Spring 2023 HRSA Tribal Advisory Council Meeting

March 8–9, 2023

Day 1—Wednesday, March 8, 2023

Opening

Chuck Hoskin, Jr., Health Resources and Services Administration (HRSA) Tribal Advisory Council (TAC) Chair and Oklahoma City Area Delegate, called the meeting to order. A representative of the Cherokee Nation offered an opening blessing.

Natasha Coulouris, Director, HRSA Office of Intergovernmental and External Affairs, and Jordan Grossman, HRSA Deputy Administrator, provided opening remarks.

HRSA TAC Business and Housekeeping

Discussion of TAC Business Items

The Oklahoma City Area Delegate and CAPT Carmen Clelland, Director of the HRSA Office of Tribal Affairs, facilitated the business items.

Approval of April 2022 Meeting Minutes
The minutes from the April 26-27, 2022, HRSA TAC meeting were approved without change.

Approval of Current Meeting Agenda
The agenda was approved without objection.

HRSA TAC Roles and Responsibilities
The Oklahoma City Area Delegate reviewed a clause from the HRSA TAC Charter on HRSA TAC's roles and responsibilities.

Nomination of HRSA TAC Chair and Co-Chair
Lee Spoonhunter, Billings Area Delegate, nominated the Oklahoma City Area Delegate to continue serving as the HRSA TAC Chair. The motion was approved without objection. Mary Harrison, Nashville Area Designee, nominated Alaska Area Alternate Jessica Mata Rukovishnikoff as the next Co-Chair. This motion was approved without objection.

Timeframe for the Next HRSA TAC Meeting
The Billings Area Delegate motioned to hold the meeting in late July 2023. The motion was approved without objection. CAPT Clelland will work with HRSA leadership to assess their availability and follow up with the HRSA TAC Chair and Co-Chair to select dates.

Location for the Spring 2024 HRSA TAC Meeting
The Nashville Area Designee, who is a citizen of the Mississippi Band of Choctaw Indians, offered to host the spring 2024 meeting. The Alaska Area Alternate motioned to recommend the next meeting take place in Indian Country at this location. The motion was approved without objection.

Health Professional Shortage Area Subcommittee Membership
The Alaska Area Alternate volunteered to serve on the subcommittee and noted that the Billings and Nashville Area Delegates offered to continue serving.

The Alaska Area Alternate motioned to reclassify the subcommittee as a standing subcommittee. The motion was approved without objection. The Designated Federal Official will work with the HRSA TAC Chair and Co-Chair to help develop the charge for the subcommittee and determine the next steps.

Technical Assistance Considerations
The Oklahoma City Area Delegate indicated that HRSA TAC's recommendation is for technical assistance support for the HRSA TAC.

Tribal Grantee Presentation: Oklahoma State University College of Osteopathic Medicine's Teaching Health Center Graduate Medical Education Program

Natasha Bray, Dean, and Douglas Nolan, Associate Dean, College of Osteopathic Medicine, Oklahoma State University at the Cherokee Nation (a HRSA Teaching Health Center Graduate Medical Education (THCGME) grantee), presented on the tribal residency programs that prepare osteopathic primary care physicians with an emphasis on serving rural and underserved communities in Oklahoma. The tribal residency programs funded through this THCGME grant include family medicine programs that serve the Cherokee Nation, Chickasaw Nation, and Choctaw Nation. The grant also supports a rural training track for the Oklahoma State University pediatrics program.

Collectively, the three family medicine residency programs have graduated 49 physicians. Among these physicians:

- 90 percent provide services to underserved populations
- 67 percent serve rural communities
- 51 percent practice within the tribal/Indian Health Service (IHS) system
- 78 percent remained in Oklahoma

These programs equip graduates with the knowledge, skills, and patient-centered approach needed to serve rural and American Indian/Alaska Native (AI/AN) communities in Oklahoma. The presenters shared that financing is the program's primary obstacle and there is a significant need for psychiatry, general surgery, and OB-GYN care in rural and AI/AN communities within Oklahoma.

HRSA staff and TAC delegates also toured the Oklahoma State University College of Osteopathic Medicine at Cherokee Nation and Cherokee Nation's outpatient health center.

Bureau of Health Workforce

Sheila Pradia-Williams, Deputy Associate Administrator for the HRSA Bureau of Health Workforce (BHW), shared updates on HRSA's health workforce efforts, noting an ongoing goal to reach more tribal communities with information about current funding opportunities. Deputy Associated Administrator Pradia-Williams also stated that over the last several months, BHW released four Dear Tribal Leader Letters. BHW works closely with the HRSA Office of Tribal Affairs and is seeking to expand their relationships with organizations that focus on AI/AN health, such as the National Indian Health Board, to gather further insight into Indian Country. BHW would like input from the HRSA TAC delegates on how to increase awareness of programs for which tribes and AI/AN organizations can apply.

