

**Department of Health and Human Services
Secretary's Tribal Advisory Committee Meeting
Washington, DC**

March 17-18, 2015

Summary Report

Members of the Secretary's Tribal Advisory Committee (STAC) saw positive movement on several complicated issues during their meeting on March 17 and 18 in Washington, DC. Members acknowledged the historic opportunity to move contract support costs from discretionary to mandatory even as they expressed concerns about administrative costs. Other key issues included behavioral health, technology concerns, and a meaningful discussion on historical trauma. This meeting also included a joint session with the Department of Interior (DOI) to pursue stronger Indian Child Welfare Act (ICWA) regulations and greater flexibility for 102-477 programs. Chair Rex Lee Jim led the meeting.

Members Present for Roll Call: Ron Allen (Portland Area), Tino Batt (Portland Area - Alternate), Dana Buckles (Billings Area-Alternate), Cheryl Frye-Cromwell (Nashville Area), Judy (Elaine) Fink (California Area), Leonard Harjo (Oklahoma City Area), Rex Lee Jim (Navajo Area), Arlan Melendez (Phoenix Area), Gloria O'Neill (Alaska Area), Roger Trudell (Great Plains Area), and Brian Cladoosby, Jefferson Keel, William Micklin and Aaron Payment (National At-Large Members). (Quorum Met)

Action Items

The Department of Health and Human Services (HHS) Budget Updates

- Rex Lee Jim requested that HHS enlist a subcommittee to address the issue of suicide and other types of prevention: how to do better research, bring the evidence, put that topic on the table and push it forward.

Indian Health Service (IHS) Discussion

- Provide Gloria O'Neill information on how the Joint Venture Construction Program review process works, including the members of the federal/tribal workgroup who participate in the process.

Intradepartmental Council on Native American Affairs (ICNAA)

- Work with the Office of Intergovernmental and External Affairs (IEA) to determine a way to have a longer conversation about self-governance between staff from the Administration for Children and Families (ACF) and interested STAC members.

Health Resources and Services Administration

- In response to a request from Ron Allen, staff will work on developing a matrix that shows which Health Resources and Services Administration (HRSA) funds tribes are accessing, along with a summary of what the tribes submitted that helped them win funding.

HHS Federal Member Roundtable Discussion — National Institutes of Health (NIH)

- NIH will look into communicating funding opportunities through the National Indian Health Board (NIHB) and the National Congress of American Indians (NCAI) to expand its reach to tribal communities.
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Secretary's Tribal Advisory Committee Meeting

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Welcome and Meeting Logistics

Mr. Dioguardi opened the March STAC meeting with an announcement about upcoming opening seats. Although it occurred early in the year, the March meeting was the last of the current year's cycle, which means openings will occur shortly afterward. The committee staggers the terms of many of the slots in order to get a good rotation of people while maintaining consistency each year.

Following the March meeting, letters will go out asking for nominations of the seats that will be available. The terms that are ending are:

- Aberdeen
- Alaska
- Billings
- Navajo
- Phoenix
- Tucson
- At-large seats held by Aaron Payment and Jefferson Keel.

Members can serve another term if they receive re-nominations as there are no term limits. Once the new members are confirmed, the STAC will conduct elections for the chair and vice chair positions for the year.

Mr. Dioguardi also discussed the meeting follow-up process, asking STAC members whether they want to receive a list of follow-up items from the staff, present a formal follow-up letter from the STAC or complete some combination of both. Spelling out the process will help everyone agree on the key issues without duplicating efforts. Before moving on with the meeting, Chairman Payment made a motion to approve the agenda. Councilwoman Frye-Cromwell seconded the motion, and the committee approved the agenda.

HHS Budget Updates

Norris Cochran, Deputy Assistant Secretary for the Budget

The 2016 budget came out on time this year, which was a good start to the process, said Mr. Cochran. The budget includes a discretionary increase of \$461 million for IHS, which is about 10 percent and reflects the hard work and due diligence of the STAC. The process also has the mandatory policy for Contract Support Costs (CSC).

Mr. Cochran also addressed these issues:

- The Low Income Home Energy Assistance Program (LIHEAP), which had been a target for proposed cuts for a number of years within a flat or declining budget, didn't face reductions in the '16 budget.
- The Administration has put forward a budget that is modeled off of discretionary spending levels that assume no sequestration. The budget proposes a 10 percent increase for IHS. The budgetary caps, assuming the lower sequester caps, would be flat.

Questions and Comments

C: (Ron Allen) Touching on the mandatory CSC topic, you will hear a consistent endorsement. The devil is in details with regard to how to get it done. We have reservations about the 2 percent administrative. We agree there is a need for that function. The question is, is there a better way to calculate it without just doing a very simple 2 percent, which causes concern from the tribes' perspective.

Next week you are going to hear a lot of tribes say yes but move it forward to '16. The Office of Management and Budget (OMB) is supportive of that if Congress will endorse it. This is a first of many generations. No one has ever thought about administering treaty trust responsibility like this.

Last, our proposal with regard to the budgetary needs to get our citizens enrolled, to be able to make sure that the Affordable Care Act (ACA) and the Marketplace and all the provisions and concerns that are out there, there are resources necessary to make it happen with respect to the 4 million citizens who are eligible. Our strategic plan has asked for around \$7 million. The Administration has stepped up to a little over \$4 million. Great move but we would like to see a better bump in that area so we can do an effective job.

C: (Brian Cladoosby) The \$460 million, the 10 percent, is thumbs up. The concern that we have is dealing with inflation and population. We estimate that it will take about \$297 million to fund actual inflation and population growth for this year and the President's budget requested \$147 million for population and inflation. So we feel there is about \$149 million in unfunded inflation and population growth.

We are asking that when the Administration looks at this, and when they have their OMB pass back in November of 2015, that if we could have that \$149 million included in that.

Q: (William Micklin) I have a question on the mandatory contract support costs appropriations proposal. You know, the big part is getting the legislation enacted. So one of the concerns we have is with the budget caps that remain in place, and even in FY16 mandatory, funding for mandatory, those funds were taken from somewhere, so it is a finite amount of funding.

One of the impositions of the legislative process we are trying to avoid is the pay go process. So in the Congressional Budget Office (CBO) scoring for mandatory appropriations, we are seeking a zero-cost determination because if we don't, we are competing. We have to take funds from somebody, some stakeholder who is going to defend their appropriations. How best do we approach seeking a zero score from CBO for this and how does the additional appropriation above the estimated cost figure into that determination?

Q: (Norris Cochran) We have in the budget \$423 billion in savings through a variety of proposals — that is over 10 years — in Medicare. Then we have a number of spending proposals, including contract support costs, changes to Medicaid, extension of the Children's Health Insurance Program (CHIP), investments in early learning programs, other proposals that when you add up those spending proposals, all of our mandatory proposals, taken together, would save \$250 billion over 10 years.

The Secretary has been asked questions along the lines of how do you pay for this proposal or that proposal, and it may sound like a dodge but it is just the way the budget is built. When we are asked, how are you paying for it? The fact is, it is paid for as part of total budget for HHS. It is just — none of our proposals have a direct alignment with a specific savings proposal.

But in total, again, there is more than enough there. Even if all of our spending proposals were enacted, if some of the savings proposals are problematic for the Congress, and we know some will be, they still would not need to take all of them in order to offset the spending proposals, including contract support costs.

With regard to the CBO, if you can figure that out let me know. This is a difficult area for us. Getting around CBO scoring conventions is very difficult, pointing to the fact that there are more than enough savings proposals in the budget to pay for contract support costs.

C: (Rex Lee Jim) Let me just share with you the top five budget increases from Navajo Nation. Obviously we are concerned about facilities, the health care facilities construction. We are asking for \$125 million in facilities.

In terms of sanitation facilities construction, there are a lot of homes in Navajo that still lack running water and we need our children and elders to have access to that. We are asking for an increase of \$75 million in that area. Clinical services, purchased/referred care, at \$52 million. Clinical services, hospitals and health clinics, at \$26 million. And then facilities maintenance and improvement at \$26 million.

C: (Roger Trudell) I was disappointed to hear about how the CBO scores in terms of prevention because there is like an epidemic of suicide in our area. If it were like some other disease, there would be somebody in there trying to find the cause. With the larger tribes in our particular region, there are a lot of almost cluster suicides. There should be some way to go in and use prevention dollars or whatever to see if some that can be cured.

C: (Rex Lee Jim) Having said that, I think we might have a subcommittee to address the issue of prevention, how to better do research and bring evidence and put that topic on the table and find a way to push it forward.

C: (Ron Allen) One of the areas that is a challenge in America and a challenge in Indian Country is aging. I don't know why it doesn't get prioritized higher and why more resources aren't made available to serve our communities so that we can help take care of our seniors and elderly citizens. That is something that I want to advocate as an important agenda.

Q: (Aaron Payment) What is happening with our advanced appropriations request? I know this is a huge ask for the full funding and mandatory funding for contract support costs but sequestration is probably something that is not going to go away. And the impact in my community was we lost six medical providers. Advanced appropriations are a critical need. It has already been demonstrated that it can be done through veterans' health.

A: (Norris Cochran) It is not in the budget, as you know, and we don't have a solution. We are fairly confident that we won't face a shutdown again but we will very likely have continuing resolutions, which I know is another challenge. We know advanced appropriations are a priority. It is not in the budget. We continue to want to work with you and keep it on our list.

C: (Aaron Payment) I wouldn't conclude that the sequester and the shutdown was sufficient to prevent it from happening again. We have seen that recently with the homeland security issue. I am not sure we are not going to see more of that coming down the road. We are heading into a presidential election cycle. So I am not sure that there isn't more sequestration coming.

C: (Gloria O'Neill) In Alaska, about 95 percent of our state's budget is based on the price of oil. You can imagine the state that we are in as it relates to slashing and burning our budget in the state. HHS will really help us in the discretionary funding and related programs. Mandatory programs such as Temporary Aid for Needy Families (TANF) will help us shore up some of the necessary resources that we will need in our communities. So as we get through the next couple of years, we will be wanting to ensure that we have a thoughtful and deep partnership with HHS to support our communities.

C: (Arlan Melendez) I would like to also reiterate the child care, that child care is only about 13 percent of what Head Start receives from the federal government. And I know there is a set-aside, I believe — I think it has increased to 2.5 percent or something like that. But actually the need is about 5 percent.

And then the issue on growth, with more tribes applying for, you know, the limited funds. I think we need to have more funds there to really provide for all.

C: (William Micklin) We talk about this with the program directors but essentially it is an issue that needs support from the Administration in working with the Congress. It has to do with the problems we have with the statutory caps on programs such as TANF and Head Start.

When it is capped at 15 percent or 10 percent, we have to incur those shortfalls in ability to recover sufficient to our overall indirect rate, and we have had to take extraordinary measures to move TANF and Head Start out of our overall budget. But there are consequences to that, and part of those consequences is our pool is reduced so our overall cost pool where we recover against the — principally Bureau of Indian Affairs (BIA) programs — is forced up. So we have to recover program dollars that really should go to the programs.

The issue here is we have tried to address this in the Congress. But because these statutory limits are spread out over appropriations committees and the authorizing committees, it is just almost impossible to get every committee staff together from a tribal perspective.

At this point, there is a significant consequence to our operational viability in delivering services to our most needy. And this includes the TANF cash distributions at \$923. In 1996, it was \$923. In 2015, it is \$923. That is a loss of 32.7 percent against inflation. It is less than half of the cost of a monthly rent for these most needy people.

If we can't even cover half the rent, it is very difficult to get folks enough to actually be in a position to fulfill their plans. And we have had to be very tough on our citizens in meeting the terms of the plans and providing fewer waivers and fewer reasons where they are compliant because there are so many people on the waiting list.

So we really need help from the Administration in working with the Congress in communicating these facts that the unchanged amounts for TANF distributions and together with the caps, statutory caps, indirect cost recoveries, is becoming an emergency in our communities.

C: (Norris Cochran) Thank you. This is a very important point, and one I will talk with Doug Steiger about. Doug is a counselor to the Secretary and he may in fact be on today's agenda, in which case we can all engage with him. He has a lot of direct interaction with the congressional staff, particularly around TANF.

C: (Leonard Harjo) One of the things we run into in the IHS budget, and the disparities within the budget itself, with respect to behavioral health and some of the issues that are raised when you have alcohol and substance abuse, when you have a need for suicide prevention, these areas

are significantly underfunded in comparison to some of the others given the magnitude of the problems that are starting to emerge in Indian Country.

At least in Oklahoma, the state has withdrawn from those areas of providing inpatient services. We have not been able to respond with an increase in the number of beds. We would urge that as you look ahead for future budgets, take the opportunity to consider those areas of need.

