

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

Fiscal Year 2014





## TABLE OF CONTENTS

<b>Introduction</b> .....	<b>1</b>
<b>Background</b> .....	<b>1</b>
Presidential Memoranda and Executive Orders .....	1
Formation of the HRAC.....	2
HRAC History .....	3
<b>Fiscal Year 2014 Activities</b> .....	<b>4</b>
Meetings.....	4
Research Roundtable.....	10
Outreach Activities .....	11
Annual Health Research Report.....	12
<b>Recommendations to HHS</b> .....	<b>12</b>
Tribal Epidemiology Centers Public Health Authority Status .....	12
National Children’s Study.....	13
General Research Recommendations.....	13
National Institutes of Health Tribal Consultation Policy .....	15
<b>Attachment A:</b> .....	<b>16</b>
<b>Member and Partner List for FY 2014–2015</b> .....	<b>16</b>
HRAC Co-Chairs .....	16
Members .....	17
Federal Partners .....	20



## INTRODUCTION

Each year the Office of Minority Health (OMH) produces an annual report that provides an overview of the American Indian/Alaska Native (AI/AN) Health Research Advisory Council (HRAC) and key activities and accomplishments. The fiscal year (FY) 2014 report includes summaries of FY 2014 HRAC meetings, a summary of outreach activities, and recommendations that the HRAC submitted to the U.S. Department of Health and Human Services (HHS). A list of current 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 with 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.

OMH serves as the Executive Secretariat for the HRAC. In this role, OMH is responsible for the administrative and fiscal operation of the HRAC, solicitation and selection of tribal delegates to the HRAC, and for ensuring that delegates and alternates to the HRAC meet Federal Advisory Committee Act (FACA) exemption's requirements.

## PRESIDENTIAL MEMORANDA AND EXECUTIVE ORDERS

Over the years, numerous Presidential Memoranda and Executive Orders have been directed at bolstering 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 towards 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.

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- 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. The HRAC's role is to facilitate communication between HHS and tribes regarding health research priorities and needs in AI/AN communities. Members of the Council are elected or appointed tribal officials, and include 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 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.

The HRAC held its first meeting in May 2006 and 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.

During the second meeting, held in November 2006, the HRAC 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 April 2009 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 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. During that time, the top health concerns reported (but not listed in priority order) were as follows:

- Access to care and coordination of care;
- Behavioral health issues, including domestic violence, substance abuse, suicide, and tobacco use;
- Cancer, cardiovascular disease, diabetes, and obesity;
- Health information technology and systems;
- Lack of funding; and
- Recruitment/retention of highly qualified health care professionals/providers.



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, and 2013); Oklahoma City Area Indian Tribal Health Board Public Health Conference (2013); and an NIHB Quarterly Meeting (2013). 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 health care research and learn how to promote best practices in health research throughout Indian Country.

## **FISCAL YEAR 2014 ACTIVITIES**

### **MEETINGS (TELECONFERENCE AND IN-PERSON)**

#### **February 7, 2014**

The HRAC held its first teleconference for FY 2014 on February 7, 2014. HRAC Co-Chairs Cara Cowan Watts, Oklahoma Area Delegate, and Stephen Kutz, Portland Area Delegate, opened the call and welcomed participants.

Commander (CDR) Tracy Branch, Public Health Advisor, OMH, announced that ACF is developing new research and data collection priorities and is seeking assistance from tribal communities.

Dr. Alan Trachtenberg, Research Director, IHS, shared that the National Children's Study (NCS) advisory group met in January 2014 to update the framework that will be used for the study. The framework will define the higher-level functions of a normal 21-year-old and serve as a basis of comparison to evaluate outcomes for cohort members at the end of the study. Dr. Trachtenberg sent HRAC members a copy of the Request for Information that solicits feedback on the framework. He asked HRAC members to review the framework and consider submitting comments regarding culturally relevant or culturally specific areas of health for AI/ANs for the attention of the advisory group.

Dr. Trachtenberg indicated that the researchers do not intend to stratify the hospital- or birth-unit-based samples. The random sample may or may not include Indian hospitals.



Councilman Kutz suggested that the HRAC ask the National Congress of American Indians to inform tribes that tribal citizens should identify themselves as AI/AN when they enter civilian hospitals to give birth. Dr. Trachtenberg suggested that the HRAC ask the NCS to do as much as possible to identify participants who are Native.

Councilwoman Cowan Watts said it was her understanding that the Affordable Care Act definition of AI/ANs might be changing again. She asked if the HRAC should recommend that the HHS and the NCS use a consistent definition. Councilman Kutz stated that it was important to ensure that the definition is clear. Hospitals and birthing centers are challenged in identifying AI/ANs, and the extent to which the study is diligent in identifying participants will be a factor in the study's effectiveness. The performance standards for determining the identity of people in the study will be of great importance. Aaron Payment, Bemidji Area Delegate, stated that the current definition is based on membership in a federally recognized tribe, which is problematic for tribes that do not have lineal descent. There has been advocacy among tribes to base the definition of tribal membership on covering the two subsequent generations, so that a child and grandchild of a tribal member will receive coverage through the Affordable Care Act. Councilwoman Cowan Watts stated that the proposed definition described by Chairperson Payment will fit with the cultural affiliation among federally recognized tribes. Councilman Kutz said he believed the HRAC was advocating for the NCS to use the IHS definition and wondered how that will change the definition.