Deputy Associate Administrator Pradia-Williams shared that the 2023 National Health Service Corps (NHSC) Loan Repayment Program is open for applications until April 25. As part of outreach to tribes, BHW recently hosted a webinar in partnership with the Association of American Indian Physicians and

the National Indian Health Board about applying for this opportunity. A list of additional funding opportunities that were open for applications was also provided during this presentation.

HRSA TAC delegates reiterated that the retention of health care providers in Indian Country is a crucial issue. They pointed to housing shortages as a barrier and emphasized the importance of increased funding to support workforce development, including additional tribal funding and placements for the NHSC Loan Repayment Program. The delegates asked about retention rates among NHSC and THCGME graduates over time.

Deputy Associate Administrator Pradia-Williams said that BHW has funded all applicants for the NHSC Loan Repayment Program through the existing 1.8 percent set-aside. At a national level, more than 80 percent of graduates of the NHSC Loan Repayment Program remain within underserved communities. Further, THCGME Program graduates are two to three times more likely to practice in underserved communities compared to providers who were not part of this program. Deputy Associate Administrator Pradia-Williams will share data gathered on the retention rates of these programs for tribal communities specifically and further noted that while HRSA cannot directly address the housing shortage issue, the agency will continue to explore ways to support the resolution of this challenge. Presently, HRSA is requesting that Congress reauthorize funding for the NHSC and THCGME Programs.

Another barrier the delegates described was the inability of residency students to switch provider tracks once they have begun a certain track. Deputy Associate Administrator Pradia-Williams indicated that each provider discipline has a different award amount and a different contract associated with that track. These differences prevent changes in discipline mid-program, but BHW can look into whether similar disciplines can be made more interchangeable. BHW can also provide technical assistance on this issue.

The delegates asked how HRSA markets the BHW scholarship programs. Deputy Associate Administrator Pradia-Williams responded that BHW visits venues where health care students and educators typically gather. In addition, they share information with academic contacts and organizations that serve tribes. Deputy Associate Administrator Pradia-Williams welcomed feedback from the delegates on additional ways to reach these audiences.

The delegates advised HRSA to establish a tribal set-aside for the THCGME Program and request more NHSC Loan Repayment Program funding from Congress. In addition, the delegates recommended that HRSA raise the tribal set-aside for the NHSC Loan Repayment Program to 5 percent and explore how this program can support mid-level provider types.

Tribal Grantee Presentation: Chickasaw Nation Pediatric Mental Health Care Access Program

Laura Kavanagh, Deputy Associate Administrator for the HRSA Maternal and Child Health Bureau (MCHB), provided a brief overview of the Pediatric Mental Health Care Access Program which aims to increase workforce capacity to enable pediatric primary care providers to engage in routine screening, diagnosis, treatment, and referral for children with behavioral health concerns. This program is proven to increase provider confidence and satisfaction in managing pediatric behavioral health conditions.

Dr. Shannon Dial, Chickasaw Nation Executive Officer of Integrated Services, presented on the Chickasaw Nation Pediatric Collaborative, which is the Chickasaw Nation Pediatric Mental Health Care Access Program project. The Chickasaw Nation Pediatric Collaborative's purpose is to promote

behavioral health integration into pediatric primary care by supporting pediatric mental health care telehealth access programs.

In its first year, the Chickasaw Pediatric Collaborative accomplished the following:

- Creation of a new access point of care for families of children with autism,
- Introduction of a consultant to assist pediatricians with psychiatric prescribing,
- Initiation of provider training opportunities on pediatric mental health and developmental disorders,
- Deployment of a provider needs assessment survey on training and consultation needs, and
- Creation and implementation of a new centralized consult/referral process to streamline provider referrals.

Pediatric Mental Health Care Access Program funding was initially designed for states. Hence, the Chickasaw Nation's application outlined how the grant could be tailored to meet the needs of the 13 counties that comprise Chickasaw lands. The program receives an award of $445,000 annually for 5 years, with a 20 percent tribal match required yearly. As a state grant, the Pediatric Mental Health Care Access Program would apply to all pediatricians across the state. While under the Chickasaw Nation Pediatric Collaborative project, it applies to pediatricians who provide care to patients served by the tribe. To bridge service gaps and enhance access to expert knowledge and training, they contracted with partners who provide services pertaining to autism spectrum disorders and child psychiatry, including the University of Oklahoma Health Sciences Center and an evaluation team. Dr. Dial also remarked that HRSA has been amenable to tribal requests and needs, such as adapting the Pediatric Mental Health Care Access Program data collection model to fit their context better.