C: (Norris Cochran) We are hopeful both for the investments in IHS as well as the companion piece within the Substance Abuse and Mental Health Services Administration (SAMHSA), that we can get them enacted — we acknowledge that it is a down payment and won't meet all of your needs but we are hopeful that we can get those increases, and this year is a starting point.

Centers for Medicare and Medicaid Services (CMS)

Mandy Cohen, Chief of Staff, CMS

Kevin Counihan, Deputy Administrator, Center for Consumer Information and Insurance Oversight (CCIIO), CMS

Vicki Wachino, Acting Director, Center for Medicaid and CHIP Services (CMCS), CMS

Lisa Wilson, Senior Advisor, CCIIO

Kitty Marx, Director, Tribal Affairs Group, CMS

The strategic plan for the CMS Tribal Technical Advisory Group (TTAG) makes recommendations as to how CMS can best support tribal activities. As Mr. Allen mentioned, the plan has recommended support of about \$7 million in funding to support a variety of goals and tasks, including tribal consultation, long-term care services, working with the Center for Medicare/Medicaid Innovation and working with the Center for Insurance and Oversight. Although CMS staff members can't always get what they want, the strategic plan recommendations assist in developing budget requests, said Ms. Marx.

Presenters for CMS also provided these highlights:

- The most recent expansion approval was at the end of January for Indiana. Many states where tribal communities have a lot at stake have been interested in expansion but there have been some legislative challenges.
- Staff members are working on proposed rules modernizing managed care regulations, which haven't been updated since 2003. Also on tap: updates for beneficiary protections and regulations to implement requirements around mental health parity in Medicaid and CHIP.
- During open enrollment, about 11.7 million people signed up for health care.
- As of March 13, CCIIO received a total of about 237,000 individual Indian tribe exemption applications. Staff members have processed more than 90 percent of those.

- A joint TTAG/CCIIO workgroup could talk in more detail about focusing on such specific issues as exemptions.

Questions and Comments

Q: (Gloria O’Neill) A couple questions: American Indians/Alaska Natives have to verify Indian status in order to qualify for certain provisions such as special enrollment periods and cost-sharing reductions. Tribes have previously requested that CMS incorporate the IHS active user data into the national data hub so that Indian status can be verified electronically. TTAG has recommended that CMS utilize the IHS active user data for electronic verification of eligibility for the ITU exemptions.

Can you provide an update that would prohibit the IHS active user database to be used to verify exemption status when applications are filed through the Marketplace?

A: (Lisa Wilson) Now that we have this option for folks to just use the 1040 form to check a box on their taxes, it certainly is a much more expedient and efficient process. Obviously not quite as efficient as just an automatic, but certainly the onus nature of it is not quite to the same level as having to file an application. Is the recommendation still to try to put together a verification system because obviously that takes resources and time both on the staff side as well as the IT side.

Q: (Roger Trudell) When I was at the Region VII/VIII Consultation in Denver, one of the Region VIII tribes brought up — I would call it an unfunded mandate I guess, the way I think, about tribes having to provide insurance to their employees. Yet tribal members are exempt. So there seems to be a little ambiguity in that. I believe it was Northern Arapaho. So if anybody has an answer for us, I hope you can get it back to Region VII and VIII and share it with the tribes.

The tribes that do not have a lot of resources and yet would have to provide insurance to employees puts them between a rock and a hard place.

My second question is as a disabled veteran, my notification was you don’t have to do anything. You are already covered. And then as a senior citizen, I have Medicare. And as an Indian, I am exempt. So could someone explain that process to me?

A: (Lisa Wilson) Basically when you go through the tax form, you have multiple ways to show that you either have minimum essential coverage. Or if you wanted to, you could also check the box on your tax form while you are going through your 1040 forms.

On the other question about the employer mandate, our colleagues at IRS are the ones who work most closely on the employer mandate portion of it. And so certainly we understand treaty obligations and the important requirement that we have to provide health insurance for Indian Country. We have brought it up with our colleagues at IRS but that is basically the status right now.

C: (Kitty Marx) We understand the concern about the employer mandate and how it applies to tribal governments but it really is an IRS or Department of Labor issue at this time. I don't know whether HHS has the flexibility at all since it is within the different departments.

Q: (Roger Trudell) But that does nothing to answer the question for Northern Arapaho or for any of the tribes in our area. Who could bring something to Region VII and Region VIII that says maybe we could have IRS come out and resolve this? Is there something that would be initiated by Health and Human Services that this is very unjust to put an unfunded mandate on tribes, especially tribes that have no resources?

A: (Kitty Marx) We don't mean to be bureaucratic and throw it off on another department but it might require a change in the law. As far as HHS, I think we support and we hear what you are saying, and to the extent that we can work with our colleagues at DOL and IRS — they are aware of the issue as well.

C: (Ron Allen) In regard to the enrollment on Medicaid expansion and CHIP, I think we can show it has been very successful. I think it begs the question of the resources that tribes need in order to help make that happen because we are the ones who actually reach out to our citizens to get them enrolled.

And Kevin, I think we are the ones who at this point are identifying people to work with you with regard to the TTAG CCIIO workgroup, which is a great idea to talk through a number of issues. So we probably need to talk through its merits if we were to go down that trail.

There are a number of issues on our plate we need to resolve. We always know the definition of Indian and its relativity to the family plans is a big issue for us to clarify. The payer of last resort issue in terms of clarification on that issue. And there are a number of issues we have raised in the TTAG forum. We have a lot of issues we need to resolve in terms of making ACA work for the tribes.

Making sure that the insurance plans include our communities in a meaningful way. We have asked you about monitoring in a way that shows whether or not — is it just on paper or is it implementation? There has got to be a way for us to start doing that, No. 1. And then No. 2, what can we do about it when it is not being respected or honored by the various plans that are out there?

C: (Vicki Wachino) Since we met, we have started a process of going back, and as you know we evaluated our outreach and enrollment grants. And so we are internally reviewing the successes of those grants generally and with respect to the tribal grants as well to look at what role do they play in helping to promote enrollment? What value do they play for the tribal community to see what data we can marshal around the effectiveness of those efforts so that we can synthesize that experience and share with you and people making funding decisions — what it really means for tribal communities.

C: (Ron Allen) I appreciate that. Which reminds me, we said that we wanted to follow up with the key budget folks in CMS who are responsible for advocating for these resources for the tribes.

Q: (Aaron Payment) How do you know how many American Indians are signed up, and based on what methodology, if you could explain that. You also just gave us a number of those who have applied for exemptions. How do you know they are American Indian?

C: (Lisa Wilson) You may have noticed that we do publish AI/AN data by ethnicity. But it is an optional category that folks can choose. I think it was about 30 percent of the folks this year did not fill out any race or ethnicity — of the total number of people who applied through the Federally Facilitated Marketplace, chose not to supply that because it is an optional category.

There are other ways that we can look into the American Indian/Alaska Native (AI/AN) status. We have been working with our colleague Niall Brennan to sort through some of this because AI/AN are eligible for free or reduced cost sharing. Then we can look at some of those plans that they may qualify for and do some research into that area. So we know that has been an ask of the TTAG.

C: (Kitty Marx) In conjunction with the February 18 TTAG meeting, we did have a data symposium, and Niall did report some numbers, the numbers — as Lisa indicated, a lot of people don't check the box on race/ethnicity but we are able to track the numbers based on who enrolled and qualified for a zero cost-sharing and a limited cost-sharing plan. And I think some of those preliminary numbers were about 28,000 American Indians/Alaska Natives enrolled in the Marketplace. About 24,000 enrolled in the zero cost-sharing plan and 4,000 in the limited cost-sharing plan. So those are just preliminary numbers right now.

C: (Lisa Wilson) You asked about how do we know. So when you go through the application, as folks are aware, you get to a place where it asks if you are American Indian or Alaska Native, and then it goes through a series of questions. One of the things that it asks you for is to upload documentation. Or you can send it in later. Our contractors go through it and if they have any questions, they refer it to our folks. So there is a verification process.

C: (Aaron Payment) So my follow up is — so without having resolved the issue of the definition of Indian, the potential exists for a whole number of people who might be interested in signing up who aren't signing up because it doesn't extend to the more liberal definition of who is Indian, which is the two generation basically below the registered member.

So that is of concern. And also when we talk about checking a box, just so you know — I don't know if you guys know this but there is a derogatory term that has been used toward American Indians, and it is box checkers. So we have our people who are enrolled members of our tribes. One of the backlashes from some segments of our own population to people who registered somewhere down the road who may not be identified Native or the blood quantum might be very low or whatever, that term box checker came up as a derogatory term against them.

One other thing is obviously there is a need for — and maybe the Health Research Advisory Council (HRAC) could provide some advice on this in consultation with other groups. I am finishing up my doctoral degree, and I am hyper critical of everything. In looking at the rates of graduation for Native Americans, they rely on the National Center for Education Statistics.

They use U.S. census information, and the problem is that they use basically sampling and they use survey information and self-report. And there are other studies that have shown that undercounts by about 5 percent. So the dropout rate is actually 5 percent worse than what they are reporting.

And so any time you use self-report, you are going to enter into a problem. And so we need to identify some way to verify — first of all, define who is Indian and who is eligible. And then some way for a verification process to include either not an enrollment number but something where tribes are participating in this process. I think there is a further rich discussion that has to happen on the data collection and analysis.

One final thing: The employer mandate — it was looked at kind of as a surprise from tribal leaders. Tribal leaders are mostly on board with the Affordable Care Act and we support it. The tribal exemption for employees is something that crosses over into potentially piercing our sovereignty. I think that is where there could be a departure in the support of the Affordable Care Act.

C: (Ron Allen) I want to continue to raise the question or the request that we made with regard to the call center. We still have concerns over its effectiveness when our tribal citizens call the call center and the call center's capacity to understand the Indian issues and options that tribal members inquire about.

Our suggestion is to require a separate 800 number for AI/AN's. This could be an easy collaboration between you and IHS to have somebody man an 800 number so that when they call in with regard to questions, they will get better answers.

C: (Kevin Counihan) I know we did talk about that last time. Maybe that is one of the items we put on a joint workgroup session and talk about how that could get realized.

C: (Ron Allen) If you could get IHS to be engaged with us on that, that would be helpful.

Q: (Gloria O'Neill) There are conflicting interpretations of the statutory provisions in Section 1402 of the ACA, the special rules for Indians, and the regulation requiring that cost sharing is only available for those who qualify for an advanced payment tax credits.

Advanced payment tax credits (APTCs) are only available for people between 100 percent and 400 percent of FPO. As a result, AI/AN below 100 percent who do not qualify for Medicaid in non-expansion states and should qualify for zero cost-sharing below 300 percent are being charged full cost sharing because they do not qualify for APTCs as required by the regulations.

Can CMS provide an update on how this issue will be resolved for our population?

A: (Kevin Counihan) It is a point we understand and it is a point we are still looking into. It is complicated.

Q: (Gloria O’Neill) Do you have a timeframe when you think you might have some resolution?

A: (Lisa Wilson) It is certainly something we are working on with our colleagues. I am not sure.

Q: (Kevin Counihan) We have got to get back to you with a timeframe.

Q: (Gloria O’Neill) So could we get a response by the next STAC meeting?

A (Kevin Counihan) We will have an update by the next STAC meeting.

C: (Rex Lee Jim) The Navajo Nation Medicaid feasibility study has been done, and stated that the Navajo Nation could run its own Medicaid agency. We need your assistance, technical assistance, on how to start that up, how much it would cost — the whole process of how to approach Congress and so on.

C: (Kitty Marx) Yes, a report to Congress was submitted by CMS in June of 2014, and the study indicated that it would be feasible for Navajo to operate its own state Medicaid agency. And that report was sent to the Senate Finance, Senate Indian Affairs, House Energy and House Resource. So the study did indicate that it would require legislation and perhaps appropriations. Maybe I can follow up with you, Vice President, and we can talk to our office of legislation to see what type of technical assistance we could provide.

C: (Ron Allen) To try to kick this can down the road on this workgroup, we are throwing out the idea that — a list of issues that we could discuss so we could have a tentative agenda. The QHP contractors, the access to data, outreach and education issues, and the call center are four issues that quickly come to mind.

Indian Health Service Issue Discussion

Robert McSwain, Acting Director, IHS

Contract support costs were the major highlight unveiled in the President’s 2016 budget, said Mr. McSwain. IHS staff members sent out a Dear Tribal Leader letter on February 9 to solicit comments and consultation on the proposal in the budget. So far there seems to be wide support. The effort serves as an incredible lift for the agency, which has analyzed 1,300 claims and extended 1,232 settlement offers. Overall IHS has settled a total of almost \$700 million.

