Annual Report of the American Indian/Alaska Native Health Research Advisory Council (HRAC)

Fiscal Year 2015

U.S. Department of
Health and Human Services
Office of Minority Health

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INTRODUCTION

Each year, the Office of Minority Health (OMH) produces an annual report highlighting the American Indian/Alaska Native (AI/AN) Health Research Advisory Council (HRAC) and its key activities and accomplishments. The fiscal year (FY) 2015 report includes summaries of FY 2015 HRAC meetings, a summary of HRAC outreach activities, and recommendations that the HRAC submitted to the U.S. Department of Health and Human Services (HHS). A list of HRAC members and federal partners is also included as an attachment.

BACKGROUND

OMH was established in 1986, following the release of the 1985 *Report of the Secretary's Task Force on Black and Minority Health.* The mission of OMH is to improve the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate health disparities. OMH advises the HHS Secretary, Assistant Secretary for Health, and other departmental leadership and works collaboratively with other HHS Operating and Staff Divisions, federal agencies, and other organizations across the country on health-related matters affecting AI/AN, Asian American, Black/African American, Hispanic/Latino, Native Hawaiian, and Pacific Islander populations.

As the Executive Secretariat for the HRAC, OMH is responsible for the administrative and fiscal operation of the HRAC, solicitation and selection of tribal delegates, and for ensuring that delegates and alternates meet Federal Advisory Committee Act (FACA) exemption requirements.

PRESIDENTIAL MEMORANDA AND EXECUTIVE ORDERS

Presidential Memoranda and Executive Orders have been developed over the years in support of the relationship between tribal governments and the U.S. Federal Government. In 1970, President Richard M. Nixon set forth a new direction for Indian policy aimed toward Indian self-determination. He stated:

"It is long past time that the Indian policies of the Federal Government began to recognize and build upon the capacities and insights of the Indian people."

An abbreviated timeline of memoranda and orders is presented below:

April 29, 1994 » President William J. Clinton issued the *Government-to-Government Relationship with Native American Tribal Governments* memorandum to executive departments and agencies. It emphasized the special relationship between tribal governments and the Federal Government regarding tribal consultation and sovereignty.

[Circa 1996] » The Domestic Policy Council Working Group on Indian Affairs requested that each department develop its own operational definition of "consultation" with Indian tribes to meet the requirements of the Indian Self-Determination and Educational Assistance Act.

August 7, 1997	»	HHS created its formal Tribal Consultation Policy to strengthen the federal to tribal government-to-government relationship and ensure that tribes are consulted on matters affecting them.
November 6, 2000	»	President Clinton issued a revised Executive Order (13175) that reinforced his Administration's commitment to tribal sovereignty and the unique government-to-government relationship that exists between the U.S. Government and tribal governments; directed agencies to establish regular and meaningful consultation and collaboration between tribal nations and the Federal Government; and directed all federal agencies to coordinate and consult with Indian tribal governments whose interests might be directly and substantially affected by activities on federally administered lands.
November 5, 2009	»	President Barack Obama issued a Presidential Memorandum on tribal consultation that reaffirmed his Administration's commitment to regular and meaningful consultation and collaboration with tribal officials through implementation of Executive Order 13175.
December 12, 2010	»	HHS, working with tribal leaders, developed and signed a revised Tribal Consultation Policy that provided more opportunities for tribal input through the development of policies, regulations, and budgets.

FORMATION OF THE HRAC

HHS solicited nominations from tribal leaders to develop the HRAC beginning in November 2005. One delegate and one alternate from each of the 12 Indian Health Service (IHS) areas as well as four national at-large members make up the HRAC. Members of the Council are elected or appointed tribal officials. Federal partners representing HHS Operating and Staff Divisions also support the Council.

The HRAC was established to fulfill three primary functions:

1. Obtain input from tribal leaders on health research priorities and needs for their communities;
2. Provide a forum through which HHS Operating and Staff Divisions can better communicate and coordinate AI/AN health research activities; and
3. Provide a conduit for disseminating information to tribes about research findings from studies on the health of AI/AN populations.

