepped in during his absence. To begin the meeting, Jennifer Gillissen, Kauffman & Associates, Inc., reviewed the meeting protocol, and Selwyn Whiteskunk, Albuquerque Area Delegate, shared an opening blessing. Next, select HRSA Bureaus and Offices presented, followed by a presentation on HRSA's finances and budget. Chuck Hoskin then opened the floor to the TAC delegates to engage with HRSA leadership. Finally, Chuck Hoskin adjourned the inaugural meeting.

1:00 pm Opening Blessing

Rhoda Jensen called on Selwyn Whiteskunk to provide the opening blessing.

1:00 pm TAC Business and Housekeeping

Rhoda Jensen turned the floor over to Ivy Vedamuthu, OTA Tribal Liaison, to take roll of the TAC delegates. She noted that they made quorum.

Roll Call of Delegates and Alternates

Chairman Chuck Hoskin Jr.

(present by proxy)

Cherokee Nation

TAC Acting Chair, Oklahoma Area Delegate

Rhoda Jensen

Yakutat Tlingit Tribe

Alaska Area Delegate

Councilman Selwyn Whiteskunk

Ute Mountain Ute Tribe

Albuquerque Area Delegate

Chairperson Aaron Payment

Sault Ste. Marie Tribe of Chippewa Indians

Bemidji Area Delegate

Kira Norton

Hoopa Valley Tribe of California

California Area Delegate

Mary Harrison

Nashville Area Alternate

Presentations of Select HRSA Bureaus and Offices

1:00 pm Bureau of Health Workforce

Melissa Ryan, Director of the Policy and Shortage Designation Branch; Israil Ali, Director of the Division of National Nurse Service Corp; Joan Weiss, Deputy Director of the Division of Medicine and Dentistry; and Michelle Washko, Director of the National Center for Health Workforce Analysis presented for BHW.

Melissa Ryan presented first. She discussed Health Professional Shortage Area's (HPSA) data considerations for scoring. HRSA has undergone many shifts in the area of HPSA and in 2020, put out a request for information on other data sources that may be used to modernize and

update HPSA scoring criteria, which is used to prioritize applications. However, since 2019, HRSA has had a set-aside for providers applying to serve in the National Health Service Corps (NHSC) at IHS, tribal, and urban Indian (ITU) sites. Because of that set-aside, BHW has been able to award all of the eligible ITU applicants through the NHSC Loan Repayment Program, regardless of their HPSA scores. In considering data for HPSA scoring, BHW looks at whether it is (1) relevant in assessing and describing need, (2) universal to all areas for designation, (3) accessible for the public and transparent regarding from where the data came, (4) specific to the targeted community level, and (5) current.

Next, Israil Ali presented on the scholarship and loan repayment programs. NHSC and Nurse Corps programs provide loan repayment and scholarships to eligible providers in exchange for a commitment to serve in high-need areas. Due to the increase in funding received this past year through the ARP Act, BHW anticipates increasing its ability to support the health workforce in Indian Country. Collectively, the programs recognize just under 1,000 ITU facilities as being eligible locations to complete service obligations. BHW's and IHS' loan repayment programs coordinate their applicant pools each year to optimize awards across both investments.

Since 2019, NHSC has dedicated more than \$45 million in loan repayment funding solely to recruit ITU providers. In tandem with their mandatory funding for NHSC, HRSA has been able to award every eligible ITU applicant in the past 3 years, resulting in over 1,000 awards. In FY 2021, BHW awarded over \$6 million in scholarships through NHSC and the Nurse Corps to AI/AN students. BHW currently supports 75 AI/AN students through post-graduate training. Collectively, these programs support 22,291 clinicians who serve nearly 23 million patients in need of primary care services.

As an outcome of this additional funding, BHW is forecasting their strongest field strength in the program's history. Using the ARP Act funds, BHW was able to award all eligible applicants this year, regardless of their HPSA score, and they plan to do the same in the upcoming application cycle. BHW is currently accepting applications for the FY 2022 NHSC Loan Repayment Program, SUD Workforce Loan Repayment Program, Rural Community Loan Repayment Program, and Nurse Corps Loan Repayment Program.

Next, Joan Weiss presented. BHW's primary care medicine programs aim to bolster the workforce and improve health care quality where it is most needed. Three such programs are the THCGME program, the Medical Student Education Program, and the Primary Care Training and Enhancement Program, which have increased the number of primary care trainees in community-based primary care settings. In FY 2020, they supported 15,844 trainees, 53 percent of whom trained in medically underserved communities. In the THCGME program, 93 percent of residents spent part of their training in medically underserved and/or rural communities, providing over 1 million hours of patient care in Academic Year (AY) 2019-2020. Almost one-third of these participants came from disadvantaged backgrounds. Of these graduates, 74 percent plan to practice in primary care.

On the pediatrics side, the Children's Hospital GME Payment Program funds freestanding children's hospitals to help programs train resident physicians and pediatric dentists. Through

annual funding, the program trains 43 percent of all pediatric residents in the United States and over half of all pediatric subspecialty residents and fellows. In AY 2019-2020, BHW supported 13,250 trainees. In FY 2019, they also implemented the first quality bonus system to recognize high-quality residency training in GME programs.

