

**Department of Health and Human Services
Secretary's Tribal Advisory Committee
December 13-14, 2010
Washington, DC**

Day 1: December 13, 2010

Tribal Opening

Day One opened with a Tribal prayer.

HHS Welcome

Laura Petrou, Chief of Staff to Secretary Sebelius, welcomed participants to the inaugural meeting of the Secretary's Tribal Advisory Committee (STAC) and thanked everyone for agreeing to serve. She said that she hoped that the committee would provide an opportunity for HHS (1) to explain how the Department is trying to integrate Tribal concerns into its activities; and (2) to better understand what the Department can do to improve the lives of people in Indian Country. Petrou stressed that Secretary Sebelius has made Tribal needs a key component of her work, and has tried to integrate Tribal issues into the Department's work (rather than allowing them to be seen as a separate set of issues). Although your needs are unique, she said, we want everyone across the U.S. Government to know that every law Congress passes affects Tribes too.

Petrou's remarks were followed by Tribal introductions.

Introducing The Secretary's Tribal Advisory Committee

Paul Dioguardi, Director, Office of Intergovernmental Affairs (IGA), said that the meeting represents the culmination of almost two years of work. He noted that Tribal leaders had, during earlier consultations, recommended the establishment of a high-level committee, and that this committee would allow the Secretary to engage in dialogue with Tribes.

Dioguardi walked briefly through the agenda, noting that the formal STAC meeting would be held the next day. He stressed that the aim of the day's meeting was to have an open, informal conversation about the work that HHS does.

Discussion

One participant opened the discussion with a question about the extent of the Department's knowledge about the STAC members' Tribes and their diversity. She stressed that the Tribes were each very different and had very different challenges and needs.

Dioguardi replied that he didn't have that information on hand. He added that STAC representatives were chosen via a very competitive selection process to reflect a mix of direct service and self-governance Tribes from the 10 Indian Health Service regions along with several at-large members. Stacey Ecoffey (IGA) added that there were a number of HHS people in the room with strong backgrounds in Tribal issues.

About HHS

Sam Mitchell, Deputy Chief of Staff, provided a high-level overview of HHS, including its role within the Federal Government and its internal structure. He noted that it was one of the largest cabinet departments because of its size and the scope of the population that it represents. In addition, he stressed that the organization has both health *and human services* missions.

Looking at the internal structure, Mitchell highlighted several divisions within the Office of the Secretary that provide guidance, coordination, and policy development. Finally, he pointed to the Office of Intergovernmental Affairs as the Department's main point of contact with non-Federal governments, including State and local governments and Tribal Governments. IGA also oversees the 10 HHS regional offices.

Lillian Sparks, Commissioner Administration for Native Americans and Chair, Intradepartmental Council on Native American Affairs, focused her remarks on how HHS provides services to American Indians and Alaska Natives.

Sparks said that one of the key functions of the Office of Intergovernmental Affairs is to help with the Intradepartmental Council on Native American Affairs (ICNAA). She explained that ICNAA was an intradepartmental group composed of the principals of the key operating groups within HHS. Sparks said that the aim is to partner and make sure that the services that HHS provides are done in a way that doesn't overlap or cause Tribal leaders to work inefficiently. That includes, she said, coordinating outreach and making sure that the agencies are doing consultations in a way that makes the most sense for Tribes.

Next, Sparks noted that ICNAA's charter calls for the group to meet at least two times per year to identify priorities and areas for collaboration. She indicated that ICNAA has met once already, and has a second meeting tentatively scheduled for after the STAC meeting (and a White House meeting later in the week). Sparks also noted that ICNAA is responsible for the annual Tribal budget consultations. We need your counsel and advice, she said, and we've gotten better at reporting back to you what we have heard and what we are doing as a result.

Sparks also talked about the Department's role in providing grants and services to constituents, including Tribes. She noted that HHS provides a broad range of services to Tribes—and not only through the Indian Health Service (IHS). As a result, she said, we want to know more than just what is going on with IHS or your Indian health clinic. Sparks added that she wanted to know about Temporary Assistance for Needy Families (TANF), Head Start, and other programs that are crucial to the health and wellbeing of Tribal communities. Sparks also noted that the Administration for Children and Families (ACF) was the second largest chunk of the overall budget (after IHS), and that other agencies also played a key role.

Next, Sparks highlighted four key types of grants:

- Mandatory grants—Notably block grants typically provided to States and local governments.
- Formula grants—Awarded to eligible agencies.
- Entitlements—Based on cost of services provided to eligible clients.
- Discretionary grants—Based on a specific program purpose (and typically much more competitive, and each agency has the opportunity to choose from a wide pool of applicants).

Sparks noted that discretionary and formula grants were the primary way that HHS disburses funds to Indian Country.

Finally, Sparks noted that HHS has a number of advisory groups with sometimes overlapping membership. She said that she hoped the STAC would play an overarching role in guiding that work.

Discussion

Opening the discussion, one participant noted that ACF has put out a very helpful book that outlines all of the grants that are available to Tribes. He recommended that the other nine agencies around the table do likewise as it was a very useful resource. The

participant also acknowledged the work of Judy Baker in Region 7, whom he said was doing an excellent job and communicating regularly with Tribes.

Mitchell noted that Tribes don't go looking for a grant (they go looking for money to solve a problem), and he acknowledged the need to have more accessible and understandable information. James Anderson added that he would make NIH's grant information available to STAC members.

Another participant suggested setting up a single source for funding and grant information across HHS to create a one-stop entry point for Tribes.

One participant noted that while HHS establishes best practices at the policy level, those best practices do not always support Tribal entities. In addition, she said, States are often less flexible in their approaches than the Federal Government. (She cited, as an example, Oregon's Alcohol and Drug Administration's rules for interviewing which are often at odds with Native Americans' willingness to have outside organizations scrutinize family relationships.) She suggested establishing a policy under which Tribes can state what their best practices are. Finally, she noted that small Tribes cannot meet population-based restrictions, which cuts them out of research opportunities and access to those funds.

Addressing the first concern, Sheila Cooper (SAMHSA) said that the challenge is to figure out how, at the Federal level, to best assist. Regarding numbers, she acknowledged an ongoing issue of satisfying both Congressional requirements and Native American data concerns. This is a larger issue as well, she said, that we are struggling with in our individual grant programs.