Mr. McSwain also covered these issues:

- Regarding facilities, the Federal Appropriations Advisory Board is looking at preparing for and putting together a report to Congress that is due in about a year. The biggest news in the facilities area has been the success in the joint venture program. Three programs

remain on the initial list of ten that the board is working on. Those three will begin work this year.

- In terms of the Resource and Patient Management System (RPMS), Meaningful Use Stage II has proved to be a bit challenging. IHS is still ahead of the other federal agencies, however, and has implemented the new software in many sites. The problem is getting ready for the direct services piece — the ability to share records, the ability for a patient to get a summary of a record off a Website and the ability to e-mail doctors. These changes have been problematic for most systems.
- For IHS, sharing Native patients' data requires agreements to protect that data. Policies and other things must also be in place to ensure data security. IHS plans to send out communication about an agreement that every site has to sign to be able to share that data.
- Yet another challenge: Other Exchanges set up in states that IHS sites must connect to, a change no one anticipated in the original plan for sharing records. As a result, IHS must do more software development. Staff members at IHS and HHS continue to work hard to meet these requirements.
- During the past open enrollment, IHS scheduled outreach events and Days of Action to educate and encourage tribal communities to sign up for affordable health care.
- As part of its memorandum of agreement with the Veterans Administration (VA), IHS has received nearly \$18 million in VA reimbursements for the care of 4,800 veterans. As it continues its work with the VA, IHS will team up with the U.S. Department of Housing and Urban Development (HUD) to focus on homeless AI/AN veterans in rural and urban areas.
- 2015 Directors' Areas Listening Sessions have begun, many in conjunction with regional tribal consultations or other meetings. Tribal delegation and urban delegation meetings with IHS have been taking place as well.
- As part of the Baby Friendly Hospital Initiative, 13 of the federal sites have achieved baby friendly hospital status. All babies born in these facilities undergo skin to skin immediately upon delivery and then are only breast-fed, which lowers the risk of children developing diabetes or asthma and helps control obesity issues.
- IHS has sent 14 officers to Africa for one final burst of activity as the Ebola outbreak winds down. IHS also has done an internal deployment, sending commissioned officers to help with the suicide cluster at the Oglala Sioux Tribe.

Questions and Comments

Q: (Brian Cladoosby) On the issue of meaningful use, I heard Dr. Roubideaux say that some won't be meeting the requirements in 2015. Will IHS be one of those? Will IHS commit to meeting the meaningful use for 2015? And I know that the personal information — that is a big issue. Is the technology in place in RPMS if the tribal agreements are signed? And No. 3, Dr. Roubideaux, I know you are in purgatory right now. So maybe just an update for the STAC on exactly where you are at today.

So Mr. McSwain, is there going to be a commitment on that?

A: (Robert McSwain) We are working hard on it but we are also very aware that given the requirements that have been laid on us, we could have some failings to meet them.

Dr. Roubideaux is working diligently on some fixes at some level to help us. There are a lot of little pieces to it: The interoperability piece is critical. The personal communication is another piece of it.

A: (Dr. Roubideaux) The IT people at IHS are doing everything they can to try to help sites meet those requirements. The problem is there are new requirements this year and complications with those new requirements that are out of IHS's control. The sensitivity of Indian data being put out into these Exchanges and exchanged with other hospitals, it is important for clinical reasons but it is also important that we protect that information.

We don't have a penalty this year for not meeting it but in future years we could have penalties. The fiscal year 2016 President's budget has a \$10 million increase proposed to help us pay for not only completing these requirements but meeting Meaningful Use III.

So the 2014 certification software is available and has been implemented in most or all places — pretty close to all places. It is just a matter of making it functional and getting the policies in place so we actually can use it.

And the purgatory question — I am not in purgatory. That would be a bad thing. So the situation with me is in February the Department called me and said, you know what? Someone was looking at appropriations language and they found this rider on a 2009 bill that says that after you have been nominated twice and your nomination has been returned to the Senate, you can no longer serve in the acting position until you are confirmed if you are still in consideration for the nomination.

So it turns out that applied not only to me but to like eight other people in the federal government. So I am grateful for Mr. McSwain stepping up and agreeing to be the acting IHS director, and the rest of the team for all they are doing to help with this. My re-nomination is in progress and the Administration still does support me for the position of the IHS director to be confirmed.

I am testifying on behalf of the Secretary on the budget, and we really need your help. This is a great budget but it is a difficult budget year. We support the goal of full funding for mandatory CSC. So we need your help with Congress to let them know you like this proposal or you want to work on getting it right so we can get it passed.

Q: (Arlan Melendez) I just want to point out, going back to the meaningful use thing, the system is really working hard on another piece. Everyone knows ICD 10 is standing up. We are on track, and the other part of it is there are questions going on about, well, what if my bills are set in ICD 9 and then we have the 10 cut over. It will be a sharp cut. Dr. Karol, do we have an answer on the ICD 9 so bills are going forward? Will they be completed and not get lost?

A: (Dr. Karol) I have inquired to Commander Reeves. I do not have an answer yet.

C: (Ron Allen) I am assuming that IHS is working hard at communicating and providing training. Many of us are well aware of that transition and the importance of dotting I's and crossing T's and making sure that it doesn't interfere with the reimbursements.

An ongoing agenda item has been for many of us who have different — we have Epic — different kinds of electronic recordkeeping systems, to be sure that they communicate. We need to reconcile that issue so we communicate well.

The second point on the meaningful use initiative, many of us are just under the qualification. We raised this issue in Region X and we have talked about it in TTAG as well. The meaningful use incentives that we should be eligible for, it is a numbers game. They have got this hard number, and if you are close but not quite close enough, you don't qualify. In my judgment, tribes should be eligible. That hard number, in terms of the qualification — there should be a waiver approach or some other technique so we can benefit from the incentive as well.

Q: (Dr. Roubideaux) Are you talking about submitting your data to National Data Warehouse or are you talking about us sharing records?

A: (Ron Allen) I think it is both.

Q: (Dr. Roubideaux) So on both things, the new interface for all the other systems to be able to communicate with IHS is in progress but close, right?

A: (Dr. Karol) Right, it is being beta tested right now.

Q: (Dr. Roubideaux) And then the issue of us — interoperability, sharing records, so if a patient from Arizona goes to a clinic and you can see the record, that is the interoperability piece of meaningful use. That is the issue of needing to get these agreements in place and protect the data and then use the software to develop the exchange and be able to exchange the records. That is the one that is tough for us in '15 because of all the policy work and protections of the data. It is going to happen eventually but whether we can get in place for some but not all in '15 I think is an issue.

C: (Dr. Karol) We are hopeful that everyone will make it in '15, especially with the new regulation coming out this week. Rather than being a full year of testing, it will be 90 days of testing. So we are scrambling to get it done by October so the next 90 days, everybody will have that opportunity and will meet Meaningful Use II implementation.

Q: (Gloria O'Neill) Some tribal organizations have raised concerns regarding the transparency of the Joint Venture Construction Program. Can you explain the JVCP selection process and how those who are not selected are notified of why they were not selected?

A: (Robert McSwain) I believe all of the applicants were notified. Either they were selected or they were not. In fact, the ones who were selected moved to the second level — and when I say

the second level is when they actually submitted their proposals. And those were rated and ranked, I believe.

Q: (Gloria O'Neill) Could you explain a little bit about the selection process?

A: (Robert McSwain) The selection process is done by using criteria that we have for a normal facility, I mean a regular facility construction process. We score them and there is a series of scores. If you go on the Website, you can see the criteria. That part of it is transparent. What criteria we will actually use, it is the age of the facility, the population to be served, and so forth. And the remoteness and all those factors come into play for that first, and then you are invited then to move to — when the prospectus comes in, then you are invited to come to Stage II, which is the final stage.

And I think we moved 37 through that process, and then ultimately selected the top group. And we look at like the top 10, and then we actually then just invited the top 3 because our experience has been — and they were all notified. They should have been all notified. If you have one that applied, then I need to know.

C: (Gloria O'Neill) We will get you some of that information.

C: (Robert McSwain) Because everyone was notified if they were — and the ones who were notified to begin construction and begin the final planning documents, and then we wind up then signing a joint venture agreement for them to proceed.

C: (Dr. Roubideaux) One thing it is important to know is the first pre-application phase was based on objective factors. Then it got screened down to 13, and it was a tribal/federal workgroup that actually reviewed the final 13. And then they scored those applicants and then the final decision was made by the agency. And then there were technically 7 that were likely to move forward in the next few years. And the other 6 were told that they would serve as alternates in case people fell out of the top 7 because often things can get delayed. But only 3 were told this year that they definitely would move forward because IHS does it year by year based on appropriations and constructions schedules.

Q: (Gloria O'Neill) My second question is about Medicare-like rates for IHS. And I understand that in December 2014, IHS issued a proposed rule to require Medicare-like rate payment for Purchased/Referred Care for nonhospital base care. Can you please give us an update on the proposed regulations, and what steps is it taking to ensure the regulations will contain sufficient enforcement provisions and not diminish current congressional efforts?

A: (Robert McSwain) We did issue it last year, and we have received a little over 50 comments from folks basically support it. And there were several that supported it but with comments about flexibility.

And so we are looking at a number of those right now, and proceeding to move along. Enforcement was not in the regulations. That enforcement provision — obviously we are doing it

administratively. The particular bill that was introduced would provide legislative enforcement. Our regulations do not have enforcement.

C: (Dr. Roubideaux) The strongest level would be tying the use of the rates to Medicare participation but that would require the statute to be amended, so that requires a legislative fix. So that is why last year the bill was introduced. I haven't seen it reintroduced this year but we are expecting it would be because tribes still support dual track. And that is why IHS did the Notice of Proposed Rulemaking as tribes told us we want to try every option.

And so it is meant to be a concurrent process of working on the legislative option, which has the stronger enforcement, but in the regulation, you can't amend the statute in the regulation so the only way — the Notice of Proposed Rulemaking was asking, how do we make this as strong as we can. And so we made it as strong as we could administratively. But asked — this might be too strong because people might drop out and not want to work with us.

So that is why it is good to hear there were comments about wanting flexibility because that could help make this work.

C: (Arlan Melendez) I wanted to go back to RPMS. As you know, I brought that up last year, I believe, on the importance of having an IT system. And I know that it was mentioned that there was \$10 million that is going to be used to try to do something with upgrading the system. And as I mentioned before, IHS is like a business. If you don't have an IT system that is working, then either you have to scrap it or either you have to put a substantial amount of funding into upgrades. And \$10 million, I don't know if that is going to do anything.

And the other thing is I think we have to know — I think Ron asked about communication with the tribes as to assessing whether or not things are working at the tribal level, whether or not as direct service or compacted/contracted tribes as to how the RPMS system is working.

I mean, it almost sounded to me that we needed a complete assessment on RPMS just like we would assess our own computer systems on our respective tribes. What are the ramifications if we fail to meet meaningful use? What is the downside to the tribes?

And this is a document — I think I read it on an IHS report and it said something about RPMS: IHS sent out an update letter and requested comments on RPMS. This is on October 30, 2014. It has about 10 tribes listed here. I asked my health director, did we receive something that asked our input since I am the one raising it to an extent. She said no. So was it just these tribes? I am still looking for the letter that asked for assessment or input on that.

I know that IHS has its own IT component, its own internal workgroup but I would think if it is an issue to all of the tribes that we would have a technical workgroup specifically that was tribal and IHS that would address this issue.

C: (Dr. Roubideaux) The letter that you mentioned was a letter to all tribes, and so it should have been mailed to you and also was posted on the Dear Tribal Leader letter. If it didn't get to you, then we are happy to receive comments on it.

There also was a survey done, like a customer survey, on RPMS actually because of the comments that you made at the last meeting. So maybe Dr. Karol can tell us a little bit about the result of that survey. And we do have a federal/tribal workgroup, the Information Systems Advisory Committee (ISAC), and they do meet regularly. And there is probably a Phoenix Area representative that we can connect you to.

C: (Dr. Karol) I would just like to say I am happy to discuss the survey with you a little bit more. The ISAC has been working aggressively on the concept. Commander Reeves is presently sending out another informational letter for RPMS to again address with you the improvements that we have made, the meaningful use issues, the ICD10 issues, so that there is additional time to comment. That letter I believe went out last week. There has been a survey done in the recent past. We can dust that off and get it to you.

C: (Dr. Roubideaux) And back when you made your original comments, we did ask the IT people to reach out to your staff. And so we want to know if they actually did that, and if they didn't then we want to follow up.