The THCGME program supports training for residents in primary care residency training programs in community-based ambulatory patient care centers. Programs prepare residents to provide high-quality care, particularly in rural and underserved communities, and develop competencies to serve these populations and communities.

The programs fund community-based training programs for GME consortia with a focus on training residents in community settings. However, it does not fund hospital-based residency programs that are eligible for CMS GME funding. Currently, the program funds two tribal entities, the Choctaw National Health Services Authority (\$1.5 million) and the Puyallup Tribal Authority (\$2.1 million). HRSA received three applications for the recent THCGME competition; however, none were funded because two of the applicants were hospital-based and one was below the full-time equivalent baseline.

The Biden Administration recently announced additional funding to support COVID-19 response and build on current equity-focused programs and initiatives through the ARP Act. Funding includes nearly \$240 million for HRSA to expand the public health workforce by creating a pipeline program for 13,000 community health workers and paraprofessionals from underserved communities. HRSA will also invest nearly \$39 million to support organizations' scholarship programs that incentivize people to pursue public health careers. Tribal entities are eligible to apply. These initiatives will launch early in 2022.

Last, Michelle Washko discussed publicly available health workforce data. The National Center for Health Workforce Analysis is the only federally mandated research center on this specific sector of the U.S. economy. They support decision-making at all levels by all stakeholders and inform the public by collecting, producing, analyzing, and disseminating data and research on the U.S. health care and health support workforces. They also serve as the designated focal point for reporting data globally. They conduct this work through many avenues, from funding external research to conducting internal research, collecting and disseminating data, and evaluating federal funding that Congress appropriates for the health workforce.

Over the past 4 years, BHW has committed to support its work with data-driven evidence in alignment with major federal data initiatives. This process has pushed BHW to modernize its data collection and IT systems and make data publicly available through the website data.hrsa.gov. The website provides data comparison tools, a Health Professions Training Program dashboard, Area Health Resources Files, and workforce project data.

Discussion

Rhoda Jensen opened up the floor for discussion.

Question from Kira Norton

Kira Norton, California Area Delegate, said the NHSC placements are largely dictated by HPSA scores for medical, behavioral, and dental care accessibility. TAC is concerned about the HPSA scoring process. While Kira Norton appreciates that Indian health providers are auto-HPSAs, the current scoring methodology does not reflect the poverty level that many tribes experience or their urgent need for providers. Census data are unreliable for Indian Country, but HRSA uses it to calculate a population's poverty status. TAC recommends that tribal providers receive the highest HPSA score possible to reflect their high level of need.

Additionally, where national data are not available, HRSA should default to the max HPSA score for tribal and urban programs. She noted that Indian Country has the highest health disparities for infant health and substance use. Finally, HRSA indicated it would publish the comments and responses they received during the HPSA scoring criteria request for information. Kira Norton asked when to expect that report. TAC also requests that HRSA work with IHS to create a unique HPSA scoring system that is reflective of the unique needs of Indian Country and based on robust tribal consultation.

Response from Melissa Ryan

Melissa Ryan said HRSA is preparing a proposal for the request for information and hopes to publish it in the Federal Register in 2022, if HRSA is able to publish the results. With regard to the census data, HRSA has to use something in the absence of other data. For entities like ITU sites that are auto-HPSAs, the site points of contact can provide data if they have it, allowing for flexibility to provide site-specific data in the current criteria. Additionally, since the ITU set-aside, HRSA has awarded every eligible applicant since 2019 and in 2021, all eligible applicants across all programs received awards due to increased funding from the ARP Act. She encouraged eligible providers to apply for the funding opportunities.

Question from Aaron Payment

Aaron Payment said he serves on the Bureau of Indian Affairs Tribal Interior Budget Council, which has a Data Subcommittee. The Department of the Interior is one of the principle data collection agencies. IHS does data collection, but it is limited to the purchase and referred service area population, which is only one-third of his tribe's population. Bureau of Indian Affairs has actual tribal enrollment data, whereas census data are best "guestimates."

For example, the census reported a 21 percent undercount for Chippewa County compared to the tribe's enrollment data, which affects their eligibility for funding. He acknowledged that tribes have not fully participated in reporting tribal enrollment information over the years for many reasons. For one, past federal policies on racial identity have led people to not self-identify as being AI/AN because they are unsure what is required to do so.

There is a critical need to be able to index available information, such as unemployment and hospital statistics. He suggested that HRSA and TAC collaborate to draft a series of listening sessions with tribal nations across the country to walk through HPSA score criteria to review the validity and viability of each of its variables and identify potential areas of improvement—how

they measure enrollment, for example. If it is something that requires a legislative act, they can team up to advise Congress.

A second issue is that some smaller counties in Alaska will be undercounted if their populations are less than 500. If they do the listening session series, they should look closely at the impact of the variables, the way they are counted, and how they can potentially lead to HPSA underscores.

A third critical issue is that community health aides are still classified as *other*, rather than *providers*, which also affects HPSA score. They rely on data to get programming into Indian Country.