During its first meeting in May 2006, the HRAC elected two Co-Chairs, Councilwoman Cara Cowan Watts and President Cecilia Fire Thunder, to serve as the leaders and facilitators for meetings, outreach events, and general activities. HRAC members participated in numerous conference calls to plan for and organize activities. During these calls, they reviewed other HHS advisory models, discussed solicitation of research priorities and needs, and planned for future meetings.

The HRAC held its second meeting in November 2006 and reached a collective agreement to focus on three objectives:

1. Establish the HRAC Charter (outlining the purpose, background, and structure of the Council and processes for voting, membership, and leadership);
2. Develop a Discussion Guide (a survey to inquire about health research priorities and needs in Indian Country); and
3. Establish future meeting dates.

HRAC Members at June 2014 Meeting

HRAC's History

From 2006 to 2014, the HRAC held quarterly conference calls and annual meetings. The topics of continued concern and interest included the National Children's Study, National Institutes of Health (NIH) Tribal Consultation Policy, data sharing, scholarships for Native researchers, and a Native health research database. Based on the findings of these discussions, the HRAC developed and presented recommendations to HHS through letters to the Secretary and testimony at the annual HHS National Tribal Budget and Policy Consultation Sessions.

The HRAC developed a Discussion Guide to help ascertain health research priorities in Indian Country and constructed survey questions to examine healthcare delivery systems and the research that tribes were conducting. The HRAC members distributed the Discussion Guide to tribal leaders in their respective IHS areas from 2007 to 2009. The Discussion Guide results provided valuable information to the HRAC from the tribes' perspectives regarding health concerns, priorities, and the methodology by which future research should be conducted.

HRAC members attended outreach events to educate and inform tribes of the HRAC's mission and objectives. Events included the Annual Native Health Research Conference (2008, 2010, and 2011); National Indian Health Board (NIHB) Annual Consumer Conference (2008, 2011, and 2012); AI/AN Health Policy Conference (2009); IHS/Health Canada Maternal and Child Health Research Meeting (2009); Third National Leadership Summit on Eliminating Racial and Ethnic Disparities in Health (2009); NIHB Public Health Summit (2010); HHS Regional Consultations (2011, 2012, 2013, and

2014); Oklahoma City Area Indian Tribal Health Board Public Health Conference (2013); NIHB Quarterly Meeting (2013); and the Oklahoma City Area Indian Health Board Quarterly Meeting (2014). These events provided an opportunity for tribes to collaborate and share their knowledge and experiences regarding the advancement of health research and its importance in Indian Country.

In addition, the HRAC collaborated with the Administration for Children and Families (ACF); Agency for Healthcare Research and Quality (AHRQ); Assistant Secretary for Planning and Evaluation (ASPE); Centers for Disease Control and Prevention (CDC); Health Resources and Services Administration (HRSA); IHS; Intergovernmental and External Affairs (IEA); NIH; Substance Abuse and Mental Health Services Administration (SAMHSA); Tribal Epidemiology Center (TEC) staff; OMH; and external researchers and scientists to advance its knowledge of healthcare research and learn how to promote best practices in health research throughout Indian Country.

FISCAL YEAR 2015 ACTIVITIES

MEETINGS (TELECONFERENCE AND IN-PERSON)

December 18, 2014

The HRAC held its first teleconference for FY 2015 on December 18, 2014. HRAC Co-Chair and Bemidji Area Delegate Aaron Payment and Mr. Rick Haverkate, Public Health Advisor/American Indian & Alaska Native Health Policy Lead, OMH, opened the call and welcomed participants.

Dr. J. Nadine Gracia, Deputy Assistant Secretary for Minority Health and Director, OMH, introduced the new HRAC Albuquerque Area Delegate, Michelle Gomez, Director of the Jicarilla Apache Health & Fitness Center. She also announced two new additions to the OMH leadership team: Carol Jimenez, Deputy Director, and Alexis Bakos, Senior Advisor to the Deputy Assistant Secretary.