Also on the topic of grants, one participant suggested including funding for grants management and accounting.

Another participant also raised concerns about having to go through the States to access Federal funds, and asked about the possibility of changing the regulations so that some of it is set up as direct funding to Indian Tribes. He also asked about the consultation process, and whether all 10 operating divisions within HHS have as yet adopted Tribal consultation policies. Paul Dioguardi said that the goal was to update each policy based on the new Departmental consultation policy.

Dioguardi said that ICNAA's two priorities for 2010 were (1) coordination and better alignment among all the consultation policies; and (2) improving coordination and collaboration across HHS on grants (so that there is transparency, access, and assistance to Tribes in applying for and managing grants). Regarding the State-Federal relationship,

he said that ICNAA would look at where there might be authority within HHS to modify grants and provide funding directly to Tribes. Judy Monroe added that the CDC recognized the need for support around grants management and business processes.

A participant asked whether anyone at HHS was coordinating, collecting, and warehousing the recommendations coming from the various consultation processes. He suggested a role for the STAC in looking at all the different Tribal advisory committees, their charters and priorities, where there might be overlap and/or opportunities for coordination. In response, Yvette Roubideaux noted that IHS alone has 20 advisory groups, and that she has been hearing a lot lately about the need for coordination and consolidation. She suggested that this might be a good issue for the STAC to take up.

Finally, in response to a question about her presentation, Sparks said that she would post the PowerPoint on the ACF Web site.

The HHS Budget

Norris Cochran, Deputy Assistant Secretary for Budget, Office of Finance and Resources, provided an overview of the HHS budget, the budget process, where funding for Tribes is located, and how funding for Tribes is distributed.

Cochran began by stressing that the current budget landscape is challenging, with large deficits looming and calls for freezes on all non-security-related expenditures. These include, he said, possible caps on Federal health care spending. He also noted that HHS is currently operating under a Continuing Resolution that funds the agency at FY 2010 levels, adding that it was unclear whether either an omnibus spending bill or a year-long Continuing Resolution might contain any increases for HHS. Cochran did add, however, that the House version of the FY 2011 spending bill would increase the budget for IHS by \$188 million (\$151 million to maintain the current level of services and \$37 million for facilities). Cochran also noted that the Special Diabetes Program was reauthorized for two more years. Finally, Cochran talked about how the Federal budget is carved up and then honed in on targeted funding to support American Indians and Alaska Natives. He concluded with a review of the budget timeline and the key steps involved in preparing the HHS budget.

Discussion

Opening the discussion, there was a question about the IHS budget and where it is housed. Cochran explained that, although the House Appropriations Subcommittee with responsibility over the IHS budget is Interior and Environment, the IHS budget is part of HHS. (Similarly, the Food and Drug Administration falls under the jurisdiction of the

House Appropriations Subcommittee on Agriculture. The rest of the HHS agencies fall under the Labor, HHS, and Education Subcommittee.)

One participant noted that the National Indian Health Board had looked at this question earlier in the year—and what the impact would be if IHS appropriations were under the jurisdiction of the Labor, HHS, and Education Subcommittee.

Another participant suggested the need to clarify the appropriations process—and what happens where—so that the information is accessible to all Tribal leaders.

One participant expressed concern that the Resource and Patient Management System (RPMS) was losing and/or not accurately reporting data—and the impact this might have on the budget justifications sent to the Office of Management and Budget (OMB). He expressed particular concern about how urban Indian Health Centers are reporting their data. In response, Cochran said that HHS is looking at data integration and how to make systems more automated so that HHS can report more accurately and consistently to OMB. At the same time, he said that OMB looks at summary-level performance data, so that HHS tries to make sure it is providing the necessary interpretation and analytics. Roubideaux added that one challenge was that not all Tribal programs are using RPMS, so it is always an issue as to what data is available for reporting. Regarding the health centers, she said that most are now using RPMS.

Another participant recommended that the Department set aside the IHS budget from being subject to cuts in spending. She noted that there are huge health disparities in Indian Country, and that current budget increases do not begin to address the magnitude of these disparities. She also noted that there are increases in funding for addressing fraud and abuse, while costs for management of Tribal funds are not being funded. What discretion does the Secretary have? She asked. Can she move any of this money around?

In response, Cochran indicated that the purpose of the annual budget process is to look across HHS and try to identify where best to place the limited dollars that exist. Roubideaux added that it *is* the Secretary's budget and that she considers IHS a priority.

The Affordable Care Act

Mayra Alvarez, Director of Public Health, Office of Health Reform, provided a brief overview of the Affordable Care Act (ACA).

Alvarez began by talking about the State-based health insurance exchanges, which are designed to help consumers compare health plans (price, benefits, services, and quality).

She then shifted to talking about the ACA's investments in prevention and public health. These include, she said, \$500 million this year: \$250 for workforce investments and \$250 for prevention (obesity, tobacco, diabetes community programs, and investments in local, State, and Tribal infrastructure).

Next Alvarez noted the creation of the National Prevention Council, which she said aims to get at the idea that health happens not only in clinical settings but also where we work, play, and go to school. For example, she said, how do EPA or Department of Labor policies impact the health of Tribes? She said that the National Prevention Council would be posing some recommendations by the end of the week.

Finally, Alvarez touched on new investments in data systems to help understand and reduce disparities and ACA provisions to promote the work of lay health educators to help reach hard-to-reach communities. Wrapping up her remarks, she pointed to healthcare.gov, which she said provides information to consumers about plan options, and has information about prevention, care quality, and the ACA itself.

Discussion

Opening the discussion, one participant noted that, while the ACA is great, how does it help someone with no income? He cited a grandmother with a son in jail and a pregnant girlfriend with no coverage. In response, Alvarez said that she would be happy to follow up and see what she could do to help.

A participant noted that Tribal leaders are best positioned to know how to work across multiple agencies on the social determinants of health, and he recommended that they be involved in the National Prevention Council. We will make sure we engage with Tribal leaders and Tribal communities, replied Alvarez.

Another participant recommended using the CMS [Centers for Medicare and Medicaid Services] Tribal Technical Advisory Group (TTAG) as a resource for advice on implementing the ACA as TTAG members are (1) representatives to their communities; (2) have technical expertise; and (3) have dealt with some of these issues already. In response, Alvarez said that her office was well aware of the CMS TTAG. She added that she was also looking to the STAC for recommendations on how to broadly bring in its expertise and help to fill the knowledge gaps that currently exists.

