

# CDC/ATSDR TAC Meeting

*The Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) hosted their Tribal Advisory Committee (TAC) Meeting and 17th Biannual Tribal Consultation Session, August 8–9, 2017, at The Artesian Hotel in Sulphur, Oklahoma. During the course of the two-day meeting, TAC members held discussions with CDC and ATSDR representatives. Topics discussed included CDC’s budget, tribal strategies for connecting cultural practices in competitive funding opportunities, Zika virus response, and tribal public health priorities.*

## TUESDAY, AUGUST 8, 2017

### Opening Blessing

The opening session began with a prayer led by Lieutenant (Lt.) Governor Jefferson Keel, Oklahoma Area Delegate. Councilman Chester Antone, TAC chair and Tucson area delegate, called the meeting to order at 9:07 AM.

Lt. Governor Keel welcomed everyone and wished them all a comfortable stay at the Artesian Hotel, Casino & Spa. He gave a brief history of the hotel, previewed its facilities and encouraged the audience to explore the amenities. He also informed everyone that the Chickasaw Cultural Center would be hosting a dinner that evening and that arrangements for transportation to the center had been made. He acknowledged Heather Summers, Chickasaw Nation, for her excellent coordination skills in managing preparations between the TAC meeting at the Artesian Hotel and the Chickasaw Cultural Center.

Lt. Governor Keel began the nomination process for the positions of TAC chair and co-chair, by respectfully nominating Councilman Antone and Vice President Jonathan Nez, TAC co-chair and Navajo area delegate, to continue serving in their respective capacities. President Alicia Andrew, Alaska area delegate, seconded the nomination.

Vice President Nez greeted all tribal leaders and advisors. He congratulated Councilman Antone on his work and team. He concluded by stating that he looked forward to having a productive meeting.

Councilman Antone replied by thanking Vice President Nez and moved the meeting along by announcing the next item on the agenda, the roll call.

Roll call was taken by Priyanka Oza, public health advisor, Tribal Support Unit (TSU), Office for State, Tribal, Local and Territorial Support (OSTLTS), CDC.

Members present for roll call:

- Alaska Area Delegate—President Alicia Andrew, Karluk IRA Tribal Council
- Bemidji Area Delegate—Representative Robert TwoBears, Ho-Chunk Nation of Wisconsin
- Great Plains Area Delegate—Chairman Robert Flying Hawk, Yankton Sioux Tribe
- Navajo Area Delegate—Vice President Jonathan Nez, Navajo Nation
- Oklahoma Area Delegate— Lt. Governor Jefferson Keel, Chickasaw Nation
- Phoenix Area Delegate—Councilwoman Delia Carlyle, Ak-Chin Indian Community
- Portland Area Delegate—Council Member Travis Brockie, Lummi Nation
- Tucson Area Delegate—Councilman Chester Antone, Tohono O’odham Nation
- Tribes-at-Large Delegate—President George Edwardson, Inupiat Community of the Arctic Slope
- Tribes-at-Large Delegate—Tribal Employee Byron Larson, Northern Cheyenne Tribe
- Tribes-at-Large Delegate—Tribal Councilor Bryan Warner, Cherokee Nation

[Quorum Met]

Members absent:

- Tribes-at-Large Delegate—Board Member Darcy Morrow, Sault Ste. Marie Tribe of Chippewa Indians

Delegate vacancies: Albuquerque, California, and Nashville Areas

Councilman Antone introduced Dr. José Montero, designated federal official, CDC deputy director, and OSTLTS director.

Dr. Montero thanked the TAC for their attendance and service. He welcomed Tribal Councilor Bryan Warner, Tribes-at-Large, as the newest TAC delegate. He invited other tribal leaders present to stand and be recognized. Chairwoman Cheryl Andrews-Maltais, stood up and was acknowledged.

Dr. Montero turned the meeting over to Captain Carmen Clelland, associate director for tribal support, OSTLTS, CDC, and TAC Secretary.

Captain Clelland thanked Dr. Montero and introduced himself. He covered a few items for situational awareness and guidance. He turned the meeting over to Commander Damion Killsback, deputy associate director for tribal support, OSTLTS.

Commander Killsback introduced himself and provided logistic updates for the meeting, highlighting the emergency exits, restrooms, restaurants, etc. He asked all participants to please speak into the microphones and state their names. Commander Killsback turned the meeting back over to Dr. Montero.

Dr. Montero read the regulations of the Unfunded Mandates Reform Act.

Councilman Antone read the TAC Roles and Responsibilities. Councilman Antone turned the meeting back over to Captain Clelland.

## TAC Business and TSU Briefing Update

Presenters

- Captain Clelland , PharmD, MPA, MPH Associate Director for Tribal Support, OSTLTS
- Commander Killsback , PharmD, MPH Deputy Associate Director for Tribal Support, OSTLTS

Captain Clelland began by stating that TSU is paperless and has passed out all necessary TAC meeting materials on jump drives. He explained that, last year, TSU decided to increase the productivity of biannual TAC meetings. TSU worked with contract support from Deloitte to evaluate the Winter 2017 TAC Meeting. TSU staff brainstormed how the information received could be used to improve the TAC meeting structure. The following three priorities were evident upon completion of the evaluation:

- Identifying opportunities
- Enhancing participant engagement
- Seeking alternative meeting formats

TSU worked with Deloitte to develop an internal tool to track advice and recommendations provided by TAC members to improve future TAC Meetings. Captain Clelland concluded by stating that TSU will be doing a pilot. Captain Clelland solicited TAC delegates for questions.

Councilman Antone concluded the session, as there were no questions from TAC delegates.

## CDC Office of the Director Updates

Presenter

- José Montero, MD, MHCDS, CDC deputy director, OSTLTS director

Dr. Montero began the CDC updates by formally announcing the appointment of Dr. Brenda Fitzgerald as the 17th director of CDC and the ATSDR administrator. Dr. Fitzgerald's appointment was effective July 7, 2017. She previously served as commissioner of the Georgia Department of Public Health and was the state health officer from 2011 to 2017.

### **Combatting the Opioid Epidemic**

AI/AN populations continue to be disproportionately affected by various types of intentional and unintentional injuries, including opioid overdose. The rate of drug-related deaths among AI/AN populations has nearly quadrupled since 1999 and is now double the rate of the US population as a whole. Decades of disparities in employment opportunity, education, and

access to medical and mental health care have created an environment in which injury prevention efforts in AI/AN communities have not been as successful in comparison with non-Native communities of similar socio-economic status. Strategic collaboration to increase the cultural relevance of intervention strategies between tribal public health experts, tribal leaders, and the National Center for Injury Prevention and Control (NCIPC) has been successful in lowering death rates attributed to motor vehicle injuries in the past decade. Adequate funding is needed for effective, long-term change.

Earlier this year, HHS Secretary, Dr. Thomas E. Price announced a five-part approach to combat the opioid overdose epidemic—

1. Strengthening public health surveillance
2. Advancing the practice of pain management
3. Improving access to treatment and recovery services
4. Targeting availability and distribution of overdose reversing drugs
5. Supporting cutting-edge research

Addressing a problem as complex as the opioid crisis requires collaboration among public health, clinical medicine, and public safety at the federal, state, and local levels. While this approach does not specifically address AI/AN populations' needs, there are many ways CDC can ensure a population-specific approach. CDC's specialty is bringing a public health approach to opioid overdose and prevention, which requires understanding the problem, developing effective solutions, and implementing those solutions through partnership with and funding of state programs.

NCIPC leads CDC's efforts to fight the opioid epidemic, but many other centers run relevant programs. NCIPC released "CDC Guideline for Prescribing Opioids for Chronic Pain" in March 2016 to help primary care doctors provide safer, more effective care for patients with chronic pain. The Guideline provides 12 voluntary recommendations for prescribing opioid pain medication for patients 18 and older in primary care settings. The Indian Health Service (IHS) has provided training to their clinical directors on practices that align with the Guideline. IHS has a chronic, non-cancer, pain management policy, which they amended to align with the Guideline. NCIPC leads three programs:

- Prescription Drug Overdose: Prevention for States
- Data-Driven Prevention Initiative
- Enhanced State Opioid Overdose Surveillance

These three programs work to improve access to treatment for opioid misuse, reduce opioid-related deaths, and strengthen prevention efforts for drug abuse across 45 states, 4 tribes, and the District of Columbia. The funding also supports improved data collection and analysis around opioid abuse and overdose, as well as better tracking of fatal and nonfatal opioid-

involved overdoses. States not funded for any of the programs are Iowa, Mississippi, North Dakota, Texas, and Wyoming.

NCIPC has piloted a communication campaign that shares real stories from people whose lives have been affected by prescription opioid abuse and overdose. The campaign's goals are to increase awareness that opioids can be addictive and dangerous. Dr. Montero informed everyone that the campaign would launch in the next few months. CDC overdose prevention awardees will have access to campaign materials and will be able to tailor them to reach their residents.

NCIPC has an interagency agreement (IAA) established in August 2016 with the IHS Office of Public Health Support, Division of Epidemiology and Disease Prevention, Tribal Epidemiology Centers (TECs). Through the IAA, CDC and IHS are working to improve the quantity and quality of injury reports available to AI/AN programs to reduce the health impact of intentional and unintentional injuries. The Albuquerque Area Southwest TEC, Navajo TEC, and Oklahoma Area TEC have been funded to develop unintentional and intentional injury atlases, reports on opioid use and suicides, and an evaluation guide for traffic safety programs.

NCIPC hopes to engage IHS to explore the potential of a regional IHS office taking part in a quality improvement (QI) collaborative to implement clinical QI measures based on CDC's opioid prescribing guideline. This collaboration is scheduled to launch in January 2018.

CDC's Centers, Institutes, and Offices (CIOs) are also doing important work to prevent opioid overdoses in AI/AN communities nationally.

CDC's viral hepatitis program in the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) provides technical assistance (but not funding) for the "Path Toward Elimination of HCV" project. The project seeks to improve health by eliminating hepatitis C virus (HCV) among American Indians in the Cherokee Nation Health System. The second phase of the project includes using community-based efforts to implement interventions to stop transmission of HCV, primarily among people who use inject drugs. The viral hepatitis program is also assessing programs proven to be effective, such as screenings for people who inject drugs in order to reduce illness and deaths among Alaska Natives.