Dr. Gracia noted that she understands that the HRAC Charter is important and her office is working hard to ensure that the HRAC Charter reflects the primary and current functions of the HRAC. She said that this process is a priority and that her office is committed to this work.

Mr. Haverkate noted that one of the HRAC requests has been a Native research database/clearinghouse and that the OMH Resource Center (OMHRC) has an extensive library/database that could be a good starting point with the ability to increase content. He asked Faye Williams, Knowledge Center Manager, to give a presentation on the AI/AN Health Research Portal/Clearinghouse. Ms. Williams mentioned the OMHRC Knowledge Center contains a collection of 50,000 documents, books, journal articles, and media related to the health status of racial and ethnic minority populations. The library collection also includes sources of consumer health material in more than 35 languages. They have three librarians on staff and an information specialist who staffs a toll-free number to respond to requests from the public.

Roland Zebina, IT Manager, OMHRC, gave a demonstration of the updated HRAC website that will be launched soon. It has a new format to match the updated OMH website. The new format will allow the HRAC to present more information. The navigation banner is now at the top of the site to make it more simplified. The information is all still there, but it has just been reorganized and updated. The website links will all remain the same.

Chairperson Payment reported that at a recent Secretary's Tribal Advisory Committee (STAC) meeting, one of the key issues mentioned was youth suicide and how this relates to historical trauma. This has been a topic discussed by the HRAC, so this was carried to the STAC.

Councilman Antone noticed that environmental issues, as they relate to mining in Indian Country, have begun to surface (specifically in Montana, Idaho, New Mexico, and Arizona). The other issue he raised is a behavioral health/mental health agenda. He suggested that HHS agencies meet to develop a long-term plan to address the mental health issue, as some form of research is needed to bolster the agenda.

Councilman Antone noted he serves as Chair of the CDC tribal advisory committee. One of the main issues is the Native specimens protocol including collection, protection, and disposal/disposition of the Native specimens. Tribes need to address the cultural sensitivity issue to ensure that cultural and traditional practices are protected since all tribes are different.

March 26, 2015

The HRAC teleconference call on March 26, 2015, began with Chairperson Payment and Mr. Haverkate opening the call and welcoming participants.

Dr. Gracia thanked Chairperson Payment and Councilman Stephen Kutz for their leadership of the HRAC and their help in moving the priorities forward as well as the HRAC members for their time and dedication in providing recommendations to HHS.

Dr. Gracia introduced the two newest members of the HRAC: Rodney Haring, PhD, who will be representing the Seneca Nation as a National At-Large Member; and Charlene Jones of the Mashantucket Pequot Tribal Nation, who will be serving as the Nashville Area Delegate.

Mr. Haverkate said that the HRAC Annual Meeting has been set for June 4-5, 2015, in Washington, DC. He indicated that the dates were set because they followed the STAC meeting, which is being held on June 2-3, also in Washington, DC.

Chairperson Payment stated he would like to see some data collection conducted before the meeting to inform the research priorities discussion in June. Ms. Gomez volunteered to participate on a work group to discuss the priorities survey. Councilman Kutz said that the audience for the data gathering could include the tribes and EpiCenters, as well as urban organizations. Mr. Haverkate volunteered to send out an invitation for others to participate in the work group. Chairperson Payment indicated that it is important to identify the priorities within the list of the HRAC priorities document.

Malia Villegas, PhD, said one topic that is rising to the top of the priorities is the discussion on marijuana use. It is important to make the science around use available to members and their communities. Chairperson Payment stated that the Department of Justice has sent a letter to the states, indicating that it is not planning to prosecute certain crimes of use. This policy sends mixed messages. The HRAC should be sharing information on addiction.

