**TSGAC Meeting**

**July 24, 2020**

Note: Due to COVID-19, the TSGAC meeting was held virtually. A quorum was established for the meeting.

**Meeting Called to Order**

Chief Lynn Malerba welcomed everyone to the call and welcomed Lt. Governor Anoatubby from the Chickasaw Nation, who begin the meeting with an invocation. Chief Malerba then asked everyone to join her in a moment of reflection to remember all of those impacted by COVID-19.

**TSGAC Opening Remarks**

Chief Malerba chose to forgo opening remarks but stated that she believes that there is a lot of work to be done with collaboration and interagency cooperation and believes the COVID virus has highlighted that. She also stated that moving forward, we need to focus on how we engage with agencies and ensure that all of the agencies are working with one another to provide the best service possible to Indian Country.

**RADM Michael Weahkee, Director, IHS**

Director Weahkee began by thanking Chief Malerba, Lt. Governor Anoatubby, each of the Self-Governance members for their leadership throughout the pandemic, and IHS Office of Self-Governance Director Jennifer Cooper and her team. Director Weahkee also expressed the importance of the relationship between TSGAC and IHS.

Director Weahkee proceeded to update the group on his participation in the HHS Regional Tribal Consultation Sessions. He stated that he appreciated the feedback on ways to improve tribal outreach and coordination and encouraged everyone to participate in the sessions that focus on regional specific issues and discuss programmatic and policy issues with HHS leadership on the national level. He noted that for more information about the past sessions or to register to participate in future regional sessions, you could visit hhs.gov and search consultation. Director Weahkee appreciates the Significance Report, provided by HHS leaders, for prioritizing the health programs and services for American Indians and Alaska Natives.

On Wednesday, Director Weahkee testified before the House Subcommittee for Indigenous Peoples of the United States. He testified on three separate bills, including The Proper and Reimbursed Care for Native Veterans Act, The Coverage for Native Health Providers Act, and the Alaska Native Tribal Health Consortiums Land Transfer Act of 2020. He communicated a firm commitment for improving quality, safety, and access to quality healthcare for the patients we serve and expressed appreciation for all efforts in helping to do so.

Earlier this month, Director Weahkee provided testimony before the Senate Committee on Indian Affairs on the HIS’s response and mitigation efforts on the COVID-19 pandemic. He also provided testimony on the proposed coverage for Urban Indian Health Providers Act. The IHS endorses the policy to extend the Federal Tort Claims Act coverage for Urban Indian organizations.

In his bi-weekly email to Tribal and Urban Indian organization leaders, Director Weahkee mentioned that the Department of Human Services has recently announced a move from the Center for Disease Control and Prevention National Health Safety Network to a newly created HHS Protect System that provides real-time hospital data during the COVID-19 epidemic. The streamlined system allows HHS to better utilize real-time automated data to improve the federal response. It ensures faster and more accurate distribution of therapeutics and supplies to all patients across the U.S. The data is accessible to hospitals and states, localities, and tribal partners using HHS Protect. The system provides better data automation, more transparency, and greater data access for healthcare experts and government officials.

While the Indian Health System is large and complex, they realize that preventing, detecting, treating, and recovering from COVID requires local expertise and local coordination. They continue to participate in regular conference calls with tribal leaders from across the country to provide us with updates, answer questions, and hear directly about our challenges and questions.

In closing, Director Weahkee spoke about the report released yesterday by the Whitehouse Presidential Task Force on protecting Native American children in the Indian Health Service system. IHS remains committed to ensuring a culture of quality, leadership, and accountability. They appreciate the Task Force's feedback and welcome any opportunity to continue to improve and sustain the culture of care throughout the agency. The report complements the HHS Office of Inspector General's ongoing work, examining the sufficiency and implementation of IHS’s patient protection policies and procedures. Together, these reports will be used to continue to make improvements to ensure the protection of patients and prevent harm.

Sexual assault and abuse will not be tolerated in the IHS. The IHS has taken aggressive action to ensure patient protection; however, there is always room for improvement, and they will continue to make this one of their highest priorities. In July of 2018, they announced new mandatory training for all employees regarding protecting children from sexual abuse in healthcare settings. They have implemented a centralized credentialing system allowing credentialing staff to access provider information in a single electronic database. They have also hired an IHS Credentialing Program Manager at the IHS headquarters level. They have just launched a new sexual abuse prevention website to provide information to patients, employees, and tribal and urban partners to prevent sexual abuse in the Indian Health System. Several recommendations in the Task Forces report would require Congressional action. IHS has already made several proposals in the 2021 Congressional Justification of Estimates for Appropriations Committees that would address several of the Whitehouse Report's recommendations if passed by Congress and signed by the President.