C: (Dr. Karol) And I have encouraged my ISAC committee that they are representing the 12 areas and that they need to report back to the tribes in their areas too.

C: (Arlan Melendez) And my further comment is it is not just the system itself. The issue has to do with the manpower behind the system. I know that in the Phoenix Area, we have one person down in the area who is supposed to be the expert, and all of the tribes are trying to get that person.

So when I look at a system, the people who train at the tribal level, that is part of the whole issue here. So if there are not enough people who are helping the tribes to train them on whatever you are trying to do to implement changes or upgrades — you know, all these different patches and all the things you are talking about, you know, then there are two parts to this. There is the system itself that is not working and then there is the amount of technical assistance down to the tribal level that seems to be not there.

C: (Dr. Karol) I appreciate your comments. In the Phoenix Area I believe there are six individuals at the area but I will check on that and get back with you.

Q: (Gloria O'Neill) Regarding the project process — what you went through, and it was objective on the first phase and the second phase you had a group that came together to sort out the top proposals — I would like to know how that group is put together and also who the group represents. And if you have that — do you have that on a Website or could you send me that information?

A: (Mr. McSwain) Sure, we can put together the process as Dr. Roubideaux and I explained, not only the process but the pieces to it.

C: (Brian Cladoosby) I think Arlan mentioned this a little bit about meaningful use, if it is not being implemented, making sure that tribes be held harmless from any penalties.

Intradepartmental Council on Native American Affairs

Lillian Sparks Robinson, Chair

Commissioner Robinson addressed these issues during her presentation:

- **Data sharing:** ICNAA is in the process of conducting a data inventory to improve the coordination of data reporting and collection across different program offices. Staff members want to get a better understanding of what they are asking for in each of the operating divisions. These efforts also include developing strategy for the collection and analysis of all the data received.
- **HHS Tribal Consultation Policy:** Staff members want to expand upon what is existing in the policy with regard to supporting tribal access to state and local data. What are the other data systems available for tribes to use, and does ICNAA have any room to expand the Tribal Consultation Policy to address that?
- **Data focus group:** Staff members are looking at coordinating with the tribal/state initiative, a subgroup of the STAC, to solicit feedback and create a long-term strategy for data collection/data reporting. Staff members also want to develop an overall HHS strategy for HHS program data to eliminate tribal reporting duplication.
- **Tribal Grant Application Data:** Federal partners don't collect application data consistently enough throughout HHS to report on a department-wide basis whether or not the grants matrix has impacted or increased the number of tribal applications received. Staff hope to do a better job of tracking how many tribal applications come in and whether the numbers are increasing or decreasing.
- **Grants reporting/training:** ICNAA has established five focus areas:
 - Improving and increasing grants training
 - Developing a tribal grants Webpage
 - Identifying best practices for the grant review process
 - Maintaining and updating the grants eligibility tool as needed
 - Identifying best practices in grants technical assistance
- **State/Tribal Relationships:** The Tribal/State Relationship Group, which had become a bit inactive, is taking another look at issues such as these:
 - Identifying which agencies have the authority to mandate or promote consultation between tribes and states.
 - Determining whether agencies have policies to require or promote tribal consultation.
 - Assessing best practices for tribal/state consultation requirements across the Department.

Through this department-led initiative, staff hope to recommend creation of uniform HHS training materials for states on tribal consultation as well as a term of award for states to notify the tribes that there is a Tribal Consultation Policy required. The final result will be language that tells states they must have a tribal consultation or demonstrate that one has occurred when they receive funding from HHS that includes services to tribes.

- Self-governance: ACF continues to look at its Tribal Early Learning Initiative (TELI) as a possible model to assess how tribes can combine early childhood programs, similar to how things are done with regard to self-governance, with programs working together. Staff members remain open to conversations on ways to promote the goals of self-governance within the grants context.

Questions and Comments

Q: (Tino Batt) Do you have a timeline of how we can see the results of the grants matrix and whether tribes are receiving or having access to those grants — you know, measuring that?

A: (Lillian Sparks Robinson) We have not developed a timeline for that particular deliverable. And I believe we will have to work with several offices that will help us figure out, you know, how they collect information and what they keep with regard to who actually applies. But that is something that we will take up at our next ICNAA meeting. The ICNAA has three in-person meetings for the council and then liaison meetings that meet a little bit more frequently.

Q: (Tino Batt) Would it be possible to have tribal leaders provide input in meeting with ICNAA during those meetings or do you foresee bringing that information back here to STAC?

A: (Lillian Sparks Robinson) So the ICNAA is our internal committee and it is made up of the heads of all of our operating divisions and our staffing divisions. And it is statutorily created and established. And so what we are hoping is that the STAC works in partnership with the ICNAA versus tribal leaders sitting on the ICNAA.

What we can do is take a look at how we might be able to have the STAC present information to ICNAA even though a lot of the ICNAA members certainly come to the STAC meeting and sit around the table and hear from you directly. But we can work with Intergovernmental and External Affairs to figure out how we might be able to do a better job of the ICNAA having a sense of what the tribal leaders' request. We do have a STAC update at every ICNAA meeting. Paul Dioguardi typically delivers that for us.

A: (Roger Trudell) Could you explain a little bit more about the self-governance expansion, what you are hoping to gain there?

Q: (Lillian Sparks Robinson) Sure. So there was a 2003 feasibility study that took a look at several programs across the Department with regards to how self-governance can be expanded outside of IHS. And so they looked at several ACF programs, including Head Start, TANF, child care, I believe some of the community service dollars, and I believe some of the child welfare programs as well. They looked at one program at SAMHSA and they looked at aging programs. I believe there were two at aging they took a look at.

And so the report developed several recommendations with regard to whether or not self-governance could be expanded into these grants programs, understanding that these programs are administered a lot differently than IHS. Where IHS provides direct services, these

are actual grants, where the tribes or the grantees already administer these programs at the local level.

There were several recommendations that came out of that report but there was also language that said we did not have the authority to move forward on any of these recommendations because we didn't have any demonstration authority.

A workgroup convened about 2 1/2 years ago and worked for a year with regard to taking a look at some short-term and longer-term strategies, helping to prioritize the programs that they would like to see move forward. There was an impasse and then the workgroup was not convened after that year. A report was developed that laid out these priorities:

- Reallocation
- Redesigning
- Reprogramming, and
- Reduced administrative burden.

And so we were then charged, each of our agencies — ACF, SAMHSA and the Administration for Community Living (ACL) to go back and take a look to see whether or not we would be able to promote these priorities within our existing authorities under any of our programs. And that is where we are now.

A letter was sent out to tribes requesting that they meet with their agencies individually to discuss next steps. And so in the meantime we have been doing internal briefings at ACF to say, this is what tribes are asking for, so what is it that we can do?

And we have been looking at the Tribal Early Learning Initiative, which is a combination of home visiting programs, child care programs and Head Start programs, and there are four tribes now that have piloted that initiative. We are still soliciting feedback about what else we might be able to do.

Q: (Roger Trudell) I was wondering, because it seemed like the food program people have a letter out requesting the tribes' capabilities to be able to contract or provide those services that are not currently being provided by tribes. Does that kind of fall in the same thing? I am not a self-governance person. I know self-governance give you a certain amount of flexibility I guess to move things around. And I was trying to think how you apply that concept of self-governance to grant programs or — because first of all you have to be a recipient of the grant. And do you have kind of that flexibility anyway when you get that grant?

A: (Lillian Sparks Robinson) So I think what you are saying is a lot of what the conversation had been during the workgroup: tribes are already administering these programs through the grants, and that they are, in some instances, discretionary and so a lot of it is dependent upon the budget, and that these are grants that everyone is able to receive.

A lot of the conversation is well, what do we mean with regard to self-governance when we are talking about grants as tribes are already administering a lot of these programs. It has not been defined, and that is what we were hoping to do within the workgroup: So what do we mean about self-governance outside of the ISDA model? We have to take a look at, in the context of grants, what is it that we are asking for?

C: (Jefferson Keel) When you talk about self-governance, going back to the creation of the workgroup and the abbreviated tenure of the workgroup — it stopped because, as you said, there was an impasse. And I think it was the fact that the tribal members that I have spoken to, and from my perspective, I will speak for myself, I didn't believe there was sufficient support from the Administration or from the agency to continue the discussion. And so therefore it died.

It appeared that — and as best I recall, the last meeting that I went to was in Denver. And at that time — prior to that we had made some progress, I believe on what we thought were some recommendations on moving forward with the self-governance initiative and possibly even creating a pilot program or some type of demonstration project.

But then some attorneys came in to the room and suddenly the complete attitude of the discussions changed and from that point it was kind of over.

From my perspective it was very frustrating because I thought we were making some progress, and then to see there was no interest being demonstrated or displayed by the federal agencies or the federal partners at that point. And I don't know what was said in the discussions with your legal folks but I do know we had our attorneys present, and they understand how the laws are written. So it just seemed the discussions, they just broke down. We have been adamant, tribes have been adamant about moving forward. We have not given up because we believe that self-governance is the way of the future.

Tribes have proven that they can do more with less than the federal government because we are closer to the communities. We can develop the priorities and deliver the services better with more efficient results.

The question was what can we do and how can we continue to move forward outside of creating another workgroup. I think we need to have this discussion with the Secretary and not just the Operating Divisions. We need to lay out our concerns and then let the Secretary make a decision as to what direction we want to continue to move.

I think we could satisfy a couple things. First of all, we could change this perception that the agency just doesn't care to move forward with self-governance. And that is my perception. And I think we can change the complexion of all of these discussions and really find a way to move forward.

C: (Lillian Sparks Robinson) I definitely want to let you know that from the perspective of ACF, and Mirtha and Cynthia can speak for their agencies, that we are very interested in moving forward but we are looking for guidance.

So two things: One, we are not necessarily certain about what the next steps are because again we are entering a new realm. We are talking about grants so we can't turn to ISDA to help us figure this out. And two: We don't want to press forward on what we think it could look like without the tribal input. So we are still looking for that feedback.

With the workgroup, what we could not do was work on legislation. And I think that is where the conversations had to stop at that point. I agree with you at that point there should be interpretations that are read in favor of terms of how to move forward, and that is probably one of the biggest things.

So we have pored over the statutes that are authorizing to see where there could be any room for us to be able to do a demonstration program. And unfortunately we just could not find that.

C: (Jefferson Keel) When we first started, we all went in with the idea that we could make something happen. But I understand the bureaucracy that is involved here too. The difference between a bureaucrat and a leader: A bureaucrat says, hey, here are the rules. We can't help you. A leader will say, here are the rules. Let's see if I can help you. Let's find a way to resolve this for the good of all of us. So that is all we are asking for is some leadership.

C: (Lillian Sparks Robinson) That is the goal. We do want to be able to come here and say, yes, this is what we are able to accomplish. But we need your feedback as well. We have to figure out a way for us to sit down. I think maybe with a few folks, and we will work with IEA — and I can only speak from the ACF portion, with regard to folks from the STAC who are interested in having a longer conversation about this.

Substance Abuse and Mental Health Services Administration

Pamela Hyde, Administrator

Kana Enomoto, Principal Deputy Director

SAMHSA covered three topics for the committee members: brief updates, a video on the recent Native Youth Conference and a discussion on historical trauma.

Leading the discussion on trauma, Ms. Enomoto noted that the issue is part of a cross-collaborative effort to address violence and the criminal justice system. The issue of trauma also affects health and chronic disease. Addressing historical trauma with the STAC gives SAMHSA an opportunity to discuss the subject with other HHS departments.

In October 2014, SAMHSA released its national working definition for trauma and a trauma-informed approach: Individual trauma results from an event or set of circumstances that are experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting, adverse effects on the individual's functioning as well as on their mental, physical, social, emotional or spiritual well-being. It is:

- An event,
- How you experience it, and then
- The effects.

First contact, federal policies, geographic relocation and boarding schools are common traumatic events experienced by tribal communities. Through its strategic initiative, SAMHSA continues to develop a framework for community and historical trauma as well training materials, data and screening tools. The Department also is aligning its technical assistance and training in supporting work on trauma throughout its grant programs. Those funding opportunities include:

- The Tribal Behavioral Health Grant Program: This new program targets the prevention and reduction of suicidal behavior and substance abuse. It also promotes mental health among young people and supports efforts to address historical trauma.
- The Circles of Care Program: This is SAMHSA's longest running grant program specifically designed for tribes. To date SAMHSA has awarded \$49 million in Circles of Care grants, which focus on developing culturally competent systems of care for children's mental health.
- Tribes have been successful grantees in the Children's Mental Health Initiative, which supports the development of comprehensive, community-based systems of care for children and youth with serious emotional disturbances (SED) as well as their families. That funding supports mental health and related recovery support services to children and youth with SED, including work around trauma for the family and the individual. A funding announcement is available now. Applications are due April 10.