Councilman Kutz said that he was a member of the STAC that went to the CDC lab where tobacco in cigarette products is tested. They had an opportunity to see the harmful additives in tobacco, and he asked if research was being done on marijuana. Councilman Kutz indicated that the CDC is not doing any testing or research because it is an illegal substance. There is a significant amount of information

available on prescription medications, but none on nonprescription drugs. He noted that the AI/AN community, as well as others, needs this information.

Dr. Haring said that there are a few common themes that fall within the issue of translation. He mentioned that many research products and papers in peer review do not get passed on to the community. When the information does get passed on, it is often not in a format that is easy for the community to understand.

Chairperson Payment said that he also attended an interesting session at the STAC on historical trauma, and he would like to see a study done that would help improve the understanding of trauma. He noted that the CDC showed there is a chemical change in the brain as a reaction to trauma.

HRAC Members at June 2015 Annual Meeting

<u>June 4-5, 2015</u>

The HRAC Annual Meeting was held on June 4-5, 2015, in Arlington, Virginia. Mr. Haverkate welcomed participants and conducted a roll call of tribal delegates and federal representatives.

Dr. Gracia reviewed the strategic priorities of OMH: 1) support the development and implementation of the provisions of the Affordable Care Act that address disparities and equity; 2) lead the implementation, evaluation, and monitoring of the HHS Action Plan to Reduce Racial and Ethnic Health Disparities (HHS Disparities Action Plan); and 3) coordinate the National Partnership for Action to End Health Disparities (NPA) and the National Stakeholder Strategy for Achieving Health Equity.

The HHS Disparities Action Plan is a department-wide commitment. It includes strategies to improve data collection and promote research methodologies to reduce disparities, including community-based participatory research. An important aspect is the implementation of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards). OMH looks to the HRAC for advice on culturally appropriate research in AI/AN communities.

Councilwoman Cowan Watts provided a history of the HRAC and reviewed the purpose of the HRAC, the structure of the HRAC, HRAC member responsibilities, and key challenges and priorities for the HRAC going forward.

A discussion on historical trauma research was included during the meeting. Chairperson Payment suggested that the STAC and HRAC could convene a colloquium, with the proceedings edited by Maria Yellow Horse Brave Heart, PhD. Councilman Kutz stated that many of the interventions developed to heal from historical trauma are not seen as valid.

Mr. Zebina introduced the revised HRAC website, which had a soft launch on June 3, 2015 (http://minorityhealth.hhs.gov/hrac). The site is more functional and easier to update. It includes a new feedback section with a dropdown feature that allows comments to be sent to a specific region, which will help to manage the volume of email that members receive.

Ms. Faye Williams provided an overview of the OMHRC Knowledge Center and highlighted resources related to AI/AN populations. Ms. Williams noted that HRAC members can stay connected with OMHRC through email updates, the website, and social media. Mr. Haverkate encouraged members to use the website to communicate with their communities and obtain feedback on HRAC activities and priorities.

Mr. Haverkate reviewed proposed revisions to the HRAC Charter. He noted that many of the revisions entailed minor changes in formatting or punctuation. Other changes made the HRAC compliant with the STAC Charter. Council members discussed the proposed revisions to the HRAC Charter, using the redlined version. The discussion of the charter was tabled to a conference call on Thursday, June 18, 2015, to be followed with an electronic vote approving the charter.

The Council broke into three groups to identify their top priorities for the remainder of the current fiscal year and for FY 2016. Council Delegates reviewed the priorities that emerged during the breakout session on Day 1 and discussed how to consolidate them. The following list of priorities emerged from that process:

HHS-wide (umbrella) policy for research:

- Oversampling;
- Funding;
- Data sharing, access, ownership;
- Accountability; and
- HHS Office of the General Counsel (OGC).

Native healthcare research database/clearinghouse:

- Include evaluation, public health activity, and surveillance research.

Institutional Review Board (IRB) Point of Contact list published in the Federal Register annually:

- Include all federally recognized tribes and tribal colleges.