Chairperson Payment reported that he spoke with Cathy Abramson, who chairs the NIHB. Ms. Abramson said there was no update about changing the definition of Indian for the Affordable Care Act, and she noted that the definition in the Affordable Care Act leaves out some Alaska Natives. The administrative fix had been reviewed and did not appear to resolve the problem; however, there is broad support for a legislative fix. Chairperson Payment stated that if the NCS uses the Affordable Care Act definition, tribes without lineal descent will be left out. Dr. Trachtenberg replied that an epidemiologic study such as the NCS will not be bound to a definition that was developed to determine eligibility for medical care. The process for collecting information is still open to input. Chairperson Payment stated the Sault Ste. Marie Tribe is a lineal tribe, so the definition covers his people. If someone must be a tribal member, then a large number of Native children will be left out of the study. Participants agreed that erring on the side of counting study subjects as Native is preferable to using a definition that excludes them.

Dr. Trachtenberg suggested that a set of questions with yes/no or multiple-choice answers record the information in a way that allows analysis of data according to the definition the researcher wants to use. Delight Satter, Associate Director for Tribal Support, CDC, stated that the California Health Interview Survey (CHIS) used that approach. She said investigators asked whether the participant was American Indian, enrolled in a tribe, in which tribe they were enrolled, and so on. This methodology has been used for more than 10 years and works very well; and the material is available for public access. The approach does not address the problem of whether the sample is large enough for each sub-population to be generalizable, but it will be the most useful way to gather the data.

Councilwoman Cowan Watts summarized that the key issues for the HRAC are sampling and oversampling, and how the NCS will identify AI/ANs. She proposed including a discussion of the CHIS methodology on the agenda for the next quarterly conference call. Ms. Satter offered to make a presentation on the approach to developing the methodology described by Dr. Trachtenberg. She noted that the University of California, Los Angeles (UCLA) validated the items with many cultural groups in California, including tribes, and across six languages.



## **March 21, 2014**

The HRAC teleconference call on March 21, 2014, began with Councilwoman Cowan Watts calling the meeting to order once a quorum was reached.

Dr. J. Nadine Gracia, Deputy Assistant Secretary for Minority Health, and OMH Director, noted that nominations were currently under review for the HRAC's vacant seats. The goal is to appoint the new members prior to the annual meeting in June. She also reported that:

- Mayra Alvarez has joined OMH as the new Associate Director, after serving at the HHS Office of Health Reform. She will now be leading OMH initiatives related to the Affordable Care Act;
- OMH has developed four infocards featuring young adults of color to increase young adult awareness and enrollment in the Health Insurance Marketplace. The infocards are available on the OMH website, and they feature young adults who are Native American, African American, Latino, and Asian American;
- Some of the Regional Health Equity Councils (RHECs) of the National Partnership for Action to End Health Disparities (NPA) have identified Affordable Care Act outreach as a priority area and have been holding community education sessions to help inform community members about provisions of the Affordable Care Act. The Southeastern Health Equity Council conducted Affordable Care Act enrollment outreach at the North Carolina Indian Unity Conference;
- A member of the Region VI RHEC is working to establish a work group of AI/AN representatives from all of the RHECs. The goal is to identify and work across RHECs to address key concerns of Native communities and to increase their membership and participation in the RHECs; and
- The OMH Resource Center is establishing a technical assistance resource center for institutions of higher education, in particular, minority-serving institutions, to include Tribal Colleges and Universities and American Indian and Alaska Native Serving Institutions.

Councilwoman Cowan Watts called for a motion to approve the minutes of the September 2013 and February 2014 meetings. Chairperson Payment moved to approve the minutes of both meetings. Dr. Jay Butler, Alaska Area Alternate, seconded the motion. Councilwoman Cowan Watts called for questions, concerns, or amendments. Hearing none, she called for a vote. The motion passed unanimously.

Councilman Chester Antone, Tucson Area Delegate, and Chairperson Payment provided an update from the Secretary's Tribal Advisory Committee (STAC). Councilman Antone stated that contract support costs were one of the main issues discussed at the February 2014 meeting. Chairperson Payment noted that Secretary Sebelius informed the STAC that Dr. Yvette Roubideaux, Acting Director, IHS, had advocated against the recommendations to cap contract support costs. Chairperson Payment reported that he reminded the Secretary of the trust obligations and reviewed the shortfall in funding for members that are exempted from the Affordable Care Act but do not live near an IHS facility. The Secretary stated that Medicaid was an option for those individuals. Chairperson Payment noted that many states are not participating in the Medicaid expansion, and Medicaid is predicated on income eligibility, which is not the case for IHS. Chairperson Payment stated that the definition of Indian has not been corrected in the Affordable Care Act. This affects individuals who are descendant members and not enrolled members. HHS suggested a legislative fix. The STAC felt that HHS should have the administrative authority to adopt the Medicare definition of Indian, which applies to a tribal member and the two generations that are born after that tribal member. Chairperson Payment stated that the STAC reiterated



its requests for forward funding for veterans health and non-discretionary funding for IHS. The STAC has some momentum on this issue and should continue to make those requests.