Motion for HPSA Subcommittee

Carmen Clelland, Director of OTA, asked Aaron Payment if he was recommending they create a subcommittee to review HPSA scoring and hold the listening sessions. Aaron Payment responded a subcommittee would be a good idea. Rhoda Jensen entertained a motion to create a HPSA Subcommittee. Aaron Payment made the motion. Kira Norton seconded the motion. Hearing no objections, Rhoda Jensen said the motion carries. Rhoda Jensen entertained a motion to have Aaron Payment lead the HPSA Subcommittee. Mary Harrison made the motion. Kira Norton seconded the motion. Hearing no objections, Rhoda Jensen said the motion carries. In the chat, Chris Waterhouse, Shoshone-Bannock Community Health Center, asked to be part of the subcommittee.

Question from Lee Spoonhunter

Lee Spoonhunter, Billings Area Delegate, requested that HRSA address the dramatic provider shortages and burnout in Indian Country. Additionally, he requested that HRSA continue to support NHSC placements within Indian health facilities to expand the reach of the program. Regarding grants and funding, he reiterated that the competitive grant process pits tribes against each other and other non-Native entities more experienced in federal grant applications. Tribes should not have to compete against other tribes or entities. Further, the grant application process and associated reporting puts undue burden on tribes.

Response from Melissa Ryan

Melissa Ryan said they know that census data are imperfect and that clinics served by IHS do not represent the total population. But HRSA found that looking at the population served by ITU sites and enrollment of those who could be served at those sites, alongside census data for anyone who identifies as AI/AN, in whole or in part, resulted in better HPSA scores in terms of population. She reiterated that they are looking for more ITU program applicants because HRSA is able to fund them all right now.

Question from Rhoda Jensen

Rhoda Jensen said Alaska's clinics should not be subject to HPSA scoring. Most of their HPSA providers are located off the road system and in small villages. IHS uses an isolation factor in their criteria for areas only accessible by boat or plane. She suggested they look at IHS' wording for the isolation factor when reevaluating HPSA scoring for Alaska's situation.

HRSA should also assist tribes and IHS in addressing provider shortages through GME. They need more schools to improve education within smaller tribal communities. She requested that HRSA create a tribal set-aside within the THCGME program for IHS and tribal medical residency programs.

Question from Jill Jim

Jill Jim, Navajo Nation Alternate, asked if HRSA has looked at how the Community Health Representative Program, Community Health Worker Program, and the CHAP are being implemented in Indian Country. There needs to be some clarification on how these programs are being addressed, which is an issue for Navajo Nation.

Question from Chris Waterhouse

In the meeting chat, Chris Waterhouse asked if there can be more trainings on HPSA scores. He also asked if tribally run HRSA clinics are part of the ITU designation.

2:00 pm Bureau of Primary Health Care

Jim Macrae, Associate Administrator; Matt Kozar, Director of the Strategic Initiatives, Division of the Office of Policy and Program Development; Alek Sripipatana, Director of the Data and Evaluation, Division of the Office of Quality Improvement; and Judith Van Alstyne, Data Production Team Lead of the Data and Evaluation Division, Office of Quality Improvement, presented for BPHC.

Jim Macrae presented first on the Health Center Program. BPHC supports about 1,400 health centers through the Health Center Program, which provide services at close to 14,000 sites across the country for nearly 29 million people. They offer patient-centered, comprehensive, and integrated care through primary medical, oral, and mental health services; SUD and medication-assisted treatment services; and enabling services, such as case management, outreach, interpretation, and transportation.

BPHC supports funded health centers and FQHC look-alikes. BPHC has jointly funded programs and they are interested in having more tribal organizations join the Health Center Program. They cannot waive certain requirements and expectations, but they have worked with organizations over the years to get to a successful place today.

Next Matt Kozar discussed ways to join the Health Center Program. The program is available for public and nonprofit entities as program awardees or FQHC look-alikes. Health centers must comply with all program requirements and related federal and state requirements. The Health Center Program has two funding opportunities, which are competitive:

- New Access Points (NAP) supports new service delivery sites in providing comprehensive primary health care services, especially in underserved areas and for vulnerable populations. The most recent NAP investment was in FY 2019. There is no currently open funding opportunity for NAP.
- The Service Area Competition makes funding available for continued access to care in already defined and funded services areas. Typically, a service area is usually competed

every 3 years, and there is usually a health center already servicing that area. However, new organizations or existing grantees may apply for the Service Area Competition and make their case that they are well suited to provide services in the service area.

[FQHC look-alikes](#) do not receive ongoing operational grant funds from HRSA, but they can apply for CMS FQHC reimbursement rates and are eligible for discount drugs through the 340B program, free vaccines for uninsured children, and other benefits. They must still comply with the Health Center Program requirements to receive these benefits.

The Health Center Program funds 35 dually-funded HRSA-IHS tribal and urban Indian health centers. In FY 2021, these organizations received more than \$87 million in ongoing Health Center Program funding and \$60 million from the ARP Act for COVID-19 response and infrastructure. Further, 32 of these health centers also received \$18 million in ARP Act Capital funding to support infrastructure.