One participant said that he was still at a loss as to what the ACA means for Tribes and the IHS. In response, Roubideaux said that her agency has been working closely with the Office of Health Reform to try to explain how the ACA impacts Indian Country. She said

that the ACA is huge for IHS because it means that more patients will be covered by Medicaid or by private insurance.

Another participant noted that many Native Americans live in urban areas without access to clinics. He also expressed concern that people will leave IHS if they get an opportunity to go elsewhere (because of private insurance). Part of this is the public health model and the *perception* that the care is sub-par. He added that it was important that Tribal leaders across the country are involved in the process of educating the community about what the ACA means. We have people who want to access our services, he said, because they are better.

A second participant reiterated the need for more education within Tribal communities about what insurance is and what insurance coverage really means. We also have to start helping IHS promote itself, he said. He also noted the need for Tribes to engage on the State health information exchanges because the States are beginning to develop their plans now (and every State was eligible for a \$1 million grant for this work). He said that it would have been nice if there had been a requirement in there about consultation with the Tribes.

Alvarez said that HHS has issued a few State grants to plan for health exchanges, but it largely laying the foundation to be ready in 2014. She added that the Department would be undertaking a formal consultation process and seeking Tribal input next year. Roubideaux added that IHS has started to hold listening sessions already. In our consultations, she said, we want to know: What guidance do you want to provide States as they start this?

Finally, one participant asked about sections of the ACA dealing with prevention and the impact on self-determination Tribes. In response, Roubideaux noted that IHS was permanently reauthorized, which she said was a vote of confidence that the Indian Health Service will always be there. Wrapping up the discussion, Alvarez said that she was looking for guidance on what a community grant transformation program looks like. We can set up a specific consultation for Tribes, she said.

The American Recovery and Reinvestment Act

Dennis Williams, Deputy Assistant Secretary, Office of the Assistant Secretary for Financial Resources, discussed the American Recovery and Reinvestment Act (ARRA) and its impact on Tribes. He started by noting that the legislation, now in its second year of implementation, provided over \$141 billion to HHS, including over \$700 million devoted to projects and programs for American Indians and Alaska Natives.

Williams said that ARRA supports two dimensions of programs: (1) recovery (supporting the economic recovery and the increased demand for health care and services during the economic downturn); and (2) reinvestments (looking to the future, including significant investments in information technology, expansion of community health centers, an expansion of the National Health Services Corps, additional funding for TANF, and communities putting prevention to work programs).

Next, Williams noted that ARRA also included discretionary funding for facilities in Indian Country, including a facility in Eagle Butte, South Dakota, and a hospital in Nome, Alaska. There was also discretionary funding for community-based health and social services and for health information technology. Williams added that the bulk of ARRA funding over the next few years will be used for electronic health records.

Wrapping up his remarks, he pointed to a chart on ARRA funding to American Indians and Alaska Natives which shows that the bulk of funds went to IHS, facilities construction, and sanitation facilities construction.

Discussion

Opening the discussion, one participant asked about the timeframe for projects that have been approved and funds obligated. In response, Williams explained that the funding for discretionary programs under ARRA was two years, so all of the money has been awarded. That led another person to ask about re-obligating funds (for projects that might have been rescinded); Williams replied that HHS' authority to do that was very restricted. Caya Lewis added that there is language under ARRA that States must consult with Tribes regarding Medicare funding.

Finally, there was a question about Federally Qualified Health Centers (FQHC) and whether Tribes can use their FQHC designation to maintain their eligibility. Roubideaux said that she would find out. Lewis added that CMS is also looking into this question.

HHS Tribal Consultations and Activities

Stacey Ecoffey, Principal Advisor for Tribal Affairs, Office of Intergovernmental Affairs, provided a brief overview of the HHS Tribal consultation policy, and discussed regional consultations, the budget consultation, and general outreach to Tribes.

Ecoffey said that HHS was the only Federal agency that had a formal Tribal consultation policy in place, and that the Department has since made improvements to that policy.

Since then, she said, it has been reviewed by Tribes. She noted that HHS had received about 10 comments, most dealing with minor editing recommendations. She said that her hope was that the policy would be finalized so that Secretary Sebelius can sign the document when she meets with the STAC.

Ecoffey added that she hoped that all of the Department's operating divisions will have a policy in place in 2011 that builds on the consultation policy but focuses more on the specific work being done in each division. She also noted that, while agency-specific Tribal advisory committees *are* specific to those agencies, there will be a mechanism in place for those committees to report back to the STAC.

Next, Ecoffey said that the Office of Intergovernmental Affairs is tackling coordination and consultation issues with the aim to not have Tribal leaders being asked to attend meetings every week. The calendar of Tribal consultations will be issued by IGA in January, she said, and STAC members are encouraged to participate in planning calls for the Tribal consultations.

Ecoffey also said that IGA is planning to hold consultations in the field between February and April each year in order to solicit both budget and policy input. She said that her office was also working on a mechanism for elected Tribal leaders to speak (and not have the sessions overrun by non-elected Tribal representatives). In addition, the 13th Annual Budget Consultation will be held March 4-5, 2011, to coincide with the National Congress of American Indians session. Ecoffey said that IGA is looking to change the format of the budget meetings and perhaps eliminate the breakout sessions. Ecoffey added that the budget consultation would be preceded by a Tribal Resource Day for grant writers and new Tribal leaders.

Following Ecoffey's remarks, one participant asked whether there was a date by which all of the HHS operating divisions needed to have their Tribal consultation policies in place. In response, Ecoffey indicated that putting in place policies (at those agencies that do not have one) is on IGA's agenda; Step 1 was finalizing the Tribal consultation policy.

HHS Agencies and their Tribal Portfolios

Administration for Children and Families (ACF)

David Hansell, Acting Assistant Secretary, said that a thread working through all of ACF's work is supporting efforts to preserve Tribal heritage and achieve social and economic improvements for Tribal members. He added that ACF sees the STAC as a renewed mandate to give even closer attention across all programs to Tribal needs and priorities.

Hansell said that ACF sees its mission as both a safety net and a launching pad for people who are disadvantaged. He said the agency has three key priorities: (1) helping families to achieve economic success; (2) promoting healthy childhood development (Office of Child Care, Head Start, etc.); and (3) improving ACF's institutional capacity to do its job and to provide support to Tribes, States, and other partners who run ACF programs. These priorities speak to fairness, choice, and empowerment, he said. Hansell also indicated that Tribes are eligible to administer a broad cross-section of ACF programs.