Other details from SAMHSA:

- SAMHSA is working with CMS and IHS on a webinar regarding the Institutions for Mental Disease exclusion. The webinar, which will occur in May or June, will help tribes clarify what can be funded in a facility-based program.
- STAC members also received an HIV/Hepatitis C handout specifically for tribes.
- Federal partners continue to seek input on a framework for a national tribal behavioral health agenda. Working with IHS, SAMHSA will offer a series of listening and consultation sessions. SAMHSA also will team up with the Department of Justice (DOJ), DOI, HUD, Department of Education and Department of Labor.
- Dr. Marcella Ronyak has come on board as the director of the Office of Indian Alcohol and Substance Abuse.
- A tribal call took place in November to announce the funding for state pilots for Certified Community Behavioral Health Centers. Staff members are now developing and revising the draft certification criteria. States will use the final criteria to certify clinics, and SAMHSA wants to ensure that tribes are eligible to become one of those clinics. Eight states can participate in the initial demonstration project.

- The Tribal Technical Advisory Committee has primary vacancies in the Phoenix and Billings Areas as well as several open positions for alternates. TTAC will meet April 15-16 at the SAMHSA offices.

Questions and Comments

C: (Brian Cladoosby) People don't understand the physical, mental, verbal and sexual abuse that came out of those boarding schools, and unfortunately a lot of that trauma followed two generations. But we are not victims. We are survivors. Many tribal leaders here have worked hard to break that cycle of historical trauma, and every tribal leader in this room can give you success stories. So thank you very much. This is really good work.

Q: (Gloria O'Neill) I want to hear a little bit more about these community grants that will be going out to states that you spoke a little earlier about. We have a crisis situation in Alaska right now as it relates to our detox services and what is open to the community. In Anchorage alone we only have 12 detox beds. And Cook Inlet Tribal Council is the only provider in the entire city. And we are in a budget situation where we are seeing our local government, because of oil prices, slashing the budget.

When states face these kinds of situations and they don't put the needed resources into the budgets, how can SAMHSA be a critical partner in problem solving with a community?

A: (Pam Hyde) We want to make sure you meet our regional administrator out of Seattle, David Dickinson. He has a background in substance abuse so I think we need to get you in touch with him. We also have new grant programs that might be of use to you as well. The demonstration project I was talking about is a very specific one about certified Community Behavioral Health Clinics. Only eight states will get to participate initially but the idea is for it to go broader if it works.

Q: (Gloria O'Neill) Detox has become so expensive because you have to, according to the National Nursing Board, you have to have an registered nurse (RN) conduct an intake. When you try to have RNs 24/7 in a detox center, it is very expensive. The board is a strong bunch to go up against. This is where SAMHSA at a policy level could really help tribal communities that might serve urban populations.

A: (Pam Hyde) We are looking for those policy-level issues that bump up against the payment mechanisms or other things so we can know where we can be helpful in making that kind of policy advocacy.

C: (Jefferson Keel) We have these tribal programs right now that are anywhere from 14 to 28 days, which is not enough. We really need long-term treatment facilities. There are one or two in Oklahoma but the wait time to get in is anywhere from six months to a year and a half. Another issue is the youth treatment facilities. We are operating one at our tribe now but we simply don't have the resources to treat all of them.

I would appreciate if you look at ways to work interagency with the VA. See what types of programs they have available because we need to look at long-term treatment for not just veterans but for all of our people.

C: (Pam Hyde) There is just not enough money to build every building that needs to be built. We have been trying to look at things. There are programs called Intensive Outpatient Treatment and some other things. But it does require capacity and people who are trained to do the work. We did a policy academy with few tribes and another one is coming up soon. A little bit at a time, we are trying to work with tribes to say, if there is not a building, then what are our other options?

C: (Rex Lee Jim) I would like you to address the issue of co-occurring disorders. That is increasing on Navajo. We would like to know the programs you have in place and the plans you have for more training and sending more qualified people our way.

C: (Aaron Payment) The pedagogy for the U.S. Government's formal policy on education in 1879 was kill the Indian; save the man.

(Slide)

So here you can see the Indian children at the Carlisle Indian School. To some this might look like a very good thing because they are very orderly kids, but if you think about the context and the time, these are Indian children who — their spirits were captured and they were held prisoner at these boarding schools.

I love this notion of the National Behavioral Health Agenda. I would ask that you bring it to the attention of the White House council so we can cross disciplines and departments. The ills of our society came from this experience.

(Slide)

This is a depiction of — when you talk about historical trauma, a lot of people think it is social jargon. But if you go back to the 1800, Durkheim wrote about this. So the issue is normlessness, and the social indicators of that are alcoholism, suicide and transience. Those are also the outcomes of historical trauma.

So this is a continuum. And what is interesting about this is the dissolution of culture that happens as a result, and conformity or holding back onto your culture, all the reports say that what is needed is to embrace culture, to embrace Indian identity, to facilitate the return of that because that is a resiliency factor that will strengthen American Indian children.

(Slide)

This is just a list of the theories that lead to this discussion. This is a legitimate field. Sometimes when you are explaining historical trauma, people's eyes' glaze over. But this goes back to the late 1800s. And the only way to address it is to bring back — and I think if we can strip it in one or two generations, we can put it back in one or two generations if we commit to that.

C: (Ron Allen) With regard to the facilities for youth, substance abuse, we understand your point but I think if programs are made available so that in different regions of Indian Country, if a facility could be accommodated that has a consistent cultural interest and it can be hosted by a tribe that serves many tribes, that is an approach to try to start solving some of these problems.

C: (Arlan Melendez) One of the best programs I ever saw was actually the Community Substance Abuse Prevention (CSAP) programs — I don't know when those were, maybe 10 years ago or something? Those programs created coalitions within the community to address the issues because they are intertwined. When you talk about detention for juveniles, and many times there are not enough facilities for adults let alone juveniles, but every one of those youth in detention, there is something — either they have a substance abuse problem or an alcohol problem or it is trauma. It is a reason why they are in these facilities.

The coalitions went to the grassroots to get buy-in from the communities — from the parents, churches, spiritual leaders, traditions. So they addressed the issue with a road map from themselves rather than saying, oh, the federal government is going to put some program in place for us. The only way we are going to address this is to get buy-in from every parent, every child, the educators. It is a holistic approach to this.

C: (Pam Hyde) We still have grants for community coalitions, and there are a handful of tribes that get those grants. The coalitions must be in existence for six months before anyone can apply so create those coalitions, and if there is something we can do to provide information or support — there is a group that actually works with these coalitions that we can get you in touch with.

C: (William Micklin) When we talk about expanding P.L. 102-477 programs or expanding self-governance or self-determination agreements, what we are talking about — and it hits home here with this program — is solving our problems through our own Native institutions and practices. The more we can do that, the more effective we are.

No one program solves those identity issues. We find that in village to village and community to community, it can be a different solution. So when we have to make things look different to meet use requirements, it causes us to do less. A program where you come in and you tell people don't commit suicide is not very effective. But when we come in and we have language classes and we have ceremonies and we have food and we bring in the elders, it provides the real solution.

When we say, let us have some discretionary authority in the use of funds and free ourselves of some of the restrictions, we are not trying to dodge burdensome reporting or administrative requirements. It is just that the need is so great that the more we can apply to the problem and the less to administration and bureaucracy, the more effective we will be.

C: (Pam Hyde) I couldn't agree more. And we went through two years where we had, as you recall, White House approval, OMB approval, Secretary approval for a program for tribes that was just that. We couldn't convince Congress. So I think what we need to do is talk more about what is the strategy about that.

We got a very small program and then we got a proposal for a larger program, a \$25 million program for '16, but it is a more traditional program — competitive, jump through the hoops kind of program. And even that, Congress will have to agree to. So I think maybe some strategic discussion at some point, maybe in smaller groups, about how we can try to get Congress to understand this a little better.

C: (Elaine Fink) I would like to address the chronic stress and depression that is a contributor to mental health and physical — and this is affecting our youth to our elders. When you get it, you don't know what it is, so you are going to the doctor and you are getting all of these tests done to see what you have. But it boils down to stress and depression.

C: (Kana Enomoto) We have a proposal in the President's budget that called for grants for addressing adult trauma screening and response. How do you help health professionals and other professionals unpeel that onion for people when they didn't go to a mental health professional because they didn't know that was what the problem was necessarily? People don't know the signs of depression or the symptoms of post-traumatic stress disorder.

C: (Leonard Harjo) We have got people who go through substance abuse and all these other things over and over largely because the original, underlying issues that produced the effect have never been dealt with.

Part of it is lack of education on the part of the people around them. One of the things I would recommend as part of the training process is you work with IHS to utilize our prevention network to provide that information. We have got grandparents taking on younger kids. What they remember from raising their own kids, there were things that they as parents were really not aware of. When our community health workers translated those concerns that kids are facing today into the Native language, it changed the discussion among caregivers and among that population about what we need to be doing to address some of these things.

Without the information, it is difficult to educate the community — even some basic things about historical trauma. Event, experience effect — that is not the first thing that people think about, especially when they are dealing with our people. It is just, okay, we will just send you here. It is an alcohol problem or it is a substance abuse problem.

Anything you could do to help expand the education of trauma-related care systems or protocols that are based on trauma, that would benefit our communities.

C: (Kana Enomoto) SAMHSA stands ready to keep coming up with tools and pushing the conversation and making the connections where we can. You as tribal leaders must keep the drum beat going, keep people talking about it, because it is uncomfortable.

Q: (Rex Lee Jim) Would you comment on the programs and training and funding for co-occurring disorders?

A: (Kana Enomoto) In most of our treatment programs, we make co-occurring conditions the norm or the expectation. About 50 percent of mental disorders appear by the age of 14. 75

percent by the age of 24. Substance use conditions tend to have their onset a little bit later. But they are often traveling companions. We had a Co-occurring Center of Excellence in the past. We don't have that now. But co-occurring materials for treatment are throughout our programming, and I think we can make lots of tools available to you.

C: (Pam Hyde) Back in November we held a first-ever Native Youth Conference about behavioral health issues in AI/AN communities. The conference had 200 representatives from about 100 SAMHSA tribal grantees. The event included Native youth, tribal leaders, tribal elders, senate and federal officials. Some of the youth got to over to the White House and talk to the President and First Lady.

We talked about best practices and ways we would support the youth. Out of that came a proposal to do something we are calling STYL: The SAMHSA Tribal Youth Leaders Workgroup. They will be advisors to our Tribal Technical Advisory Committee, which includes Native elders and officials. They are between the ages of 14 and 24, having expressed interest in behavioral health issues. We want to show you a little bit about what happened at the conference.

(Video of Native Youth Conference)

Health Resources and Services Administration

Mary Wakefield, Administrator

After announcing that she will be leaving her position at HRSA to take a different position in HHS, Ms. Wakefield provided these updates:

- Jim Macrae, who will be the acting administrator for HRSA, has a long history with the agency. Mr. Macrae attended the STAC meeting with Ms. Wakefield.
- Recruitment and retention of the health care workforce: Ms. Wakefield reminded tribal leaders of the HRSA programs available not only for the development and training of the next generation of health care providers but also for placing them in underserved communities. More than 14,000 clinicians visit the Job Center website each month looking for places to practice to help reduce their medical school loans. However, only 40 percent of eligible tribal clinical sites have placed information on this site.
- Regarding behavioral health, of the 384 clinicians serving in Indian Country, 79 provide mental and behavioral health services at tribal sites as licensed professional counselors, health services to psychologists, licensed clinical social workers, psychiatric nurse specialists and so on.
- AI/AN serving institutions, colleges and universities that serve a high proportion of AI/AN, including tribal colleges, have received more than \$7 million in awards from HRSA in 2013 for educational and training opportunities. By 2014, that number had increased to more than \$28 million for the training of health care providers.