NCHHSTP is also working with IHS on an analysis of existing data sources that could inform IHS about regions and counties at potential risk for spread of HIV and HCV infection associated with injection drug use to identify priority localities for HIV and HCV prevention and harm-reduction interventions. The project will produce peer-reviewed summary reports and presentations to IHS and partners to guide prevention and care efforts.

NCBDDD is working to improve the availability and quality of data to help inform clinical management decisions for health care providers of women of all races and ethnicities who are pregnant or could become pregnant. Currently, CDC is supporting two pilot projects on

neonatal abstinence syndrome (NAS) to better understand the incidence, severity, and long-term developmental and educational outcomes associated with NAS. The “Treating for Two: Safer Medication Use in Pregnancy” initiative tracks trends in prescription opioid use among pregnant women and women of reproductive age to monitor the opioid epidemic in the United States.

NCCDPHP’s Division of Reproductive Health has conducted an Epi-Aid on the prevalence of maternal substance use (including opioids and NAS) in the Sisseton Wahpeton Oyate and the Cheyenne River Sioux Tribes. An Epi-Aid is a mechanism for public health authorities to request short-term assistance of CDC Epidemic Intelligence Service officers to respond to an urgent public health issue. Epi-Aid activities in this area include providing claims data and documenting substance use during pregnancy.

### **Tribal Public Health Authority and Tribal Epidemiology Centers**

Originally passed in 1976 and subsequently amended, the Indian Health Care Improvement Act (IHCIA) declared, “it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.” IHCIA established the legal and programmatic structure for providing health services to AI/AN populations.

The 1992 amendments to IHCIA authorized the establishment of TECs to serve each IHS region. TECs perform a variety of functions—in consultation with and at the request of Indian tribes, tribal organizations, and urban Indian organizations—to elevate the health status of these communities. TECs do so by carrying out activities that include the following:

- Collecting and monitoring data on the health status objectives of IHS, Indian tribes, tribal organizations, and urban Indian organizations
- Evaluating delivery and data systems that affect Indian health and assisting tribes, tribal organizations, and urban Indian organizations to determine health status objectives and services needed to meet those objectives
- Making recommendations of services to assist Indian communities and to improve Indian healthcare delivery systems
- Providing technical assistance to tribes, tribal organizations, and urban Indian organizations to develop local health priorities and disease incidence and prevalence rates
- Providing disease surveillance and promoting public health

In 1996, the Health Insurance Portability and Accountability Act authorized TEC access to data held by HHS. In 2010, Congress enacted the Patient Protection and Affordable Care Act (ACA), which permanently reauthorized IHCIA. IHCIA’s 2010 reauthorization included a provision designating TECs as public health authorities.

Adequate access to AI/AN public health data is a continuing issue for TECs. Access to data is essential to performing TEC functions successfully. To secure AI/AN health data, TECs often collaborate with other jurisdictions, including state, local, and federal agencies. Data-sharing agreements make some of these data requests possible. State and local jurisdictions do not always have data-sharing agreements with TECs, which can cause delays. Some jurisdictions require fees to acquire the data. TECs also face difficulties securing relevant data, fostered by a concern from state and local jurisdictions and private entities regarding the release of identifiable health data, as well as by state laws limiting access to certain health data.

### **Tribal Accreditation Support Initiative**

The OSTLTS Accreditation Support Initiative (ASI) is a direct funding initiative to help health departments prepare for public health accreditation. ASI will award up to \$10,500 to 20 eligible Tribal entities in fiscal year (FY) 2018. There is a separate funding category for tribes new to public health accreditation. This category will allow Tribal entities to explore—in-depth and in a cohort of beginners—the potential of achieving public health accreditation with the option of taking the first steps on the accreditation path. Applications are due September 1, 2017.

### **Emergency Preparedness and Response**

CDC's Office of Public Health Preparedness and Response (OPHPR) funds the Public Health Law Program (PHLP) in OSTLTS to develop legal resources related to tribal emergency preparedness law. The program received \$75,000 in FY 2016 and \$75,000 in FY 2017 to develop a training protocol and resource compendia that tribes can use to help them prepare for public health emergencies.

In the project's first year and early in its second year, facilitators met with more than 100 tribal leaders and elders, tribal emergency responders and coordinators, and tribal coordinators within public health departments who partner and closely work with tribes from multiple regions of the country including the Northwest, Midwest, Southeast, West, and Washington, DC.

PHLP has developed tribal emergency preparedness legal resources used by

- Tribes developing and updating their public health codes
- TECs navigating public health data sharing issues with state, local, and tribal partners
- Federal, state, and local agencies seeking to better understand tribal sovereignty and authorities on public health issues

Tribal involvement in the Zika virus response activities of CDC's Emergency Operations Center (EOC) included the following:

- CDC subject matter experts collaborating with Indian-serving partners, such as AAIP and the National Indian Health Board (NIHB), to provide briefings during Zika-specific calls hosted by these organizations
- CDC subject matter experts giving presentations to various audiences on Zika-related topics, including vector control, transmission concerns, epidemiology and surveillance,

pregnancy and birth defects, laboratory science, traveler and border health, and blood safety

- Tribal partners participating in routine calls with states throughout the Zika response
- Tribal leaders from nations in affected states attending the Zika Action Plan Summit, in Atlanta, Georgia, in April 2016 and initiating a coordinated response dialogue with the states

In addition, the EOC's State Coordination Task Force created the Tribal Liaison Officer (Tribal LNO) position on July 7, 2016. The Tribal LNO works closely with HHS and its operating divisions, OPHPR and other CDC programs, tribal governments, organizations, and communities during an emergency preparedness event. Tribal LNO duties include reporting tribal activities at key briefings and informational meetings, gathering and sharing critical tribal response information, and being alert to the direction the response is taking and how that direction will affect tribes and tribal communities.

### **CDC's Epidemiology and Surveillance Capacity**

The TEC Directors' Annual Meeting was held in Portland, Oregon, on March 23, 2017. Dr. Montero and Dr. Bauer, director, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) attended the meeting to provide updates and information about OSTLTS and NCCDPHP work in Indian country, respectively. The TEC directors provided feedback about how CDC can better support their work, new approaches, and new partnerships.

### **Workforce Development**

The Public Health Associate Program (PHAP) expansion into Indian Country for FY 2016 included nine PHAP associates. The 2017 matches and offers are in progress and will be shared when the process is completed. Below is the list of current PHAP host sites working in tribal public health:

- Choctaw Health Center, Choctaw, Mississippi
- Eastern Band of Cherokee Nations' Public Health and Human Services Division, Cherokee, North Carolina
- Indian Health Service Field Office (also working with CDC), Albuquerque, New Mexico
- Indian Health Service Headquarters' Division of Epidemiology and Disease Prevention, Rockville, Maryland
- Maniilaq Association, Kotzebue, Alaska
- Montana Department of Public Health, Helena, Montana
- North Dakota State University, Fargo, North Dakota
- Rocky Mountain TEC, Billings, Montana
- Southcentral Foundation, Anchorage, Alaska

### **TAC Questions and Discussion**

Councilman Antone solicited TAC Delegates for questions.

Chairwoman Andrews-Maltais explained that as a tribe, they are finding heroin has become a problem in the Northeast. She posed the question, "Is there a way to encourage changing the

language of FOAs to be more inclusive of tribes? The language leaves many tribes out. If we have a few thousand dollars, we are able to stretch that dollar further than most.”

Dr. Montero acknowledged the rising opioid epidemic. He expressed the need for a long-term strategy to address the opioid epidemic. He stated that in addition to opioids, the language should include drugs such as heroin. Dr. Montero also stated that CDC had to proceed with caution when editing funding language as not to misrepresent or misstate anything. He informed Chairwoman Andrews-Maltais that a meeting would take place that coming Friday to discuss funding mechanisms and incorporating traditional values and medicine in Notice of Funding Opportunity Announcements (NOFOs). Dr. Montero concluded by stating that Dr. Bauer would speak more about NOFOs later.

President Edwardson introduced himself. President Edwardson informed everyone that about three weeks prior to the Summer TAC meeting, his tribe joined forces with their local police commander to work together to combat the opioid epidemic.

Dr. Montero acknowledged the efforts of President Edwardson’s tribe and local community.

Councilman Antone discussed a previous meeting held with former CDC Director Dr. Tom Frieden and a few tribal leaders. He informed the audience that the topics of discussion included suicide and substance abuse. He posed the following questions for Dr. Montero:

- How many partners or agencies has CDC partnered with to address public health concerns in Indian Country?
- What eligibility criteria was established for the Public Health Emergency Preparedness (PHEP) NOFO?
- Does the NOFO have tribal language for opioid addiction funding?
- Are tribes eligible to apply for the NOFO?
- Which funding opportunities will be allocated to states and which will be considered for tribal and local health departments?

Dr. Montero explained that the NOFO included language about tribal eligibility for opioid addiction funding, but he did not have the language available to him at that time. He stated that there was specific language and some of the funding would go to tribes. He offered to send the NOFO eligibility criteria language to the TAC. Dr. Montero concluded by stating that he would get the information on the language explaining how much funding will go to states and how much flexible funding could be allocated to tribes.

Councilman Antone thanked Dr. Montero for his efforts. Dr. Montero responded by informing the TAC delegates that CDC intends to provide answers and better follow-up following all current and future TAC meetings.

Lt. Governor Keel stated that the recent NOFO (due the previous day) for the public health infrastructure was only available to TECs. He asked Dr. Montero how tribes would be included.

Dr. Montero yielded his time and the floor to Dr. Bauer, and Lt. Gov. Keel decided to wait for a response until the budget portion of the presentations.

Councilman Antone invited Chairwoman Andrews-Maltais to express her concerns. Ms. Andrews-Maltais expressed her concern for money going into Indian Country of which tribes are unaware. She stated that 50% of funding in Indian Country went through the states, but the tribes never received it. She suggested that if CDC could allocate funding for tribes that may help tribes get their portion. Dr. Montero informed Chairwoman Andrews-Maltais that CDC would consider her idea.