Next, Alek Sripipatana presented on the UDS. High-quality and standardized health center data and data systems are central in ensuring that health centers help achieve HRSA's mission. Data allow HRSA to recognize health center accomplishments in continuing to provide care to over 29 million patients throughout the pandemic, highlight that health centers are meeting and exceeding national benchmarks in care quality, and identify opportunities to improve care delivery. UDS data are the backbone for informing the Health Center Program. Each datum in the UDS represents a person, which HRSA takes very seriously, paying close attention to what data elements are included, how they are operationalized, and how they can be leveraged to improve the program and support patients.

Last, Judith Van Alstyne presented on UDS data. Each year, health center programs and FQHC look-alikes are required to report on standardized measures defined in the UDS as a primary source of performance data. UDS data support HRSA's efforts to expand access to care, address health disparities, improve quality of care, and reduce costs.

Pursuant to the Paperwork Reduction Act, the Office of Management and Budget (OMB) approved the UDS for collection efforts on a 3-year review cycle. Outside of that cycle, BPHC tries not to make changes to the UDS measures or add reporting burden to maintain consistency and comparability of UDS data, year over year. Each report has at least 1,000 data elements. The next substantial OMB review is slated to be in support of the 2023 UDS instrument for reports due in February 2024.

Each year, BPHC issues official policy guidance on UDS measures to inform health centers and program stakeholders of any UDS instrument updates. Updates are communicated through a UDS changes program assistance letter. These updates may be informed by national reporting standards to keep pace with the current and evolving primary health care landscape and to inform evaluation needs of bureau, agency, and departmental priorities.

The UDS captures financial, clinical, staffing, and demographic data as well as CHAP data in UDS Table 5, Line 22, as *other professional services*. CHAP is incredibly important to the primary

health care landscape in Indian Country, such as in Alaska, where the program was created. Line 22 allows health centers to report the role of the full-time employees and the number of visits and patients associated with the reported professionals. Appendix A of the UDS Manual provides a comprehensive list of personnel contributing to the functioning or operation of health centers.

The UDS does not predicate or play a role in determining reimbursement for services provided. From the latest UDS data, which is 2020 data, there are 35 dually-funded HRSA-IHS BPHC health centers. Of these health centers, 11 reported community health aide practitioners on Line 22. As policy, standards, and practice restrictions may evolve or change, BPHC will continue to discuss CHAP UDS reporting.

For 2021 UDS reporting, HRSA and IHS provide technical assistance through an interagency agreement to lessen the burden of reporting. This agreement supports the translation of IHS' Resource and Patient Management System data elements for the purpose of UDS reporting in support of the dually-funded health centers. She provided the following resources:

- [2021 UDS Program Assistance Letter](#)
- [2021 UDS Manual](#)
- [2022 UDS Proposed Program Assistance Letter](#)
- [BPHC UDS Resources page](#)
- [UDS Training Website](#)
- UDS Help Line: udshelp330@bphcdata.net and 866-UDS-HELP (866-837-4357)

Each year, in partnership with state and territory primary care associations, BPHC hosts state or region UDS trainings, the schedule for which is posted on the UDS Resources page.

BPHC is preparing for UDS beyond the 2023 performance year. Their UDS modernization initiative aims to reduce reporting burden, improve data quality, and better measure program services and outcomes with a focus on reporting modernization, content review, stakeholder engagement, and testing. Reporting modernization entails improving UDS reporting through advances in health information technology and includes the UDS+ initiative to transfer measures from the health center level to the patient level.

BPHC is also updating the UDS tables to improve data standardization and quality and to align with electronic clinical quality measures. These electronic clinical quality measures reduce the burden of manual data extraction and reporting and help demonstrate point-of-care quality improvement and support clinical decisions. The [UDS modernization website](#) is available for more information and resources.

Discussion

Rhoda Jensen opened up the floor for discussion.

Question from Rhoda Jensen

Rhoda Jensen said she respectfully disagrees with HRSA's recent decision to continue its policy of classifying community health aides as *other* instead of as *provider* under the UDS. By not counting Alaska's community health aides, their work is undervalued and the cost of care delivery in Alaska looks exceptionally high in UDS calculations, which impacts tribal providers' ability to access numerous HRSA and HHS program resources.

Any formula-based funding that uses medical visit counts results in underfunding because CHAP activity is not included. Some small Alaska villages only have a community health aide and miss out on funding as a result. Community health aides are federally certified, medically trained providers whose certifications and standards come from the CHAP Certification Board, which is a division of HHS that IHS manages.

Response from Jim Macrae/Discussion with Rhoda Jensen

Jim Macrae said it would be helpful for him and his team if Rhoda Jensen could show what Alaska programs currently report in the UDS and what it would look like, based on the last year, if community health aides were reported as *providers*. Rhoda Jensen said she has a team that is ready to provide the requested documentation. Jim Macrae said BPHC follows the provider licensing requirements of IHS and CMS while relying on state licensing for what BPHC can support. He asked if community health aides in Alaska are recognized by the state and by CMS as a provider type. Rhoda Jensen confirmed that they are.

Question from Aaron Payment

Aaron Payment said, regarding state licensing, tribes are not subordinate to states. He added that they have similar challenges getting the dental therapist program approved. Some tribes have decided to move forward with the program without reimbursement due to the needs in their areas. If HRSA and Rhoda Jensen can communicate on how the AK CHAP program is legitimate, tweak it, or advise on legislation, then they should move forward with doing so to ultimately support UDS reporting for these programs.

