Spring 2022 HRSA Tribal Advisory Council Meeting

April 26–27, 2022

Day 1 Tuesday, April 26, 2022

Opening

Rhoda Jensen, HRSA Tribal Advisory Council Co-Chair and Alaska Area Delegate, called the meeting to order. Bryan Warner, Oklahoma Area Alternate Delegate, offered an opening blessing.

Natasha Coulouris, Director of Office of Intergovernmental and External Affairs (HRSA IEA) and Designated Federal Officer of the HRSA Tribal Advisory Council, provided opening remarks.

CAPT Clelland, Director of the Office of Tribal Affairs and Executive Secretary of the HRSA Tribal Advisory Council, welcomed the attendees to the meeting.

HRSA Tribal Advisory Council Business and Housekeeping

Discussion of Tribal Advisory Council Business Items

The Alaska Area Delegate and Director CAPT Clelland facilitated the business items.

Health Professional Shortage Area Subcommittee Membership
Bryan Warner, Oklahoma Area Alternate Delegate, moved to appoint Leander Mase, Tucson Area Delegate; Kira Norton, California Area Delegate; and Rhoda Jensen, Alaska Area Delegate to the HRSA Tribal Advisory Council Health Professional Shortage Area Subcommittee. The motion was approved without objection. The Alaska Area Delegate noted that during the tribal caucus, she was identified as the lead delegate for the subcommittee.

Technical Assistance Consideration
Delegates asked if they could bring a technical advisor with them to HRSA Tribal Advisory Council meetings to assist delegates and provide them with advice during the meeting.

HRSA Tribal Advisory Council Delegate Terms of Appointment
CAPT Clelland stated that HRSA developed a list to identify delegates who would serve 2 and 3-year terms and would send it to all HRSA Tribal Advisory Council delegates.

Approval of December Meeting Minutes
The minutes from the December 1-2, 2021, HRSA Tribal Advisory Council Meeting were approved without change.

Changes to Meeting Agenda
The Alaska Area Delegate motioned to remove the Alaska Delegation's White Paper presentation from the agenda. The motion was approved without objection.

The HRSA IEA Director proposed consolidating the two Bureau of Health Workforce sessions on Health Professions Shortage Area scoring and Graduate Medical Education opportunities to support increased engagement with Bureau of Health Workforce leadership. The motion was approved without objection.

Tribal Grantee Presentation

Dr. Mary Platt, Residency Director for the Puyallup Tribal Health Authority, a HRSA Teaching Health Center Graduate Medical Education program grantee, presented on the Puyallup Tribal Health Authority family medicine residency program that prepares graduates to find rural American Indian and Alaskan Native communities where they provide a full spectrum of care for the community in a culturally appropriate way. Dr. Platt shared that this is the first tribally owned and operated program to receive osteopathic recognition and now provides osteopathic and allopathic services and serves more than 2,300 patients on the Puyallup reservation. Program curriculum emphasizes American Indian and Alaska Native culture, including traditional medicine, and incorporates medication for opioid use disorders. Since the program's launch in 2012, it has produced 28 graduates, 18 of whom have gone on to work in underserved communities. Sixteen graduates accepted positions within American Indian and Alaska Native healthcare facilities. Some of the graduates who chose careers in Indian health did not initially plan to do so but were inspired by their experiences in the residency program.

HRSA Tribal Advisory Council Discussion with HRSA Administrator Carole Johnson

Administrator Johnson described several of HRSA's current priorities, including behavioral health services, maternal health, and workforce. The HRSA Administrator thanked tribal leaders for their work over the last 2 years, including ensuring people had the information needed to make informed decisions about COVID-19 vaccination, and managing the surge of demand on hospital and healthcare systems.

Administrator Johnson described several of HRSA's current priorities:

- **Behavioral health services.** The American Rescue Plan (ARP) Act provided direct appropriations to HRSA to support the mental health and wellbeing of the workforce. In turn, HRSA awarded funds to healthcare organizations to increase access to mental health services for their personnel. HRSA also funds peer supports to grow individuals through career ladders and community connectors to make sure people are connected to services by people who come from their communities.
- **Maternal health**. HRSA is funding initiatives to improve health outcomes for women and children and working to increase obstetrics capacity in rural areas. Sharing best practices is a key component of this work, and Administrator Johnson acknowledged the need to involve tribes in identifying best practices for maternal health. HRSA has also received an increase to support maternal health, including continuing to work on addressing maternal depression and expanding on addressing the social determinants of health.
- **Workforce**. HRSA awarded Teaching Health Center Graduate Medical Education funds to tribal programs and is working on expanding physician and nurse training programs. HRSA has also made planning dollars available for those in the field that are building GME programs.