## Zika Virus Update

Presenter

- Stephanie Dulin , MBA, Deputy Director, National Center on Birth Defects and Developmental Disabilities (NCBDDD)

In this session, Ms. Dulin presented on short- and long-term health consequences associated with Zika, and she described the US Zika Pregnancy and Infant Registry (USZPR). The purpose of the USZPR is to monitor pregnancy and infant outcomes following Zika virus infection during pregnancy and to inform clinical guidance and public health response. The system monitors pregnant women with laboratory evidence of Zika virus infection and exposed infants born to these women, as well as infants with laboratory evidence of congenital Zika virus infection and their mothers. CDC coordinates this supplemental surveillance effort, which depends on the voluntary collaboration of state, tribal, local, and territorial health departments.

Ms. Dulin invited tribes to spread the word about the registry's importance as well as encourage healthcare providers to work with their state, tribal, local, or territorial health departments. She stated that healthcare providers could work with these departments to:

- Report cases to the registry
- Collect clinical and follow-up information for pregnant women and infants who are part of the registry
- Provide information to health departments or directly to the registry, if asked to do so by local health officials, and notify health department or registry staff of adverse events

She described several tribal engagement efforts in progress, including targeted communication, CDC Emergency Response Team deployment to tribes before an emergency, Tribal Zika summits, webinars and trainings, and more. Ms. Dulin also described collaboration activities, including a cooperative agreement with NIHB, the April 2016 Zika Action Plan Summit, technical assistance for tribes, American Mosquito Control Association trainings, and more. She concluded by describing Zika Care Connect, a healthcare professional web-based network formed in collaboration with March of Dimes and designed to improve access to clinical

services. Zika Care Connect includes a referral network to identify specialty healthcare providers, and information for healthcare professionals caring for patients with Zika.

The floor opened for questions, and Lt. Governor Keel asked if any AI/AN children have been reported to be infected with the Zika virus. He also wanted to know specifically the symptoms and conditions affecting tribal children and the support systems available to these children and their communities.

She explained that the majority of that work has been done through IHS. Ms. Dulin responded by stating that she would look into this and report back. She went on to clarify that the image in her PowerPoint Presentation represents a severe case of Zika. She did not have the data present to show what percentage of cases have congenital Zika syndrome, nor if cases are broken out by type of anomaly.

Lt. Governor Keel also asked how tribal health systems will be able to access vaccines and if the vaccines would be in their formularies.

Ms. Dulin replied that the vaccines are being developed by private companies with public funds and dissemination is being discussed. She assured the audience that she would provide updates on the matter.

Chairwoman Andrews-Maltais added that AI/AN populations are often not included in vaccine testing. She asked what efforts are being made to reach out to tribes and tribal women to make sure that the vaccines are as effective for AI/AN people as they are for others.

Ms. Dulin responded by stating that the Biomedical Advanced Research and Development Authority (BARDA) is leading vaccine development. She will check with them regarding AI/AN inclusion in testing.

Chairwoman Andrews-Maltais also asked if there is a best practice for prevention. She suggested that since there are tribal members throughout the country, CDC could provide prevention info throughout networks.

Ms. Dulin replied that most of the cases in our country have been travel-associated cases, and did not originate in United States. The Zika website has guidance on both [testing](#) and [prevention](#). CDC is still telling pregnant women not to travel in areas with high Zika prevalence, and that they should be careful about conception, especially if their partner has traveled to an area with a high Zika prevalence.

Chairwoman Andrews-Maltais also asked if Zika testing is mandatory as part of typical pregnancy testing.

Ms. Dulin replied that CDC's guidance is to test symptomatic women or at high risk who are asymptomatic. However, some jurisdictions still prefer to monitor.

Mr. Larson asked how CDC is collaborating with tribes on surveillance.

Regarding what has been done with TECs, she stated she would have to defer to CDC staffs who have worked in the EOC's Tribal LNO role, which include TSU Staff members Delight Satter and Nicolas Rankin. She encouraged calls to come directly to CDC for additions to the registry. She concluded her response by stating that CDC's intent regarding Zika surveillance is that all cases are monitored.

Councilman Antone concluded the session by emphasizing the importance of documenting statistics on tribal nations.

## Budget Overview

### Panel participants

- Jenny Sewell, JD, MPA, Public Health Analyst, Congressional Team, Office of Appropriations, Office of Financial Resources, CDC
- Georgia Moore, MS, Associate Director for policy, OSTLTS, CDC
- Ursula Bauer, PhD, MPH, Director, NCCDPHP

Ms. Sewell and Ms. Moore provided a FY 2017 Budget Summary. Dr. Ursula Bauer also provided an update on funding from her center, NCCDPHP.

Ms. Sewell described the FY 2017 distribution of CDC's \$7.2 billion in funding. Compared to FY 2016, there were decreases in funding for the following areas:

- Environmental health (-\$1.7 million),
- Workforce (-\$2.2 million) and occupational safety (-\$3.9 million)
- Immunization (-\$4.1 million)
- Sexually transmissible infections (-\$5.0 million)
- Tobacco (-\$5.0 million)
- Heart disease and diabetes (-\$30 million each)

Funding increases included the following:

- Birth defects (\$2.0 million)
- National Diabetes Prevention Program (\$2.5 million)
- Global Health (\$8.0 million)

- Opioid overdose prevention (\$50 million)

She described the President's budget request for FY 2018 would decrease CDC's budget from \$7.2 billion in FY 2017 to \$5.976 billion. Major changes between FY 2017 enacted funding and the President's FY 2018 budget included these decreases:

- Environmental health activities (-\$23.8 million)
- Antibiotic resistance initiative (-\$26.0 million)
- Public health surveillance and informatics, workforce, and statistics (-\$29.4 million)
- Birth defects programs (-\$37.6 million)
- Immunization program (-\$93.5 million)
- Public health emergency preparedness grant program (-\$109.0 million)
- Occupational safety and health (-\$135.2 million)
- Preventative Health and Health Services (PHHS) Block Grant eliminated (-\$160 million)
- Chronic disease prevention activities (-\$163.3 million)
- HIV, STD and TB activities (-\$183.3 million)

The FY 2018 House Appropriations Committee budget estimates for CDC are:

- CDC's overall FY 2018 program level is \$7,001.5 million, a decrease of \$198.4 million compared to FY 2017
- The House proposal does the following:
  - Eliminates funding for the Racial and Ethnic Approaches to Community Health (REACH) program
  - Maintains funding for the Good Health and Wellness in Indian Country (GHWIC) program at \$16 million and prohibits CDC from decreasing funding for the program and from other chronic disease lines
  - Specifically does not fund the America's Health block grant proposed in the President's Budget
  - Maintains funding for the current PHHS Block Grant at \$160.0 million

Ms. Moore presented updates on CDC and ATSDR funding to tribes and tribal organizations and committed to providing an analysis of funding supporting tribes by the Winter 2018 TAC meeting. She explained that the analysis is not always straightforward because of the way funding streams are documented. As a result, it may take further investigation after the Winter TAC meeting to get the full information TAC members have requested. For example, funding by sub-grantees is documented in grantee individual work plans maintained by their respective project officers. Ms. Moore concluded by stating that the funding is difficult to track and will take some time.

Dr. Bauer provided an update from NCCDPHP. She explained that CDC operated under a continuing resolution for the beginning of FY 2017. During that time, CDC deployed its funding as directed. At that point, NCCDPHP had \$50M for one of its public health program. When CDC received its budget in May, NCCDPHP was allocated \$34M for that program, a \$14M decreased from the \$50M decided on during the continuing resolution. They also learned they had \$16M for the REACH program. To cover the deficit between the \$50M and the \$34M, NCCDPHP pulled money back from REACH programs that they had already deployed. NCCDPHP also found some internal efficiencies and cancelled some contracts in order to deploy funding to tribal programs.

Dr. Bauer described NCCDPHP's support for TECs. Specifically, NCCDPHP designed its plan to support TECs to be consistent with Congress's message to CDC to increase support for TECs. NCCDPHP deployed about \$8.5M to TECS to follow through with directives from the President and Congress. With the funds deployed yesterday (August 7, 2017), NCCDPHP has about \$3M left to support a NOFO in the fall for tribes and Urban Indian Health Centers. With this funding, NCCDPHP will follow through on the TAC's request to find out what traditional practices keep AI/AN populations well. In addition, NCCDPHP will make progress in supporting cultural practices and learning what connects people to culture. Funding recipients will be able to decide how to spend the dollars. NCCDPHP designed the NOFO based on several years of dialogue and input from tribal convenings, NIHB listening sessions, and meetings with Indian Health Boards (IHBs) and tribes. Tribal participants in these meetings have recommended funding amounts ranging from \$75,000 to \$150,000. Dr. Bauer concluded by stating that she would like the TAC's input on those amounts so NCCDPHP can fund as many tribes as possible with adequate resources.

Melanie Fourkiller, Policy Analyst from Choctaw Nation Health Services, raised the need for consistent and reliable funding for tribal public health infrastructure. She explained that tribes have primary responsibility for infrastructure—not TECs, or IHBs. Tribes partner with states and locals, but to do so they need to carve from funds they receive for treatment and care. State governments get funding for infrastructure, so tribes really want CDC to continue not only to emphasize, but also to provide a reliable and consistent source of funding to tribes for infrastructure that does not have to be negotiated each year.

Ms. Fourkiller further explained that while it is nice to see tribes eligible for NOFOs—public health emergency response funding, for example - tribes still need to compete for them, and the capacity to compete with entities that have so much more infrastructure and capacity is not present in Indian Country. She suggested another approach, which would be for tribes to compete among themselves for a percentage of CDC's budget that is designated for Indian Country.

Regarding the NOFO that Dr. Bauer had mentioned was released August 7<sup>th</sup>, Ms. Fourkiller asked if there was a directive to restrict that to TECs, or if CDC was required to restrict it in some way. She highlighted the fact that \$42 million is a lot of money.