Councilwoman Cowan Watts asked if HRAC members wished to remove, elevate, or add anything to the HRAC priorities list. Violet Mitchell-Enos, Director of Health and Human Services for the Salt River Pima-Maricopa Indian Community in the Phoenix Area, noted that caring for members who have dementia or Alzheimer's disease is a challenge within the Salt River Tribe. The relationship between those conditions and diabetes or other types of chronic illness is not known. If managing these conditions is a challenge for other tribes, Ms. Mitchell-Enos said she would like to see the issue included in the research priorities. Councilman Kutz expressed interest in discussing dementia and Alzheimer's disease at a future meeting. He suggested that the HRAC members determine whether this is an issue in their communities.

### **June 23, 2014**

The HRAC held its annual in-person meeting for FY 2014 on June 23, 2014, in Rockville, Maryland. Councilwoman Cara Cowan Watts opened the meeting and confirmed a quorum, after which time Chairperson Payment provided an opening blessing. Following welcoming remarks from Co-Chairs Cowan Watts and Kutz, Councilwoman Cowan Watts reviewed the provisions and exemptions of FACA, as the HRAC operates under an exemption from the FACA identified in the Unfunded Mandates Reform Act of 1995.

Dr. Gracia reminded the group of the two vacancies on the Council for which OMH was actively pursuing nominations; and she announced that Rick Haverkate recently joined OMH as a Public Health Advisor and AI/AN Health Policy Lead. He will serve as Executive Secretary of the HRAC and as staff liaison to the White House Initiative on AI/AN Education. Mr. Haverkate will also support Dr. Gracia on intradepartmental tribal committees and councils and other initiatives.

Dr. Gracia assured council members that the HRAC remains a priority for OMH. To that end, Dr. Gracia requested the Council's input on strengthening communications to ensure that Council members have access to information disseminated by OMH and can inform OMH of opportunities for collaboration.

Dr. Roubideaux addressed the Council by video, expressing IHS's belief that tribal consultation and partnerships are an integral part of research efforts in Indian Country. Stating that IHS is not authorized or funded to do research, she indicated that research and evaluation help IHS deliver high-quality, evidence-based care and help IHS see the impact of their programs. She commented on IHS's Institutional Review Board (IRB), work with TECs, and support of the Native American Research Centers for Health (NARCH) initiative. Dr. Roubideaux also stated that IHS is continuing to look for opportunities to work with academic and research institutions in formal, research-related arrangements, noting existing memoranda of understanding.

During the *Business Items* portion of the agenda, a motion was unanimously passed to approve the minutes of the March 31, 2014, quarterly conference call; nominations for the Co-Chair positions were called and resulted in a unanimous vote that elected Councilman Kutz and Chairperson Payment as new Co-Chairs of the HRAC.



Sheila Cooper, Senior Advisor for Tribal Affairs, SAMHSA, presented on SAMHSA's challenges in obtaining data specific to AI/ANs. She discussed its tribal discretionary grant portfolio and provided other highlights related to SAMHSA activities concerning AI/AN populations. She also indicated that SAMHSA's Tribal Technical Advisory Committee (TTAC) was revising its charter and SAMHSA's Tribal Consultation Policy. Following the presentation, various council members echoed the need for AI/AN-specific data and increased access to tribal data. The group discussed the prevalence and impact of suicide on tribal communities. Other topics included the use of wrap-around services and racial misclassification on death certificates.

Ms. Mitchell-Enos and Councilman Kutz provided information supporting the need for research in the area of dementia/Alzheimer's disease in AI/AN communities. Councilwoman Cowan Watts proposed adding this issue to the list of HRAC research priorities.

Councilman Kutz provided an update on the STAC, reporting that the Committee is currently working on revising its by-laws and identifying priorities that it would like Secretary Burwell to address. He and Chairperson Payment highlighted several STAC priorities, including the Indian Child Welfare Act compliance; SAMHSA funding; HRSA (concerning needed support for mid-level oral health providers); expansion of tribal self-governance; the Affordable Care Act definition of Indian; and support for the use of priority points for AI/AN HHS grant applicants. They welcomed the HRAC's input on the list of items; and they suggested that the new Secretary's previous experience working with the Office of Management and Budget and the Bill and Melinda Gates Foundation would inform her approach to working with tribal communities. It was suggested in follow-up discussions that a more formal process be established for communications between the HRAC and STAC.

Councilwoman Cowan Watts asked HRAC members to identify two or three research projects that would have the greatest impact on Indian Country if funds were available at the end of the fiscal year. The group agreed on the following: (1) funding for a Native research database/clearinghouse; (2) funding for the Navajo TEC survey; and (3) review of tribal applications that were approved but not funded due to lack of data and then working with the tribe and/or a TEC to collect qualitative data. After reviewing the HRAC's FY 2014 priorities and activities for the upcoming year, participants decided that it would be beneficial for the new leadership at both HHS and the HRAC to have a table that lists: (1) the HRAC priorities; (2) what has been done to request action on each priority, and when; (3) what response was received; and (4) contact information at the relevant HHS agency.