Currently, HRSA is examining how to build upon the telehealth flexibilities and services established during the pandemic. She also shared that there is an overlap between priorities of work on rural issues and work in tribal communities and wanted to hear from delegates about their needs.

In the discussion following, ideas and recommendations shared by TAC members were to increase support of National Health Service Corps placements within Indian Health Service (IHS) and tribal facilities; add Community Health Aides/Providers to the Uniform Data System indicators; support tribes' ability to use their own data for Health Professional Shortage Area scoring; and work with IHS to identify criteria to define poverty in Indian Country. HRSA Tribal Advisory Council delegates also shared how

competitive funding applications and reporting requirements can be burdensome and create barriers for tribes to apply for programs; and asked for a five percent set aside of funds for tribal nations.

Federal Office of Rural Health Policy

Michael Fallahkhair, Principal Advisor for the Federal Office of Rural Health Policy (FORHP), presented on current FORHP activities, including maternal and behavioral health. To help address maternal health challenges, FORHP created the Rural Maternity Obstetrics Management Program to improve patient engagement in prenatal care and education and maternal health outcomes, enhance maternal social support, and integrate culture into maternal care. After two pilot cohorts, the program engaged its first competitive cohort this fiscal year. Additionally, the Rural Communities Opioid Response Program is designed to help rural communities address behavioral health and substance misuse and FORHP is prioritizing American Indian and Alaska Native communities under this program. In addition, FORHP offers a program to address neonatal abstinence syndrome and plans to roll out a new medication-assisted treatment program. Both initiatives were established as a direct result of community input.

HRSA Tribal Advisory Council delegates suggested that tribal providers should be eligible for HRSA grants that go to designated rural areas and that FORHP should work with IHS to address critical workforce shortages across Indian Country while partnering with tribes to remove obstacles to funding, offering non-competitive grants for rural tribal health providers, and a five percent tribal set aside within all FORHP grants. Delegates reiterated their challenges with the administrative burden of grant applications. HRSA Tribal Advisory Council delegates also shared how many of their communities are fighting other substances just as pervasive as opioids and that misuse of these substances often occurs in conjunction with opioid use. It was recommended that HRSA consider expanding programs, where possible to include other substance use disorders.

Office for the Advancement of Telehealth

CDR Heather Dimeris, Director for the Office for the Advancement of Telehealth (OAT), delivered a presentation on the office's purpose, priorities, and activities and shared that telehealth services rely on broadband access. OAT collaborates with broadband funders across the federal government to help improve internet access and is involved in the American Broadband Initiative.

Director Dimeris noted that while providing technical assistance amid the COVID-19 pandemic, the National Consortium of Telehealth Resource Centers observed and documented the following four needs for American Indian and Alaska Native communities (1) optimization of broadband connectivity, (2) improved access to federal telehealth subsidies, (3) funding for the purchase of telehealth equipment by both providers and end-users, and (4) solutions to address credentialing challenges for tribal health providers to offer telehealth services. The National Consortium comprises 12 regional centers and two national centers, one of which is the Telehealth Technology Assessment Resource Center operated by the Alaska Native Tribal Health Consortium. The center is currently piloting a telehealth broadband program in 25 rural counties across four states to measure access to broadband as it pertains to telehealth and bridge the identified gaps in collaboration with OAT and other federal partners.

HRSA OAT funds tribal activities through the Evidence-Based Tele-Behavioral Health Network Program, operated by the University of California, Davis. The program served more than 150 patients within nearby tribal communities through more than 400 encounters in its first three years.

HRSA Tribal Advisory Council delegates shared their concerns with the U.S. Department of Commerce ensuring that the Bipartisan Infrastructure funds of $2 billion are directed toward tribal telehealth and broadband capacity. Delegates also requested that HRSA OAT create non-competitive funding mechanisms for tribes. HRSA Tribal Advisory Council delegates also noted that many tribal clinics have benefited from expanding telehealth during the public health emergency and were interested in learning how OAT would prepare rural communities for the end of the public health emergency.

Day 1 Recess

The Alaska Area Delegate recessed the meeting for the day.