- HRSA also has a funding opportunity that supports paraprofessional training of students in community and technical colleges, including tribal colleges and universities. Students can ultimately receive certifications as behavioral health paraprofessionals focusing on the behavioral health needs of at-risk individuals and families.
- About 550 new community health centers have opened within the last three years as a result of the Affordable Care Act. In 2013, more than 259,000 AI/AN's received services from those health centers.
- In September 2014, \$295 million in ACA funds were awarded to expand services at community health centers. Of those, 24 tribal health centers and 7 urban Indian health centers received more than \$6.3 million to expand their services. The health centers that receive those funds expect to serve more than 15,000 new patients and add about 54 new jobs in FY15.
- In 2013, the Ryan White HIV/AIDS Program served 5,907 AI/AN's living with HIV and AIDS. Of that number, 286 were Native youth between the ages of 13 and 24. Culturally competent resources about treatment, testing and prevention are available for tribal communities through this program.
- Two Ryan White grants are going to AI/AN communities in Anchorage, Alaska. The Anchorage Neighborhood Health Center received \$330,000, and the Alaska Native Tribal Health Consortium received more than \$500,000. The funds will flow over three years to provide comprehensive HIV primary medical care.
- In 2014 about \$68 million in HRSA funds went to tribes and tribal entities through such areas as Maternal and Child Health, HIV/AIDS, funding for National Health Service Corps clinicians, community health centers and so on. Those responding to grant announcements should identify themselves as tribes or tribal organizations to help HRSA better identify which grants are going to Indian Country. HRSA also continues to offer webcasts and outreach to train tribes on the application process.

Questions and Comments

C: (Ron Allen) Regarding the number of tribes that have been accessing HRSA money, I think it would be helpful if you are able to provide us some sort of a matrix that breaks down the different areas where the tribes are accessing and maybe some sort of a summary on what they submitted that was successful in that respective area.

C: (Mary Wakefield) We will go ahead and try to put some of that information together just as you described and bring it back.

Q: (Rex Lee Jim) Can you speak more about the HIV programs and assistance? On the Navajo Nation that is increasing.

A: (Mary Wakefield) Two parts of that might be most relevant. One part is that we have about eight or nine AIDS education and treatments centers across the United States. These are resources for communities to get information, and they have been working with tribes.

The second part is that we periodically have competitions to provide primary care services through HIV/AIDS clinics. And those were a couple of the examples I was giving in my remarks, where we have got some funding going into Alaska sites, where those sites competed successfully for HIV/AIDS clinical care. I don't know when the next applications are due. But the AIDS education and treatment center information is available all year round. We would be happy to make the connections between Navajo Nation and the appropriate AIDS education and treatment center.

Q: (Roger Trudell) Are you getting a good turnout on your training seminars?

A: (Mary Wakefield) Yes. The one we just did last month that focused on tribes — you might want to know we also had tribal representatives, successful grantees who actually talked about what they did to submit successful grants that were ultimately funded. When we did that in mid-February, we had 344 participants. We are taking that same program to the National Indian Health Board meeting in April. We archive everything so if somebody missed it, we have got it archived on our Website.

C: (Aaron Payment) I am sorry to see you go. You have always presented yourself with great professionalism, preparedness and enthusiasm with getting information to us so I want to thank you for that.

Whereupon, the meeting adjourned at 4:24 p.m., to resume at 9:00 a.m. on Wednesday, March 18.

Secretary's Tribal Advisory Committee Meeting

Wednesday, March 18

The second day of the Secretary's Tribal Advisory Committee opened with a review of the previous day as well as remarks and discussion with HHS Secretary Sylvia Burwell.

In her brief comments, Secretary Burwell expressed her appreciation to the STAC members as well as to federal staff and partners for their efforts in creating a successful meeting. Further announcements included:

- Mary Wakefield will be the acting deputy director of the Department.
- The President's 2016 budget makes real progress on contract support costs. Secretary Burwell brings up the issue in every one of her appropriations hearings to demonstrate this is a priority for the Administration.
- The joint meeting on ICWA has been in the works for a while as staff worked to get the right people in the room — not just HHS but such colleague departments as the Bureau of Indian Affairs.

Questions and Comments

C: (Ron Allen) You mentioned the CSC mandatory for contract support. That is a big deal to us and the tribes are fully supportive. We want to raise our concerns with you. The three-year cap, we understand that it is there in order to try to get a toehold into the mandatory, and that you and OMB expect Congress to want to know what the numbers are. There are concerns in terms of is it accurate or is it going to cover the actual new and expanded contracts that will probably unfold as a result of paying 100 percent.

In other words, many compacts/contracts are not being administered because of not paying 100 percent. So you are going to see an influx of those kinds of contracts so there is that issue that is out there. Further, tribes are not comfortable with the 2 percent administrative fee but we are supportive of the recognition that you need additional — will probably need additional administrative assistance and support for the new and expanded as well as the five-year reconciliation initiative that is being advanced.

We think you need to step back and figure out a better way to calculate it rather than just insert up to 2 percent for it. It calculates out to somewhere in the neighborhood of \$18-\$22 million. That could be just a grab for administrative/bureaucratic purposes.

The desire of the tribes is to try to move it into an ongoing. In other words, within three year we are already going to be asking for reauthorization. And we also want to work with you on where you statutorily authorize it to be moved into mandatory.

C: (William Micklin) On the topic of contract support costs, I would refer you to the March 10th from the National Tribal Contract Support Costs Coalition. We have been on the hill as recently as a few weeks ago and we think we have very strong support from leadership on both sides of the aisle in the House and the Senate for the Administration's proposal. The letter gives some depth to some of the finer tuning that we think we have support for in the Congress. We are appreciative of your support for this in actually putting it forward as the Administration's request. It hasn't been done before, and because you are doing it, you deserve the credit.

Q: (Secretary Burwell) One question and one comment. Who are you all seeing as the champions just because I am there so much and so often, can I just understand — I know the people I am talking to and meeting. Whom do you feel has good energy behind this, in terms of members, so we make sure we are aligned?

A: (William Micklin) We have had support from Senator Murkowski. Senator Sullivan is new and a junior but he understands it.

C: (Ron Allen) Congressman Tom Cole.

C: (Secretary Burwell) If you will just keep that information moving because it is helpful to me. Now that I know that you have actually reached out to Sullivan, that is very simple. Knowing where you are having good positive conversations — I can try to reinforce those conversations.

C: (William Micklin) Senator Cantwell, Dr. Reese in the House, who is the ranking to Shuster.

C: (Ron Allen) I would note that next week tribes are coming in, in large numbers, to testify, and we are urging them to make a note that this is a national priority.

C: (Secretary Burwell) I think you can see I am serious about getting it done. It is always hard to get something on the mandatory side because people feel that once it is on the mandatory side, it is very hard to control with regard to deficit reduction. From the perspective of members, this can grow without controls.

In order to get people to agree that it should be on the mandatory side, it is the program integrity. You all know why we put those things in: It was to meet that. So if there are other ways that you think of that can get us further on that path of showing that there will be program integrity, means by which the costs can be controlled, if you have better ideas, make sure we know them.

C: (Ron Allen) One thing about paying 100 percent of these contracts and compacts is it is truly implementing the Self-Determination Act. It empowers tribes to take control of our own affairs.

C: (Secretary Burwell) Where we want to get to is a place where we can meet that 100 percent in that commitment and we do it in a way that people see that the costs that are coming through, which are at 100 percent, are reasoned and thought through in that way.

C: (Ron Allen) The rules in what is allowable are very consistent across federal contracts. It doesn't matter whether it is defense contracts or contracts with the universities or other entities that contract with the federal government. And the federal government honors that process. Every entity that recovers those kinds of administrative costs all have to go through the same kind of process. We just want to be treated fairly like everybody else.

C: (Arlan Melendez) I would like to talk about two things. With the newly reauthorized Child Care Development Block Grant, the Secretary now has the authority to increase the tribal set-aside above two percent. Though increased to, I believe, 2.5 percent, I believe the tribes for many years have advocated for 5 percent. And as you know, there are waiting lists on probably every tribal program.

As far as Indian child welfare, we want to acknowledge the recent policy change at the Children's Bureau that will no longer require tribes to have termination of parental rights provisions in their tribal codes in order to be in compliance with Children's Bureau/child welfare programs. This change will allow tribes to pursue their customary and traditional culture placements for their children without having to terminate parental rights.

We also want to acknowledge Commissioner Chang's efforts to improve Children's Bureau consultation practices with Tribal Nations. We have been very concerned with the lack of tribal engagement over the last few years but we are noticing notable improvement.

ICWA compliance has been an ongoing discussion and concern here at STAC. For 25 years, Tribal Nations have been asking federal agencies at Health and Human Services to increase their monitoring in response to state noncompliance with ICWA.

One of the critical pieces that is missing is the collection of data, case-level data that can inform Health and Human Services, states and tribes of the status of our children in state care. ACF is now proposing changes to their data system called AFCARS, and we request that data elements be added for states that will produce data that gives us the critical information on ICWA implementation.

We also urge Health and Human Services to send an updated letter to inform states of the importance of collaborating with tribes on ICWA and related child care matters.

C: (Secretary Burwell) On the letter, we are hopeful that we are having some conversations with the other departments because I think one of the questions we have is will a letter that comes from us together be more effective than a singular letter.

C: (Mark Greenberg) In the child care block grant, we were pleased to be able to do the increase to 2.5 percent. During the next couple of months, we will be engaging in consultation with tribes around a whole set of the provisions of the new law so we will continue that conversation.

C: (Gloria O'Neill) We have three requests about 477:

We would like you to consider removing the new guidance requiring one or two years of managing a program and three previous clean audits, already required by the 477 initiative, before inclusion into a tribes 477 plan.

Assure in writing that funds will continue to be transferred through ISDA contracts and compacts.

Include other eligible programs into 477 such as LIHEAP, Community Services Block Grant, tribal vocational rehabilitation and Head Start. These programs provide direct funding and should be permissible under the current statute.

Please provide a timeline for this decision so that we have an answer, either yes or no, and can plan accordingly. Tribes and tribal organizations unanimously support the 477 program and expansion.

C: (Aaron Payment) We created a calculator that is highly predictable. When we got to Congress, if we roll that out and show it, we can demonstrate that contract support costs are very predictable. I think it is the strongest piece of us being able to make this case, and you have staff right within your division who can show that. Indian Country helped to create that, and we are behind that.

I am here to talk about the Affordable Care Act. The tribal exemption for the employer mandate is something that I brought up last time, and I want to reinforce that. To me, that threatens our

sovereignty. Most of us — our casinos and our revenues and whatever sources are for a public benefit, not for a private interest. And so, the Affordable Care Act, I don't believe, is requiring governmental entities to implement and mandating the employer mandate over all governmental entities.

And so the way we perceive our enterprise is as a means to generate revenue to fill the hole that the federal government doesn't fulfill in their trust responsibility. In my tribal community, 56 percent of our identified need for our service area is covered by IHS. The rest is not. And then all of our members, 2/3 of our members who don't live in that area, don't get anything.

So we supplement that through our revenues, and if we are required to provide health insurance for team members, in some case our balance with our markets in rural areas will move our casinos into insolvency. We believe there is a provision and the authority of the Administration to be able to exempt tribes from that.

Indian Country is 100 percent in support of the Affordable Care Act. Switching gears, there are some areas that need attention that we can help with. The definition of Indian — law mandates within 90 days a status report on that issue. So we stand ready to assist you with that. And we are wondering what consultation is happening or has happened to provide that report back to Congress. We support adopting the Medicare definition, which is the American Indian and two generations below.

There are some issues with the exemptions and how we can make it easier for people to get the exemptions. I think if we collaborated between NIHB, NCAI, STAC, and the Health Research Advisory Council (HRAC) we can come up with some ways to appropriately ask the question and streamline the process so more American Indians who are eligible — and again the definition is important because then more people are going to be eligible, can sign up for the Affordable Care Act.

Last, I want to provide a report. Before the rollout of the Affordable Care Act, we test-marketed through NIHB the call centers, and whether or not they were sensitized to be able to work with Indian Country. One of the questions in particular that is fundamental was when an Indian person said to the call center person, I have IHS, the call center person said, is that insurance?

That is fundamental. It is not insurance. A lot of Indian people think it is insurance. They don't think they need any other coverage, and that is why we end up with big contract health bills. But if the call center person doesn't know the distinction of that, then we have potentially lost an opportunity to get somebody signed up for the Affordable Care Act.

C: (Secretary Burwell) Education of our call centers, that is something that we can work on and put on our list right now. We are evaluating how open enrollment went, so that is helpful input.

Making sure that people have access in terms of how they come in, the customer service, is one area. I think the definition is another area. I think we think that is a statutory issue. We have

expressed our willingness to work on that. The question is how can we go about making that a reality.

The other issue — and understand the economic burden that occurs. I think we need to think creatively about the maintenance of a government-to-government relationship but that there are special things in terms of how we think about health care in this community. And think about this problem, which is the economics of paying and how that interacts with the population you serve. How can we move forward on this issue in way that respects our relationship? I don't want to erode that by how we treat this issue but are there other ways to get at the problem.

C: (Ron Allen) We want to make sure that the Indian components that you have inserted into your budget proposal hang in there as hard as possible. We are going to do our part with the regard to the request that we are going to be making for these different programs. But we want to make sure we are working together and sing of the same song sheet in terms of the budget agenda.