**HHS Health Information Technology Modernization Project Update-Mitchell Thornburgh, Chief Information Officer, and Director, Office of Information Technology, IHS.**

Mr. Thornburgh began his update on the Modernization Project by stating that with FY 2020 funding and funding from the Cares Act, they expect to substantially move the project forward.

Mr. Thornburgh indicated that they are looking to replace the RPMS Electronic Health Record system. The current infrastructure is unsustainable and unable to deliver critical capabilities to meet modern healthcare systems' continually evolving needs. They recognize that the IHS relies on the VA Vista Development Team for significant updates such as lab, radiology, and pharmacy components. They are responding to the VA's announcement to move away from the Vista platform and ensure that the IHS and the tribal and urban partners have the technology and IT infrastructure that they need to successfully provide care throughout the country. He reiterated that modernizing the health IT infrastructure is a molder effort that requires planning, equipment standardization, building interfaces, the configuration of EHR environments, increased governance and oversite of the infrastructure, as well as significant staff training to ensure the IHS and our tribal and urban partners have a modern effective and efficient tool to improve health throughout the country.

Mr. Thornburgh highlighted the expected benefits for the Modernization Project. They are improving patient safety, improving patient outcomes, better disease management, helping population health quality measures, opioid tracking, patient tracking, patient data exchange, third party revenue generation, agency performance reporting, and ensuring a sustainable support cost model. He went on to say that while looking at the scope of the Modernization Project, they recognize that they are providing care to and serving 2.6 million Americans and that the technology changes that they make changes each of those, and they have to modernize in a way that is respectful of the Tribal self-governance programs and Public Law 93-638 programs. They know there are roughly 116 IHS facilities and almost 500 Tribal as well as over 40 Urban facilities. As they look to modernize, they are keeping the full scope and scale of the ITU health delivery infrastructure in mind and designing solutions that can scale to that level as well as be respectful to the various stakeholders' needs.

Mr. Thornburgh went on to do a rundown of the funding, which includes $8 million provided in the FY 2020 appropriations and $65 million provided in the Cares Act - some of which was based on projections for FY 2021. This did not include the amount identified to complete the EHR procurement, so they are pending additional funding from Congress to complete the FY 2021 request.

He provided an update on technical needs. Scaling the suite of products and infrastructure can support over 20,000 users, over 50 hospitals, and up to 600 outpatient clinics. That has to be kept in mind as they design the infrastructure. It is designed to be EHR agnostic. Recognizing that they have tribal and urban stakeholders that have already moved off of RPMS, they are currently piling connections to eHealth Exchange to create interoperability between the VA, the DOD, tribal partners, and any certifiable EHR.

They are looking to partner with MITRE FFRDC to make sure they have PMO support as well as justification for acquisition assistance. The project management organization will evaluate and document the project acquisition needs and support the project across several deliverables. They will make sure they are able to stand up resources to support the HIT Modernization project and overall program management, to establish governance and support governance models, to sustain infrastructure once they move into operations, to create the acquisition and program planning documentation, which includes acquisition planning, and strategy, pre-award acquisition, policy standards, and training support. There will also be definition and management, enterprise system engineering, cybersecurity, and privacy support, as well as enterprise integration of all of the critical efforts, which includes data management and integration. Lastly, they will support the integrational change management component making sure that they stay fully engaged throughout strategy and planning.

The next steps are to ensure that they have the support that they need to continue the project piloting the eHeath Exchange as well as executing the MITRE FFRDC. They are recruiting for some federal positions. This will better allow them to support the federal acquisitions process and manage the PMO. In the next few weeks, they plan to host listening sessions for tribal consultation and urban confer so that they may answer any questions that may arise.

**Office of Tribal Self-Governance Update-Jennifer Cooper, Director, Office of Tribal Self-Governance, IHS**

Director Cooper began by sharing that their office has hired two new financial analysts - Anastasia Watson from the Choctaw Nation of Oklahoma and Seneca Hodahkwen from the Prairie Band Potawatomi Nation.