Finally, Hansell said that, under the Obama Administration, ACF has undertaken several new initiatives to strengthen its relationship with Tribes. He highlighted them:

- Holding the first Tribal consultation in five years.
- Renewing ACF's commitment to hold annual Tribal consultations.
- Drafting ACF's first Tribal consultation policy. Hansell added that he expected the document to be out for public comment by week's end, and he urged STAC members to provide comments.
- Creating the Native American Advisory Committee, an internal committee to make sure that ACF is coordinating all of its activities that impact Tribes.

Discussion

Opening the discussion, one participant asked about coordination of social services between ACF and the Bureau of Indian Affairs (BIA). In response, Hansell said that ACF is working closely with both BIA and IGA to improve that relationship. Another participant said that he was told by BIA in Kansas that there was no money for social services for Tribes in his State. Hansell promised to look into the problem and get back to him.

Another participant expressed concern about loss of Tribal languages, and he asked whether Head Start had programs to address this. He also pointed to problems with coordination within the education system (i.e., with public schools and immersion programs). Lillian Sparks said that she had recently learned that a number of Head Start programs thought they were not allowed to do immersion activities. In fact, she said, we encourage them to do so and are looking at immersion activities that can be run jointly through the Administration for Native Americans and Head Start. (Later, another participant also stressed the importance of immersion programs to preserve Tribal languages.) Regarding coordination with public schools, Sparks said that she has a meeting set up with the Department of Education (ED) to stress the importance of coordination in this area. Sparks added that ED has been supportive in preliminary discussions; the challenge, she said, is driving that message down to the local level.

One participant noted that, while the ACA includes provisions for outreach and enrollment, there is need for better coordination with Head Start to get children qualified for the Children’s Health Insurance Program (CHIP). He recommended streamlining the applications’ process so that a family does not have to get qualified agency by agency. I agree, replied Hansell, and we are focused on using the ACA to simplify the enrollment process. Hansell added that ACF was also working with CMS on the new Medicaid platforms and exchanges and that his agency is committed to using these systems to qualify people more easily.

Finally, one participant suggested that the ACF consultation workgroup might be a model for the STAC moving forward. He then shifted to raise concerns about the lack of coordination among some ACF programs. He noted that Tribes have found benefits when they have taken control of their programs (via 638 contracts) and administered them with local hires and assistance from the Federal level. In Alaska, he said, we have held internal discussions about expanding this conversation across all ACF programs. He added that he still needed to find a way to create an integrated, comprehensive program administered by the Tribes with Federal support.

Health Resources and Services Administration (HRSA)

Mary Wakefield, Administrator, said that her agency is responsible for a wide range of programs, and for both deploying health care services to underpopulated areas and for educating health care providers. She said that some of the key areas of activity related to Indian Country include strengthening HRSA’s relationships with IHS and American Indians and Alaska Natives in order to better deploy resources to help Tribal communities; improving HRSA’s internal teams to better provide coordination on services to American Indians and Alaska Natives; posting resources and information on the Indian Health Web page; and planning a stakeholder’s workshop to hear about what HRSA can do to better support and facilitate the work Tribes are doing across all of HRSA’s services.

Next, Wakefield highlighted two specific areas of work:

- **Health Care Workforce**—Wakefield said that HRSA is working to increase the number of eligible Tribal sites that can host National Health Service Corps (NHSC) clinicians. There are currently 166 eligible sites, she said, and we are trying to convert all sites by April. She also asked members to spread the word that the NHSC is looking to recruit new health care providers.
- **Community Health Center Program**—Wakefield said that HRSA is working to increase the number of health centers. She added that HRSA put over \$50 million

into the dually-funded health centers last year and were able to serve close to 134,000 patients.

Wrapping up her remarks, Wakefield said that she has asked all of the bureau leaders within HRSA to identify all existing statutory authority to do more on behalf of Tribes and Tribal members. We will continue to push forward on this, she said, and anything else we can do on behalf of the health of American Indians and Alaska Natives.

Discussion

Opening the discussion, one participant expressed serious concern for environmental issues (notably the impact of contaminated fish on early childhood development). Wakefield said that she would look to see what HRSA might be doing, and—if not her agency—who else might be addressing this.

The same person cited the lack of studies of environmental health impacts on Native American populations. She also expressed concern about the lack of health data on Native American populations (and the absence of a Native American “check box” so that accurate statistics can be generated). In response, Wakefield said that HRSA is looking now at where her agency is and is not capturing good data. She acknowledged the need for better data around health care for Native Americans, adding that HRSA researchers were struggling with data sampling strategies. We’re also trying to collect better information using cell phones rather than landlines, she said, but we also recognize that there are pockets in Indian Country that have neither.

In response to a question about converting health sites to make them NHSC-eligible, Wakefield clarified that the designation is intended to qualify sites to get a NHSC clinician in them. This mattered less when there was no money, she said, but now that has changed.

One participant asked about resources for managers and executives. We’re doing our best to try to deal with the complexities of the ACA and funding opportunities, he said, and it would be helpful to have some resources there. In response, Wakefield said that the workforce programs are generally designated by statute (and there is no program right now for managers and health executives). She suggested that HRSA might be able to do some training via Webinars.

Finally, one participant said that the workforce programs should help to encourage more providers to stay in Indian Country. Wakefield agreed, saying that the ACA upped the limits of everything. We think it helps to level the playing field now that the resources (and annual loan repayment limits) are higher, she said.

Administration on Aging (AoA)

Kathy Greenlee, Assistant Secretary, highlighted her agency's four dedicated funding programs:

- Nutrition and Supportive Services Grants
- Native American Caregiver Support Grants
- Nutrition Service Incentive Grants
- Medicare Improvements for Patients and Providers Act (MIPPA) Grants

Greenlee added that there are two bills pending in Congress that would increase funding for both Nutrition and Supporting Services Grants and Native American Caregiver Support Grants. If this increased funding is approved, she said, then it would go directly to Tribal Governments.