Build local capacity to inform practice:

- Scholarships/training/pipeline; and
- Promote IRB best practices throughout Indian Country.

Social determinants of health:

- Historical trauma, adverse childhood experiences;
- Culture as prevention/intervention; and
- Working with researchers to develop more applied research.

Culture-specific modes of intervention:

- Special study sections; and
- Federal Requests for Application (RFAs) reflecting more culturally based research questions.

Representatives of HRAC's federal partners provided briefing reports to the HRAC along with brief updates from their respective agencies or organizations. Many of the reports generated a discussion from HRAC members. The following representatives presented reports: the AHRQ; ACF; ASPE; NIH; HRSA; IHS; and CDC.

Chairperson Payment and Councilman Kutz were re-elected as Co-Chairs by unanimous vote. Chairperson Payment closed the meeting with a traditional prayer and reminded members that their work on the Council was on behalf of their people at home.

Anita Frederick, Dawnette Weaver, Cara Cowan Watts, and Michael Peercy

OUTREACH ACTIVITIES

The HRAC conducted outreach throughout the year to share its priorities and recommendations, provide updates to tribes on HRAC activities, and to gather feedback and input from tribes and tribal communities regarding research issues, concerns, and priorities. HRAC written materials were submitted for the HHS Region VI and VII Tribal Consultation held on May 5-7 in Norman, Oklahoma. Chairperson Payment attended the 17th HHS Annual National Tribal Budget Consultation held on February 25-26, 2015, in Washington, DC, and provided testimony on behalf of the HRAC. Finally, the HRAC disseminated materials through an exhibit booth at NIHB's Annual Consumer Conference held September 21-24, 2015, in Washington, DC.

RECOMMENDATIONS TO HHS

The HRAC submitted recommendations to HHS via testimony on February 26, 2015, on issues of concern from the tribal communities that the HRAC represents. The recommendations that were submitted are provided below.

TRIBAL EPIDEMIOLOGY CENTERS' PUBLIC HEALTH AUTHORITY STATUS

Tribal Epidemiology Centers are having difficulty gaining access to datasets held by state governments, even though the Affordable Care Act established TECs as "public health authorities" as that term is defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Affordable Care Act also provided new statutory authority for IHS-funded TECs to access "data, data sets, monitoring systems, delivery systems and other protected health information in possession of the Secretary."

Access to state-maintained datasets is particularly important given the high rates of misidentification of AI/ANs in most state data and resulting publications and use of misinformation concerning AI/AN health status and access to health services. Access to state datasets, such as vital statistics records and the Pregnancy Risk Assessment Monitoring System, is important because access to IHS-provided services varies greatly within the IHS delivery system, and many service areas do not have access to IHS-operated hospitals or IHS specialty providers. This results in IHS data alone being incapable of reflecting a more accurate picture of AI/AN service utilization and health status in those states.

The HRAC recommends that the Secretary send a letter to the governor of each state identified as failing to comply with Affordable Care Act and HIPAA regulations and their state's department of health requesting that they facilitate TEC access to state data and datasets for the purposes of assessing and reporting the health status of AI/ANs in each state for health program and facility planning. Furthermore, when TECs access state data, fees charged should not be higher than those paid by other governmental entities. The HRAC respectfully requests that states be encouraged to work with the TECs to provide comparable data on health status of the general population for benchmarking and to track progress in eliminating health disparities. The HRAC also asks that TECs have a place, such as the Secretary's office, where they can report any further difficulties in accessing the data and that states be made aware of this reporting mechanism.

GENERAL RESEARCH RECOMMENDATIONS

The HRAC is acutely aware of the high and disproportionate rates of morbidity and mortality experienced by AI/ANs; therefore, many of the recommendations focus on addressing the health disparities that continue to plague Indian Country. Additionally, the HRAC would like to recommend that HHS increase its activities to address the suicide epidemic in AI/AN communities, including the research of the root causes of the epidemic.