Since we last met, there is one new Self-Governance Tribe, The Round Valley Indian Tribe, with a start date of March 1, 2020, which brings them to 105 Self-Governance compacts and 131 funding agreements.

Director Cooper stated that they had transferred about $597 million to self-governance tribes since the COVID-19 pandemic began. This figure only includes about a quarter of the Payment Protection Program and Health Care Act bilaterals. They are working with tribes to send in those bilaterals and budget documents to return those as fast as they can.

Director Cooper also commented that they had started an update of the PSFA Handbook. This will be done in a three-stage process. In the first phase, they will be internally reviewing the written documentation they already have. The second phase will consist of compiling updated drafts and working with the subcommittees that have been working on the Tribal Negotiations Handbook update. The final phase will be moving toward a full consultation. They are still in the first phase and hope to have a complete draft by our next meeting.

**Indian Health Service Budget Update-Jillian Curtis, Director, Office of Finance & Accounting**

Director Curtis commenced the update with an overview of COVID-19 funding, stating that Congress has enacted four supplemental appropriation bills associated with COVID-19 preparedness and response thus far. They are IDDAs from the HHS Public Health and Social Services Emergency Fund. All funding decisions regarding these dollars were communicated to tribal and urban Indian organization leaders in writing, and those letters are posted on the IHS website. They are continuing to monitor the situation toward a fifth supplemental bill. The House has already passed its version of the fifth supplemental bill, the Heroes Act, which included $ 2.1 billion for IHS continued preparedness and response activities for Corona Virus. In his June 11, 2020 hearing before the House Interior Appropriations Subcommittee, RADM Weahkee highlighted the challenges that the tribes experience applying and competing for grants, especially during a public health emergency, and the importance of the speed of making those IHS administered dollars available. They hope for their message to be heard and those funds directly appropriated to IHS in the next round of COVID-19 supplemental funds.

Moving to the next issue, Director Curtis touched on potable water and sanitation needs. Thus far, $9.4 million has been distributed to over 209 tribes. The 1st distribution of $4.7 million was provided to all 12 IHS areas, and the 2nd distribution of $4.7 million was provided to the Navajo area. Three priority areas funded the twelve IHS areas. Those areas were; failed treatment and distribution equipment, water chemical treatment needs, and nonoperational individual water or wastewater system repairs and replacement.

The next issue was the CARES Act “Unallocated” amount. IHS has allocated $30 million to support unanticipated near-turn needs. Thus far, $10 million has been identified for an interagency agreement for additional PPE and medical supplies. The IHS is implementing an IAA to procure hard to find PPPE and medical supplies through the Strategic Nation Stockpile to supplement National Service Supply Fund resources. Supplies procured under this method would be provided to I/T/Us at no cost.

Director Curtis then moved on to the FY 2021 House Bill, which includes a total discretionary budget authority of $6.5 billion, which is $445 million above the FY 2020 enacted. The budget includes $4.5 billion for services, $935 million for facilities, $916 million in contract support costs, and $101 million for Section 105 Leases. The FY 2021 House Bill also includes a separate $1.5 billion appropriation for IHS Facilities programs. This includes $1.25 billion for the Health Care Construction Facilities Priority List, and the Small Ambulatory program, $200 million for maintenance and improvement needs, $50 million for new and replacement staff quarters, and $50 million for equipment.

Moving on to Section 105 Leases, Director Curtis mentioned that they had paused the Cost Projections Subgroups National Tribal Budget Formulation Workgroup efforts since the last meeting. They will be reaching out to them shortly to see when it may be best to restart this work. Regarding the Policy Recommendations Workgroup, they are still evaluating the recommendation to establish this group at this time.

Going into Exception Apportionment, Director Curtis stated that IHS is beginning to prepare the Exception Apportionment for FY 2021. Lastly, she mentioned Advance Appropriations. They have held a dialogue with VHA to understand how they formulate and execute their Advance Appropriations in Congress. They are also closely monitoring any Hill action on Advance Appropriations to be prepared to implement if Congress were to enact that new authority for IHS.

**Patient Protection and Affordable Care Act (ACA) Implementation Update-Cyndi Ferguson, Self-Governance Specialist/Policy Analyst, SENSE Inc.**

Mrs. Ferguson provided an update on the ACA Outreach and Education Project. She reported that they are on track with the work and the deliverables that have been outlined in the agreement despite the recent challenges with COVID. She also reported that they had had two successful webinars on COVID-19 in the past few months with excellent open discussion. The most recent webinar on the use of COVID funding had over 300 participants. That webinar, along with the supporting documents, is on the tribalselfgov.org website under the Healthcare Reform section.