Next, Greenlee said that the Administration would move forward next year with a position on reauthorization of the Older Americans Act. She encouraged everyone to pay attention to that process, as well as to work with James de la Cruz. Finally, Greenlee noted that AoA has three resource centers that provide technical assistance. Wrapping up her remarks, she noted that AoA would work with people at the local level and coordinate with State partners as discretionary funding becomes available.

Following her remarks, Roubideaux added that she was grateful to have AoA working with IHS as long-term care is a new area of focus for the Indian Health Service. She added that she was seeking comments on how IHS can work with and leverage other partners in the long-term care arena.

Discussion

Opening the discussion, one participant said that his Tribe had elected to build senior housing (where an elder could live along with a family caregiver) rather than a nursing home. The problem, he said, has been finding enough providers and medical staff to help people in their homes. In response, Greenlee said that she would be interested in working with IHS to address co-location of services.

A participant expressed concerns about State budget deficits and the impact on Tribal resources. Our resources are fairly limited, he said, and we need to make sure resources are protected for Indian people. He also pointed out that funding for Title VI has been flat for several years while the population of elderly people has gone up. The funding formula needs to be reviewed, he said. We raise this every year and seem to get nowhere. In

response, Greenlee encouraged STAC members to talk with everyone they can about the needs of their local communities so that everyone has the same information.

Finally, another participant reiterated the need to integrate services for Native American elders. In Alaska, beds are short and people are spread out far from home, he said. He said that while he recognized that funding was an issue, it was important to have a conversation about breaking down barriers and co-locating facilities where it makes sense. Greenlee reiterated that AoA has discretionary funding and is always looking to fund innovative programs. Wakefield added that the Extended Stay Clinics in Alaska might be one model to look at.

Centers for Medicare and Medicaid Services (CMS)

Caya Lewis, Chief of Staff, said that CMS serves approximately one in every four Americans through its programs. She said that the agency has few direct grant dollars, but can work with other agencies within HHS and with Indian Country in other ways. By way of example, Lewis noted that CMS in April announced grants to 41 health programs as part of the effort to enroll children in CHIP. This includes outreach materials for Native Americans, she said.

Lewis also highlighted her agency's role in providing data to other HHS agencies. Our claims data holds so much information, she said, and we're trying to dive into it. Lewis added that it was very important that CMS work well with Indian Country on how services are delivered and to make sure that the agency's policies, programs, forms, and Web sites work for Tribes moving forward.

Finally, Lewis noted that her agency has an internal Tribal Affairs Group that reports to the CMS Administrator. In addition, she noted that the CMS TTAG was established in 2003, has met three times this year, and also holds monthly phone calls. We're consistently and constantly reaching out to hear how we can facilitate better services and relationships between CMS and Indian Country, she concluded.

Discussion

Opening the discussion, a participant commended Nancy Rios in Region 7 for doing a terrific job in working with the Oklahoma Tribes. I want to recognize that commitment, he said. Another participant expressed appreciation to Kitty Marx and her colleagues in the Tribal Affairs Office.

One participant asked whether there was ever a request to establish a carve-out of Medicare, Medicaid, and CHIP funding. Is there a way to eliminate the administrative barriers to providing services? he asked. In addition, he asked whether it would be

possible for the Tribes to do the eligibility determinations (rather than the States), because that would also help to streamline things. Finally, he asked whether there was a requirement for individual programs' reporting?

In response, Lewis acknowledged that State-Tribal-Federal issues were ongoing and all-encompassing. She said that while she could not comment in detail, CMS was constantly looking at this. Dioguardi added that some of the processes were enshrined in statute and limited what HHS could do. At the same time, he reiterated that there have been a number of discussions about whether there are ways to have a more direct relationship with Tribes with regard to programs administered between the Federal Government and the States. At some point our hands are tied, he said, but we are certainly willing to listen to interpretations of the law (within our authority) to address this.

Wrapping up the conversation, a participant said that he hoped to have a conversation about Tribal providers being deemed essential community providers so that they can be included in the exchanges. He and another participant also both stressed the need to work on overriding and crosscutting issues around Tribal-State relations.

Office of Minority Health (OMH)

Garth Graham, Deputy Assistant Secretary of Health, and Director, Office of Minority Health, said that OMH has heard consistently that it needs to open up more funding to Tribes. We have worked proactively to do this in the last two years, he said, including dramatically increasing funding and opening up five Tribal Epidemiology Centers.

Graham also briefly talked about the role of the Office of the Assistant Secretary of Health (OASH). He said that there were new funds allocated to OASH, and that the office has two priority areas: (1) tackling infant mortality within Tribal communities (Graham noted that OASH has had success in this area with other target populations, and that OASH will be working with the Seattle Indian Health Board on a campaign); and (2) tackling methamphetamine abuse.

Centers for Disease Control and Prevention (CDC)

Judith Monroe, Director, Office for State, Tribal, Local, and Territorial Support, said that CDC was focused on protecting health, promotion of health, and prevention. Her office, she said, has been newly formed at the agency to focus specifically on State, Tribal, local, and territorial issues.

Monroe noted that CDC has a Tribal Consultation Advisory Committee that meets two times per year. In addition, she said, CDC collaborates with its HHS partners on Tribal

health issues (including with NIH in the area of diabetes and cancer control and with IHS to address public health prevention and disease control).

National Institutes of Health (NIH)

James Anderson, Deputy Director for Program Coordination, Planning, and Strategic Initiatives, said that NIH works primarily in two ways: (1) funding research and translating outcomes to improve health; and (2) training researchers and supporting the infrastructure to get this work done.

Anderson said that 22 of the 27 NIH Institutes and Centers have programs that are very specific to Tribal communities. He said that NIH supports the prevention, diagnosis, and treatment of health issues that affect all Americans (e.g., cardiovascular disease, cancer). Anderson added that there was a strong commitment at NIH to research on diseases that specifically impact Native American communities. Wrapping up his remarks, he said that NIH wanted to increase the representation of American Indians and Alaska Natives in health research.

Substance Abuse and Mental Health Services Administration (SAMHSA)

Sheila Cooper, Senior Advisor for Tribal Affairs, said that her office was pushed to develop a roadmap for Indian health care. She said that the enactment of the Tribal Law and Order Act set out requirements for new interagency collaboration and coordination among HHS, the Department of the Interior, the Department of Justice, and other agencies, and offers an opportunity to develop a one-stop shop for resources.