In order to address the health concerns identified by the HRAC, research should focus on:

- Data quality and accuracy to address under-representation of AI/ANs in population health data;
- The lack of access to healthcare services for AI/ANs in both rural and urban settings;
- Lack of incorporation of traditional healthcare practices and traditional diets;
- The efficacy of health promotion/disease prevention activities; and
- The lack of health insurance coverage for AI/ANs.

The HRAC has identified and recommends several research priorities (list is not prioritized), including:

- Quantification of chronic disease prevalence (e.g., cancer, heart disease, diabetes) and associated risk factors (e.g., obesity, diet, physical activity) through sustained support of prospective studies among AI/AN populations;
- Chronic disease risk factor reduction;
- Intentional and unintentional injuries;
- Hypertension – evaluating methods to improve awareness and treatment of hypertension;
- Stroke prevalence/prevention;
- Methamphetamine prevalence/prevention;
- Evaluation of the use of emerging technology (such as telemedicine, electronic health records, health information exchange, etc.) for the provision of care;
- Health services research (such as utilization of prenatal care, preventable hospitalizations, emergency room utilization, etc.);
- Autoimmune disorders;
- Suicide (prevention, causality, and incidence rates);
- The readiness of tribal governments for public health accreditation;
- Healthcare reform impact and effectiveness;
- Environmental justice;
- Alzheimer's disease/dementia;
- Historical trauma; and
- Autism.

In addition, efforts should be made to support research aims that attempt to understand exposure to risk and vulnerability over the lifespan to American Indian health due to social determinants such as social exclusion, marginalization, and inequality. Research should address the complex interactions between health determinants and long-term exposure to risks unique to AI/ANs as an indigenous population.

It is important to stress that all research conducted should be evidence-based and to the extent possible, community-based participatory. Tribal governments are the rightful owners of their respective data, and therefore all efforts should be undertaken to ensure tribal governments are consulted before such data is shared with any entity. In addition to health concerns and research priorities, many barriers exist regarding research activities in Indian Country. These barriers could be addressed by:

- Increasing cultural sensitivity among researchers;
- Increasing the number of AI/AN researchers (a possible avenue is through additional funding through the IHS Health Professions Scholarship Program and Loan Repayment Program);
- Improving the accuracy of data related to AI/ANs and the interoperability of data among HHS Operating and Staff Divisions;
- Increasing the amount of available comparative data (when research includes a comparison of racial or ethnic data that does not include AI/ANs, we recommend that HHS make oversampling a priority to provide this data for comparison);
- Improving infrastructure among tribal governments to increase tribal capacity to carry out research and/or implement recommendations identified through research;
- Increasing the amount of community-driven research;
- Providing IHS with a research-funding line item to support research by and for AI/ANs;
- Holding a consultation with tribes for the purpose of developing a department-wide policy on data management in Indian Country; and
- The establishment of single data sources. (As an example, the Federal Government maintains several AI/AN data sources through IHS, Bureau of Indian Affairs, Centers for Medicare & Medicaid Services, CDC, NIH, SAMHSA, U.S. Census Bureau, and several others. A single, integrated Internet-accessible website with data available to calculate simple statistics, such as incidence and prevalence rates, etc., would assist in identifying areas of focus within AI/AN communities. The resource could provide access to published data as well.)

While the HRAC would like to see more grants awarded directly to tribal governments, the HRAC realizes that academic institutions and research organizations are often the most suitable awardees for certain highly technical and advanced research grants. Unfortunately, when academic institutions and research organizations are awarded grants for research affecting AI/AN communities, no uniformity or requirements exist for collaboration and cooperation with tribal governments. The HRAC recommends that grant requirements include demonstrated cooperation and collaboration with tribal governments, such as with the submission of a tribal resolution. While some grant awardees may consider such a requirement too burdensome, numerous resources exist to reduce any burdens on grant awardees. Resources that are readily available to assist include the HRAC, other AI/AN federal advisory bodies, inter-tribal organizations, Area Indian Health Boards, TECs, and numerous others. The HRAC offers this recommendation not only because it is the right thing to do, but the HRAC has seen too many times where a research project has been rendered useless by the AI/AN community because it was conducted without adequate collaboration, or relied on invalid AI/AN expertise.