**Update on COVID-19**

**PPE Update-Capitan Rob Hays, Director of the National Service Supplies Center**

Capitan Hays reported that the National Service Supplies Center has been working with IHS and have distributed over 60 million units of PPE and other COVID related products. This has been done for the most part at no cost to the tribes. They are working with the area offices to distribute these products to the Tribes. They have procured 6.3 million N-95 respirators and are close to closing in 15 million levels 1, 2, and 3 gowns, 10 million loop masks, and 31 million pairs of gloves. They have already distributed 3 million face masks, goggles, and glasses, along with many other items that are needed. Their goal is to have a three-month supply as they head into the fall so that in the event of a surge, they can quickly distribute the items needed. They are working with the Anchorage Regional Supply Service Center, the Gallup Regional Supply Service Center, and Project TRANSAM to stage and supply products throughout the country. They are also working closely with FEMA to help distribute products to the tribes.

Captain Hayes also reported that they are preparing for the vaccines that will be produced and distributed through Operation Warp Speed. They are doing everything they can to make sure the tribes are included in the vaccine distribution. He included that they have a stock of a promising drug called Remdesivir that they are sending out at urgent request.

**Sanitation Facilities priorities, Use of COVID-19 Resources/Funding -RADM Mark Calkins, Director of the Division of Sanitation Facilities Construction, IHS**

Admiral Calkins spoke on their use of the CARES Act funds. They have sent out $9.4 million in funding to all areas. A large portion of that funding went to the Navajo area to address some of their immediate needs related to lack of access to water. When they first learned that they would be receiving the funds, they made sure that priority was given to those homes without access to piped water. Their first priority was to increase access to temporary water points at no charge to the homeowners with failed individual water systems or other homes without piped water. This was mainly to address the problems in the Navajo and Alaska areas. They also included, under priority one, public outreach information that could be posted for people to read through to make sure they are doing the proper things related to hygiene when they are hauling the water. Priority two was to provide PPE for the solid waste and wastewater utility operators to reduce work-related biohazard exposures. Priority three was to provide emergency project funding to address failed or nonoperational individual water or sewer systems to ensure all tribal homes have access to reduce the risk of Coronavirus spread and provide basic needs and hygiene. They also provided emergency project funding to address failed treatment and distribution equipment and ensure that treatment chemicals are available to continue the operation of the water supply and waste disposal systems during the COVID-19 outbreak. They reached out to tribal contacts in order to identify potential projects, and the funding was distributed based on the three priorities. They currently have a balance of over $500 thousand remaining, and they fully expect to expend those funds for priority one through three items.

**Long-term changes to the IT system**

Mr. Thornburgh had left the call, so Jennifer Cooper spoke briefly on this issue. She shared that since April’s telehealth expansion, the IHS has had a ten-fold increase from roughly 75 telehealth visits each week on average to 727 weekly telehealth visits. This does not include other modalities such as care provider phone calls, which is not uncommon in a bandwidth constraint environment such as Indian Country. IHS is also working on standardization of how stakeholders document telemedicine in RPMS. IHS has not seen an increase in telephonic visits, but at this time, it needs further analysis to differentiate healthcare services provide by telephonic visits as opposed to other general care coordination such as scheduling, reporting lab results, etc.

**Open Discussion**

**Q**: (Chairman Allen) With the 10 million dedicated for PPE and medical supplies, will the unanticipated $30 million be able to be used for medical countermeasures, for example, vaccines?

**A:** (Jillian Curtis) The $10 million that we are currently targeting is predominately intended for the procurement of PPE and other medical supplies, but as vaccine development continues, we are keeping a careful watch on that development; so we can potentially identify existing resources to support them if it is necessary for procuring or distributing those particular countermeasures. We aren't there yet, but we are watching closely and monitoring the current purposes of the dollars that we have to determine whether we can support that activity. I also understand that Congress is considering the cost and implication of the distribution of a vaccine and if it's supplemental and fits what they are currently considering.

**Q:** (Chairman Allen) Will you support interagency transfers because that is \what we have been asking for, and will you support statutory language in the next COVID package, and provide some technical assistance for that because I think that is what is needed?