Dr. Bauer responded that the \$42 million would fund activities over five years, which is equivalent to about \$8.5 million each year. She reiterated that CDC followed through on the directive in the President's proposal and that the NOFO was developed over a couple of years. The GHWIC grant budget also changed, causing NCCDPHP to focus their grant funding on chronic disease outcomes. She went on to explain that for both the GHWIC and the new budget line, CDC plans a couple of years in advance for a number of years. CDC assesses what is needed in Indian Country, and what opportunities CDC would like to seize or create. Dr. Bauer stated that because they had planned ahead, NCCDPHP was prepared when they received the new budget line.

Dr. Bauer stated she would like input on how best to support tribal health departments. Questions she would like input on include the following:

- How much funding per tribe is adequate?
- How should funding be disseminated and to how many tribes—all or some?
- Should dissemination of funds start with larger tribes?

Dr. Bauer stated that she would be willing to help in any way she is able. She concluded by stating that if the planning process started now, NCCDPHP would be ready if another opportunity opens up. She clarified that while CDC does not do advocacy, tribes would need to determine if and how to advocate for funding.

Mr. Larson shared that the biggest issue is the parity tribes want between state and local health departments, and that the federal government gives resources to them to execute services to tribal populations. Mr. Larson stated that tribal needs must be clarified so tribes have a basis for requesting 2% of CDC CIO budgets. He concluded by emphasizing the need to develop a framework for that discussion so tribes can be assertive in their request for 2% of CDC's budget.

Ms. Moore shared that an innovative emergency response NOFO is expected. From her understanding, it will identify tribal response opportunities and capacities, so that when a tribe is in need of an emergency response, CDC can look in this queue and match funding capacity to reach tribes.

TSU is also working on a tip sheet for project officers who write NOFOs in an effort to address the issue of tribes competing with states for funding. For example, it would guide project officers to state explicitly in the NOFO any intent to reach a certain number of tribes. CDC

would still rank the proposal, but would look at separate rankings for states, tribes, and large cities, and fund as many from each group as possible. Regarding opportunities, there currently is a lot of concern and focus on rural communities. This focus provides another opportunity to talk about, and reach, tribes. Ms. Moore encouraged the participants to collaborate.

Dr. Bauer added that her center does struggle due to the large number of Federally Recognized Tribes (567). She explained that NCCDPHP does fund tribes directly and meets the 2% threshold. She requested TAC members to give her ideas on specific funding arrangements that would provide adequate, consistent, reliable funding. Dr. Bauer concluded by giving the following examples: a five-year funding term, a formula instead of a competition, or some other approach.

Lt. Governor Keel explained that though 567 is a large number of tribes, not all of the tribes have health systems that would apply or have a need. Several tribes are doing well in some areas, but all of them need some help. He explained how it's possible to group tribes in different ways. For example, there are 227 in Alaska and 330 in the lower 48 states. Many have consolidated their efforts with other tribes, so they could be considered together for funding (i.e., tribes in Alaska).

Lt. Governor Keel went on to explain that although many states have good relationships with tribes, most do not because there is no legislation stating they need to work with tribes. Pandemic flu and Homeland Security were exceptions since legislation allowed for tribes to get funding directly. He stated that though it is up to tribes to advocate to Congress, CDC has to be the advocate when we talk about public health, and to get people to include direct funding to tribes in legislative language. Sometimes agencies use legislative language as a crutch to avoid or justify not funding tribes.

Mr. Warner stated that he is brand new to the committee and it is an honor. He asked if Congress directed CDC to make the new NOFO open only to TECs, or if CDC made that decision.

Dr. Bauer explained that CDC responded to a Congressional directive that half the funding needed to go to TECs. The language was crafted over the past two years with input from the TAC and others, and with language from Congress regarding stronger support for the TECs.

President Andrew stated that when people hear there are 229 tribes in Alaska alone it might scare them. However, she mentioned that Alaska has a consortium in Anchorage that has a funding formula. She also emphasized that all the people in those tribes matter, even those in the smallest tribes.

Dr. Bauer expressed her appreciation for this dialogue. She appealed to Councilman Antone that it would be helpful to have a proposal from the TAC describing their recommendation for who and how to fund tribal activities. Dr. Bauer emphasized that there is a lot of support, and having a game plan would make it is easy to move forward—having a game plan helped move forward the FY 2017 activities that got funded.

Councilman Antone asked Ms. Moore and Dr. Bauer if TSU provides them with information on what the tribal needs are as they formulate the President’s budget.

Ms. Moore answered, “Absolutely.” She explained that she constantly get inputs on tribal needs, including getting appraised of travel to Indian Country and input received from those site visits.

Chairwoman Andrews-Maltais added that doing the Special Diabetes Program for Indians (SDPI) has worked for her tribe.

Dr. Montero added that TSU has contracted with NIHB to conduct a scan of public health capacity in Indian Country. He stated he is not aware of the number of tribes that have a public health department or the number of tribes that rely on the TECs. He stated that in order to be effective, CDC and tribes need to be able to articulate the illness burden and the capacity. “Often times, the 2% funding number allows us to get sidetracked, but unless the budget request can be documented with the public health need, we won’t be ready to justify the budget requests.” Dr. Montero informed everyone that the information on public health needs and capacity does not exist, so the scan being conducted is incredibly important. Dr. Montero emphasized that anything TAC delegates can do to help support the scan, including telling CDC with whom to work, is incredibly important because it will provide the much-needed baseline information.

Councilman Chester Antone concluded the session.

## Welcome and Overview of Chickasaw Nation Public Health Programs

### Panel participants

- Heather Summers, MS, RN, Under Secretary of Operations, Hospitals and Clinics, Chickasaw Nation
- Bobby Saunkeah, RN, MSGCE, CIP (Kioawa Tribe), Manager, Research and Population Health Division, Chickasaw Nation Department of Health (CNDH)

- Valarie Blue Bird Jernigan, DrPH, MPH (Choctaw Nation), Associate Professor, Health Promotion Sciences, College of Public Health, University of Oklahoma Health Sciences Center
- Miranda Willis, Data Analyst, Strategic Prevention, Chickasaw Nation

Mr. Saunkeah gave a few details on the background of native presence in Oklahoma. At around 400,000 Indigenous folks, Oklahoma has the second largest Native American population in the United States, second to the state of California. About 45% of the population resides in urban areas, such as Tulsa and Oklahoma City. Due to the fact that it is not a reservation-based state there is a lot of diversity. There are about 38 federally recognized tribes, 18 non-federally recognized tribes, and 28 different tribal languages in the state. There is no Pan-Native American culture as the Native communities are blended communities. The Native population is integrated with the general population, so public health services impact non-Native folks, as well as Chickasaw Nation citizens. Oklahoma's diversity presents unique challenges when applying for grants because the community is often pre-defined for them. The panel members suggested that the definition of community be less strict on NOFOs. By not strictly defining community, the tribes will be able to define what community means to them and how it is composed.

The main issue with tribal data is that there is a lack of quality public health data in terms of demographics. The panel members explained that Chickasaw Nation uses data from electronic health records to reflect what the population data are. Since public health data is difficult to collect for tribes, tribes are using clinical data instead. Panel members acknowledged that while this approach is not always better, it is the best they can do to collect data because a tribal health system is a closed system.

A few details on the services provided by the Chickasaw Nation Department of Health (CNDH) were provided. CNDH has added a new mobile prevention service unit, nurses, staff members who deal with informatics, and a health promotions director. They explained that funding for this department is carved out from other areas, causing the other programs not to grow. This issue emphasizes the need for direct funding for tribes to build the public health workforce and infrastructure in Chickasaw Nation. They stated that CNDH has received the Tribal ASI grant from NIHB to facilitate accreditation. CNDH has a representative from every major department as all 10 essential public health services occur in every department. External stakeholders include organizations like the Robert Wood Johnson Foundation and NIHB. CNDH is the only tribal community to be a Robert Wood Johnson sentinel community—a community recognized for developing its own culture of health and known for innovation and fostering of community engagement. In addition, Oklahoma University Health Sciences Center has a clinical and translational research center grant.

Dr. Jernigan explained that her research focuses on intervention methods. She enjoys working with Chickasaw Nation to make science rigorous and feasible. She emphasized how valuable

partnerships are for the intervention process. A few projects CNDH is currently implementing include mobile food basket study and initiatives on farmers markets.

Mr. Saunkeah provided details on intervention efforts CNDH is involved with to combat childhood obesity. CNDH hosts non-competitive and family focused 5K runs and walks to combat childhood obesity. In addition to runs and walks, CNDH has two mobile units: the Inchokma Medical Unit, a mobile unit for prevention services, and the Chickasaw Caring Van, a partnership with Bluecross® Blueshield® of Oklahoma. The mobile unit services are an initiative lead by public health nurses. Additional initiatives by CNDH include a farm safety event with activities for kids who live on rural lands and work on farms.

Ms. Willis, Strategic Prevention Data Analyst at Chickasaw Nation, explained that public health data is limited in Chickasaw Nation. She stated that the Strategic Prevention Tribal Grant is a successful partnership built on the SPLIT (structure, process, language, identity and technology) framework. She informed the audience the “Define Your Direction,” a media campaign led by herself that has been implemented and running for the last year. “Define Your Direction” is a media campaign that reaches over 3,000 people with one message. The social media campaign posts about services and tools in Chickasaw Nation of which citizens are unaware. All activities are community and youth driven, such as a zombie chase and a safe-all-night event after a local high school’s prom. In addition, students who participated in the activities led by the campaign designed a mural displaying the logo and phrase of the campaign to show their support and appreciation. She concluded by stating “Define Your Direction” has won multiple advertising awards and continues to gain recognition for its contributions to the community.

Councilman Antone took the floor next to ask the panel members a few questions. He asked if any public laws exist in the Chickasaw Nation court system that developed because of their multiple collaborations for the “Define Your Campaign” campaign.

Mr. Saunkeah answered by stating that the Chickasaw Nation legal department will be presenting at 3:00 PM and can answer questions as they are involved in stakeholder groups.

Panel members played their award-winning “Define Your Direction” video.