The HRAC also recommends that agencies allow more time between when the funding opportunity announcement is released and the application deadline. Tribes and tribal organizations typically have internal requirements, such as tribal council approval through a resolution, to meet before developing and submitting a proposal. These meetings may only be held monthly; therefore, a 30-day response period to a funding announcement is not enough time. The HRAC also recommends that a Dear Tribal

Leader letter be sent out as an early announcement before a funding announcement is released to allow additional preparation time.

In addition to requiring tribal collaboration and cooperation as part of grant-funding requirements, it is important to have grant reviewers who have demonstrated experience with tribal governments and who are culturally sensitive. Such reviewers can ensure that grant applications adequately include collaboration and cooperation components. These reviewers are often more prepared to assess grant applications submitted by members of AI/AN communities who may have extensive subject matter experience but fewer academic credentials and degrees. The HRAC recommends a training module be developed and shared to assist non-Native reviewers.

ATTACHMENT A:

MEMBER AND PARTNER LIST FOR FY 2015

HRAC CO-CHAIRS

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HRAC Co-Chairs Stephen Kutz and Aaron Payment

FY 2015 MEMBERS

Tribal Members by IHS Area	
Alaska Area **Region 10: Seattle**	**Delegate** Ileen Sylvester Vice President of Executive & Tribal Services Southcentral Foundation
Alaska Area **Region 10: Seattle**	**Alternate** Timothy Thomas Division of Community Health Services Alaska Native Tribal Health Consortium
Albuquerque Area **Region 6: Dallas** **Region 8: Denver**	**Delegate** Loyola "Michelle" Gomez Director Jicarilla Apache Community Health & Fitness Center
Albuquerque Area **Region 6: Dallas** **Region 8: Denver**	**Alternate** Pamela B. Cordova Councilwoman Mescalero Apache Tribe
Bemidji Area **Region 5: Chicago** **HRAC Co-Chair**	**Delegate** Aaron Payment Tribal Chairman Sault Ste. Marie Tribe of Chippewa Indians
Bemidji Area **Region 5: Chicago**	**Alternate** Larry Jacques Director of Strategic Planning and Development Sault Ste. Marie Tribe of Chippewa Indians
Billings Area **Region 8: Denver**	**Delegate** Patty Quisno Councilwoman Fort Belknap Indian Community
Billings Area **Region 8: Denver**	**Alternate** Darrin Old Coyote Chairman Crow Nation
California Area **Region 9: San Francisco**	**Delegate** Daniel J. Calac Chief Medical Officer Indian Health Council
California Area **Region 9: San Francisco**	**Alternate** (VACANT)
Great Plains Area **Region 7: Kansas City** **Region 8: Denver**	**Delegate** Patrick Marcellais Councilman Turtle Mountain Band of Chippewa Indians