**A:** (Dir Weahkee) We are definitely open to any innovative flexibilities provided. We know that getting resources to our tribes as quickly as possible, especially in an emergency, is vitally important. One way of doing that is through IDDAs from one agency to another. That is something we would be willing to look at and support. I know that in the agency's past, some of our largest and most successful programs were the initial results of funding being provided from CDC to IHS in the case of an SDPI Program or NIH to IHS for tribal epicenters. So, we are definitely open to that type of innovative out of the box thinking. That being said, it is also just as important that the funding that comes to the IHS, as we have been advised, if the funding is provided to the CDC and it must go out in a competitive grant, and then they transfer that money to IHS, the rules governing those funds must follow the money, so we would have to put it out through a competitive grant. Those are the types of things we can work through.

**Q:** (Melanie Fourkiller) My comments go to HIT Modernization as well as telemedicine. Regarding HIT modernization, I want to focus on the $65 million that was held out of the Cares Act funds. I appreciate Mitch’s report saying those would be used to accelerate the EHR modernization effort. However, we note that those are Cares Act funds, so are there specific Cares Act activities because the funds must be used to prevent, prepare, and respond to Corona Virus, that the IHS will target those funds for? What activities would be funded? Can you give us a breakdown? Will tribes be able to propose to access those funds? For instance, we found very quickly, related to Cares, that our laboratory information system (LIS) is totally inadequate to deal with the public health emergency we have been dealing with. If we were to get and LIS modern interface, it would help us with the record-keeping and reporting without so many manual systems, the quality assurances and quality control on that record-keeping when we report to IHS, when we report to the state, and interfacing with our outside labs. All of that has risen to the forefront, and RPMS is totally inadequate. We know it is inadequate in a number of areas, but the lab has really risen to the forefront. So, can tribes access those funds?

**A:** (Jillian Curtis) Starting with telehealth activities, the $95 million that we allocated from the Cares Act funds is intended for centralized services and a shared technology infrastructure to deliver patient care and provide a solid foundation that supports the long-term sustainability of telehealth infrastructure across the country. So, the vision there is to use the $95 million for nationwide improvements that both the IHS Tribes and Urban Indian organizations can access. For example, right now, we have expanded our telehealth through Sysco Systems, and it is working for this emergency situation. It is not designed to be a telehealth provider, so if there is an interest in finding a more telehealth appropriate modality, then we could establish that nationwide contract, and others could leverage that for providing telehealth services. The goal here is really to have system-level planning and support for telehealth, which is something that we don't have at IHS right now. We have much more of a fragmented approach so that we can not just address the emergent COVID-19 situation, but also have a longer-term support structure that can improve the continuity of primary care access management and sort of platform standardization across the country. So, the intention for those dollars is to keep them at the national level. I will note that the Cares Act dollars that tribes received to support their preparedness and response can be used for their own specific telehealth needs. So, that doesn’t preclude the tribes from using their Cares Act allocations to support whatever telehealth activities you need to implement in your own facilities in your own systems while we are developing this more nationwide plan.

Turning to Electronic Health Records stabilization and support, that $65 million is intended for the stabilization and support of RPMS and prepping for the transition to a new modernized Electronic Health Record infrastructure. I know that if Mitch or Dr. Toedt were on the line, they would be able to explain the challenges we are experiencing trying to respond to COVID-19, much like the challenges you identified in your own remarks regarding your laboratory capacity and feeding that out through RPMS. The appropriations committee here has recognized that our existing Electronic Heath Record infrastructure is not sufficient to support the needs of our system during the pandemic and that a modernized HER ultimately would be able to support those needs and approaches. The intention, therefore, for the $65 million is to use that specifically for the EHR modernization effort here at IHS as we look to the future beyond RPMS.

**A2:** (Maia Laing) The funding that is identified through the Cares Act for the purpose of stabilizing is that the activities around modernization are so tightly tied to stabilization that these activities in so many ways cannot be decoupled. We have talked about not wanting to overinvest in the existing system while recognizing that we need to ensure that there is a stable system in place while we modernize. These activities are very coupled together as we go through this transition. The $65 million is identified for the purpose of doing activities up to the modernization of the system, which includes stabilization as well as preparing for modernization, but it will require additional funding for us to get into a modern environment because we would need to be able to conduct the acquisition activities to do that.