Response from Jim Macrae

Jim Macrae said dental therapists are included in the UDS now, which is a good example of how they can ultimately get there with community health aides. Regarding state licensure, the challenge is that these programs do not just serve AI/AN patients, so BPHC must make sure the billing and the licensure applies to the entire community. His team is trying to figure out what steps to take to get to the place where HRSA can recognize these provider types.

Question from Elizabeth Coronado

In the chat, Elizabeth Coronado said Washington State is also going through a state plan amendment process to include community health aides for Medicaid reimbursement.

Motion to Discuss Alaska UDS CHAP

Rhoda Jensen recommended BPHC follow up with her to discuss the UDS CHAP designation further. Jim Macrae agreed. Aaron Payment supported that action. Rhoda Jensen entertained a motion to have HRSA staff contact her to discuss specific UDS issues with regard to the CHAP. Aaron Payment made the motion. Mary Harrison seconded the motion. Hearing no objections,

Rhoda Jensen said the motion carries. After meeting with HRSA staff, Rhoda Jensen will provide the information to the TAC between now and the next TAC meeting, or at the next TAC meeting. Jim Macrae will work through Carmen Clelland to set up the meeting.

Question from Rhoda Jensen

Rhoda Jensen said Alaska tribal Community Health Centers (CHC) and FQHCs were asked to assist during the ongoing COVID-19 public health emergency as the state responded to the worst COVID-19 outbreak in the United States this year. Their hospitals operated under crisis standards of care for several months. They need clarification from HRSA on the waivers for data counts as tribal CHCs and FQHCs treated one-time patients.

HRSA promised a waiver for these patients, so their care provision does not impact data reporting, but there has been no further guidance on the waiver. Further, CHCs and FQHCs are not traditionally equipped for emergency medical services or monoclonal antibody administration centers. These centers are ready to assist, but they need resources to support this influx of patients.

Response from Jim Macrae

Jim Macrae said HRSA provided significant resources through the ARP Act to health centers across the country to support these activities. These resources are available for 2 years. With the Build Back Better Act, HRSA hopes there may be another capital opportunity. With respect to data, HRSA is being consistent across the country in terms of counting patients who show up for a face-to-face visit or encounter with providers. HRSA is not using that data to adjust funding.

Response from Matt Kozar

Matt Kozar said HRSA has invested over \$950 million in health centers for capital infrastructure needs. In terms of the Build Back Better Act, they are thinking about additional capital investments for health centers' infrastructure needs.

Response from Judith Van Alstyne

Judith Van Alstyne said, for the purposes of UDS reporting, they define patients and visits through criteria based on [UDS Countable Visit Guidance](#). An encounter for a vaccine or test likely will not qualify as a countable visit. The encounter needs to be with a licensed or credentialed provider who offers independent, clinical professional judgement. Also, the encounter needs to be documented, and the care needs to be individualized with few exceptions. The visit can be in person or virtual.

Response from Alek Sripipatana

Alek Sripipatana said, in understanding that health centers are providing care outside of the scope of the Health Center Program, they also have a Health Center COVID-19 Survey to count patients who come in for testing.

Response from Jim Macrae

Jim Macrae added that HRSA is looking to provide at-home COVID-19 tests. They hope to get those out by the first of the year.

Question from Rhonda Harjo

In the chat, Rhonda Harjo from NIHB said IHS sent a Dear Tribal Leader Letter to consult on the IHS funding before the Build Back Better bill passes.

3:00 pm Provider Relief Fund

Danita Hunter, Associated Administrator, Provider Relief Bureau (PRB), presented on the Provider Relief Fund (PRF).

The PRF was created to help providers weather the challenges of this pandemic. In Phases 1 and 2, general distribution payments went to Medicare, Medicaid, Children's Hospital Insurance Program (CHIP), Dental, Assisted Living Facilities, and other providers based on 2 percent of patient revenue, regardless of the provider's payer mix. This approach enabled HRSA to get the funds out quickly. In Phase 3, general distribution payments went to a broad range of providers. Payments were the greater of (1) 88 percent of operating losses and increased expenses in the first half of 2020 or (2) 2 percent of annual patient care revenues. Currently, there is an ARP Act distribution of \$8.5 billion to support rural providers and \$17 billion going toward the PRF Phase 4.

HRSA based Phase 4 payments on lost revenues and/or eligible expenditure from July 1, 2020, to March 31, 2021. It includes elements specifically focused on equity, such as reimbursing smaller providers at a higher rate and providing bonuses based on the amount and types of services provided to Medicaid, Medicare, and CHIP beneficiaries. As of the end of November, the vast majority of ARP Act payments were distributed based on the amount and types of Medicaid, Medicare, and CHIP beneficiaries living in rural areas. PRF awarded more than \$38 million ARP Act Rural payments to more than 50 tribal providers across 11 states. PRB is currently reviewing the Phase 4 applications.

Recognizing that some geographic areas, populations, and provider types are disproportionately impacted by the pandemic, HRSA made several targeted distributions to groups and providers who were likely to have increased expenses and decreased revenue. For these distributions, HRSA leveraged available information sources to identify providers and payments. Because of the urgent financial challenges, HRSA made push payments to providers.