CDR Tracy Branch (OMH) led a discussion on HRAC charter revisions, noting that the HRAC and the other advisory committees have been asked to revise their charters to align with the STAC charter. A work group will be making revisions for the HRAC to review.

The balance of the day comprised updates from numerous federal partners: AHRQ, CDC, HRSA, IHS, and NIH. In addition, Councilwoman Cowan Watts stated that she would report back to the HRAC regarding how the Cherokee Nation handles the issue of an NIH-funded researcher who claimed to be Cherokee conducting research with the Cherokee Nation and Choctaw Nation.

The meeting ended with Councilwoman Cowan Watts confirming that the agenda items had been addressed and indicating that the next steps included the Research Roundtable on June 24, 2014; quarterly conference calls for the full HRAC; and monthly meetings for the charter revision work group. The meeting adjourned with Chairperson Payment offering a closing prayer.



**HRAC Members at June 2014 Meeting**

**September 12, 2014**

The HRAC teleconference call on September 12, 2014, began with Chairperson Payment and Mr. Haverkate calling the meeting to order.

Dr. Gracia welcomed the attendees on behalf of OMH and noted that the HRAC contributions to AI/AN health research priorities provide the Department with more meaningful insight into tribal communities. She noted that the HRAC charter is an important part of the HRAC, and a work group will review the charter and make recommendations to OMH. She stated that she is looking forward to working with the work group and the HRAC to complete the charter.

Mr. Haverkate stated that he has been meeting with Dr. Gracia on a regular basis. Dr. Gracia and OMH are committed to supporting health research for AI/AN communities. OMH has reviewed the priorities identified by the HRAC and will be working to help support these priorities. He would like to work with the Co-Chairs and HRAC members to develop a logic model for the HRAC.

Chairperson Payment reminded the HRAC that there is a current list of priorities and then additional suggestions identified during the Research Roundtable. He commented that some of the priorities overlap and that the group should develop a way to merge them into one list. He added that he supported the idea of a logic model for identifying tasks and timelines.

Dr. Yvonne Maddox, Acting Director, National Institute of Minority Health and Health Disparities, NIH, reported that NIH has had several meetings with AI/AN scientific leaders and physicians. She noted that NIH will hold an AI/AN Research Symposium in November during Native American Heritage Month. Scientists will be invited to discuss the challenges of being an AI/AN researcher. She stated that they would like for the HRAC to be represented at the event.

Chairperson Payment commented that one of the HRAC priorities is the Native research database/clearinghouse. He noted that a lot of current work relates to studying American Indians as well as studies conducted by American Indians.



Chairperson Payment stated that it sounded like HRAC has a ready subcommittee in the formation with a focus on data collection. He asked Dr. Malia Villegas, National At-Large Member Alternate, if she would be willing to facilitate a process with partners to consolidate the different data points. He will also be involved in the process to help achieve this goal. Dr. Villegas agreed and indicated that the starting place would be looking at the Westat report from 2007 where extensive data were compiled on all the existing AI/AN data sets.

Dr. Villegas also suggested that the HRAC begin developing one-pagers related to some of the HRAC priorities as a way to move forward with identifying existing resources and policy recommendations.

Ms. Mitchell-Enos commented that there has been a lot of discussion on genetics data and biobanking. Chairperson Payment reported that at a CDC consultation session the issue of human samples and appropriate use and disposition of samples were discussed. He noted that one item to be considered is the cultural perspective. For example, in the Anishinaabe culture, a person's hair should be protected and bodily fluids should be handled in an appropriate and culturally sensitive manner. Ms. Mitchell-Enos stated that she did not see allowance for Native researchers. In the past it has been primarily non-Native researchers looking to do genetic research. She noted that tribes can develop an agreement on how samples will be handled for research, but the challenge is for tribes to get federal agencies to agree that the tribes maintain data ownership when federal funding is secured. She suggested that the HRAC relook at the issue of human sampling and research.

## **RESEARCH ROUNDTABLE**

The HRAC Research Roundtable, held on June 24, 2014, in Rockville, MD, brought together HRAC members, Native health researchers, TEC representatives, and federal partners to discuss research priorities in Indian Country. Councilwoman Cowan Watts welcomed attendees and then introduced Councilman Kutz. Councilman Kutz offered an opening blessing, followed by participants' self-introductions. On behalf of OMH, Dr. Gracia and Mr. Haverkate gave opening remarks.

Mr. Haverkate provided an overview of OMH activities, followed by an overview of the history and purpose of the HRAC.

Robert McSwain, Deputy Director, IHS, welcomed tribal leaders, tribal researchers, and federal partners to the meeting and IHS. He emphasized the importance of updating tribal leaders on research, acknowledged that research in the field entails challenges, and highlighted IHS collaborations with agencies throughout HHS that conduct research on issues important to Indian Country.