**A3**: (Director Weahkee) All of that being said, if there are other technical issues that our tribes and other programs are contending with, that we have not taken into account and we have not, and we have not highlighted for appropriators, we would love to have that information to provide that in our technical assistance discussions with appropriators as they are putting this supplement together. We have already shared that our provider relief funding lost third-party revenues. The initial $500 million made a dent in the lost revenues but has not compensated for all of the losses, so we are hopeful to see some additional funding there. If there are other issues, we know that broadband access, telehealth, anything that falls under that umbrella, but if there are lab connectivity issues that we are not aware of that we can better speak to, we would love to have that information.

**Q:** (Chairman Allen) On health IT and broadband funding that needs to be a larger priority at this time and as we know, well into the future. You seem to be trailing in the country due to a lack of infrastructure. It is true in my state, Washington, and it is true elsewhere in the country. I know you are well aware of it. I know our state partners have been trying to assist us, for the most part, with funding and resources, with hotspots and dealing with the need for tools like laptops, cell phones, etc. to improve that infrastructure system. I have seen a lot out there in terms of different kinds of resources, and I have to admit, I am having trouble tracking all that is relevant to this particular need. What are you doing to try to facilitate improvement in that capacity?

**A:** (Director Weahkee) Like you, we are scrambling to keep our eyes on all the opportunities that have presented with the various waves of Corona Virus supplemental funding—taking a look at what the FCC is doing with extending the 2.5 gigahertz priority window for tribes. We know that there is an opportunity for tribes to request that 2.5 gigahertz opportunity, but it closes soon, and we are trying to get the deadline extended. We have many tribes that are currently operating with limited capacity. Internally, what we are doing is with the White House Corona Virus Task Force and the Indian Country Task Force, we are engaging in conversations about the need for broadband access across Indian Country. I have heard the secretary say directly, a number of times, that now that we have had a taste for telehealth in the heal care industry and we have proven the concept that patients accept that modality of receiving care, that he doesn’t want to see many of the flexibilities that CMS has put in place go away, not only on the payment side but in the use of various handhelds and other technological ways of promoting telehealth. So, we are hopeful that will stand. But I think if we look at the reopening of schools as an example, how are we going to reopen schools in Indian Country if we don’t have internet connectivity, and we don't have access for our children in our rural reservation sites? That same thing holds for telemedicine. The slow bandwidth and the slow connection speeds are prohibiting us from realizing what the rest of the country can capitalize on that sharing of information, making sure that people in the decision-making rolls and other agencies are well aware of the limitations in Indian Country, and keeping our eyes open for the available funding sources or solutions to address the issue.

**Comment:** (Chairman Allen) We are on the same page, and not only is it improving the capacity of our facilities, from the perspective of our clinics and hospitals as well, but it also increases our ability. In preparation for our future, if we have to quarantine, how we deal with the quarantine in a safe way. Telehealth is a vehicle for those kinds of issues. It is also getting training. We need you guys to work with us on the argument to Congress and the administration on why we need training resources, particularly with our elders, getting them comfortable using that tool. A pandemic is only one of the issues, as you well know. That's why I think that issue is critically important for us as we move forward, whether we are moving into another pandemic or moving forward with expanding our healthcare capacity.

**A2:** (Maia Laing) The only component I would add is that it is our continued commitment to ensuring that the infrastructure needed for the modernization effort is in place. As many are highlighting, COVID has certainly demonstrated where we have challenges in the infrastructure that we certainly are aware of. I have recently, in conversations with the CIO of HHS, had discussions around direct engagement with FCC for the identification of funds to further advance infrastructure in rural America, particularly within our tribal communities as we prepare for the modernization of health IT infrastructure. I just want to echo that these are active discussions. They are certainly on our radar, and we are looking to work with our federal partners to support this effort. It is also helpful to hear that telehealth training could be of use, particularly for your elders. I can also take that into discussions with other parts of the department that are focused on these efforts as well, and see what can be done there.

**Comment:** (Chairman Allen**)** I am learning through my own clinic that retrofitting our clinics to deal with telehealth is another factor that most people don’t think about. It is a different kind of system. It is not like your typical pods of doctors and nurse practitioners that process the different patients coming in and out regardless of what the issue is. When you have a telehealth system, it is a different configuration of a pod on how you would structure it. Now that we are moving that agenda forward, that is a construction retrofitting need. Also, best practices. What is the best system for the doctors and the nurses that are engaging with the patient? I’m spending our money retrofitting our system to be able to comply with that. If pandemics extend or surface, you see a lot of us putting these temporary tents out there for the drive-bys. We can't keep doing that. If you are in the middle of winter or down in Arizona or other hot areas. It's hot! Those guys have to stand there. Even if you have fans, etc., it doesn’t work. I just want to bring those points out because we are learning a lot of interesting lessons through this experience.