Maternal and Child Health Bureau

Deputy Associate Administrator Kavanagh announced that the Pediatric Mental Health Care Access Program funding opportunity would be open for applications by the end of March and provided updates pertaining to maternal and child health in Indian Country. MCHB leverages tribal and federal partnerships to share information through their networks and welcomes input from HRSA TAC on additional ways to conduct outreach to Indian Country. In August 2022 MCHB held a listening session with tribes regarding the Pediatric Mental Health Care Access Program. Much of the input they received emphasized the importance of widespread outreach about future funding opportunities. The Advisory Committee on Infant and Maternal Mortality is a key partner in guiding these efforts. In December 2022 this federal advisory committee submitted the following recommendations to the Secretary of Health and Human Services:

- Ensure funding opportunities for studies and programs on AI/AN maternal and infant health employ more inclusive language.
- Promote greater diversity and expertise by including more AI/AN representatives on the federal advisory committee.
- Prioritize holding federal advisory committee meetings within the communities of focus.

Deputy Associate Administrator Kavanagh highlighted several MCHB programs that further its mission, including the Maternal, Infant, and Early Childhood Home Visiting Program, the State Maternal Health Innovation Program, and the National Maternal Mental Health Hotline. In 2021, tribal grantees of the Maternal, Infant, and Early Childhood Home Visiting Program served more than 3,500 parents and children and conducted more than 19,000 home visits. Last fiscal year, 27 tribal grantees received

awards under this program, and the number of tribal recipients is projected to increase to 45 in fiscal year 2023. Recently, Congress reauthorized this program and doubled the associated tribal set-aside, raising it from 3 to 6 Percent.

The delegates observed that many rural tribal communities are losing the capacity to provide maternal and child health services. To help compile more data on this issue, the delegates encouraged HRSA to use a reservation-specific approach for the National Survey of Children's Health.

Tribal Grantee Presentation: Hunter Health Clinic, Dually Funded Health Center

Amy Feimer, Chief Executive Officer for Hunter Health Clinic, a dually funded clinic that receives funding from both HRSA and IHS, delivered a presentation on how Hunter Health Clinic is addressing health care needs in their community and how HRSA and IHS funds combine to support this work. In 1985, Hunter Health Clinic became the first federally funded community health center in Kansas. In 1987, it added a homeless shelter and mental health and substance use disorder services to its offerings, becoming the first federally funded health care program for homeless individuals in Kansas. The health center now operates three clinics, and all clinicians serve several hours per week at homeless resource centers.

The health center serves 15,665 patients, engaging in approximately 51,711 patient visits annually. Over time, the non-AI/AN population served has grown. Currently, 11 percent of patients are AI/AN; a uniquely low proportion among urban Indian health organizations. Among the patient population, approximately 45 percent are uninsured, and 29 percent have Medicaid. At least 58 percent have a household income lower than 200 percent of the federal poverty level, and 8 percent are homeless.

Chief Executive Officer Feimer further remarked that using HRSA funding to supplement IHS funds has been tremendously helpful for Hunter Health Clinic's development of health care programming and highlighted similarities and differences between HRSA and IHS funding. For example, while there are many similarities in the compliance requirements for HRSA and IHS funding, the HRSA grant is more standardized and defined.

Delegates highlighted the prevalence of homelessness in Indian Country and noted that in AI/AN communities it often presents as multiple families living in the same home. They encouraged collaboration between HRSA, IHS, and tribal and urban Indian programs to connect homeless AI/AN people with services. The delegates recommended that HRSA consider a Health Center Program New Access Point grant for tribal and urban Indian facilities only and revisit funding compliance requirements to determine where there may be opportunities for increased flexibility for tribal programs. Additionally, they suggested that HRSA consider capacity-building funding to support tribal and urban Indian programs and to provide technical assistance to these programs.

Bureau of Primary Health Care

Matt Kozar, Director of Strategic Initiatives, Office of Policy and Program Development, HRSA Bureau of Primary Health Care (BPHC), provided an update on BPHC's reach and services in Indian Country. The Health Center Program serves approximately 389,000 AI/AN patients through patient-centered, integrated care and offers a range of services, including primary, dental, and mental health care, as well as community outreach, case management, eligibility assistance, health education, interpretation, and transportation.