Councilwoman Carlyle responded by stating that she is very impressed with the work and message of the campaign. She stated that the video sends a message in a “strong but simple way.”

Councilman Antone concluded the session and invited the next panel members to present on cultural practices and mental health prevention.

## Cultural Practices That Inform Mental Health Prevention Programs

### Panel participants

- Shannon Dial, PhD, LMFT, Executive Officer, Integrated Services Division, Department of Family Services, CNDH
- Kelly M. Roberts, PhD, LMFT, Family Initiatives Advisor, Department of Family Services, CNDH

Panelists presented on Chickasaw Nation's clinical research and the impact of cultural connectedness on health outcomes. Presenters shared the Chickasaw Nation's work to integrate behavioral health services to create a system-wide approach to their Zero Suicide Initiative, domestic violence programs, and opioid abuse.

Dr. Dial stated that to reach persons with behavioral health needs effectively, it was critical for Chickasaw Nation to think outside the box. The Chickasaw Nation determined the most effective way to reach tribal members with behavioral health services was by developing and implementing an integrated behavioral health system. By embedding behavioral health providers into general clinics and emergency rooms, Chickasaw Nation was able to increase the reach and impact of behavioral health services dramatically. Chickasaw Nation required all staff to look at mental and behavioral health in a new way, gaining a true biopsychosocial perspective. The approach resulted in a 152% increase in access to behavioral health care in three years. Before integration, the system had approximately 400 behavioral health patient encounters per month; now it averages closer to 1,100.

Dr. Dial presented the [Zero Suicide](#) as an example. When the Zero Suicide challenge came to Chickasaw Nation, the team considered how it could reach the program goal inside of its integrated care system. Zero Suicide is a project of the Education Development Center's Suicide Prevention Resource Center. It is a key concept of the 2012 National Strategy for Suicide Prevention. Zero Suicide believes that suicides in persons receiving care through a health system are preventable.

Chickasaw Nation began by implementing the Zero Suicide strategies in its emergency rooms, where they serve approximately 4,500 patients per month. They also standardized their depression screening process. Chickasaw Nation leaders soon realized the screening concept could be carried throughout the entire health care system, being performed at every point of system entry, including dental services. To date, they have screened 71,000 persons, and 275 have been identified at moderate to high risk for suicide. They immediately connected high-risk individuals to appropriate services. From the point of identification, Chickasaw Nation routinely monitors these patients until their treatment is complete. Chickasaw Nation hopes this work enables them to never lose another tribal member.

Dr. Dial emphasized that other tribal health systems can easily replicate screening across their entire systems. Included in this same work has been an approach to address opioid addiction. Chickasaw Nation is beginning to talk through unique challenges that the opioid epidemic presents, including that the issue exists not just in the patient population base but in its employee base as well.

Dr. Roberts shared violence prevention activities and these notes from Chickasaw Nation leaders:

- Chickasaw Nation has a 24-hour on-call service and is ready to respond.
- Chickasaw Nation collaborates closely with its medical team through its protocols; coordination is strong and solid.
- A new facility is under construction; it will quadruple the space for shelter services.
- Regarding violence prevention, the domestic violence nurse examiner and sexual assault examiner roles are distinct; the certification and follow up are different. Chickasaw Nation is also exploring the distinction from elder abuse.
- Domestic violence nurse examiners address all intimate partner assaults in all Chickasaw Nation clinics, including strangulation for which there has been a demonstrative uptick. Examiners encourage patients to have a medical screening and hospital monitoring after such an event.
- Chickasaw Nation reviews each case to identify any process that can be improved to address and implement trauma-informed care more comprehensively.

Dr. Roberts shared that the interdisciplinary group working on violence includes police, chaplains, nurses, and social service workers. All of these professionals train continuously to increase their knowledge and skills around trauma-informed care.

Dr. Roberts expressed the critical importance of reflecting the Chickasaw Nation culture in the care environment, and how extending the culture through all services has increased patient wellbeing. As an example, she described a process they began two years ago to explore how culture could be incorporated in therapy protocols throughout the system of care. For context, she first defined historical trauma as “trauma passed on through generations.” In their process, Chickasaw Nation considered how to include elements of culture in their treatment plans to enhance identity, cohesiveness, and awareness. For context, Dr. Roberts shared that enculturation is “reintroducing people to their first culture.” They explored an AI Enculturation Scale that was created about ten years ago. It was tested in a variety of ways with several populations and had significant outcomes. In a pilot study, Chickasaw Nation determined that the AI Enculturation Scale was too pan-Indian and too generic to resonate with Chickasaw people. So, the Chickasaw Nation elders met with the Chickasaw Nation cultural department and identified 38 items that should appear in a Chickasaw Nation Enculturation Scale. The

Chickasaw Nation Institutional Review Board (IRB) further refined and strengthened the tool. Eventually the Chickasaw Nation health clinics tested it and determined that it is valid and reliable. The tool includes three primary measures: Satisfied Subscale; Identity Subscale; and Enculturation Subscale. In the pilot test, all subscales were above 0.8 with a variance of 0.61. Two hundred fifty Chickasaw Nation members filled out the instrument in the preliminary test phase. Chickasaw Nation will now use the instrument to measure the impact of its efforts to incorporate a sense of identity and cohesion into wellness plans.

At this conclusion, Councilman Antone opened the floor to the TAC delegates, and invited CDC senior leaders and other tribal nation leaders to sit at the table for questions and answers.

Chairwoman Andrews-Maltais commented on the “extraordinary achievement” of this effort. She was excited to see the pilot outcomes, and recounted that she often sees that the lack of a “cultural rudder” limits the recovery of AI/ANs from incarceration and drug addiction.

Dr. Montero congratulated the doctors on the “amazing work.” He stated that before working at CDC he was not able to get his organization to a 100% depression screening at all points of entry. He asked the panelists about the organizational capacity to manage the demand that is generated from the screenings.

Dr. Dial confirmed that their success always drives a demand for more behavioral health workers to meet the identified need. By screening everybody, there is an identifiable subpopulation of the most severe cases. These cases create the highest demand on staff time. Those persons who screen in the low-risk category are simply monitored when they see their primary care provider. The integrated visits reflect a low effort base-style interaction. All of the behavioral health providers now see 10–16 patients a day, as opposed to previously seeing only 6. Right now, Chickasaw Nation has great communication between our providers and patients. The nurses do the actual screenings in the nurse triage. If the electronic screening score warrants the behavioral health team’s intervention, it will trigger an encounter in the clinic.

Dr. Roberts stated that learning clinical patterns has been key to maximize capacity. For example, the data from clinics reveals that every 8 hours there will be a blip on the dental radar. In addition, it was important to learn the best communication channels to make the team more efficient. For example, the behavioral health team uses a text message system. Dr. Dial also asserted that integrated care is made or broken based upon the staff that is hired. Certain personality traits and high confidence in the behavioral health clinician are critical.

Councilman Antone thanked all panel members. He noted that culture is a protective component of mental health and wellbeing. He stated that cultural practice is not pan-Indian and that the strength of native people is in their unique historical and cultural identities. All

tribes need to understand what Chickasaw Nation has presented as a model. He applauded Chickasaw Nation for finding the power to make their people stronger and more resilient. With this comment, he concluded the session.

## Tribal Health Policy and Law Interventions

### Panel participants

- Debra Gee, JD, (Navajo Nation), General Counsel and Executive Officer, Legal Division, Chickasaw Nation
- Carolyn Romberg, JD, Director/Deputy General Counsel, Legal Division, Chickasaw Nation
- Kym Cravatt, JD, MPH, (Seminole/Muscogee/Creek/Chickasaw), Assistant General Counsel, Legal Division, Chickasaw Nation

This session explored the legal framework of tribal sovereignty and how tribes engage with other health law partners while maintaining their tribal sovereignty.

Ms. Gee introduced the session by defining sovereignty as the inherent right to govern. Within the context of tribal sovereignty, the issue of jurisdiction is often the greatest challenge for the Cherokee Nation Legal Division to address. The organizational structure of tribes in Oklahoma makes jurisdictional determinations very challenging. In regards to health care, Oklahoma has some tribes operating their own care in part or in full under the Indian Self-Determination and Educational Assistance Act (Public Health Law 93-638). While other tribes continue to receive care provided directly through IHS using PH Law 93-638, Cherokee Nation contracted with IHS to open a seventy bed medical facility in Ada, Oklahoma in 2010.

Ms. Gee explained that Cherokee Nation has created a tribal framework to address tribal health issues. Law, policy, and legal intervention and regulation all play a role in the structure of the tribal health system. She stated that there might be a US Code, a tribal code, a state statute, and a policy (defined as a set of principles established by a system or a body to determine future direction) and that all of these may have authority and influence over the same health issue. In addition, there may also be regulations (federal, industry, or other) that define how issues are addressed. Each of the different concepts intersect and interplay. It is the responsibility of the Cherokee Nation legal counselors to review carefully and to discern what does or does not apply. Ms. Gee concluded by stating that the legal division delves deeply into the gray areas of these factors and explores the risks associated with each desired course of action in order to advise the Cherokee Nation leadership.

Ms. Cravatt presented a few examples of Tribal Health Law and Policy Interventions that have affected tribes including Chickasaw Nation. These included Tribal food safety where 53 tribes

have adopted food safety codes. Chickasaw Nation along with many other tribes have adopted the Food and Drug Administration's food safety code. Another area that frames decision-making is the IRB. Chickasaw Nation has an IRB with a set of policies that frame the scope and type of research that can be conducted on Chickasaw people. Proposed research must be carefully reviewed and adjusted to be in compliance with these policies in addition to other influencing laws and regulations. A special area of interest in the current state of health is the use of policy and law to address the opioid epidemic. Ms. Cravatt reported that the state of Oklahoma ranks in the top 5 of states for opioid prescribing rates and the top 10 for high-dose opioid prescriptions. In Chickasaw Nation, three counties rank among the top 5 in the state for unintentional poisoning deaths and AI/ANs living in the Chickasaw Nation reported a statistically significant higher rate of prescribed opioid misuse when compared with non-natives. Garnering recent national attention was the court case of Cherokee Nation vs. McKesson Corporation, et al. filed in the District Court of Cherokee Nation this April. This case was featured on many national new outlets. Ms. Cravatt concluded her section by stating that the assertion by Cherokee Nation was that the defendants had the ability to reduce the diversion of opioids but chose not to.