Cooper said that SAMHSA has eight strategic initiatives and that addressing the needs of Indian Country are embedded and addressed within each. She highlighted two top priorities: (1) suicide prevention; and (2) prevention of substance abuse. She added that under SAMHSA's substance abuse initiative, the FY 2011 proposed budget includes funding for a new Prevention Prepared Communities Program to enable people (individuals, families, schools, workplaces, etc.) to work together to take action.

Finally, Cooper said that while SAMHSA cannot provide block grants directly to Tribes, the agency can provide guidance to States on consulting with Tribes and require States to report back to the agency on what they heard and what they are doing. Wrapping up her remarks, Cooper said that she hopes SAMHSA will have complete presence in all 10 regions by 2012 (with a presence in five regional offices in 2011).

Indian Health Service (IHS)

Yvette Roubideaux, Director, offered brief remarks. She said that IHS has its own challenges, including too-limited resources. As a result of the discussions here today, she

said, I encourage STAC members to think about how to leverage all HHS resources and to think about IHS can partner with other agencies to tackle the needs in Indian Country.

Tribal Closing

Day 1 concluded with a Tribal Prayer.

Day 2: December 14, 2010

Tribal Opening

Day 2 opened with a Tribal Prayer.

HHS Welcome

Laura Petrou, Chief of Staff to Secretary Sebelius, welcomed participants to the first official meeting of the Secretary's Tribal Advisory Committee and reaffirmed both President Obama's and Secretary Sebelius' commitment to addressing Tribal issues. I hope that the STAC and other Sebelius initiatives will become engrained in the Department and across HHS, she said.

Election of STAC Chair and Co-Chair

STAC members nominated **Ken Lucero** (Tribal Council Representative, Pueblo of Zia), **Buford Rolin** (Tribal Chairman, Poarch Band of Creek Indians), and **Reno Franklin** (Vice Chairman, Kashia Band of Pomo Indians of Stewarts Point Rancheria).

Voting was conducted by secret ballot.

Motion:

To elect the two top vote-getters as Chair and Co-Chair of the Secretary's Tribal Advisory Committee.

The motion was unanimously adopted.

Ken Lucero was elected STAC Chair; Buford Rolin was elected STAC Co-Chair.

STAC Meeting Overview

Stacey Ecoffey said that the aim of the inaugural STAC meeting is to look broadly at issues across HHS in both the areas of health and human services. Ecoffey noted that HHS officials attend a lot of Tribal consultation sessions where the Tribal leaders in the room represent their individual Tribes. You are sitting here today as representatives of your region, she said, and to add a national perspective. Ecoffey added that she hoped that, after Secretary Sebelius provided the STAC with its charge, STAC members would establish priorities for the Committee and provide direction to HHS.

The STAC Charter

Stacey Ecoffey said that the STAC Charter lays out how meetings will be conducted, what will be addressed, how elections will be conducted, and how alternates will be replaced. She added that the document also identifies senior leaders within HHS that it anticipates will be actively involved in the STAC in order to help ensure that the document has a permanent place within HHS. Finally, Ecoffey said that it is generally a pretty standard charter—but we want to give you an opportunity to review it and see if you have any comments.

Discussion

There was some discussion about funding for STAC meetings and whether it would be possible to provide funding for alternates to attend in-person meetings. One participant noted that alternates sit on all phone calls as part of the Department of Interior Tribal consultation process, and that it was essential that this happen here. A second participant said that he thought one primary representative was enough as he believed it was his responsibility to correspond and communicate with the Tribes in his area. A third participant said that disseminating information to the 109 Tribes in his region was a challenge and that it would be helpful to have funding for both delegates and alternates.

Laura Petrou said that she would have to look at the budget options to see whether it is possible to fund both delegates and alternates. We can certainly have alternates on the phone calls, she said.

Next, there was a concern raised about how HHS funding for the STAC meeting was handled. This is a big “no” for our Tribal Government, said one participant. My Tribe paid for me to attend this meeting, he said, because as an elected official I cannot have this money put directly into my account. Can my alternate use this money instead? He asked.

Petrou said that this was an issue that HHS would need to look at. Dioguardi added that he’s heard similar concerns before about how Tribal officials are funded for consultations. The system is based on how Federal employees are reimbursed and is designed to streamline payments, he said. Dioguardi added that, given the concerns being raised, HHS needs to see if there is another approach.

Wrapping up the discussion, one person said that he would prefer a system in which HHS could coordinate travel arrangements (versus delegates having to make their own arrangements).

See page 24 for final comments and approval of the STAC Charter.

Remarks by the Secretary and STAC Member Discussion

HHS Secretary Kathleen Sebelius welcomed members, said she was pleased that the STAC was operational, and said that she thought it would provide a great opportunity for HHS and Tribes to work together on a wide range of high-priority initiatives. As evidenced by the HHS people gathered around this table, she said, we think it is critical that our senior leadership team be very involved and engaged in the dialogue that we are having.

Sebelius stressed that she saw the inaugural STAC meeting not as ceremonial but rather as a working meeting. She said that she wanted to talk about how to improve the delivery of preventive services to close some of the glaring health disparities gap for American Indians and Alaska Natives that we continue to measure but haven't done a particularly good job of closing. Sebelius also talked about the need to better get social services to Indian families across the country; to provide better technical assistance to ease navigation of what is often a complicated and cumbersome system; and the need to continue to work on the Government-to-Government relationship.

We are well aware of the health status and enormously difficult economic circumstances that you live in day in and day out, said Sebelius. The more time and energy we can spend on identifying specific challenges and figuring out ways to deal with them will be time well spent, she said.

Sebelius said that the STAC was her Department's commitment to honor the Government-to-Government relationship. The Secretary added that the entire Obama Administration is committed to improving the relationship between Tribes and the Federal Government—and to taking the action steps that have too long been ignored.

We are taking concrete steps and translating them into reality, she said, and we want to measure our commitments and our progress. One of the measures of success is the new Tribal consultation policy which is being signed here today.

Secretary Sebelius signed the HHS Tribal Consultation Policy.

Discussion

Opening the discussion, one participant said that she appreciated the stated aim of HHS to remain flexible toward working with the Tribes, including its willingness to look outside the box to try to find new funding streams and to remove administrative barriers.

She cited the sometimes rocky roads and contentious times in dealing with States, and said she would like to see more direct contracting and grant funding for contract support services. In addition, she said that the Special Diabetes Fund was critical because there was not funding before to address the growing epidemic of obesity in Indian Country. She also expressed her concerns about children's mental health.