Director Kozar reported that BPHC is conducting an equity assessment to examine opportunities to improve access for organizations that serve high-needs communities and populations. As part of the

assessment, on February 7, 2023, BPHC held a listening session to gather tribal input. The feedback gathered through this event focused on the following areas:

- Tribes would like to enhance their understanding of how HRSA defines and measures need in areas where health centers already exist.
- Tribes have experienced inconsistent assistance from primary care associations, which are the mechanism for training and technical assistance related to the Health Center Program.
- It is important for HRSA staff who are working with tribal and urban Indian entities to have subject matter expertise or lived experience regarding these communities.
- Accreditation and funding requirements through HRSA and IHS pose an ongoing administrative burden for tribes and tribal organizations.

The Health Center Program also focuses on improving the customer experience for health centers. As such, the program shifted from a geographically based approach to a more specialized approach. BPHC staff now work on specialized teams, with each team focused on a specific functional area. Additionally, the Office of Health Center Program Monitoring is creating a special populations compliance workgroup and has established a new compliance liaison position to provide compliance-related support to those undergoing operational site visits.

HRSA is also modernizing its Uniform Data System (UDS) with an aim to better streamline data. This modernization effort includes the UDS+ project, which will involve transitioning to de-identified and secured patient-level data reporting to collect insight on patient experiences.

Delegates expressed concerns about the subject matter expert model that BPHC has begun using for Public Health Service Act Section 330 programs and the gaps in regional representation on the UDS+ Test Cooperative Steering Committee. Delegates also noted the need for HRSA to conduct tribal consultation regarding the upcoming changes to the UDS and conveyed concerns about the possibility that patient-level data may be easily identifiable due to the small sizes and close-knit nature of tribal communities. Concerns were also shared regarding the questions about unaggregated payment data in the most recent UDS reporting process. The delegates underscored the long-standing requests from tribes to ensure that they can retain control of their data and shared that they feel provider visits are not counted within the UDS, which reflects the contribution of community health aides/practitioners. HRSA noted that there will be processes to address and prevent issues regarding identifying individual patients in areas or facilities with a small number of patients or close-knit communities.

Delegates recommended that BPHC increase staff training on tribal requirements and exemptions under Section 330 of the Public Health Service Act or designate individuals as tribal project officers for Section 330 programs. Further, they encouraged HRSA to deploy a tribal-specific BPHC operational site visit team who is well-versed in tribal requirements and exemptions under Section 330.

Director Kozar will share these concerns with the BPHC team and follow up with the delegates on these issues if changes are made.

HRSA TAC Discussion with HRSA Deputy Administrator Jordan Grossman

During this session, delegates and Deputy Administrator Grossman discussed areas of significance to Indian Country and HRSA. HRSA and the delegates share many goals, including culturally competent care and responsiveness and emphasized behavioral health, maternal and child health, and workforce development as key priorities for rural and tribal communities. Last year, HRSA made 107 funding awards to 64 tribes and tribal organizations to support their efforts to serve their communities effectively. Finally, Deputy Administrator Grossman shared that one of his key takeaways from the

delegates' comments is that expansion of HRSA programs must be responsive and flexible to truly meet tribal community needs. HRSA is committed to continuing to work with tribes on the broad range of our programs.

Delegates highlighted several needs, including meaningful tribal consultation before any HRSA actions that may affect tribes, training for all HRSA employees on tribal consultation requirements, non-competitive grant processes for tribes through formula funding designed through tribal consultation, a minimum 5 percent tribal set-aside for all HRSA funding opportunities, support for under-resourced tribes in the grant application process, flexibility for tribes to self-govern their HRSA awards, streamlined application processes and reporting requirements for HRSA grants, and support for the infrastructure needs of tribal health centers. Delegates further suggested that HRSA commit to providing technical assistance to Congress on the draft legislation that would allow for HRSA programs and funds to be self-determined and self-governed by tribes through existing mechanisms. Finally, it was advised that HRSA continue to support funding for new, existing, and expanded tribal medical residency programs and create a tribal set-aside of $15 million for the THCGME Program.

Delegates reiterated concerns about patient-level data. Deputy Administrator Grossman emphasized the importance of data security and addressing concerns about ensuring data is truly not identifiable.

Day 1 Recess

The Oklahoma City Area Delegate recessed the meeting for the day.

Day 2—Thursday, March 9, 2023

Opening

Chuck Hoskin, Jr., HRSA TAC Chair and Oklahoma City Area Delegate called the meeting to order. Tucson Area Delegate Leander Mase offered the opening blessing.