**Comment 2:** (Chief Malerba) One of the things I want to highlight is that pandemic or no pandemic, there are many applications for telehealth that are going to be very important to our tribes. In particular, think about behavioral health. We have tribal members who live everywhere, but we can surely provide those services using our own clinicians if we had better connectivity. It’s just another reason why we should invest in those systems.

**Comment 3:** (Terra Branson-Thomas) It has been a little while since we have seen a visual from HIT and kind of where you are in your process. It might be very helpful for the committee to see where you are in the decision-making process. I know there were phases or steps that you were initially talking about. I'm having a hard time, you know, there is lots of money, in general, kind of moving around related to the Coronavirus. I know there are special projects for HIT that you are working on. It might be helpful if you could put something visual together for those of us who are not as technical. That’s just one request I would make for HIT.

**Q:** (Terra Branson-Thomas)The other question I had was about the 105(l) lease workgroup. The TSGAC Workgroup had asked for a policy workgroup to talk about the process for negotiation and items for negotiation under a 105(l) lease. Having experienced the fallout after the CFC indefinite appropriation and how long it took the CFC Workgroup to reach some consensus around the final policy. I didn't hear it in the update that you intended to move forward on that recommendation. I did hear that you would bring the group back together that worked on the projected expenses but not necessarily a group on a policy. The two groups may have different participation. I would ask one if I missed it and two if IHS is considering that recommendation?

**A:** (Jillian Curtis)I briefly mentioned that acknowledged the recommendation that you all had made, and that is something we are taking into consideration. We have been delayed in our consideration of that recommendation in that we are having an all hands-on deck experience with COVID-19. It is still something we are considering and discussing internally.

**Comment:** (RADM Weahkee) I have two items to put on the radar screen - one opportunity and one threat. One opportunity, there is renewed interest in establishing an Indian Health Service Foundation, much like what exists for CDC, NIH, and FDA. The pandemic has really brought a lot of people out in the interest of various clusters throughout Indian Country. We have had a lot of people interested both domestically and internationally in contributing to Indian health. So, that dialogue is new and ongoing. If we look at some of our sister agencies that have foundations, like CDC, they bring in an additional $60 to $70 million dollars a year on top of their annual appropriations to address issues that are difficult to address with their federal appropriations. I just wanted to put that onto everyone's radar screen as a potential topic that you may want to see and hear more about. The other being the threat. We hear rumblings behind the scenes about a potential initiative to extend 100% FMAP beyond the IHS and tribal healthcare systems to non-IHS and non-tribal without going through a referral. So, I just wanted to put that on to your radar screen as a potential threat as well.

C**omment**: (Chief Malerba) I will tell you that I actually chatted with the CDC Foundation recently, and they are providing boots on the ground assistance during the pandemic, so I think that they can be very flexible with their resources and their funding. I think that is a really good opportunity to pursue in terms of the 100% FMAP to tribal providers. I think that is hugely problematic. I will tell you that we will be addressing that, and we hope that you will be doing the same because we think that really diminishes the resources available in Indian Country because then our patients will be going to non-tribal providers, whether it's IHS or tribal program providers. It will further dilute the funding that we have available, so we have communication almost ready to roll out. We are also sharing that with our org partners as well, to make sure that there is a consistent voice throughout Indian Country on that topic. So, thank you for raising that.

**Q:** (Chairman Allen) This is an issue with IT and the database system, like the National Data Warehouse System and Epic Systems. We have to log this information manually, and it can be very time-consuming. Is there any effort to improve that? I have to admit that I don't even know if the data we have relative to COVID patients and deaths, etc., are part of that issue and accuracy and timeliness. I'm just wondering what's going on. Are we making any progress on that end?

**A:** (Director Weahkee) A few years ago, we implemented a data mart that was meant to be able to collect information at the National Data Warehouse from all EHRs regardless of them being agnostic of HER being used. I do know that much of our Coronavirus data collection we have had to do manually because our system just doesn't collect the data that we need for this particular response.

**Closing**

Lt Governor Anoatubby closed out the meeting with a blessing.