Concerning the issue of data sharing/ownership facing tribes, the HRAC heard brief presentations from representatives of TECs, Native researchers, and HRAC members. The presentations identified a range of current issues that could be presented to Secretary Burwell, as well as be used to further the HRAC's priorities. Among the challenges cited included explaining the difference between research data and public health data to tribal councils; getting state legislatures to recognize tribal organizations; states not recognizing TECs as public health authorities; racial misclassification; timeliness of HHS responses to questions from the HRAC; data gaps due to states upgrading electronic infrastructures; inconsistencies in the way that states collect data that result in persistent discrepancies; TECs' lack of infrastructure, capacity, and funding; the federal government's lack of a research policy and research infrastructure for tribes; and the need for local-level data. Appreciation was expressed to Dr. Roubideaux for developing the template that TECs can use to enter into a data-sharing contract with IHS; and Councilwoman



Cowan Watts noted that HRAC advocacy for basic research infrastructure had emerged as a new issue during this discussion.

Delight Satter (CDC) and Teshia Solomon, PhD, University of Arizona, Arizona Study Center, served as presenters for the National Children’s Study (NCS) session. Noting the HRAC’s concerns about the lack of quality survey data on AI/AN populations, Ms. Satter presented the methodology used in the California Health Interview Survey (CHIS), which is a collaborative project of the UCLA Center for Health Policy Research, the California Department of Health Services, and the Public Health Institute. The CHIS surveys 55,000 households every two years, with high participation rates from AI/ANs. This is the only survey in the country that captures subpopulations of AI/ANs and Asians.

For her portion of the presentation, Dr. Solomon first noted that the National Academy of Sciences had recently released a report with concerns about the NCS that resulted in NIH putting the main study on hold, and she suggested that the HRAC may want to advocate for a role in the planning efforts for moving forward. Dr. Solomon reported on work the Arizona Study Center performed under the NCS, a geographic sampling of three counties for the NCS—Maricopa County, Apache County (Navajo Nation), and Pinal County—and the challenges they faced in trying to develop a subsequent toolkit to enhance the recruitment and retention of AI/AN participants. Dr. Solomon agreed to send a copy of the toolkit to the HRAC.

Next, Councilwoman Cowan Watts invited Native researchers and TEC representatives to propose research topics that the HRAC could consider recommending to HHS. Topics ranged from having a Native research database/clearinghouse, to environmental justice, to the need for basic research infrastructure for Indian Country, to the social determinants of health, among others. Councilwoman Cowan Watts also asked researchers to identify “shovel-ready” projects that end-of-year funds could support. That discussion resulted in the identification of various projects, including completion of the NCS toolkit, supplemental funding for the NARCH to enhance existing training/projects; projects that support indigenous healing and nutrition; establishing a field-based public health education and training center; and reinstatement of the NIH Science Education Partnership Award. Councilwoman Cowan Watts proposed to add the totality of suggestions researchers offered to the HRAC’s list of potential projects and have the Council prioritize the list during subsequent conference calls.

After discussing the issue of an NIH-funded researcher who claimed to be a Cherokee Nation citizen and conducted a study without IRB approval, the group shifted its discussion to the problem of prescription drug use/abuse among children and adults in Indian Country. The latter discussion resulted in Councilwoman Cowan Watts proposing to add the following items to the HRAC priorities: (1) research on the prevalence of prescribing behavior-modifying medications for children and adults; and (2) research on abuse of prescription medications.

The meeting closed with Councilwoman Cowan Watts thanking HRAC members, researchers, and staff for a productive meeting.

## **OUTREACH ACTIVITIES**

The HRAC members 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. An HRAC update was provided at the Oklahoma City Area Indian Health Board Quarterly Meeting in Shawnee, Oklahoma, on



January 14, 2014. Councilman Antone attended the 16th HHS Annual National Tribal Budget Consultation Session on March 7, 2014, in Washington, D.C. and presented testimony on behalf of the HRAC. Updates on the HRAC were also provided during HHS Regional Tribal Consultations in the spring of 2014.

## **ANNUAL HEALTH RESEARCH REPORT**

The HRAC produced its Annual Health Research Report, a compilation of findings related to important health research topics in AI/AN communities. This report is utilized as a resource to share research findings, topics, and available federal programs with tribes.

## **RECOMMENDATIONS TO HHS**

The HRAC submitted recommendations to HHS via testimony on March 7, 2014, 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**

TECs are having difficulty gaining access to data sets 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 data sets 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 data sets, such as vital statistics records and 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 means IHS data alone is incapable of reflecting an 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 HIPPA regulations and their departments of health requesting that they facilitate TECs' access to state data and data sets 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 Office of the Secretary, where they can report any further difficulties in accessing the data and that states be made aware of this reporting mechanism.



## NATIONAL CHILDREN'S STUDY

While the HRAC fully supports the intent and purpose of the NCS, the study could have more meaningfully included the participation of tribal nations and the AI/AN community. Tribal consultation should have been required before the study was planned and funding committed in a manner consistent with longstanding federal policy. Consultation should also be utilized at each new stage of the study so that local tribes are consulted during the planning phase.

The HRAC believes there is still an opportunity at this stage of the NCS to implement the following recommendations:

- Health research participants defined as AI/AN must present proof of enrollment from a federally recognized tribe as provided in the current “Indian Entities Recognized and Eligible to Receive Services from the United States Bureau of Indian Affairs” or meet the Bureau of Indian Affairs (BIA) definition of AI/AN as provided by a “Certificate of Degree of Indian Blood.” Self-identification is not adequate;
- Oversampling of AI/AN populations should be done through the inclusion of AI/AN majority hospitals and clinics in any data set to improve understanding of disparate infant mortality rates and childhood death and disability. Data are needed to determine the root causes of these disparities and to develop effective intervention strategies and programs;
- Sampling protocols promised by the NCS, including preservation of DNA and tissue samples, must be followed and tribes must be consulted before, during, and after as ongoing partners;
- Commitment to tribal sovereignty must be kept;
- De-identification of data must be reviewed with tribes; and
- A data-sharing agreement with tribes must be established before the local study commences.