HRSA made targeted distributions to about 4,000 rural hospitals, rural critical access hospitals, rural health clinics, and CHCs in rural areas. Shortly after, HRSA received feedback about the need to include specialty hospitals and hospitals in smaller metropolitan areas serving significant rural populations. In response, HRSA made an additional round of payments to those providers. HRSA made \$513 million in target distributions to 437 ITU providers. As of September 10, 2021, ITU providers received an additional \$161 million in PRF payments in addition to the targeted distributions.

PRB also administers two claims reimbursement programs:

- Through the Uninsured Program, HRSA makes payments to eligible providers who provided COVID-19 testing, treatment, or vaccine administration to uninsured individuals.
- Through the Coverage Assistance Fund, HRSA makes payments to eligible providers who administered COVID-19 vaccines to patients whose health insurance does not cover or does not fully cover vaccine administration fees.

PRB's other priorities include supporting providers as they comply with the reporting requirements by providing timely resources and information. Providers who receive PRF funding must report on its use. On November 30, 2021, the 60-day grace period for Reporting Period 1 ended. HRSA considers providers who failed to submit a report on time as non-compliant and will be subject to further enforcement actions, such as repayment or other debt collection activities and exclusion from obtaining future PRF payments. Providers who failed to report or who have unused funds must return those funds by December 31, 2021. Funds for Reporting Period 2, which runs from January 1, through March 31, 2022, must be used by December 31, 2021. Providers are required to report if they received PRF payments exceeding \$10,000 between July 1, and December 31, 2020. HRSA will not approve deadline or grace period extensions.

Discussion

Rhoda Jensen opened up the floor for discussion.

Question from Rhoda Jensen

Rhoda Jensen requested that HRSA extend the deadlines for both reporting periods to September 2022 due to the difficulties distributing the funds and spending guidelines. Additionally, she requested that HRSA distribute formal announcements related to the PRF and reporting through a Dear Tribal Leader Letter.

Response from Danita Hunter

Danita Hunter said at this time, HRSA cannot approve any extensions to ensure consistency across the program and that all funds are returned within a timely manner for potential redistribution in the future. HRSA can assist with increasing communication through Dear Tribal Leader Letters or other avenues.

4:10 pm Finance and Budget Overview

Elizabeth DeVoss, Chief Financial Officer, presented HRSA's finance and budget overview.

The federal budget process is a three-part cycle that typically begins 24 months prior to the fiscal year in which the funds will be needed. From April through August, HRSA develops and presents the budget request to HHS. From August through November, HHS, to include HRSA, presents the budget to OMB for consideration in the president's budget. Then, from November through February, the president's budget is submitted to Congress. The appropriations bill or the Congressional report that accompanies the bill specifies how to allocate funding among

HRSA’s programs. HRSA’s current funding is appropriated to nine accounts and allocated to over 90 program activity lines (Table 2).

Table 2. HRSA Funding (dollars in millions)

HRSA Program	FY 2021 Enacted
Primary Health Care	\$5,684
HIV/AIDS	\$2,424
Maternal and Child Health	\$1,358
Health Workforce	\$1,679
Rural Health	\$330
Family Planning*	\$286
Program Management	\$155
Healthcare Systems	\$129
Vaccine Injury Compensation	\$11
Total	\$12,056

* Administered by the HHS Office of the Assistant Secretary of Health, Office of Population Affairs

In addition to HRSA’s annual budget, HRSA has received supplemental funding in response to the COVID-19 pandemic.

- Through the ARP Act, HRSA received \$17.9 billion for activities such as increasing the number of primary care clinicians who serve in tribal, rural, and urban communities; \$80 million in grants to implement evidence-based strategies to address provider burnout and mental health; and \$150 million to provide emergency assistance to families through the Home Visiting program.
- Through the CARES Act, HRSA awarded \$16.3 million to 57 grant recipients through the Rural Tribal COVID-19 Response program.

Through a continuing resolution, HRSA operated at last year’s funding levels through December 3. The House and Senate appear to have agreed to extend the continuing resolution to February 18. During a continuing resolution, HRSA cannot start new activities. The House and Senate Labor, HHS, Education and Related Agencies appropriation committees’ FY 2022 bills far exceed the FY 2022 president’s budget for HRSA. Further, the House’s Build Back Better Act would provide over \$10 billion to HRSA, which includes health center infrastructure and capital investments, health workforce, and maternal health. The Senate took up this bill in December. HRSA also continues to administer the \$178 billion PRF.

Discussion

Chuck Hoskin opened up the floor for discussion.

Question from Aaron Payment

Aaron Payment said in honor of the federal government's treaty and trust obligations, tribes are asking for a set-aside of 5 percent of budgets so they do not have to compete for their share. It would be helpful for the TAC and HRSA to start examining the federal budget to see how tribes are actually fairing. The HHS Secretary's Tribal Advisory Committee has been working with Norris Cochran, Acting Assistant Secretary for Financial Resources at HHS, on this recommendation as well.

Response from Elizabeth DeVoss

Elizabeth DeVoss said they can have that review.

