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

Fiscal Year 2016

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

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INTRODUCTION

The Office of Minority Health (OMH) of the U.S. Department of Health and Human Services (HHS) 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) 2016 report includes summaries of FY 2016 HRAC meetings, a summary of HRAC outreach activities, and recommendations that the HRAC submitted to 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

In November 2005, HHS solicited nominations from tribal leaders to develop the HRAC. HRAC is composed of one delegate and one alternate from each of the 12 Indian Health Service (IHS) areas as well as four national at-large members. Federal partners representing HHS Operating and Staff Divisions also support the HRAC.

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.

The inaugural co-chairs elected in May 2006 were Councilwoman Cara Cowan Watts and President Cecilia Fire Thunder. 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

The HHS OMH established an American Indian and Alaska Native Health Research Advisory Council (HRAC or the Council) to serve as an advisory body to HHS, helping to ensure that tribes and American Indian and Alaska Native (AI/AN) people have meaningful and timely input in the development of relevant HHS policies, programs, and priorities specific to AI/AN research. Through the HRAC, representatives of HHS can better communicate and coordinate the work of their respective organizations in AI/AN health research, and the Department can better disseminate information to tribes about research findings from HHS-sponsored studies focusing on the health of AI/AN populations. HRAC delegates will also have a responsibility to communicate critical information, research findings, and any other policy related activity back to their respective tribes, communities, and IHS Area. From 2006 to 2015, 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 health care 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, 2012 and 2015); 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, 2014 and 2015); 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 2016 ACTIVITIES

MEETINGS (TELECONFERENCE AND IN-PERSON)

December 11, 2015

The HRAC held its first teleconference for FY 2016 on December 11, 2015. Councilman Stephen Kutz, HRAC Co-Chair, and Rick Haverkate, OMH, welcomed participants, and Mr. Haverkate conducted a roll call of tribal delegates and federal representatives.

Mr. Haverkate announced that there is an HRAC fact sheet on the new HRAC website located under the "About HRAC" tab. It is a one-pager that explains what the HRAC is, as well as its mission and research priorities.

The HRAC priorities compiled from the 2015 meeting were sent out for review before the meeting. Councilman Kutz informed the members that the discussion would be on whether the list covered all the priorities or if there were ones to add. In addition, he advised that the six main priorities should be narrowed down to two or three to work on this fiscal year.

HRAC priorities identified and compiled from the 2015 meeting were:

1. HHS-wide (umbrella) policy for research;
2. Native healthcare research database/clearinghouse;
3. Institutional Review Board (IRB) point of contact list published in the Federal Register annually;
4. Build local capacity to inform practice;
5. Social determinants of health; and
6. Culture-specific modes of intervention.

It was mentioned that subtopics under the HHS-wide (umbrella) policy are items that the HRAC works on continually. Mr. Haverkate asked members if they thought there was a hot topic under the HHS-wide policy that HRAC should focus on this year. Rodney Haring, PhD, stated that the recent information

shared about the proposed changes to the Federal Policy for the Protection of Human Subjects, also known as the Common Rule, is important. Some of the proposed changes are around informed consent, single IRB review of multisite research, and clinical trials coverage under the rule. It is imperative for tribes to understand the potential effect and to review the information from the National Congress of American Indians (http://www.ncai.org/policy-research-center/research-data/priorities/fed-res-priorities).

Councilman Kutz noted the Native healthcare research database/clearinghouse has been a priority for several years and indicated that it would be more long-term work for the HRAC.

Mr. Haverkate asked that members select one or two of the main priorities to work on over the next nine months in order to have a product by the end of this fiscal year. He will then develop a logic model, activities and a timeline.

March 11, 2016

The HRAC teleconference call on March 11, 2016 began with Chairperson Aaron Payment and Mr. Haverkate welcoming participants, and Mr. Haverkate conducting a roll call of tribal delegates and federal representatives.

Chairperson Payment reported that he brought issues forward at the Secretary's Tribal Advisory Committee (STAC) meeting and HHS Tribal Budget and Policy Consultation Session on behalf of the HRAC. He spent time with the HHS Secretary discussing the Flint, Michigan, water crisis and the ongoing issues with suicides, overdosing and historical trauma. He explained that a comprehensive study is needed to get to the systemic reason why AI/ANs are facing the worst health related statistics.