Pam talked to us about the SAMHSA, \$25 million — mental care, substance abuse issues. Big deals in Indian Country. So we want those initiatives to get through.

C: (Roger Trudell) I want to talk about prevention in the sense that we know we have an epidemic crisis of suicide in Indian Country, especially in our Great Plains. Compare it to measles: A small number of people had measles, yet it made national news. And a lot of resources were put into let's find out where the measles came from.

And I think they should do that but there is also a vaccine to take care of measles. I don't know of a vaccine to take care of suicide but it is an epidemic and maybe needs to be treated like an illness, and have the resources put in to finding what are the root causes? We can't continue to lose our young people. Even the long-term illnesses we have — diabetes, all those things. Preventable in a lot of cases. It is just getting to resources to put in, instead of treating the issue.

C: (Secretary Burwell) I think you know this is one that is a priority for us. I hope we can get the funding but we will work with whatever funding we have.

C: (Brian Cladoosby) I need IHS to commit to meeting meaningful use in 2015. And we need a commitment that tribes will be held harmless from penalties if meaningful use is not in place.

C: (Ron Allen) The Community Living programs are a big issue for Indian Country as it is across America. And we really need the Administration to step up with regard to the challenges that we have to care of our elders as well as our veterans. It is about how we can take care of them with an array of programs.

So there are best practice opportunities out there. There are also resources to better serve that community. There are all the challenges that you see with the elders — everything from Alzheimer's to Parkinson's or dementia issues. There are a limited resources in the budget to tackle those needs.

C: (Rex Lee Jim) The last item has to do with facilities. We need to continue funding the priorities list. We also need to continue funding the joint programs, where tribes build the facilities and then the personnel and operations are done by the federal government. We would like to expand those partnership options for long-term facilities such as assisted living and for in patient substance abuse and mental health treatment centers.

C: (Ron Allen) Self-governance is a very important agenda for the tribes. 340 of the 566 tribes are in the middle of the self-governance initiative. We are not happy about what has unfolded with regard to the opportunity for self-governance in HHS. It is successful in IHS as well as in Interior and we think that agenda should be advanced. We would like an opportunity to sit down with you to talk about future opportunities that this administration should advance on that initiative.

Q: (Aaron Payment) Gen I is the President's initiative. If anybody is interested, they should go to the White House Website and look up Gen I. What can you do as a Secretary to either corral resources to make them available or to do some kind of specific initiative through the programs that are under your direction? And what can we do to help you?

A: (Secretary Burwell) So what are the resources for Gen I? That is something we will have to come back in terms of the internal resources we have committed. HHS funded when the youth came, and so we are doing it through those specific efforts. So we are using moneys — we don't necessarily call them Gen I but maybe we need to think about it that way.

Thank you all. I feel like we are making some progress on some of our issues. As always, we can continue to make more. I think the meetings and your conversations with us are helpful to the focus we need on the most important issues. We are looking forward to continuing the work that we are doing together and even more looking forward to seeing that impact in your communities.

HHS Federal Member Roundtable Discussion

This session began with a report from Stacey Ecoffey that provides detailed follow-up on each of the issues addressed during the December 2014 STAC meeting. The front of the report includes information from the follow-up letter from STAC members. The rest of the letter includes the current status and response to issues as well as a point of contact. Vice President Jim then turned the floor over to the federal partners. The discussion covered these points:

National Institutes of Health

- NIH continues making progress in standing up its Tribal Consultation Advisory Committee. The deadline for receiving member nominations was extended until March 18 for Alaska, Albuquerque, Billings and Phoenix as well as national at-large members. The committee should launch in April.
- NIH also recently issued a request for information entitled Reducing Suicide in Alaska Native Communities Rapidly, Substantially and Sustainably. The request is a first step on

getting input on innovative research strategies and determining the factors that would protect against suicide in Alaska Native communities.

- Responding to concerns in AI/AN communities, NIH has released a funding opportunity announcement: Interventions for Health Promotion and Disease Preventions: Native American Populations. This opportunity focuses on wellness and health promotion. Those responding to the grant must submit tribal resolutions with their applications. NIH has funded 14 projects so far.
- NIH continues to seek reviewers from under-represented communities for its peer review system. STAC members should contact Mr. Tabak if they know of a person in their community who might be interested.

Centers for Disease Control and Prevention (CDC)

- CDC hosted a successful Tribal Advisory Committee (TAC) meeting and consultation in Atlanta in February. Highlights included a roundtable discussion with senior leaders from across the agency. Representatives from SAMHSA, ACF and the Food and Drug Administration (FDA) also attended the TAC meeting. One at-large seat on the TAC remains vacant.
- Capt. Carmen Clelland will join the CDC as the new associate director of the Tribal Support Unit after many years of working with IHS. Anabelle Allison joined Tribal Support Unit as the deputy associate director back in January.
- Training on working effectively with tribal governments will be available in April and September for staff members from CDC and the Agency for Toxic Substances and Disease Registry (ATSDR).
- In FY14, 51 tribes and tribal organizations received direct funding from CDC. These entities successfully competed for \$60.4 million in contracts, said Dr. Judith Monroe, Director of the Office of State, Tribal, Local and Territorial Support (OSTLTS). NIHB, one of the funded tribal organizations, announced small amounts of funding to five tribes to help them achieve accreditation for their health departments.
- The National Institute for Occupational Safety and Health (NIOSH) has announced the state occupational health and safety surveillance program, and federally recognized tribes are eligible to apply.
- Dr. Monroe will be attending the NIHB Tribal Public Health Summit in April. On April 7, Dr. Monroe will conduct a second CDC listening session along with Dr. Ursula Bauer, director of the National Center for Chronic Disease and Health Promotion. As a result of the first listening session, Dr. Bauer mobilized funding for Tribal Epidemiology Centers.

Administration for Community Living

- ACL is expanding long-term care ombudsman again in response to a lot of conversation about caring for people in nursing homes both on and off reservation. The tribes can pick a long-term care ombudsman, someone to visit seniors in nursing homes. States are responsible for the training with funding provided by Title III.

- Many domestic violence programs also are working in elder justice and elder abuse issues, including shelters. Ms. LaCounte will work on merging these two networks together.
- Ms. LaCounte also is working to help urban Indian centers tie in with the state and local entities that operate senior centers.
- The notice of new funding for Title VI will be available late March/early April.
- The Corporation for National and Community Service has foster grandparent and senior companion program money available only for tribes. Grants are due May 14. A webinar on writing for these grants will take place April 8.
- A White House Conference on Aging Tribal Listening Session will take place May 5 in Norman, Oklahoma. An HHS Regional Consultation will occur in the same city May 6 and 7.
- ACL will hold a conference in Washington, DC, August 10-13.
- Indian Country is beginning to address the disabilities issue. A diversity plan at ACL now includes working with tribes. Further, wherever there is a state with tribes, tribes have membership on the Independent Living Council and on the state disability council.

Questions and Comments

Q: (Arlan Melendez) We had this measles outbreak. At the tribal level, people wanted to know what our health centers were doing about it. Does the CDC issue something that goes out through Health and Human Services to the IHS director so the tribes will know about special precautions? We were hit with that really quickly in our clinics and our directors were kind of scrambling.

A: (Dr. Judith Monroe) We do have direct communication with IHS, especially with outbreaks like this. There are a lot of notifications that do go out. I will take that question back and see if there is something in our process that we could improve upon. But really with measles, the message really was to get vaccinated.

Q: (Aaron Payment) Do we have a communication plan for communicating funding opportunities?

A: (Lawrence Tabak) I am unaware of any unique conduit, and if there are things that are working with other agencies, if you could let us know, we could certainly feed that information through those existing conduits.

C: (Aaron Payment) NIHB and NCAI are really good conduits because whether you are actually a member of either of those organizations, they do try to provide information out.

C: (Lawrence Tabak) We put it out electronically, we think we are reaching those we hope to reach but obviously we could enhance that. We will look into putting it into those conduits.

Q: (Ron Allen) Are resources being made available to conduct analysis in collaboration with IHS on topics such as aging, Alzheimer's or Parkinson's? The one in your report refers to suicide in Alaska but it has got to be broader than that.

A: (Lawrence Tabak) Surveys typically fall among IHS/CDC. We often work in partnership. There are some other topics you raised where we might take more of a leadership role. We typically do not just do surveys per se. We do them to inform either subsequent research questions or work that would ultimately inform approaches to intervention. And then other agencies take that information and work with it to come up with the appropriate interventions.

C: (Ron Allen) I am interested in more analytical analysis. What are the common causes that we are finding in our respective communities, and do you have some assessment?

C: (Pam Hyde) Sometimes it is confusing for us as to who is doing what. CDC, for instance, does the suicide mortality data. SAMHSA does a lot of the suicidal thinking, thoughts and actions. The National Institute for Mental Health (NIMH) does a lot of work on the causes of suicide, what is behind it.

NIMH and SAMHSA are working together. We have a Center for Behavioral Health Statistics and Quality, so an entire center that focuses on this. Maybe we need to do a little more work with you on how to best reflect that.

We are just about to release the first-ever Behavioral Health Disparities Barometer. So we have a whole series of barometers that tell us sort of what behavioral health is like in the country by state. We will try to do a disparities barometer that will look at it by population group. And we have a brand-new unit inside our Center for Behavioral Health Statistics and Quality that is actually an analysis unit. Prescriptions drugs is an area where we deal more with the National Institute on Drug Abuse (NIDA), another institute. It may be worth another conversation at another time about how we can be more helpful collectively around this issue.

C: (Gloria O'Neill) I would say that one of the most engaged conversations that I have heard sitting on the STAC over the last five or six years is the conversation we had yesterday about historical trauma. When I think of HHS, I would really like to hear where you are going with creating these units that cross NIH, CDC and SAMHSA. This really needs to be inclusive development. If we could make that a focal point over the next couple years, think of what could come out of it that really could guide what we imbed in programs.

C: (Jefferson Keel) We need to fight these things the way you would fight a war. If we are going to fight certain things, whether it be chemical addiction, suicide or whatever, we need to marshal the right resources and get the right people — not just in Indian Country but across the country to talk about these issues. We spend billions on Ebola trying to keep it from coming here. All we need is a fraction of that in Indian Country to focus our efforts on what is really causing these things.

I am amazed at times when we give lip service to these things and we don't really mean it because really meaning it means we are going to go back and do something about it.

C: (Rex Lee Jim) Grandparents on Navajo blame clustered homes. When we live out in the country, we ranch, farm, we do all these wonderful activities where our children are engaged in positive productive activities. Clustered homes, that is not our tradition. That is why people, they just hang out with nothing else to do, and they learn to vandalize and do graffiti there. So how do we bring HUD and other programs into that because clustered homes are efficient and cost-effective?

Q: (Pam Hyde) You ask us frequently to collaborate and we think we are doing that but I have heard a couple comments about getting the right people at the table. I guess I would ask, who is that? And my staff just reminded me we have established a data working group across IHS, CDC, NIH and the Departments of Interior and Justice. So we have got the federal data group. Who are the right people to work with you guys on that? If you could give us some help on that.

A: (Jefferson Keel) We have technical geniuses back there working for us in every area who are very well-versed in these issues. So if we have some type of arrangement where we can invite these people to come and not worry about the FACA rule and all of those things. I know there are times when that is very important and appropriate. But there are times when many of the conversations don't lead to a productive end because they don't get the right people involved.

C: (Elaine Fink) I just want to add that I think we need to get to the grassroots of the problem. tribal leaders, depending on what programs we have, or even if we don't have any programs, we need to get in among our people and find out the why's because you do have behavioral health, you have mental health but a lot of things are confidential. We need to find what the why's are. We hear all the stories. We know these things are happening but why are they happening. And I think the tribal leaders need to find that out so we can bring it to the table.

C: (Rex Lee Jim) I am a medicine man, so that means every weekend I am with a family. So they talk to me about these issues. How will you get at some of that information without breaking the trust that these families have? But it is an important question: How do we as tribal leaders go into the communities and actually be there with the people and walk with them in their poverty and their suffering?

C: (Aaron Payment) We have a great diversity in the American Indian people but a common experience and a common outcome, and the statistics tell a story. The common experience is the boarding school experience and the forced reservation living where identities are stripped away.

When we look to find the source of these issues, then we have to identify ways to fix it. This effort has to be across agencies. It is the trust responsibility of the federal government. There is a way to do this: It is called a mixed methods study. I think the starting point is to take all of this good work that we have done so far, and we need to commission a national study on historical trauma to look at not only what is happening but what will change it.