Ms. Romberg presented on mental health and law stating that the Oklahoma court system created a unique set of specialty courts termed "drug courts" for offenders in recognition of the close connection between illicit drug use and mental health issues. This model developed by the state's department of justice allows local jurisdictions, like Chickasaw Nation and other community partners, to collaborate with the court to provide services to Chickasaw people facing a drug charge. It has been found to be a good partnership. Ms. Romberg shared that the current law allows for Emergency Detention/Civil Commitment, a 72-hour involuntary commitment if an individual poses a danger to him or herself or others. In the case of Chickasaw Nation, when an individual is taken from trust property and placed in a state health facility the nation loses jurisdictional authority. Therefore, it is in the nation's best interest to work closely with the court system to ensure important mental health resources are available at sentencing. The ultimate goal of Chickasaw Nation is to have its own mental health court system because the problem is not going to go away. Chickasaw Nation health services securing hospital admissions for Chickasaw people caught in the court system has been far easier to accomplish. This work is carried out under executive directives from the Chickasaw Nation's governor. Ms. Romberg concluded by stating that the policies and procedures have been adopted to support this direction as legal codes can be far more difficult and time consuming to change.

In closing, the panelists shared with CDC that the Cherokee Nation Legal Division also reviews grant opportunities. When tribes are treated like states within the context of a funding opportunity it makes it very challenging to compete successfully. The nation advises that this be kept in mind as the agency develops future NOFOs.

Councilman Antone opened the session for comments and questions.

Councilwoman Carlyle stated that in the Ak-Chin Indian Community, there are too few pain management doctors and it is, therefore, too easy to hop from doctor to doctor to support an addiction. The physicians are also unable to view the records of outside prescribing. With a dramatic lack of professional care and expertise to follow up with patients who are prescribed narcotic medications for pain, the severity of the opioid abuse issue continues to grow.

Ms. Romberg responded that Oklahoma does have a prescription drug monitoring system (PDMS) and that both providers and pharmacists can review prescribing records in this system. In addition, Chickasaw Nation employs a pain management contract within its clinics to support the pain management policy. This allows the doctors prescribing narcotics to hold patients accountable for compliance. If violated, the physician will no longer prescribe narcotics to that patient.

Councilwoman Carlyle asked the panel if they had any experience around “medical marijuana cards”. Panelists responded that they have a zero tolerance policy regarding marijuana. Patients living in tribal housing submit to random drug testing. In the one case where a screen came back positive for a resident with a medical marijuana card, much dialogue ensued as an effort to assure that the resident’s housing and job were not threatened. Ms. Romberg shared that Oklahoma has not adopted a medical marijuana statute nor a recreational use statute.

Councilman Chester Antone concluded the session.

## Adjourn

Councilman Antone adjourned the meeting.

# WEDNESDAY, AUGUST 9, 2017

## Opening Blessing and Reminders

Members present for roll call:

- Alaska Area Delegate—President Alicia Andrew, Karluk IRA Tribal Council
- Bemidji Area Delegate—Representative Robert TwoBears, Ho-Chunk Nation of Wisconsin
- Great Plains Area Delegate—Chairman Robert Flying Hawk, Yankton Sioux Tribe
- Navajo Area Delegate—Vice President Jonathan Nez, Navajo Nation
- Oklahoma Area Authorized Representative—Lt. Governor Jefferson Keel, Chickasaw Nation
- Phoenix Area Delegate—Councilwoman Delia Carlyle, Ak-Chin Indian Community
- Portland Area Delegate—Council Member Travis Brockie, Lummi Nation
- Tucson Area Delegate—Councilman Chester Antone, Tohono O’odham Nation
- Tribes-at-Large Delegate—President George Edwardson, Inupiat Community of the Arctic Slope
- Tribes-at-Large Delegate—Tribal Employee Byron Larson, Northern Cheyenne Tribe
- Tribes-at-Large Delegate—Tribal Councilor Bryan Warner, Cherokee Nation

[Quorum Met]

Members absent:

- Tribes-at-Large Delegate—Board Member Darcy Morrow, Sault Ste. Marie Tribe of Chippewa Indians

Delegate vacancies: Albuquerque, California, and Nashville Areas

## Tribal Public Health Accreditation Panel

Presenter

- Lisa Pivec, MS, Senior Director of Public Health, Cherokee Nation

Ms. Pivec began by thanking Lt. Governor Keel for hosting the TAC meeting and by giving thanks to Chickasaw Nation. She acknowledged her staff for their efforts.

Ms. Pivec stated that Cherokee Nation is fortunate to have been working closely with the Chickasaw Nation, Choctaw Nation, and the Muscogee (Creek) Nation. Ms. Pivec and her staff pledged that they would help other tribes get accredited after they became accredited. She believes that if every tribe in Oklahoma becomes accredited they can make a big difference in the health of people of Oklahoma, which is currently ranked 48 in several health issues.

She explained that one lesson she has learned over the last year is that public health professionals do not tell their stories. They do not talk about who they are as people and why they are so passionate about what they are doing. As an early step, Cherokee Nation defined public health for themselves, including what it means to Cherokee people. Namely, that they take care of people collectively—mind, body, and spirit.

Ms. Pivec presented a brief overview of Cherokee Nation:

- Cherokee Nation is multi-jurisdictional; it has 14 counties and a tribal jurisdictional service area spanning 9,200 square miles
- Cherokee Nation is home to more than 315,000 citizens
- 210,000 Cherokee Nation members live in Oklahoma
- 140,000 reside in a tribal jurisdictional service area
- There is a Tribal Public Health Advisory Committee to the Oklahoma State Health Department of Health , and they have a great relationship

She went on to describe her view that direct care is part of public health, and that when people walk through the doors of her facilities they should walk out healthier.

When she and her staff began the accreditation process, they began by reviewing the standards, deciding what they meant to them, and how they compared to others. She illustrated this by sharing a strategy map that can be used to assess community health status. Each box on the map has a Public Health Accreditation Board (PHAB) domain. She and her team determined what each domain means to Cherokee Nation. They also assessed who already had capacity for different activities, which helped identify potential partnerships, and what Cherokee Nation needs to build themselves.

She pointed out that tribes will never have enough direct care dollars, and that they need to start focusing on healthier communities. She shared that it is important to make the healthy choice the easy choice.

Ms. Pivec presented a timeline describing their accreditation process:

- 2007 – began exploring upcoming accreditation
- 2009–2010 – participated in PHAB beta test, which helped them to be successful in the application
- 2011 – received National Public Health Improvement Initiative (NPHII) funding of \$800K for 4 years; it didn't completely fund their work, but did help
- 2012 – completed the National Public Health Performance Standards Program
- 2013 – applied for accreditation
  - NPHII funding covered the \$25,000 cost to apply for accreditation
- Nov 2014 – uploaded all documents
- Oct 2015 – hosted a site visit with the PHAB team

- Aug 2017 – received PH accreditation; Cherokee Nation is the first tribe to receive PH accreditation

Ms. Pivec described that tribal public health systems are diverse and unique, and linked closely to direct care. She believes tribes have the perfect system to assess how public health and health care can intersect.

Using the accreditation template, Ms. Pivec and her staff identified potential partnerships with state and local organizations. She emphasized that it is important to leverage capacity where it already exists. For example, it is more efficient and effective to partner with an existing public health lab than to create a new one at the tribal level. “Partnership is essential for the future of AI/AN health.”

Partners may include national organizations, other tribes, clinical providers, state and local health departments, and communities—including both communities of interest and communities by location. Partnership is mutually beneficial; tribes have a lot to offer states, including a lot of people on the ground.

Some lessons learned include:

- Cherokee Nation does not have a public health code; they need to establish one
- Governance standards should be clearly outlined at the start, and should include who the governing body is, and how information flows
- Performance management/quality improvement needs to show how that clinical health piece works with public health
- Prepare Memorandum of Understanding (MOU) templates for services a tribe needs from the state
- Pay attention to the prerequisite documents, as they are an important foundation

For next steps, Ms. Pivec and her staff are developing a conceptual map for organizational design, and are still struggling to implement what they have documented. They will put it into an organizational design they can implement practically in their health system. They want it to be something that other tribes can use too.

She emphasized that community engagement is the primary driver for the design, and that it is important to talk to the people living in communities. They have seen great outcomes when community coalitions take ownership and action. She also pointed out that sustainability is needed, and that they need to determine how to continuously dedicate a piece of their budget so they are not reliant on grants. Internal (within the tribe and tribal public health department) and external (with other tribes) mentorship is also important.

Ms. Pivec also pointed out that it will take leadership to make accreditation happen, along with political courage on behalf of all the leaders around the table. In addition, it will require education of community members and decision makers about what public health is. For

example, some decision makers have told her they will take care of public health once all the health care needs are met. Accreditation is a shift in thinking, requiring approaches such as job sharing, inclusion—a shift from clinical to community, embracing what is good now, and creative financing. She said it is no longer “optional.”

She concluded that tribal public health infrastructure needs to be a priority. Tribes need people to do the work (through workforce capacity and technical assistance), consistent funding mechanisms and to be eligible for NOFOs, and access to successful state models. Ms. Pivec illustrated the impact of community health infrastructure by sharing that her own mother has suffered a stroke and has dementia. Her health is affected by her zip code, and we need to build healthy communities for all.

Mr. Warner thanked the Cherokee Nation and reiterated that sustainability can only come with strong infrastructure funding for all of the tribes. Cherokee has a group that is paving the way. To be sustainable, any type of funding tribes get has to support infrastructure.

Councilman Antone added that on a recent call, when he asked about public health accreditation, Cherokee Nation mentioned they had multiple counties and that it would be easier with fewer counties. He asked Ms. Pivec to elaborate.