Chairperson Payment and Mr. Haverkate reported that a poll was sent out asking members to rank HRAC priorities. The results of the HRAC priorities poll are:

1. Development of an HHS-wide (umbrella) policy for conducting AI/AN research;
2. Recommend that HHS agencies include AI/AN culture-specific modes of intervention in funding proposal requests;
3. Encourage a stronger focus on social determinants of health among tribal and HHS policy makers and health practitioners and a stronger focus on social determinants in public health research;
4. Advance specific initiatives in Indian Country that are designed to build local capacity to use research data to inform public health practice;
5. Creation of a web-based searchable AI/AN health research and reference collection with links to university and government libraries that encourages voluntary submissions of scholarly articles and projects; and
6. Creation of an AI/AN-specific IRB point of contact list published annually in the Federal Register.

Chairperson Payment asked for input on the first priority—development of an HHS-wide (umbrella) policy for conducting AI/AN research. Malia Villegas, PhD, stated that the NIH Tribal Consultation Advisory Committee is working on developing guidance for tribal consultations that can help guide other agencies. This could be useful in addressing Priority 1.

Other suggestions for consideration of the HHS-wide (umbrella) policy for AI/AN research provided by committee members included:

- Ethics
- Cultural appropriateness of the question
- The need to oversample
- When research opportunities are promoted or conducted, ensure comprehensive information is provided regarding the reason why AI/ANs are sometimes categorized as minorities and other times considered "other" in the race classification.
- Best practices
- Making the results translational
- Dissemination (local, state and national)
- Sustainability
- Whom we are studying when talking about AI/ANs (e.g., federally recognized tribal members, descendants)
- Identify and work through mixed methodology and community-based participatory research in Indian Country
- Importance of informed consent and data ownership
- Specimen protocol and ownership
- Federal policy should recognize that there are tribes with research codes that must be followed.

June 9-10, 2016

The HRAC Annual Meeting was held on June 9-10, 2016, in Arlington, Virginia. Chairperson Payment welcomed HRAC members and staff, and invited meeting participants to introduce themselves.

J. Nadine Gracia, MD, Deputy Assistant Secretary for Minority Health provided updates on the work of OMH. Highlights were as follows:

- National Partnership for Action to End Health Disparities (NPA): The NPA is a national, community-driven initiative that utilizes social determinants of health (SDoH) approach to address health disparities. A new partnership with the NIHB will support the integration of SDoH into strategic planning and public health accreditation activities of tribal public health departments. There is an AI/AN NPA Caucus working to address health disparities and SDoH among Native populations, with a focus on the Affordable Care Act, diabetes, oral health and public health accreditation. The caucus is seeking new members, and OMH would welcome nominations from HRAC members.
- Hepatitis B and C viral infection: Hepatitis is becoming an epidemic, and there are significant disparities among AI/AN populations. OMH partnered with CDC and the National Academy of Science on a study to determine the feasibility of setting national goals for the elimination of Hepatitis B and C. The first phase of the study determined that setting elimination goals would be feasible; the second phase will set specific goals and targets. The OMH Resource Center (OMHRC) is conducting training on hepatitis, including a webinar on June 22 that will focus on hepatitis among AI/AN populations.
- Culturally and Linguistically Appropriate Services (CLAS): Think Cultural Health is a national clearinghouse for curricula and training materials for health professionals (www.thinkculturalhealth.hhs.gov). A new Tracking CLAS feature on the website shows states that have enacted or introduced legislation on cultural competency training for health

professionals and/or have expressed support for the National CLAS Standards. A new compendium tracks state-sponsored activities related to the implementation of the National CLAS Standards. OMH receives numerous inquiries regarding culturally appropriate approaches for Indian Country and would value input from the HRAC.

Michael Peercy provided an overview of the HRAC's history and accomplishments since its inception in 2005 and reviewed HRAC's purpose, structure, participating HHS components, meetings and member responsibilities.

Chairperson Payment called for a motion to approve the minutes of the March 11 quarterly meeting. The motion was made by Tom Anderson, seconded by Dan Calac, MD, and carried by unanimous voice vote.

Elton Naswood and Tamara Henry, PhD, from the OMHRC described how a logic model is structured and how it is used for planning and evaluation. Working in groups, HRAC members developed logic models for the top two priority issues for the coming year:

- Priority 1: Development of an HHS-wide (umbrella) policy on AI/AN research
- Priority 2: AI/AN culture-specific modes of intervention

For Priority 1, HRAC members suggested initial activities could include conducting a scan to identify existing policies on data collection and human subject protections with indigenous communities (federal agencies, universities, tribal governments, foreign governments) and identifying existing data sources (e.g., electronic databases, morbidity and mortality data, state data).