## 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 research of the root causes of the epidemic.

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 health care services for AI/ANs in both rural and urban settings; lack of incorporation of traditional health care 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 reduction;
- 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 research;
  - Suicide prevention;
  - Readiness of tribal governments for public health accreditation; and
  - Health care reform impact and effectiveness evaluation.

In addition, efforts should be made to support research aims that attempt to understand exposure to risk and vulnerability over the entire lifespan 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 risk unique to AI/ANs as an indigenous population resulting from misguided federal Indian policy.

It is important to stress that all research conducted should be evidence-based, and to the extent possible, community-based participatory research. 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 are 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 (possible avenue is through additional funding through the IHS Health Professions Scholarship Program and Loan Repayment Program, and CDC and NIH, specifically, for research positions);
- 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, the HRAC recommends that HHS make oversampling a priority to provide these 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; and
- Holding a consultation with tribes for the purpose of developing a department-wide policy on data management in Indian Country.

Additionally, one of the most beneficial improvements would be to establish single data sources. As an example, the federal government maintains several AI/AN data sources through IHS, BIA, Centers for Medicare & Medicaid Services, CDC, NIH, SAMHSA, U.S. Census Bureau, and others. A single, integrated Internet accessible website with data available to calculate simple statistics, such as incidence and prevalence rates, would assist in identifying areas of focus within AI/AN communities. Additionally, 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 are available to reduce any burdens on grant awardees. Resources that are readily available to assist include the HRAC, other AI/AN federal advisory bodies, intertribal 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 also because too many times a research project has been rendered useless by the AI/AN community because it was conducted without adequate collaboration or had relied on invalid AI/AN expertise.

The HRAC 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. Tribal Council meetings may only be held monthly, so 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 use grant reviewers that have demonstrated experience with tribal governments and who are culturally sensitive. Such reviewers can ensure that grant applications include adequate collaboration and cooperation components, as well as evaluate grant applications from the AI/AN community that may have extensive subject matter experience but fewer academic credentials and degrees. The HRAC recommends developing a training module to assist non-Native reviewers.

## **NATIONAL INSTITUTES OF HEALTH TRIBAL CONSULTATION POLICY**

The HRAC is encouraged that the NIH has started to address tribal consultation with the Guidance on the Implementation of the HHS Tribal Consultation Policy. However, the HRAC is concerned about the delays in implementation. It is recommended that all tribal leaders be informed of NIH’s efforts and receive a copy of the guidance for their review as well as any upcoming consultation opportunities.

In addition, more focus should be placed on putting AI/AN leadership throughout the NIH to provide advice on issues of importance to Native communities and to ensure tribes are consulted on priorities, research design, and community-based research.

## ATTACHMENT A:

### MEMBER AND PARTNER LIST FOR FY 2014–2015

#### HRAC CO-CHAIRS

##### **Stephen Kutz**

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**HRAC Co-Chairs Stephen Kutz and Aaron Payment**

## MEMBERS

2014 Area Representatives	2015 Area Representatives
<p><b><i>Great Plains Area (formally the Aberdeen Area)</i></b>  <b>Delegate:</b> Patrick Marcellais            Councilman, Turtle Mountain Band of Chippewa Indians  <b>Alternate:</b> John Black Hawk            Chairman, Winnebago Tribe of Nebraska</p>	<p><b><i>Great Plains Area (formally the Aberdeen Area)</i></b>  <b>Delegate:</b> Patrick Marcellais            Councilman, Turtle Mountain Band of Chippewa Indians  <b>Alternate:</b> John Black Hawk            Chairman, Winnebago Tribe of Nebraska</p>
<p><b><i>Alaska Area</i></b>  <b>Delegate:</b> Ileen Sylvester            Vice President of Executive &amp; Tribal Services,            Southcentral Foundation  <b>Alternate:</b> Jay Clarence Butler            Senior Director, Division of Community Health            Services, Alaska Native Tribal Health Consortium</p>	<p><b><i>Alaska Area</i></b>  <b>Delegate:</b> Ileen Sylvester            Vice President of Executive &amp; Tribal Services,            Southcentral Foundation  <b>Alternate:</b> Jay Clarence Butler            Senior Director, Division of Community Health            Services, Alaska Native Tribal Health Consortium</p>
<p><b><i>Albuquerque Area</i></b>  <b>Delegate:</b> Vacant  <b>Alternate:</b> Vacant</p>	<p><b><i>Albuquerque Area</i></b>  <b>Delegate:</b> Michelle Gomez            Director, Jicarilla Apache Community Health and            Fitness Center  <b>Alternate:</b> Pamela Cordova            Councilwoman, Mescalero Apache Tribe</p>
<p><b><i>Bemidji Area</i></b>  <b>Delegate:</b> Aaron Payment            Tribal Chairperson, Sault Ste. Marie Tribe of            Chippewa Indians  <b>Alternate:</b> Vacant</p>	<p><b><i>Bemidji Area</i></b>  <b>Delegate:</b> Aaron Payment            Tribal Chairperson, Sault Ste. Marie Tribe of            Chippewa Indians  <b>Alternate:</b> Vacant</p>
<p><b><i>Billings Area</i></b>  <b>Delegate:</b> Patty Quisno            Councilwoman, Fort Belknap Indian Community  <b>Alternate:</b> Darrin Old Coyote            Chairman, Crow Nation</p>	<p><b><i>Billings Area</i></b>  <b>Delegate:</b> Patty Quisno            Councilwoman, Fort Belknap Indian Community  <b>Alternate:</b> Darrin Old Coyote            Chairman, Crow Nation</p>
<p><b><i>California Area</i></b>  <b>Delegate:</b> Daniel Calac            Chief Medical Officer, Indian Health Council  <b>Alternate:</b> Vacant</p>	<p><b><i>California Area</i></b>  <b>Delegate:</b> Daniel Calac            Chief Medical Officer, Indian Health Council  <b>Alternate:</b> Vacant</p>