Question from Rhoda Jensen

Rhoda Jensen reiterated that, while thankful for the funds, it is hard to build anything with the allocation received through the Build Back Better bill. The need for facilities is high in Indian Country, and especially in Alaska where travel to facilities may not be possible by car.

Response from Elizabeth DeVoss

Elizabeth DeVoss said HRSA will work on their plan once the Build Back Better funding is allocated, so these comments are timely.

4:45 pm Tribal Engagement with HRSA Leadership

Next, Chuck Hoskin opened the floor for engagement between the TAC delegates and Diana Espinosa.

Diana Espinosa said she sees this meeting as the beginning of meaningful discussions. She hopes HRSA demonstrated their openness to figuring out how to work together to improve health throughout Indian Country. She heard important issues for Indian Country, such as eligibility for the NHSC, HPSA scoring, figuring out effective ways to access grant funds, and telehealth needs. She sees TAC as an opportunity for HRSA to understand the issues with which tribal nations are struggling and what the TAC would find helpful.

Additionally, it is helpful for TAC to understand what constraints HRSA is working under and to determine ways to address the issues raised. She would like HRSA and TAC to identify action steps to ensure work moves forward quickly to improve tribes' access to HRSA resources and break down any barriers. She also hopes to increase transparency and communication through the tribes' preferred communication methods.

Aaron Payment thanked Diana Espinosa and her team for setting a strong, positive tone. Mary Harrison said she looks forward to the outcomes and solutions. Those next steps are important for tribes.

5:30 pm Summary, Closing Prayer, & Adjournment

Chuck Hoskin turned the floor over to Aaron Payment for the closing blessing. He then yielded the floor to Diana Espinosa for closing comments, during which she thanked Carmen Clelland, the HRSA presenters, and TAC for their dedication. TAC delegates responded with appreciation for the participation of HRSA leadership and the tone that was set in working together going forward. Finally, Chuck Hoskin entertained a motion to adjourn the meeting. Aaron Payment made the motion. Rhoda Jensen seconded the motion. Hearing no objections, Chuck Hoskin adjourned the meeting.

Action Items

- Organize the HPSA Subcommittee.
- Hold a call with the Alaska delegate on UDS issues with regard to CHAP.
- Explore Technical Assistance for TAC.
- Plan the next TAC meeting.

Appendix A: Participant List

Day 1

TAC Delegates

Cyrus Ben
Chuck Hoskin
Kira Norton
Rhoda Jensen
Jessica Mata
 Rukovishnikoff
Aaron Payment
Lee Spoonhunter
Selwyn Whiteskunk

HRSA Staff

Diana Espinosa
Chrissy Abrahms
 Woodland
Onyeka Anaedozie
Jeffrey Beard
Bernice Boursiquot
Elaina Boutte
Tonya Bowers
Mickaela Brierre
Carmen “Skip” Clelland
Kip Castner
Sabrina Chapple
Winnie Chen
Shalonda Collins
Natasha Coulouris
Melanie Deal
Theresa Devine Kimak
Heather Dimeris
Samantha Ebersold
Fay Ferguson
Pamela Garten

Chandak Ghosh
Stephen Hayes
Eliza Heppner
Anne Huang
Danita Hunter
Andrea Jackson
Rhonda Jackson
Pam Kania
Laura Kavanagh
Gloria Laryea
Susan Marsiglia
Kathleen McAndrews
Megan Meacham
Sara Minnich
Susan Monarez
John Moroney
Nancy Mautone-Smith
Luis Padilla
Wanda Pamphile
Krista Pedley
Rachel Piotrowski
Christine Ramey
Nancy Rios
Julie Ross
Elizabeth Ruiz
Amishi Shah
Kim Shiu
Stephanie Sowalsky
Sharaye Stroman
Jade Tan
Sharyl Trail
Sharon Turner
Judy Van Alstyne

Antonio Vargas
Ivy Vedamuthu
Elizabeth Wieand
Ekaterina Zoubak

Kauffman & Associates, Inc. Staff

Tom Dineen
Jennifer Gillissen
Yvette Journey

Other

Elizabeth Coronado,
 Northwest Portland
 Area Indian Health
 Board
Melanie Fourkiller,
 Choctaw Nation
Melissa Gower, Chickasaw
 Nation
Rhonda Harjo, National
 Indian Health Board
Jill Jim, Navajo Nation
Martha Ketcher, Cherokee
 Nation
A.C. Locklear, National
 Indian Health Board
Adam McCreary, Cherokee
 Nation
Gene Perry, Cherokee
 Nation
Violet Rush, Hobbs Straus

Day 2

TAC Delegates

Cyrus Ben
Chuck Hoskin
Rhoda Jensen
Aaron Payment
Kira Norton
Lee Spoonhunter
Selwyn Whiteskunk

HRSA Staff

Diana Espinosa
Tasha Akitobi
Israil Ali
Andria Apostolou
Jeffrey Beard
Elaina Boutte
Mickaela Brierre
Kip Castner
Sabrina Chapple
Winnie Chen
Carmen "Skip" Clelland
Shalonda Collins'
Natasha Coulouris
Melanie Deal
Kimberly Derwinski
Elizabeth DeVoss
Fay Ferguson
Pamela Garten
Chandak Ghosh
Dara Gideos
Stephen Hayes