For Priority 2, proposed activities included: identifying existing efforts for resources and gaps; requesting representation on grant review sections and funding for a nationwide search to identify potential candidates to serve as reviewers for grant review sections; engaging agency tribal liaisons; and drafting a letter or recommendations to HHS. Outcomes might include: 100 percent increase in AI/AN representation in grant review sections; training for tribal liaisons for special study section placement; and increased grant awards to AI/AN tribes and organizations. It was noted that CDC was using its tribal convening process to identify culturally specific aspects that could be incorporated into its grant programs. Tribal traditional practitioners developed a list of 10 components to include in funding opportunity announcements (FOAs). HRAC members agreed that formalized logic models for Priorities 1 and 2 should be developed for discussion.

Dan Calac, MD, Presenting Logic Model at June 2016 Annual Meeting

Federal partners provided updates on AI/AN funded projects and initiatives relevant to Indian Country. In addition, federal representatives requested input from members on topics of interest. Representatives included AHRQ, NIH, CDC, SAMHSA and IHS.

Kenneth Johnson from the HHS Office for Civil Rights provided an overview of the final rule implementing Section 1557 of the Affordable Care Act, which is the nondiscrimination provision of the law. He noted that Section 1557 prohibits discrimination based on race, color, national origin, sex, age or disability in certain health programs and activities. It has been in effect since the Affordable Care Act was enacted in March 2010. The final rule aims to educate consumers about their rights and help covered entities understand their obligations. Section 1557 extends protection to populations that have been most vulnerable to discrimination in health care and health coverage including women, members of the lesbian/gay/bisexual/transgender community, individuals with disabilities and individuals with limited English proficiency. It is the first federal civil rights law to broadly prohibit sex discrimination in health programs and activities.

Faye Williams from OMHRC provided an overview of the services and resources available from the OMHRC Knowledge Center. Knowledge Center services include document retrieval, literature searches, organization searches, statistics and data, and legislative tracking. The Knowledge Center is the nation's largest dedicated repository of health disparities information, with a public catalog of more than 55,000 records. Sixty percent of the collection is available online. The Knowledge Center's catalog search can be used to create customized bibliographies on any subject.

HRAC Members and Federal Partners at June 2016 Annual Meeting

September 7, 2016

Dr. Gracia introduced David Wilson, PhD, the new AI/AN Health Policy Lead at OMH. Dr. Wilson reminded members that the HRAC updated its charter in 2015 to be in alignment with the Secretary's Tribal Advisory Committee (STAC) charter, which included terms of membership on HRAC. This affected half of the committee members as they rotated off at the end of June 2016. OMH is currently working to fill the vacant positions. He asked that HRAC members contact potential new members and encourage participation. The call for nominations is being reestablished, and a new deadline will be added so that new members can be recruited.

Dr. Wilson reviewed the HRAC priorities during the conference call to get input from members to make sure that the priorities can have achievable outcomes for the upcoming year. He noted that some priorities would take many years to accomplish.

The first HRAC priority is the development of an HHS-wide (umbrella) policy for conducting AI/AN research; Dr. Wilson stated that it is a large initiative. He recommended holding discussions to determine how to make the priority achievable in a one- to two-year timeframe.

The second HRAC priority recommends that HHS agencies include AI/AN culture-specific modes of intervention in funding proposal requests, with special grant review sections to review proposals. Dr. Wilson indicated that this priority is very doable and could show measurable and achievable outcomes, especially in terms of Native representation on grant review sections. Dr. Villegas stated that there is a significant backlog of individuals who have applied to serve on grant review sections but have not been processed, including many Native scholars with extensive credentials. There was a report commissioned from the NIH Office of Behavioral and Social Sciences Research, and she requested to get an update on the status of the report.

CDC has a standard template that all FOAs are modeled under, which includes culturally specific interventions, noted Delight Satter (CDC). When FOAs are developed, there can be a request for reviewers across HHS, which might be a temporary fix to the backlog.

Mose Herne (IHS) added that a lot has been learned with the Native American Research Centers for Health (NARCH) Program, and the Center for Scientific Review at NIH has been key. There have been grant review sections for NARCH grant reviews with 90 percent or more AI/AN scholars, and all those on the sections had experience working in AI/AN communities.