2014 Area Representatives	2015 Area Representatives
<p><b><i>Nashville Area</i></b>  <b>Delegate:</b> Sandra Yarmal            Health Director, Passamaquoddy Tribe Pleasant Point  <b>Alternate:</b> Tihtiyas (“Dee”) Sabattus            Health Policy Analyst, United South and Eastern Tribes, Inc.</p>	<p><b><i>Nashville Area</i></b>  <b>Delegate:</b> Vacant  <b>Alternate:</b> Tihtiyas (“Dee”) Sabattus            Health Policy Analyst, United South and Eastern Tribes, Inc.</p>
<p><b><i>Navajo Area</i></b>  <b>Delegate:</b> Rex Lee Jim            Vice President, Navajo Nation  <b>Alternate:</b> Larry Curley            Executive Director, Navajo National Division of Health</p>	<p><b><i>Navajo Area</i></b>  <b>Delegate:</b> Rex Lee Jim            Vice President, Navajo Nation  <b>Alternate:</b> Vacant</p>
<p><b><i>Oklahoma Area</i></b>  <b>Delegate:</b> Cara Cowan Watts            Tribal Council Representative, Cherokee Nation  <b>Alternate:</b> Tom Anderson            Tribal EpiCenter Manager, Oklahoma City Area Inter-Tribal Health Board</p>	<p><b><i>Oklahoma Area</i></b>  <b>Delegate:</b> Cara Cowan Watts            Tribal Council Representative, Cherokee Nation  <b>Alternate:</b> Tom Anderson            Tribal EpiCenter Manager, Oklahoma City Area Inter-Tribal Health Board</p>
<p><b><i>Phoenix Area</i></b>  <b>Delegate:</b> Diane Enos            President, Salt River Pima-Maricopa Indian Community  <b>Alternate:</b> Violet Mitchell-Enos            Director, Health and Human Services, Salt River Pima-Maricopa Indian Community</p>	<p><b><i>Phoenix Area</i></b>  <b>Delegate:</b> Vacant  <b>Alternate:</b> Violet Mitchell-Enos            Director, Health and Human Services, Salt River Pima-Maricopa Indian Community</p>
<p><b><i>Portland Area</i></b>  <b>Delegate:</b> Stephen Kutz            Councilman, Cowlitz Indian Tribe  <b>Alternate:</b> Vacant</p>	<p><b><i>Portland Area</i></b>  <b>Delegate:</b> Stephen Kutz            Councilman, Cowlitz Indian Tribe  <b>Alternate:</b> Vacant</p>
<p><b><i>Tucson Area</i></b>  <b>Delegate:</b> Chester Antone            Councilman, Tohono O’odham Nation  <b>Alternate:</b> Vacant</p>	<p><b><i>Tucson Area</i></b>  <b>Delegate:</b> Chester Antone            Councilman, Tohono O’odham Nation  <b>Alternate:</b> Vacant</p>



2014 National At-Large Members	2015 National At-Large Members
<p><b>Delegate:</b> Jefferson Keel Lt. Governor, Chickasaw Nation <b>Alternate:</b> Malia Villegas Director, Policy Research Center, National Congress of American Indians</p>	<p><b>Delegate:</b> Jefferson Keel Lt. Governor, Chickasaw Nation <b>Alternate:</b> Malia Villegas Director, Policy Research Center, National Congress of American Indians</p>
<p><b>Delegate:</b> H. Sally Smith Chair of the Board of Directors, Bristol Bay Area Health Corporation and Alaska Representative of National Indian Health Board <b>Alternate:</b> Stacy Bohlen Executive Director, National Indian Health Board</p>	<p><b>Delegate:</b> H. Sally Smith Chair of the Board of Directors, Bristol Bay Area Health Corporation and Alaska Representative of National Indian Health Board <b>Alternate:</b> Stacy Bohlen Executive Director, National Indian Health Board</p>
<p><b>Delegate:</b> Michael Percy Epidemiologist, Choctaw Nation Health Services Authority/Chickasaw Nation <b>Alternate:</b> Mickey Percy Executive Director of Health Services, Choctaw Nation of Oklahoma</p>	<p><b>Delegate:</b> Michael Percy Epidemiologist, Choctaw Nation Health Services Authority/Chickasaw Nation <b>Alternate:</b> Mickey Percy Executive Director of Health Services, Choctaw Nation of Oklahoma</p>
<p><b>Delegate:</b> Vacant <b>Alternate:</b> Vacant</p>	<p><b>Delegate:</b> Vacant <b>Alternate:</b> Vacant</p>