Day 2 Meeting – Wednesday, April 27

Opening

Rhoda Jensen, Alaska Area Delegate and HRSA Tribal Advisory Council Co-Chair called the meeting to order.

Bureau of Health Workforce

Dr. Luis Padilla, Associate Administrator of the Bureau of Health Workforce (BHW) provided an overview of BHW activities. He provided an overview of HRSA's Health Professional Shortage Area (HPSA) scores and how HRSA's scoring approach has been modified to account for differences in the health care needs of American Indian and Alaska Native communities. Associate Administrator Padilla stressed that to support accuracy in HPSA scoring, HRSA provides tribes the option to request auto-HPSA rescores at any time and submit supplemental data to be used as a part of the scoring process. Accepting supplemental data from tribes responds to the Census data gaps identified by HRSA Tribal Advisory Council delegates.

Dr. Padilla shared that of the 950 Indian Health, Tribal, Urban organization facilities, close to 40% have conducted rescoring and HRSA has approved all of the updated scores.

Associate Administrator Padilla also presented on the Teaching Health Center Graduate Medical Education, Teaching Health Center Planning and Development, Primary Care Training and Enhancement, and Community Health Worker Training programs. Additionally, he discussed that HRSA released $103 million under the American Rescue Plan Act to support workforce resilience. This opportunity marks the first time the BHW has had a program that solely supports the mental health of the health care workforce. Finally, he mentioned that Congress continued to allocate funding to the National Health Service Corps to support clinicians serving at IHS facilities, tribal health providers, and urban Indian health programs.

HRSA Tribal Advisory Council delegates stressed that HPSA scoring does not always accurately reflect the poverty level many tribes experience or the urgent need tribes have for providers. Delegates suggested that HRSA engage in a tribal consultation regarding the recalibration of HPSA scoring criteria and share the results of the Request for Information (RFI) on the HPSA scoring methodology. Delegates discussed that they are not sure that the HPSA scores accurately reflect their levels of need. Finally, a request was made for HRSA to also consider provider configurations when HPSA scoring small Alaska communities.

HRSA Tribal Advisory Council delegates also discussed that Teaching Health Center Planning and Development, and Primary Care Training Enhancement (PCTE) programs should establish culturally appropriate curricula to help prepare fellows and residents to serve tribal and rural areas. Dr. Padilla

noted that the purpose of the PCTE tribal program's purpose is to create culturally relevant curricula to address this need.

Bureau of Primary Health Care

Tonya Bowers, Deputy Associate Administrator of the Bureau of Primary Health Care (BPHC), provided an update on BPHC outreach activities. Since the previous HRSA Tribal Advisory Council meeting, BPHC has met with the Alaska Area Delegate, held discussions with the Indian Health Service (IHS) on intersecting programs, and met with Centers for Medicare & Medicaid Services (CMS) to discuss Community Health Aide/Practitioner categorization.

Matt Kozar, Director of Strategic Initiatives for the BPHC Office of Policy and Program Development, stated that nearly 1,400 health centers operate more than 13,500 service delivery sites, serving approximately 29 million patients. There are two main paths for organizations: (1) New Access Points, under which new organizations or existing grantees compete for funds to support new delivery sites to provide comprehensive primary care services, and (2) Service Area Competition, through which existing grantees or new organizations compete for funds to support continued access to care in defined service areas.

It was noted that new organizations could pursue Health Center Program look-alike designation. Health Center Program look-alikes are entities that must comply with all Health Center Program requirements but do not receive HRSA Health Center Program funding. Look-alikes are eligible for reimbursement as a federally qualified health center for services provided under Medicaid and Medicare, receive discount drugs through the 340B program, and apply for loan repayment under the National Health Service Corps. Applications for look-alike designation may be submitted at any time, unlike competitive applications, which have specific deadlines. Currently, 35 tribal or urban Indian organization health centers are dually funded by HRSA and IHS that serve more than 350,000 American Indian and Alaska Native people across through more than $87 million in funding under the American Rescue Plan Act.

Uniform Data System

Judy Van Alstyne, Data Production Team Lead within the Data and Evaluation Group, presented an overview of the UDS. The UDS is a standardized reporting system for health center data. Health Center Program awardees submit annual reports on specified measures. These reports typically contain more than one thousand data elements, capturing data on performance measures, demographics, staffing, financials, and more. Policy guidance on the UDS is issued each year, announcing any changes needed to align with national reporting standards and keep pace with the evolving health care environment. HRSA issued the 2022 manual in the fall. HRSA also works with IHS to provide technical assistance with translating the Resource and Patient Management System data into the UDS as required by the data elements. Technical assistance includes webinars, fact sheets, a 24-hour helpline, and a UDS training hosted in partnership with state primary care associations.