Tribal Members by IHS Area	
Great Plains Area **Region 7: Kansas City** **Region 8: Denver**	**Alternate** John Blackhawk Chairman Winnebago Tribe of Nebraska
Nashville Area **Region 1: Boston** **Region 2: New York** **Region 3: Philadelphia** **Region 4: Atlanta**	**Delegate** Charlene Jones Third Party Administration Customer Service Supervisor Pequot Health Care Mashantucket Pequot Tribal Nation
Nashville Area **Region 1: Boston** **Region 2: New York** **Region 3: Philadelphia** **Region 4: Atlanta**	**Alternate** (VACANT)
Navajo Area **Region 6: Dallas** **Region 8: Denver** **Region 9: San Francisco**	**Delegate** Russell Begaye President Navajo Nation
Navajo Area **Region 6: Dallas** **Region 8: Denver** **Region 9: San Francisco**	**Alternate** Jonathan Nez Vice President Navajo Nation
Oklahoma Area **Region 6: Dallas** **Region 7: Kansas City**	**Delegate** Cara Cowan Watts Tribal Council Representative Cherokee Nation
Oklahoma Area **Region 6: Dallas** **Region 7: Kansas City**	**Alternate** Tom Anderson Tribal EpiCenter Director Oklahoma Area Tribal Epidemiology Center
Phoenix Area **Region 6: Dallas** **Region 9: San Francisco**	**Delegate** (VACANT)
Phoenix Area **Region 6: Dallas** **Region 9: San Francisco**	**Alternate** (VACANT)
Portland Area **Region 10: Seattle** **HRAC Co-Chair**	**Delegate** Stephen Kutz Councilman Cowlitz Indian Tribe
Portland Area **Region 10: Seattle**	**Alternate** Kim Zillyett-Harris Health Director Shoalwater Bay Indian Tribe
Tucson Area **Region 9: San Francisco**	**Delegate** Chester Antone Councilman Tohono O'odham Nation
Tucson Area **Region 9: San Francisco**	**Alternate** (VACANT)

National At-Large Members	
National At-Large Member	**Delegate** Jefferson Keel Lt. Governor Chickasaw Nation
National At-Large Member	**Alternate** Malia Villegas Director, Policy Research Center National Congress of American Indians
National At-Large Member	**Delegate** H. Sally Smith Ekuk Village Representative Bristol Bay Area Health Corporation
National At-Large Member	**Alternate** Stacy Bohlen Executive Director National Indian Health Board
National At-Large Member	**Delegate** Rodney Haring Seneca Nation of Indians
National At-Large Member	**Alternate** Timothy J. Waterman Chief Executive Officer Seneca Nation Health System
National At-Large Member	**Delegate** Michael Peercy Epidemiologist Choctaw Nation Health Services Authority Chickasaw Nation Division of Health
National At-Large Member	**Alternate** Mickey Peercy Executive Director of Health Services Choctaw Nation of Oklahoma

FEDERAL PARTNERS

Federal Partners	
Office of Minority Health	**Delegate** J. Nadine Gracia Deputy Assistant Secretary for Minority Health
Office of Minority Health	**Alternate** Rick Haverkate Public Health Advisor
Agency for Health Research and Quality	**Delegate** Kishena C. Wadhwani Director, Division of Scientific Review Office of Extramural Research Education and Priority Populations
Intergovernmental and External Affairs	**Delegate** Stacey Ecoffey Principal Advisor Tribal Affairs
Intergovernmental and External Affairs	**Alternate** Elizabeth "Liz" Carr Tribal Affairs Specialist
Indian Health Service	**Delegate** Mose A. Herne Director Division of Planning, Evaluation, and Research Office of Public Health Support
Indian Health Service	**Alternate** Asantewa Gyekye-Kusi
Centers for Disease Control and Prevention	**Delegate** Delight Satter Senior Advisor for Tribal Research and Program Integration Office for State, Tribal, Local and Territorial Support
Centers for Disease Control and Prevention	**Alternate** Kimberly Cantrell Public Health Advisor Office for State, Tribal, Local and Territorial Support
Assistant Secretary for Planning and Evaluation	**Delegate** Adelle Simmons Senior Program Analyst Office of Health Policy

Federal Partners	
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National Institutes of Health	**Alternate** Joyce A. Hunter Deputy Director National Institute on Minority Health and Health Disparities
Health Resources and Services Administration	**Delegate** Michael Weaver Public Health Analyst Office of Health Equity
Health Resources and Services Administration	**Alternate** Gwenivere Gordon Rose Public Health Analyst Office of Health Equity
Administration for Children and Families	**Delegate** Aleta Meyer Office of Planning, Research and Evaluation
Administration for Children and Families	**Alternate** Hilary Forster Office of Planning, Research and Evaluation
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