The third HRAC priority is to encourage a stronger focus on social determinants of health. Historical trauma, adverse childhood experiences, and culture as prevention/intervention are all components. Dr. Villegas noted the Tribal Behavioral Health Agenda from SAMHSA would be released soon, and one of the foundational elements is historical and intergenerational trauma.

Priority four is to advance specific initiatives in Indian Country that are designed to build local capacity for using research data to inform public health practice. This includes providing scholarships and training to build a pipeline and promoting IRB best practices throughout Indian Country. Dr. Wilson stated that training young professionals is important so they get on a path to practice science in the public health setting.

The fifth priority is the creation of a web-based, searchable AI/AN health research and reference collection with links to university and government libraries. Dr. Wilson noted that there might be an opportunity to leverage other efforts, such as a database for AI/AN researchers who are interested in participating in study sections. Dr. Villegas commented that the National Congress of American Indians has been involved in developing a range of resources and databases. They have learned there is always a tendency to be comprehensive, but a very specific database is much more useful. She would like to see HRAC think about who the user would be and divide out the resources into different areas for different users.

The last ranked priority is the creation of an AI/AN-specific IRB point of contact list published in the Federal Register annually. Mr. Herne shared that IHS has created a list on its website of about two dozen tribal IRBs. It is working on expanding that list, and he will share the link with the HRAC members.

OUTREACH ACTIVITIES

The HRAC conducted outreach to share its priorities and recommendations, provide updates to tribes on HRAC activities, and gather feedback and input from tribes and tribal communities regarding research issues, concerns and priorities. Chairperson Payment attended the 18th HHS Annual National Tribal Budget Consultation held on March 2-3, 2016, in Washington, DC, and provided testimony on behalf of the HRAC. The HRAC was also represented at NIHB's Annual Consumer Conference held September 19-22, 2016, in Scottsdale, Arizona.

ATTACHMENT A:

MEMBER AND PARTNER LIST FOR FY 2016

HRAC CO-CHAIRS

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HRAC Co-Chairs Stephen Kutz and Aaron Payment

FY 2016 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** (VACANT)
Albuquerque Area **Region 6: Dallas** **Region 8: Denver**	**Alternate** (VACANT)
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** (VACANT)
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** Willie J. Carrillo Councilman Tule River Tribe of California
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** Harold Frazier Chairman Cheyenne River Sioux Tribe
Nashville Area **Region 1: Boston** **Region 2: New York** **Region 3: Philadelphia** **Region 4: Atlanta**	**Delegate** Charlene Jones Mashantucket Pequot Tribal Nation
Nashville Area **Region 1: Boston** **Region 2: New York** **Region 3: Philadelphia** **Region 4: Atlanta**	**Alternate** Hope Shwom Mashpee Wampanoag Tribe
Navajo Area **Region 6: Dallas** **Region 8: Denver** **Region 9: San Francisco**	**Delegate** Simental "Sy" Francisco Project Manager NDOH/Navajo Epidemiology Center
Navajo Area **Region 6: Dallas** **Region 8: Denver** **Region 9: San Francisco**	**Alternate** Philene Herrera Program Manager III NDOH/Health Education/HIV Prevention and Acting Program Manager for Navajo Special Diabetes Project
Oklahoma Area **Region 6: Dallas** **Region 7: Kansas City**	**Delegate** Tom Anderson Director Oklahoma Area Tribal Epidemiology Center
Oklahoma Area **Region 6: Dallas** **Region 7: Kansas City**	**Alternate** (VACANT)
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** (VACANT)
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** David Wilson Public Health Advisor, AI/AN Health Policy Lead
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 Deputy Associate Director Tribal Support 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	
National Institutes of Health	**Delegate** Eliseo J. Pérez-Stable Director National Institute on Minority Health and Health Disparities
National Institutes of Health	**Alternate** Joyce A. Hunter Deputy Director National Institute on Minority Health and Health Disparities
Health Resources and Services Administration	**Delegate** CAPT Elijah Martin Jr. Tribal Affairs Manager Office of Health Equity
Health Resources and Services Administration	**Co-delegate** Sylvia E. Joice 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
Substance Abuse and Mental Health Services Adminstration	**Delegate** Sheila K. Cooper Senior Advisor for Tribal Affairs
Substance Abuse and Mental Health Services Adminstration	**Alternate** Chipper Dean Behavioral Research Scientist

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