Tribal Grantee Presentation: Choctaw Nation Rural Community Opioid Response Program

Lacey Callahan, Program Director for Choctaw Nation Behavioral Health, delivered a presentation on the Recovery Is Possible Project, which is operated by the Choctaw Nation of Oklahoma and supported by HRSA funding. In September 2022 the Choctaw Nation received a 4-year behavioral health grant from HRSA. These funds enabled them to hire three case managers for the Recovery Is Possible Project. The project has contracts with county jails to allow for regular case manager visits and highlighted several challenges the project has encountered, including HRSA's encouragement of tribes to rely on external partnerships with non-tribal entities, since these partnerships are not always a good fit for tribes. Finally, tribal budget restrictions often prevent tribes from cost matching, which may hinder the pursuit of additional HRSA funding opportunities. Director Callahan said that overall, HRSA's funding has supported the project well, bridging a variety of service gaps and that the project anticipates a 20 percent increase in the incarcerated population annually. The partnership with HRSA enables the Choctaw Nation to continue serving this population in an impactful way.

Delegates noted that cost-matching is often a significant barrier to pursuing HRSA funding and recommended that HRSA remove cost-matching requirements for tribes in HRSA funding opportunities.

Federal Office of Rural Health Policy

Michael Fallahkhair, Deputy Associate Administrator for the HRSA Federal Office of Rural Health Policy (FORHP), discussed FORHP's collaboration with a variety of partners to promote capacity-building in rural communities through grants, technical assistance, and policy analysis. Last fiscal year, FORHP issued $7 million to grantees in Indian Country. FORHP is also developing guidance to make funding opportunities more accessible to all communities, highlighting the importance of diverse independent review panels to ensure that communities of various cultural backgrounds are represented. In August 2022, the White House released the Biden-Harris Administration's Blueprint for Addressing the Maternal Health Crisis, which includes the HRSA Rural Maternity and Obstetrics Management Strategies Program. Deputy Associate Administrator Fallahkhair said the program will continue 10 awards to support this work, including two awards that serve large tribal populations.

Delegates noted that the proportion of FORHP funding that reaches Indian Country often does not align with the percentage of rural community members who are AI/AN. The Billings Area Delegate invited HRSA to visit rural tribal communities to see how they have used HRSA and IHS funds and where HRSA funds can meet needs. Additionally, delegates recommended that HRSA establish a tribal set-aside of 50 to 55 percent for all the FORHP grants that serve Alaska. This amount aligns with the percentage of rural Alaskans who are AI/AN. Delegates also urged FORHP to direct funds to tribes in a way that places a minimal burden on them. They suggested that a funding mechanism be developed in consultation with tribes and advised HRSA to allocate additional funding for outreach and education to ensure tribal awareness of funding opportunities and how to access them. Finally, it was asked that HRSA work directly with IHS to address workforce shortages affecting Indian Country and allocate funding to support these efforts.

Health Professional Shortage Area Subcommittee Update

The Alaska Area Alternate, Jessica Mata Rukovishnikoff, yielded her time to Winn Davis, Technical Advisor to the Alaska Area Delegate, who provided an overview of the HRSA TAC Health Professional Shortage Area (HPSA) Subcommittee activities and resulting recommendations.

After reviewing HRSA's list of tribal engagements on HPSA modernization and scoring, the subcommittee determined that HRSA had not conducted a stand-alone tribal consultation on this issue. This topic was included alongside other topics during HRSA's Annual Tribal Consultation and Regional Consultations but not in a separate tribal consultation. Further, HRSA has not published responses to the comments provided by tribes through the public comment process. The subcommittee proposed that delegates advise HRSA to publish comments received during the request for information on HPSA Shortage Designation Modernization scoring with HRSA's responses to the comments. Also proposed for the delegates' consideration was conducting tribal consultation on HPSA scoring before a notice of proposed rulemaking is published and updating the HPSA scoring process to adequately and accurately account for the shortages of providers in rural and remote facilities based on tribal recommendations. Winn Davis yielded back to the Alaska Area Alternate, who motioned for the adoption of the recommendations. The motion was approved without objection.

Ivy Vedamuthu, Public Health Advisor for the HRSA Office of Tribal Affairs, asked what aspects of HPSA modernization and scoring the delegates would like HRSA to cover during the recommended tribal consultation. The Alaska Area Alternate indicated they would like the tribal consultation to include discussion on scoring, rulemaking, definitions, processes, and data.

Closing

Director Coulouris provided closing remarks thanking the delegates and other participants for their thoughtful input throughout the meeting, the Cherokee Nation for hosting the meeting, and the presenters and other attendees for their time. Director Coulouris observed that addressing the tremendous need in Indian Country will require true partnership. As a next step, HRSA personnel will take input from this meeting back to their respective HRSA offices.

The Tucson Area Delegate offered a closing prayer.

The Oklahoma City Area Delegate adjourned the meeting.