C: (Leonard Harjo) I spent many years working and observing my own people. One of the things I have noticed about our people, and I will concur with the chairman, in our experience, you put us close together we are going to kill each other. We like to fight. So to put us in these little clustered homes just invites a lot of problems.

You have to understand who you are as a people to solve these problems but people have to understand what to look for. Our youth are pursuing the gang life because they are looking for an identity. I would say, you have an identity. But when I look around my community, I see people 65 and older and I see people under 18.

Most of the people raising families are not in the Seminole Nation proper. They have moved out. The end result of that is that the very institutions that were designed to provide for transmission of our heritage and culture and language are not as prevalent as they once were. The solution that I see is to build self-sustaining communities designed by us that give our people an opportunity to learn our language and live in the values of Seminole people.

One of the things that needs to come out of discussions such as this is HUD, you need to give us the flexibility to build homes that fit who we are locally. The standard HUD home, is not how we prefer to live. For HUD to do that, they need the information that you are talking about. There are a whole range of other issues — justice, health care — for which these same things are applied.

We have to have federal help in doing a study so that the basic structure — people who are searching for the answer can use those tools to find that answer. And when we go back to another agency, we could say, here is what it is. In your world, if we don't have your study, they are not going to listen to us. They won't listen to what I have observed. They will say, well, what does the National Institutes of Health say about that? To be able to move Congress and those other agencies, we are going to have to have those studies.

C: (William Micklin) When we look at the question of what do we do about it, in my mind the example goes to what I call foreign aid. When this government gives money to other countries, they give it without going into very detailed use restrictions, saying — we talked about HUD housing, moneys for needy families, adoptions and foster care. In each of those, there are restrictions that cut against some of our very important cultural practices. We don't give money to Egypt and say, you have to be Americans in the way you spend this money. When they give money to our communities, they say, well, you have to spend this but you have to spend it like White people in mainstream society.

So we take it. We have very little resources, we have been heavily impacted. I think sometimes we err in taking too much and using it in a way that is very detrimental to our life ways. The question for us is how do we translate these problems and solve them? And part of this is continuing the dialogue where we can become more autonomous.

C: (Rex Lee Jim) We need an update on the human specimens.

C: (Dr. Judith Monroe) Native specimens were discussed at our last TAC and has been for several of the meetings. We are working at CDC — first of all, we have got to get the inventory and that has been delayed a little bit because of Ebola. But we are getting the inventory and at this point, I believe from our last TAC, I certainly walked away with much more to the message that once we have those identified, that we need to notify all of the tribes to let them know what we have.

We have been working on a tribal policy at CDC but I believe we are closing in on that the policy really needs to be that we would reach to each of the individual tribes, let them know what we have, explain what specimens we have and then find out how they would like those managed.

Joint Meeting of the DOI and HHS

This session provided a look at the joint work and concerns of ACF and the BIA. The discussion included these issues:

- An available tribal funding opportunity will make announcements by the end of fiscal year. The grant is up to \$300,000 for two years.
- The comment period on the Adoption and Foster Care Analysis and Reporting System (AFCARS) is open until April 10.
- The Attorney General's Advisory Committee on American Indians Exposed to Violence gave specific recommendations to HHS and DOI to work together. The departments are working together on compliance and data collection.

Indian Child Welfare Act Implementation

HHS, DOI and the Department of Justice (DOJ) also are working together on ICWA. Updated ICWA guidelines came out a few weeks ago. Those guidelines had not been revised since 1979.

During listening sessions conducted as part of the update process, tribes requested updated guidelines as well as regulations with teeth. Consultations and public meetings also will occur in response to a proposed rule on ICWA compliance that came out March 18. Dates are available on the BIA website. Tribes must respond to the proposed rule within 60 days.

Questions and Comments

C: (Roger Trudell) I come from four different tribes and there is a lot of teepee creeping or whatever you want to call it. It leaves some of those children not eligible — they meet all the standards for being considered Indian but don't meet any of the tribes enrollment standards. Is there a way to address the needs of those children?

A: (Larry Roberts) That is something we would have to take a look at but I think right now the rule is focused on — if they are not eligible for enrollment in any specific tribe, which tribe would have jurisdiction over that adoption proceeding?

Q: (Roger Trudell) What if the judge doesn't recognize that? That is the problem some of these children are running into. They are not recognized by the Judge as being a tribal child. So no tribe has the ability to take jurisdiction.

A: (Larry Roberts) One of the things we have in the proposed rule is that courts have to ask that question straight out very early on: Is this an Indian child? If so, courts should reach out to tribes that would have jurisdiction over that proceeding for notification.

If a state court didn't follow regulations, I think the potential is there for it to give not only a hook to tribes, a hook for a lawsuit. And one of the reasons we think regulations would be helpful is it would give a hook for DOJ to take action.

Q: (Ron Allen) How are the two agencies collaborating with DOJ because it has made a very aggressive initiative to educate the state court systems with regard to what their obligations are? And because the Indian Child Welfare implementation cuts across so many different agencies, can we get a collaborative report with regard to each aspect of implementing the act and updating where we are with regard to compliance?

C: (Larry Roberts) In terms of our work with DOJ and HHS we are meeting every couple of months or every six weeks to focus on how do we make sure ICWA is being implemented effectively. How do we get into cases early on? We are working on an actual retreat to think about what we can do over this administration to implement ICWA and make sure all these agencies are working together. Maybe all of this could be a subset of the President's report at the end of the year that goes to Tribal Nations.

Q: (Ron Allen) You mentioned the four or five tribes that are now implementing IV-E. Are we trying to be more aggressive at getting more tribes? That number seems small relative to the amount of time we have been trying to empower the tribes to take over those programs.

A: (Joo Yeun Chang) We were surprised that there weren't more tribes already implementing direct IV-E. What we heard was that at least in part it was due to a lack of funding. And the second challenge was a policy issue. I think the issue of termination of parental rights was bigger than we imagined. So we worked to make sure that wouldn't be a barrier to getting direct IV-E access.

Q: (Leonard Harjo) On direct IV-E funding, how is that determined for a tribe?

A: (Joo Yeun Chang) Once you are approved, once you have an approved IV-E plan, there are all kinds of details around figuring out how you are going to determine your cost allocation plan. If you have a child in your system who is eligible for Title IV-E, which is described in federal law, then for every child that you have in your system, you can draw down a federal match. It is not a matter of community poverty. It is per child, whether they are individually eligible.

C: (William Micklin) We have some specific recommendations like combining the Title IV-E waivers with the Title IV-E applications as a way of improving flexibility and the design of tribal child welfare systems that are sensitive to our culture and practices. We need better data and we

need better funding for our tribal court system. The state is falling back from its responsibilities based in its budget challenges.

C: (Gloria O’Neill) Our state has to cut \$3 billion in the next couple of months. We are 95 percent dependent on oil, so what goes first is the support to families in need and children.

P.L. 102-477 Implementation

This discussion provided an update on the efforts of ACF and Indian Affairs on P.L. 102-477 program implementation as it relates to Tribal TANF, Native Employment Works and the Child Care Development Fund. Speakers addressed such issues as these:

- Noting the growth of the Tribal TANF program, Ms. Patel reported 70 programs representing 284 federally recognized AI/AN tribes and villages. There are 6 pending programs and 2 proposed expansions.
- Ms. Patel has established two priorities for the TANF office during the next two years:
 - Increase family economic security and stability by supporting tribal/state and community partners in designing and implementing programs that focus on parental employment and child/family well-being.
 - Promote greater collaboration among human services agencies, workforce agencies and educational institutions to encourage holistic service delivery.
- In late August/September Tribal TANF leaders will meet in Washington, DC. The event will include joint sessions with states and tribes.
- A funding opportunity for Tribal TANF/Child Welfare Coordination Grants is available. The program offers \$1.8 million in funding for competitive grants for demonstration projects that will test the effectiveness of coordination between Tribal TANF and child welfare services.
- The 477 program is moving from the Office of Indian Energy and Economic Development to the Office of Indian Services within the Bureau of Indian Affairs.

Questions and Comments

C: (Gloria O’Neill) I feel a bit frustrated because we have engaged in this conversation at a very high level, at least with the reporting, for the last several years. What we are trying to get down to is the flexibility question. The key issue is we want to include other eligible programs into 477 such as LIHEAP, Community Services Block Grant and tribal/vocational rehabilitation and programs like Head Start.

I have never heard a representative from the federal government tell us what the reason — where we feel there are so many barriers to moving forward in having flexibility. This successful tool has been demonstrated in Indian Country since 1992. We have had amazing impact and outcomes. So my frustration is can we just have a direct conversation to figure out how we can best use this tool for our communities as we think about providing holistic services.

(Nisha Patel) We definitely hear you loud and clear, and I think your request for a direct conversation is reasonable. So we will be going back with our team and figuring out how to best make that happen.

Substance Abuse and Mental Health Services Administration

This session highlighted the joint work occurring with the Tribal Law and Order Act (TLOA) and coordination regarding Indian alcohol and substance abuse. Highlights included:

- This program provides no funding for tribes or for the federal agencies. TLOA is a law about coordinating.
- In 2014, BIA allocated \$3 million toward the establishment of an additional 26 tribal and 9 BIA regional and agency case worker positions to deal with family violence. Those positions were located at locations that had high rates of domestic/family violence, teen suicide, child abuse and neglect.
- BIA is in the process of distributing an additional \$5 million for social services that will be going to all tribes that have social services programs.
- The 2015 budget included an additional \$5 million for Tribal ICWA programs.
- The 2016 budget includes a \$10 million increase for a tribal family services initiative coordinated among BIA education, social services, law enforcement and job placement/training programs. BIA also will work with other agencies and bureaus as well as state programs. The initiative will focus primarily on four pilot sites.
- In 2012, IHS, SAMHSA and DOJ collaboratively developed Tribal Action Plans and produced a two-part Webinar series. Since the original development of the TAP guidelines, IHS, together with SAMHSA, DOJ and the Department of Interior, have hosted these Webinars in the Phoenix and Billings Areas to help tribes develop their own TAPs to address alcohol and substance abuse in their communities. IHS stands ready to collaborate with its federal partners to offer additional training.

Questions and Comments

C: (Aaron Payment) Our TAP is good but in some ways I think we are pretty progressive and we have resources. But there needs to be a greater effort to facilitate in those communities where those alignment of variables aren't there.

I have argued against access to SAMHSA funding having to go through states because the states usually take a piece and keep it. If tribes have to line up and get a TAP program initially to qualify for other sources of funding, that is creating a standard that — a lot of tribes just aren't there.

There is also huge shortage of law enforcement in Indian Country, and they are the front line. We want to train them to be sensitive to the issues of substance abuse.

C: (Ron Allen) In Washington state, marijuana is legal now — for medicinal and recreational. I had a general meeting last Saturday, and I had two elders come up to me and ask, we are not going into the marijuana business, are we? No, we are observing it but we are not going into it. But it is a multibillion dollar industry. So tribes are looking at it. I had another elder and a young person come up: Hey, we are going to take advantage of this, right? So you get mixed messages from your community.

Q: (Gloria O’Neill) We too legalized marijuana in Alaska. There is starting to be conversation in our community about how people are going to commercialize it. What is SAMHSA’s position? And is there a place where we can get information because I have heard marijuana isn’t addictive long term, which I don’t believe. What is the impact? How can we better educate our community?

A: (Pam Hyde) We are in an odd place because it is illegal federally. But it is not legal for any child anywhere. Nowhere is it legal for children recreationally.

So we have been focusing where we can, which is the under 21 age group. There is absolutely some evidence and some data that for young people, the use of marijuana does have negative consequences. So we have been taking a preventive approach.

The problem is there are a lot of things we don’t know. People are starting to put marijuana in brownies and cookies. We aware of at least one death because of ingesting too much. We have a subcommittee on marijuana looking at surveillance. So as states do more of this, watching what happens is important.

C: (Dana Buckles) Another thing too is a lot of our tribal members live in HUD homes, and according to HUD, you have to be drug free. And we sit here and think Colorado and all these states are declaring recreational marijuana. Some people think, our tribes are going to make millions of dollars. We should be making money in other ways.

C: (Charles Roessel) As we are in the process of reorganizing and redesigning the Bureau of Indian Education, one of the first things we have to do is acknowledge the institution that we work for is part of the problem. The federal government — the BIE, the BIA, HHS — that this government is part of that problem that has created this historical trauma.

We have to acknowledge our past and come to grips with it as we move forward because as our students come to school, they see that. And how does that shape what we are going to do in the future? How does that shape how we are going to address the focus on substance abuse, the focus on academic excellence — whatever that is? We need to acknowledge that past. We need the understanding of what we have done so we can change as we move forward.

Whereupon the meeting adjourned at 5:00 p.m.