Another participant expressed concern about likely cuts in discretionary funding and said that he had written to President Obama asking him to withhold cuts from Indian programs. He said that he had received a reply from OMB on the President's behalf saying that he would be mindful of the concerns. He noted that the real challenge is that there has for decades been a lack of funding for Indian Country.

Sebelius said that budget uncertainty and what the overall resource picture will look like are huge concerns across HHS. At the same time, she noted that IHS had in the last two budget cycles received the largest increase of any of the HHS operating agencies. She added that she felt that it was very important that this continue to happen moving forward. Finally, Sebelius urged all STAC members to have direct communications with OMB moving forward.

One participant said that he would like to see more training on grants management and accounting. Sebelius said that HHS would look at technical assistance in this area. She added that, while IHS was helping Tribes address issues with their grant accounting, it would be helpful to do this training in advance.

Another participant encouraged the Secretary to police States that receive grants applied for on behalf of Indian Country. In my scheme of the world, he said, we would never have to apply through States for our grants. He also talked about youth suicides and the red tape that is preventing concerned parties from helping (including a principal who was barred from transporting students to needed help).

Regarding the issue of youth suicides, Sebelius noted that HHS has a National Suicide Prevention Strategy. She said that, as part of the initiative, HHS was working closely with the Department of Defense regarding military families. She added that it would be helpful to also have a specific subset of the initiative focus on Tribal families (and also to bring BIA into the discussion).

Regarding the Tribal-State relationship, Sebelius cautioned that the huge turnover in governors means that many new relationships will need to be formed. She said that HHS is trying to make sure that the regional directors are paying attention to grant and service anomalies. She said that the more that Tribes can keep HHS informed of specific issues,

she said, the more we can try to intervene and address them. Sebelius added that she was willing and happy to reach out to governors if that relationship wasn't going well or if there was a block in services (e.g., in getting Swine Flu Vaccines last year).

A participant indicated that he co-chaired the Tribal Leaders Diabetes Council and was very pleased that funding for the Special Diabetes Program had been extended by Congress. He noted that \$150 million was a lot of money, and that what Tribes were doing to combat the disease was fantastic. He added that he was pleased that Tribal peoples were getting the message that "we have to be the change." As a result, he said, we are seeing change and a decrease in diabetes.

Sebelius said she was happy to hear that the Special Diabetes Program was having an impact. She added that three of the grants that were part of the ARRA funding on prevention health strategies went to address challenges in Indian Country. We look forward to learning what strategies really work in getting some turnaround in health statistics, she said.

Another participant said that a major concern in his region was for Tribes in Nevada. They are a contract State, he said, and their funding for services is very low and limited. They need buildings, clinics, and hospital improvements to serve their own people, he said, adding that the medical services are with the doctors they contract in town. He said that the Phoenix area was trying to split its agencies so that Nevada could have some primary contracts. The Tribes are in support of this and working closely with them to make it a possibility, he said, and your support would be appreciated. He also expressed concern about budget shortfalls in Arizona, particularly with regard to services in the areas of child care, juveniles, and the elderly.

Sebelius cautioned that, because a number of governors start with a fairly hostile attitude toward the Federal Government, these relationships will not be easy to address. She again urged Tribal leaders to provide feedback to HHS as problems arise so that she could try to address them.

Finally, one participant reiterated some key challenges in Indian Country (health care disparities, lack of behavioral health services, and lack of access to care). He said that Tribal leaders were ready to jump in and work with HHS on implementing the ACA. We need all the resources and help we can get to deal with these very difficult issues, he said.

Wrapping up the discussion, Chairman Lucero said that he would like to see the STAC attack the issue of providing some resource to Tribes if the Federal Government does not uphold its commitments.

Setting Priorities for HHS

Chairman Lucero opened the discussion about priority setting by saying that he would like the STAC to identify three or four top priorities that are within the Secretary's purview to address. He noted that Secretary Sebelius has said that she wants the committee to be a change agent. Although funding is a big concern, he said, I'm not sure it is something we should focus on in terms of pushing change.

Dioguardi added that it would be helpful if the committee would set some specific priorities for HHS to work on that do not require Congressional action (i.e., not ideas like funding that are outside the Secretary's control).

One participant identified three issues of big concern in Region 7: (1) family preservation and how this works with the State; (2) foster care and grant money; (3) child support enforcement; (4) issues of care for older Americans.

These are great examples, said Dioguardi. It would be helpful to focus on particular programs that cut across programs or perhaps grants and technical assistance, he said. He added that it might be helpful to limit the scope of the priorities for this year.

Lucero asked the participant if there were any particular issues he wanted to drill down on. In reply, the participant said that all three issues he cited involved the States. If State funding isn't there, how will Indian Tribes access these programs? he asked. This led Lucero to suggest perhaps focusing on the State-Tribal-Federal relationship.

Another participant suggested that it might be helpful to steer the issue of State-Tribal-Federal relations in a way that would enable HHS to have some attainable goals. He noted that States are often using Tribal numbers and just saying they are including Tribes in their plans (e.g., emergency preparedness dollars). He suggested tackling the issue of enforcement, saying that he thought it was something HHS could implement Department-wide to put some teeth behind it and hold up funds when States are not including Tribes.

Still on the issue of the State-Tribal relationship, a participant said that there is an effort underway in Oregon to identify all the services and to contract or compact for them. She noted that doing so would allow Tribes to develop their own best practices and standards. We need to have the administrative barriers removed so that we can do this as a single contract, she said, and support from the Secretarial level is very important. She added that it was also important for Tribal clinics to be designated public health stations so that they can receive supplies directly (e.g., vaccines).

Several other participants also expressed support for addressing the State-Tribal-Federal relationship. One person specifically talked about the need to do something about Tribes' relationships with States and the fact that so much funding is intercepted by the States.

One participant suggested that the STAC look at what issues Tribal leaders have already raised. He suggested that IHS develop a matrix of recent testimony and consultations as a starting point to help the STAC focus its work. He also suggested that the STAC focus on how to tackle suicide and providing services with the resources that exist today.

Next, a participant recommended four specific areas of focus: (1) providing guidance on ACA implementation; (2) engaging on implementation of the Indian Health Care Improvement Act, including new provisions dealing with Veterans Affairs and reimbursements (he also asked: What kind of resources do we need to bring to get long-term-care services implemented? How can we address the need for new facilities and new construction?); (3) better coordination with HHS to remove barriers and improve access to care; and (4) better coordination and collaboration with other Federal agencies.