Ms. Pivec responded that with fewer counties there will be fewer cross-jurisdictional issues. For Councilman Antone’s area, she said the state partnership will be important. There will be some measures/domains that his tribe would not need to develop since they could get them through collaboration and partnership.

She suggested looking at the conceptual map to identify what his tribe already does, what they could partner to access, and what they’d need to build. She emphasized that if they can get a public health code passed that would be key. PHAB can help with that—it would have helped Cherokee Nation a lot.

Councilman Antone commented that his tribe may already be close, but they have not assessed it, and that it would be the key to get forward movement. They are also large enough and have done things with counties around them. They may be further ahead of the game than they think.

Dr. Montero congratulated Ms. Pivec and agreed that technical assistance is an important tool. He mentioned there is ASI funding available via NIHB. Applications are due September 1. He encouraged meeting participants to get in touch with CDC if they need help.

Lt. Governor Jefferson Keel also thanked Ms. Pivec, and discussed the need for creative financing. There are tribes that are interested; some are already doing many of the things mentioned, but without sufficient funding some do not see why they should do it. He encouraged her to reach out to other tribes, or present at the NIHB conference so she can provide an example. This is particularly important for remote tribes that do not have access to clinics; if they can develop a collaboration with state and local authorities that would help.

There is a creative way to get funding to these programs, whether it is for infrastructure for this or for other programs.

President Andrew added that she represents Alaska, but is from a small community. Every person matters. For years, her area has been fighting to get the support need for their people. Although Alaska has come a long way with a consortium, politics is still the hardest part. They want what is best for their people, who often fall through the cracks.

Ms. Pivec stated that it is important to educate their own citizens on trust responsibility and what it means to be a tribal citizen, how to advocate, and what they can do.

Councilman Antone concluded the session.

## Empowered Living – A Chickasaw Nation Youth Wellness Clinic

### Panel participants

- Neilsson Rais, MD Pediatric Medicine Specialist and General Practitioner, Chickasaw Nation Medical Center, CNDH
- Jeffrey Wells, PT, DPT (Chickasaw Nation), Outpatient Physical Therapist, Ardmore Health Clinic, CNDH
- Ashley Weedn, MD MPH, FAAP, Assistant Professor, General and Community Pediatrics, University of Oklahoma Health Sciences Center; Medical Director, Healthy Futures, University of Oklahoma
- Stephen Gillaspay, PhD, Associate Professor, General and Community Pediatrics, University of Oklahoma Health Sciences Center
- Sheryl Goodson, MBA, Executive Officer of Satellite Clinics, CNDH
- Bobby Saunkeah, RN, MSGCE, CIP (Kiowa Tribe), Manager, Research and Population Health Division, CNDH

This session addressed pediatric obesity through the Chickasaw Nation's multi-disciplinary behavioral modification clinic. It highlighted the collaboration with Chickasaw Nation's public health teams, including a research component and an external collaboration with Oklahoma University Children's Hospital.

Mr. Saunkeah, provided the background for the presentation explaining that the clinic concept formed out of the relationship between clinical and public health work on the health issue of obesity. Epidemiological data from FY 2016 shows that Chickasaw Nation has high rates of obesity starting in childhood and progressing through adulthood. Chickasaw Nation identified that pediatric obesity was a top health priority for making impactful population health change. The clinic focuses on wellness behaviors, including behavioral modification with goal setting rather than just weight control and monitoring. Children are referred along with a responsible adult to the Empowered Living Clinic and a comprehensive first appointment is scheduled. Each person referred spends one hour with each provider on the Empowered Living team. Once

these sessions are completed, the team meets to discuss the information they have gathered and develop a plan of care for the child. From this point forward, the child's progress is monitored every two weeks. Each provider on the team works with the patient and his or her family on setting a specific goal. All factors that contribute to obesity in children such as sleep patterns, physical activity, and relationship building are considered. The clinic focuses on creating healthy habits with a slow introduction of the new behavior, followed by affirmations as each goal is reached and new goals are set. In April 2017, the clinic hosted an "Empowered Living Garden Party" to help clinic participants enjoy the process of growing and preparing healthy foods.

Dr. Rais stated that he serves as the team pediatrician. He reported that prior to his work in the Empowered Living Clinic, he understood there was a need for intervention that adequately addressed pediatric obesity as he was seeing a vast array of comorbidities in children directly linked to their weight. Only seeing the child in a medical appointment limited his ability to influence the change required. Comorbidities in children can be hard to identify as children often compensate so well that there are no outward signs of disease. Instead, disease is detected via clinical examination and mostly through laboratory test findings (i.e. hyperlipidemia, insulin resistance, elevated blood sugar). The children rarely understand their own mortality, but their parents do. Thus, it is incumbent upon health care providers to engage the parent in order to experience the greatest success in addressing pediatric obesity. At the Empowered Living Clinic, the goal is to show families how small changes can make a big difference in these complicated diagnostic measures that they may struggle to understand.

Mr. Wells emphasized that this approach is "wildly unique," although they have collaborated with Healthy Futures, a non-profit organization dedicated to supporting positive youth development. He stated that this multi-factorial approach is the only way to address fully the intricacies of childhood obesity. He explained that children tend to reach for what is convenient and easy to eat, while parents buy what is affordable when under financial duress. The Empowered Living Clinic's behavioral health counselor is integral to addressing such challenges. In addition, they assist with the anxiety and depression that frequently occur while battling obesity. Mr. Wells stated that the role of the physical therapist is to rule out musculoskeletal issues and to identify any limitations that may impede a patient's ability to obtain their physical activity goals. Once this review is complete, a plan is developed to support the patient in obtaining his or her self-identified targets. A benefit to the interactions with various clinicians on the team is that it provides children an opportunity to build a genuine connection with at least one provider. Often these trust relationships become integral to promoting changes in the patients behavior.

The clinic uses a behavioral modification technique based upon motivational interviewing, which is patient-centered and challenges the negative thought processes and beliefs held by the patient by focusing instead on the patient's wants and needs. The clinical team serves as a sort of navigation system giving the patient guidance on where they want to go through finely

tuned adjustments and small changes. The clinical team addresses many common challenges seen among pediatric patients, such as no desire by the child to change or the parents refusing to change along with the child, which creates lack of modeling behavior in the child's support environment. The clinical team serves as one of the support environment role models by participating in activities with the children from 5Ks to gardening to healthy cooking.

Dr. Rais affirmed that it is important to weave the clinical team into the life of the pediatric patient. In so doing, the team creates a relationship in which the child feels as though he or she can rely fully on the team, which creates a community of support.

Mr. Wells emphasized that the clinic strives to foster a compassionate environment. He concluded by stating that the program does not focus on just the weight management but rather the entire environment which causes one to gain weight.

Dr. Weedn stated that the model for the program came from the expert pediatric committee on obesity, which includes CDC, the Health Resources and Services Administration, and the American Medical Association. Ten years ago, the guidelines were used to build a staged model for weight management were addressed. For reference, stage 1 (primary care) and stage 2 (allied health) were separated from each other because that is how they operate inside the health care system. The model sought to take primary care engagement and allied health care engagement and reach stage 3 (multidisciplinary care program). In 2012, the Oklahoma University Health Science Center developed and implemented the model in Oklahoma and began to study its impacts. In 2014, a registry was developed where every academic center or community team could report its data. Looking back over five years, the biggest outcomes that have changed are laboratory values (done every 6 months). These changes are connected to the activities and changed behaviors of the patient and are further linked to future health impacts.

Dr. Weedn stated that intriguingly, there is a decrease in body mass index (BMI), a finding often ignored. For the pediatric population, the observed change is instead in weight gain velocity as opposed to weight loss significant enough to create BMI change in children. The laboratory values represent the changes." As the pediatric patients move from abnormal to normal laboratory values their future health risks decrease substantially. From a research perspective, the next steps are to begin the Empowered Living Registry Evaluation. Since the Empowered Living Clinic is a closed system, it is possible to explore the additional family impacts of the clinic rather than just the effect on the pediatric patient. Chickasaw Nation is the only community based multidisciplinary team, all other teams are academic institutions, further making this clinic design a unique opportunity to evaluate. Dr. Weedn concluded by stating that at the Empowered Living Clinic, when a goal is set by the child, each family member supporting that child commits to this change as well (e.g., removal of sugary drinks from the home).

Dr. Gillaspay, noted that the clinic itself is the “clinical intervention” for the patient but serves as “early intervention” for the rest of the family members. Due to the closed electronic medical record system, the ability to track the family member impacts exists.

Mr. Saunkeah, shared that Chickasaw Nation is developing a biorepository as part of the Empowered Living Clinic with infrastructure currently in the planning phase of development. Another research component is the health messaging consistency within the health system. Anecdotally, patients in the health system are getting different messaging. Chickasaw Nation wants to assess the validity of this claim in order to develop and implement consistent health messaging regarding obesity across all areas of care within its health system.

Lt. Governor Keel thanked the group for the presentation. He also shared that the inclusion of the registered dietician in the team is valuable as there are native communities across the country who depend on the commodity distribution. It is critical to assist them in the healthy ways to prepare these challenging foods.

Ms. Goodson shared a story of a patient who had cleaned out all unhealthy food from the home’s cabinets, but did not know how to move forward. The team stepped in to provide critical education on how to shop, what to buy, and how to cook and prepare healthy foods. For the younger generation who may not cook and therefore may rely upon fast food services and convenience store foods, the clinical team works to help them improve selections from among these items.

Dr. Rais added that the clinic also creates “Get Fresh” videos that help to do some of this important re-education. Currently, this pilot program of the clinic is operational only one half day each week.

Mr. Wells shared that while “food cabinet cleaning” is great to start, the issue occurs when the “diet” mentality fades away. People resort back to old habits that may not be conducive to sustaining their weight loss. Hence, the real change is in helping change behavior. Mr. Wells concluded by stating that is why Empowered Living Clinic teaches and educates other on healthy behavior, so that they are not just giving instruction but are also showing clients how to live a tangibly healthy lifestyle.