Danita Hunter
Anne Huang
Rhonda Jackson
Pam Kania
Sarah Klein
Matt Kozar
Gloria Laryea
Jim Macrae
Kathleen McAndrews
Susan Marsiglia
Sara Minnich
Nancy Mautone-Smith
John Moroney
Wanda Pamphile
Rachel Piotrowski
Nancy Rios
Julie Ross
Elizabeth Ruiz
Melissa Ryan
Amishi Shah
Stephanie Sowalsky
Alek Sripipatana
Sharaye Stroman
Leah Suter
Jade Tan
Sharyl Trail
Sharon Turner
Judy Van Alstyne
Ivy Vedamuthu
Michelle Washko
Joan Weiss

Elizabeth Wieand
Ekaterina Zoubak

Kauffman & Associates, Inc. Staff

Tom Dineen
Jennifer Gillissen
Yvette Journey

Other

Elizabeth Coronado,
Northwest Portland
Area Indian Health
Board
Melanie Fourkiller,
Choctaw Nation
Melissa Gower, Chickasaw
Nation
Rhonda Harjo, National
Indian Health Board
Jill Jim, Navajo Nation
Martha Ketcher, Cherokee
Nation
A.C. Locklear, National
Indian Health Board
Violet Rush, Hobbs Straus
Chris Waterhouse,
Shoshone-Bannock
Community Health
Center

Appendix B: TAC Delegates and Alternates

Area	Name, Role	Title, Tribe/Organization
Alaska	Rhoda Jensen, Delegate	Chief Executive Officer, Yakutat Community Health Center
	Jessica Mata Rukovishnikoff	Aleut Community of St. Paul Island
Albuquerque	Selwyn Whiteskunk, Delegate	Vice Chairman, Ute Mountain Ute Tribe
	Beverly Coho	Vice Chairman, Albuquerque Area Indian Health Board
Bemidji	Dr. Aaron Payment, Delegate	Chairperson, Sault Ste. Marie Tribe of Chippewa Indians
	<i>Alternate VACANT</i>	
Billings	Lee Spoonhunter, Delegate	Co-Chairman, Northern Arapaho Tribe
	<i>Alternate VACANT</i>	
California	Kira Norton, Delegate	Health Benefits Coordinator, Blue Lake Rancheria Tribal Appointee, California Rural Indian Health Board
Great Plains	<i>Delegate VACANT</i>	
	<i>Alternate VACANT</i>	
Nashville	Cyrus Ben, Delegate	Tribal Chief, Mississippi Band of Choctaw Indians
	Tarina Anderson	Mississippi Band of Choctaw Indians
Navajo	Jonathan Nez	Tribal President, Navajo Nation
	Myron Lizer	Vice President, Navajo Nation
Oklahoma	Chuck Hoskin Jr., Acting Chair	Principal Chief, Cherokee Nation
	<i>Alternate VACANT</i>	
Phoenix	<i>Delegate VACANT</i>	
	<i>Alternate VACANT</i>	
Portland	Kathy Pierre, Delegate	Treasurer, Lummi Indian Business Council
	<i>Alternate VACANT</i>	
Tucson	<i>Delegate VACANT</i>	
	<i>Alternate VACANT</i>	

Appendix C: TAC Summary Agenda



HRSA Tribal Advisory Council Meeting Agenda

December 1-2, 2021

Zoom meeting link: [\[Please click and register here\]](#)

Tribal Moderator: Tribal Advisory Council Chair (acting)

Federal Moderator: Administrator, Director IEA

Time	Session and Description
12:00 pm	
	Tribal Caucus (TRIBAL MEMBERS ONLY)*
1:00 pm	Opening Blessing, Welcome, & Introductions Chuck Hoskin Natasha Coulouris, CAPT Carmen “Skip” Clelland
1:20 pm	TAC Business and Housekeeping Ivy Vedamuthu, Chuck Hoskin, Carmen Clelland
2:00 pm	Break
2:15 pm	HRSA Senior Leadership Roundtable Discussion Opening: Diana Espinosa, Acting Administrator
4:00 pm	Break
4:10 pm	HRSA Office for the Advancement of Telehealth Heather Dimeris
5:00 pm	Recap of the Day and Next Steps Chuck Hoskin, Natasha Coulouris
5:30 pm	Day 1 Adjournment

Day 2 Thursday, December 2, 2021

Time	Session and Description
12:00 pm	Tribal Caucus (TRIBAL MEMBERS ONLY)*
1:00 pm	HRSA Bureau of Health Workforce Melissa Ryan, Israil Ali, Joan Weiss, Michelle Washko
2:00 pm	HRSA Bureau of Primary Health Care Jim Macrae, Matt Kozar, Alek Sripipatana, Judith Van Alstyne
3:00 pm	HRSA Provider Relief Fund (PRF) Danita Hunter
4:00 pm	Break

Time	Session and Description
4:10 pm	HRSA Finance and Budget Overview Elizabeth DeVoss
4:45 pm	Tribal Engagement with HRSA Leadership Tribal Advisory Council Delegates, Diana Espinosa
5:30 pm	Summary, Closing Prayer, & Adjournment Diana Espinosa, Chuck Hoskin