Dr. Alek Sripipatana, Director of Data and Evaluation, Office of Quality Improvement, delivered a presentation on modernization efforts for the UDS to include efforts to tell the story of the patient care journey accurately. Significant updates under this modernization, which is referred to as UDS +, include:

- A transition to patient-level data reporting provides valuable insights into patient experiences to inform decisions regarding health centers, prioritize areas for quality improvement, and optimize the workflows of the care team
- Addition of "Routine Patient" indicators

- Full alignment with CMS clinical quality measures
- Countable visits using electronic standards
- Alignment of Table 6A data elements with the National Library of Medicine value sets where possible

The HRSA Tribal Advisory Council delegates requested that HRSA designate funding specifically for tribes and tribal health centers to improve primary care and behavioral health outcomes, as well as the need for additional dually-funded health centers. Delegates noted that dually-funded sites experience administrative burden when they have to provide data in different formats to HRSA's Uniform Data System (UDS) and the Indian Health Service's Resource and Patient Management System.

HRSA presenters were thanked for their work on the UDS piece and collaboration with the Alaska Area Delegate, the Indian Health Service (IHS), and the Centers for Medicare & Medicaid Services (CMS) on the subject and for the updated 2022 manual with Community Health Aides/Providers listed under line 22 and marked as a provider. It was asked whether patient encounters with other provider types are included in the larger encounter number calculated for the facilities. An inquiry was also made as to whether or not HRSA distinguishes between community health workers and Community Health Aides/Providers in that the latter follow a more clinical approach.

Director Sripipatana confirmed that the patient encounters with other providers are counted toward the overall patient counts reported on the UDS. Deputy Associate Administrator Bowers also indicated that HRSA is examining the alignment of data measures across HRSA, IHS, and CMS as part of the UDS modernization process.

FY2023 Budget Overview

Elizabeth DeVoss, HRSA Chief Financial Officer, shared highlights from the FY 2023 budget request, which HRSA submitted to Congress approximately one month ago.

The FY 2023 budget requests $13.3 billion for HRSA, including the annual discretionary and mandatory budgets. The proposed budget prioritizes efforts to:

- Reduce maternal mortality and poor maternal outcomes
- Expand the mental health and substance use disorder workforce
- Expand critical child health programs and provide early childhood screening and development services in health centers
- Increase and diversify the health care workforce to promote well-being for those on the front lines
- End the HIV epidemic by investing in access to treatment and prevention services
- Strengthen rural health care access through increased funding for providers and residency programs

Discussion

HRSA Tribal Advisory Council delegates emphasized the unique relationship the federal government has with tribes and the federal responsibility to ensure the health and welfare of American Indian and Alaska Native people. Additionally, they remarked on the importance of cultural and traditional practices and reiterated the reporting requirements of HRSA grants are cumbersome for tribes. Delegates reiterated their ask that HRSA work with Congress to create a 5 percent tribal set-aside for all HRSA funding program, and promote equitable tribal access to non-competitive funds, and offer maximum flexibility within these funding mechanisms. Regarding HRSA's planned budget to expand

workforce diversity, delegates noted that outreach tailored to American Indian and Alaska Natives for recruitment into the health workforce is essential, as members of tribal communities are more likely to remain in those communities long-term.

HRSA Tribal Advisory Council Follow-Up Discussion with HRSA Administrator

The Alaska Area Delegate remarked on current needs and encouraged HRSA to continue the momentum on its work with tribal communities toward expanding broadband access and telehealth services, and data system modernization. She also identified HPSA scoring, HPSA designations, provider shortages, provider burnout, and the integration of traditional healing as other areas to work on. She thanked HRSA for the transparency in communication and said she was pleased with the amount of work going into tribal efforts.

Administrator Johnson thanked everyone for their engagement in a productive two-day meeting. She said robust dialogue is important to the government-to-government relationship and will take back specifics for HRSA's ongoing work to identify options and solutions.

Closing

Administrator Johnson thanked the delegates for their participation and input. She highlighted the HRSA Tribal Advisory Council Health Professions Shortage Areas Subcommittee as a forum for addressing, in detail, solutions to many of the challenges raised and noted the importance of refreshing the HRSA tribal consultation process.