One participant recommended focusing on programs for mental health services. He noted that there is a lack of best practice models and that many Tribes have no social workers on staff. He specifically pointed to the need for more coordination between IHS and BIA in delivering services to children and families, and asked whether perhaps all of this work should be under the HHS umbrella. (Later, another participant noted that CMS and the Department of Veterans Affairs also should be a part of the mental health services discussion.) Finally, he noted the need for Tribes to look at best practices outside their own communities. Children are facing the same issues whether they are American Indian, Asian, Black, etc., he said. What are the best practices that work throughout the U.S., he asked, and how we can start implementing these programs at the Tribal level?

In response to his comments, Wakefield noted that NHSC supports a complement of mental health providers and that more behavioral health workers are now signing up with the Corps.

Another participant cited support for tackling both the State-Tribal-Federal relationship and issues of funding (including contract support services). She said that other key priorities should be to elevate and remove health disparities; contractibility of programs, services, and grants (including removal of administrative barriers); recognition of Tribes' unique standing (including cultural and spiritual practices); and a focus on children and infants (including the impact the environment has on them). Lucero commented that, in

another meeting recently, the conversation centered around eliminating disparities by increasing health equity.

Cooper suggested thinking about the STAC's priorities in terms of setting measurable priorities for making progress in the short term. She suggested perhaps identifying what a "healthy Tribal community" might look like and what resources around the room can be brought to bear to achieve a healthy community. She added that HHS can also bring in its external knowledge (including other Federal agencies and outside partners).

Several participants expressed support for the concept of developing a roadmap for a healthy Tribal community. One person suggested having a handout that outlines and defines all available grants, adding that technical expertise to help Tribes apply for ANA and other grants would also be helpful. He noted that ANA has a good technical assistance model that might be adopted by other HHS agencies. Sparks said that HHS could look at developing grant directories for each department. Another participant added that it might be useful to put together a list of resources from Federal agencies outside HHS and look at whether some of the grants and other funding can work together to reach goals for healthy communities.

One participant suggested that the STAC also prioritize things on which there is already consensus (e.g., all agencies need to have a Tribal consultation policy, there needs to be a uniform definition of Indian). He also said that the STAC should identify what its role will be in the budget process.

Nothing that a lot of direct service Tribes are ineligible for many programs (and need to be made eligible), a participant said that it was important for the STAC to understand the differences between direct service Tribes and compacted Tribes. He said another issue that needs to be addressed is that of funding going from Tribes to urban centers.

Lucero highlighted three key issues: (1) better coordination of workgroups (with IHS and HHS); (2) education of Tribal communities about what HHS is and what services are available (he added that he would like to see funding available by area or region to coordinate meetings so that STAC delegates can take the information back to their communities); and (3) data issues (including data collection and sharing of data).

Sparks noted that the Intradepartmental Council on Native American Affairs has talked about both the Tribal-State relationship and access to funding and technical assistance.

Roubideaux reiterated that it would be helpful if the STAC can identify its top priorities and provide some specific recommendations for HHS to work on.

Several participants reiterated support for addressing the State-Tribal-Federal relationship (including access to funding and data issues) as well as for developing a roadmap for a healthy Indian community. Other issues that were brought up included removing health disparities (which one person noted cuts across all agencies—and involves research, education, and direct services) and education and training across Federal agencies about Tribes.

Priority Setting: Next Steps

There was some discussion about next steps, including the need for participants to review draft priorities and the need for them to consult with and solicit input from Tribal leaders and Tribal communities in their regions.

There was also discussion about the need to not only identify the broad themes but also to develop specific deliverables for HHS to focus on in the short term. Dioguardi noted that IGA had two priorities in 2010: (1) establishing a Federal consultative process and policy; and (2) setting up and convening the STAC. He suggested perhaps identifying 1-3 specific and attainable deliverables with timelines attached that HHS can do over the course of 2011, 2012, and 2013. Monroe added that, regarding the State-Tribal-Federal relationship, STAC delegates might want to think about what specific items they would like HHS to share as it starts to meet with and develop relationships with the 24 new governors and their staffs.

One participant suggested setting up a STAC blog so that people can follow-up and see what the committee is doing. Roubideaux said that IHS was developing a Tribal consultation Web site with the intent that it be a one-stop shop for all Tribal consultation activities. She suggested that it might be valuable to have a STAC Web site with short announcements and calls for input in order to demonstrate accountability to Indian Country.

Finally, Ecoffey suggested setting up a STAC conference call in mid-January to review the draft list, after which delegates could vet the priorities within their regions. She added that it might be helpful to have an opportunity for Tribal leaders to discuss the priorities during the Tribal Budget Consultation in Washington in early March. Finally, she reminded participants to vet the priorities list broadly (including social services folks as well as health boards).

Motion:

That HHS will transmit, via e-mail, to STAC delegates a compiled list of potential priorities based on the STAC meeting discussion. Delegates will have an opportunity to comment on the priorities. The draft priorities will be finalized on a January conference call, with a final vote to be held in March after the Tribal Budget Consultation is complete.

The motion was unanimously adopted.

STAC Charter and Terms of Office

There was a brief discussion about how delegates' terms should be staggered. The STAC agreed to ask the Office of Intergovernmental Affairs to hold a lottery to determine which 50 percent of both regional and at-large delegates' terms will be up at the end of 2011 and which will run through 2012.

Prior to a vote on the STAC Charter, one participant indicated that he would like to know whether there will be funding for alternates to attend STAC meetings. In response, Dioguardi said that HHS will make the change if the funding can be found. One participant suggested an amendment to the motion to adopt the charter that allows for the document to be amended.

Motion:

To adopt the STAC Charter.

Amendment:

To include language stating that the Charter may be amended at any time by the STAC.

The amendment was approved by acclamation. The motion was then unanimously adopted.

Final Remarks

Both Laura Petrou and Paul Dioguardi thanked everyone for participating. Petrou added that the STAC was a big step forward in institutionalizing some of the principles around Tribal consultations that everyone has talked about. Finally STAC Chair Ken Lucero added his thanks to everyone.

Tribal Closing

The STAC meeting concluded with a Tribal prayer.