## FEDERAL PARTNERS

2014 Federal Partners	2015 Federal Partners
<p><b><i>Administration for Children and Families</i></b>  <b>Delegate:</b> Anne Bergan                      Office of Planning, Research and Evaluation  <b>Alternate:</b> Hilary Forster                      Office of Planning, Research and Evaluation</p>	<p><b><i>Administration for Children and Families</i></b>  <b>Delegate:</b> Anne Bergan                      Office of Planning, Research and Evaluation  <b>Alternate:</b> Hilary Forster                      Office of Planning, Research and Evaluation</p>
<p><b><i>Agency for Healthcare Research and Quality</i></b>  <b>Delegate:</b> Kishena C. Wadhvani                      Director, Division of Scientific Review  <b>Alternate:</b> Vacant</p>	<p><b><i>Agency for Healthcare Research and Quality</i></b>  <b>Delegate:</b> Kishena C. Wadhvani                      Director, Division of Scientific Review  <b>Alternate:</b> Vacant</p>
<p><b><i>Assistant Secretary for Planning and Evaluation</i></b>  <b>Delegate:</b> Sue Clain                      Indian Health Desk Officer  <b>Alternate:</b> Ansalan Stewart                      Program Analyst</p>	<p><b><i>Assistant Secretary for Planning and Evaluation</i></b>  <b>Delegate:</b> Adelle Simmons                      Senior Program Analyst  <b>Alternate:</b> Vacant</p>
<p><b><i>Centers for Disease Control and Prevention</i></b>  <b>Delegate:</b> Delight Satter                      Associate Director Tribal Support  <b>Alternate:</b> Kimberly Cantrell                      Deputy Associate Director Tribal Support</p>	<p><b><i>Centers for Disease Control and Prevention</i></b>  <b>Delegate:</b> Delight Satter                      Associate Director Tribal Support  <b>Alternate:</b> Kimberly Cantrell                      Deputy Associate Director Tribal Support</p>
<p><b><i>Health Resources and Services Administration</i></b>  <b>Delegate:</b> Michelle Allender-Smith                      Director, Office of Health Equity  <b>Alternate:</b> Chrisp Perry                      Public Health Analyst, Office of Health Equity</p>	<p><b><i>Health Resources and Services Administration</i></b>  <b>Delegate:</b> Michelle Allender-Smith                      Director, Office of Health Equity  <b>Alternates:</b> Chrisp Perry and LCDR Gwenivere Rose                      Public Health Analysts, Office of Health Equity</p>
<p><b><i>Indian Health Service</i></b>  <b>Delegate:</b> Alan Trachtenberg                      Research Director, United States Public Health Service  <b>Alternate:</b> Mose A. Herne                      Director, Division of Planning, Evaluation, and Research</p>	<p><b><i>Indian Health Service</i></b>  <b>Delegate:</b> Mose A. Herne                      Director, Division of Planning, Evaluation, and Research  <b>Alternate:</b> Vacant</p>



2014 Federal Partners	2015 Federal Partners
<p><b><i>National Institutes of Health</i></b>  <b>Delegate:</b> Yvonne Maddox            Acting Director, National Institute on Minority Health and Health Disparities  <b>Alternate:</b> Joyce A. Hunter            Deputy Director, National Institute on Minority Health and Health Disparities</p>	<p><b><i>National Institutes of Health</i></b>  <b>Delegate:</b> Yvonne Maddox            Acting Director, National Institute on Minority Health and Health Disparities  <b>Alternate:</b> Joyce A. Hunter            Deputy Director, National Institute on Minority Health and Health Disparities</p>
<p><b><i>Office of Minority Health*</i></b>  <b>Delegate:</b> J. Nadine Gracia            Deputy Assistant Secretary for Minority Health and Director  <b>Alternate:</b> CDR Tracy Branch and Rick Haverkate            Public Health Advisor</p>	<p><b><i>Office of Minority Health*</i></b>  <b>Delegate:</b> J. Nadine Gracia            Deputy Assistant Secretary for Minority Health and Director  <b>Alternate:</b> Rick Haverkate            Public Health Advisor, AI/AN Health Policy Lead</p>
<p><b><i>Substance Abuse and Mental Health Services Administration</i></b>  <b>Delegate:</b> Sheila Cooper            Senior Advisor for Tribal Affairs  <b>Alternate:</b> Vacant</p>	<p><b><i>Substance Abuse and Mental Health Services Administration</i></b>  <b>Delegate:</b> Sheila Cooper            Senior Advisor for Tribal Affairs  <b>Alternate:</b> Vacant</p>

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**For Additional Information on the HRAC:**

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