Ms. Goodson wanted to stress the research component of the clinic stating that Chickasaw Nation has developed funding relationships with Oklahoma University Health Sciences Center and the State of Oklahoma. What they need most is a full-time clinic coordinator with exceptional health-coaching skills, as there is a high degree of patient interaction. She emphasized that there is a vast amount of work that could be done if there is appropriate funding.

Dr. Montero posed a question to the panel stating that it is known that excellence in clinical management of obesity is required. He stated that in their presentation, it was mentioned that consistency in messaging is an area for improvement in the health system. He asked the panel

how they address the cultural needs in the prevention arm when health behaviors may be culturally specific.

Dr. Weedn responded that development of cultural messaging is tribally specific and would need to occur at the tribal level rather than the state level. She relayed that the university's pilot data regarding health messaging was observed among mothers of young Native American children. In this specific group, there were differences in opinion on how to prepare foods.

Mr. Saunkeah responded that the program just received IRB approval last month to begin the research piece within the program. Every component has the Chickasaw culture embedded in it. Consent forms for participants are being finalized now and an application for an Empowered Communities grant with the Office on Minority Health will be submitted. It is anticipated that next year Chickasaw Nation will have data to share.

With this final response, Councilman Chester Antone concluded the session.

## Tribal Epidemiology, Data, and Research

### Panel participants

- Michael Peercy, MPH, MT(ASCP)H, Epidemiologist/Biostatistician, IRB Administrator, Division of Research and Population Health, CNDH
- Bobby Saunkeah, RN, MSGCE, CIP (Kiowa Tribe), Manager, Research and Population Health Division, CNDH

This session highlighted issues such as disease surveillance, data protection, and research partnerships.

After introducing himself and his colleagues, Mr. Peercy shared that Chickasaw Nation Division of Research and Population Health staff focus on the surveillance of chronic disease, infectious disease, emerging pathogens, community health assessments, outbreaks, and more. The division employs many tools to explore community health, including geographic information system mapping. In an outbreak response, the division frequently encounters complex jurisdictional issues and must work to ensure all appropriate response actions occur within these restrictions. For example, to surveil influenza outbreaks, the division must work with regional and local health departments to procure the vaccine, distribute and administer it to Chickasaw community members.

Research is also a large part of the division's work, and all of the work requires a high degree of partnership engagement. Mr. Peercy reported that most recently, his division has been converting their Resource Patient Management System (RPMS), used for the Chickasaw healthcare system, to a more friendly database that can interface with statistical software to perform better data analytics. For example, when a baby is born, it is assigned a new medical record number in RPMS and is immediately de-linked from its mother's electronic record. The Chickasaw Nation has identified twelve key data components in the RPMS system that can be

used to re-link the charts and allow for the longitudinal examination of patient data. Mr. Peercy affirmed that in the tribal world it is very hard to separate clinical from public health. Therefore, he and his staff look at patients as groups, or “panels,” and they work closely with their clinic infection control offices to provide sentinel alerts on issues in their population.

Mr. Peercy explained slides the depicted Chickasaw Nation statistical data that had been linked and corrected, including death rates by cause. He paused on the slide showing “Cancer Death Rates 2010–2015 for Chickasaw Nation Counties - American Indian Population.” He shared that the data is derived from Oklahoma State’s Department of Vital Statistics and that the Chickasaw Nation has developed a new cancer registry. Providers have reported that there is a high rate of late-stage cancer diagnosis in Native Americans due to lack of routine screening.

Mr. Peercy also highlighted on the slide “Years of Potential Life Lost” that motor vehicle accidents remain the number one cause of death for the nation, while a new number two cause has emerged—from 2010–2015, accidental opioid poisonings jumped to this position. Accidental poisoning was not even in Chickasaw Nation’s top five two years ago.

Chickasaw Nation is starting to see a small decline in tobacco use rates, but overall these rates are still very high and are reflective of the high rate of lung cancer observed on the “Cancer Death Rate” slide shown earlier in his presentation. He added that they derived tobacco use rates from clinical data, which tribes frequently use as a proxy, since public health data are often not available.

Mr. Saunkeah described the Chickasaw Nation IRB stating that IRBs are designed to protect human research subjects from harm during the research process. The Chickasaw Nation has had an IRB since 1998. Tribal IRBs came about due to historical abuses regarding research with tribes, and the reluctance many tribes had to participate in research due to these abuses. When done correctly, research is a great opportunity for tribal people and nations; it can help increase and expand services when done in a culturally appropriate way. The difference between an academic and tribal IRB is that a tribal IRB is charged not only with protecting the individual, but also the tribe as a whole. The Chickasaw Nation IRB reviews all publications without exception. The tribal IRB maintains partnerships that are respectful with academia but does have differing responsibilities in the actual IRB process.

Mr. Peercy discussed “data sovereignty,” (i.e., data ownership) as it applies to tribes, stating that it is the right to govern the collection, use, and storage of its own data . As with most tribes, the Chickasaw Nation does not allow for research data transfer or secondary analysis without tribal approval. Chickasaw Nation supports meaningful sharing with its partners, but emphasizes that the tribe retains total control over the “how, when, who, and disposal of” data. Through epidemiology and research many data are created, so the division operates very conscientiously, spending a great deal of time to build trusting relationships with partners. The division has ability and skill to do many important public health data analytics, but could always use more capacity. The state health department employs epidemiologists across all of their

sections; tribes may not have an epidemiologist at all, or at best may have one who must take his or her skills and evolve into a “jack of all ‘epi’ trades.”

Mr. Saunkeah shared that strongly written guidelines that are shared upfront with all research partners have greatly helped their IRB. The nation’s research agreements all acknowledge data sovereignty. This transparency has been helpful in establishing trust and promoting research.

Councilman Antone asked about the essential components of an IRB.

Mr. Peercy replied that for federal recognition, an IRB must have community involvement, directorship, and a mix of scientists and nonscientific members. A tribe can form a research review board without having a federally recognized IRB. This would route all research decisions to the council or other designated tribal group. Chickasaw Nation chose to have the federal registration, which does give more influence when engaged with academic institutions should a difference of opinion occur. President George Edwardson described research abuses within his tribe. Mr. Saunkeah responded that this example provides the context for why tribes are forming IRBs and exerting their sovereign authority to review all potential research. The tribal IRBs can prevent these abuses.

Representative TwoBears asked the panel if Chickasaw Nation provides insurance coverage for tribal members, and if so, if it shares information with the insurer.

Mr. Peercy replied that there is no close work with the insurance company, although there is effort to break down the barriers in the separate caches of data that the tribe owns. If able to do so, they could identify a greater economic impact of prevention activities through the sharing.

Mr. Saunkeah also shared that the division strives to improve its external communications through newspapers and the website, and are exploring additional communication strategies through community focus groups and leadership presentations. Mr. Peercy stated that they share some of the more clinical projects within Grand Rounds, so that providers have the information as quickly as possible.

With no further questions, Councilman Antone concluded the session.

## **Built Environment: FITWEL, Resources for Tribes**

### **Panel participants**

- Joel Kimmons, PhD, Health Scientist, Division of Nutrition, Physical Activity and Obesity, NCCDPHP, CDC
- Giselle Sebag, MPH, LEED AP, FITWEL Ambassador, Healthy Places Programs Director. Center for Active Design, Strategic Planning and Partnerships Consultant, Equitable and Sustainable Cities, Greater New York City Area

Dr. Kimmons started the presentation by stating that “built environment” is a scientific theory around health behavior that aims to make a healthy lifestyle part of the environment, the infrastructure around you, and the opportunities it provides for healthy behavior. Dr. Kimmons explained that at NCCDPHP, his division uses the Star Community Index as a strategic planning and performance management system. The system offers local governments a road map for improving community sustainability by focusing on initiatives that make a whole community healthy. He explained the connection between the environment and health behaviors by stating that a built environment aims to make a healthy lifestyle more accessible, affordable, and sustainable. Built environment theory encompasses social structures, cultural norms, and personal values to change behavior by changing individual components. Dr. Kimmons defined “society” as a built environment that provides individuals with opportunities. Culture influences the choices we make because other members in our family make similar choices. The question built environment theory aims to answer is: how do we adjust society to make it supportive for health behaviors? He explained that behavioral choices are reactive and driven by sensory exposure, availability, cultural norms, and mindset. Analyzing how design affects behavior will facilitate impact on individual behavior.

Ms. Sebag presented on Fitwel<sup>SM</sup>—a certification system that incorporates behavioral design into buildings to promote healthy behavior. Ms. Sebag explained how atmosphere can affect the brain by providing the example that subliminal triggers can affect the vagus nerve and make someone irritable. She stated that Fitwel is a high-impact building certification that supports healthier workplace environments and improves occupant health and productivity. Fitwel is an independent non-profit organization in New York and is currently into its beta phase in terms of product development. Fitwel is an effort lead by CDC and the General Services Administration. Ms. Sebag concluded by stating that Fitwel aims to create value in the marketplace around health.

Dr. Kimmons explained that CDC scientists have researched the link between built environments, physical activity, and buildings. Dr. Kimmons and his CDC colleagues spoke on health issues that are becoming an increasing priority for Fitwel. These priorities include chronic disease risk factors, mental health, social equality for vulnerable populations, occupational safety, and improvements in community health. Fitwel’s unique value lies in the fact that all strategies suggested by the certification program are voluntary and require no prerequisites strategies that could be cost-prohibitive. Dr. Kimmons explained the certification process, which has the following steps:

- An organization’s staff registers and inputs information
- A scoreboard is completed and a benchmark is received
- Verification documents are uploaded by staff
- Staff submits all documents and receives a Fitwel rating

Dr. Kimmons stated that as a part of built environment, food service operators ideally should provide a spectrum of food options that can create a healthy environment by default. A

component of built environment is rebuilding the worksite food environment to make healthy eating more accessible. Dr. Kimmons concluded by stating that federal, tribal, and state governments can work together to change the culture in terms of diet. Dr. Kimmons and Ms. Sebag concluded the session by giving a few more facts about the Fitwel program. Ms. Sebag explained that the program is a result of five years of rigorous empirical public health evidence analysis. Fitwel has been optimized for existing buildings and aims to strengthen the link between built environment and health outcomes. In conclusion, Dr. Kimmons and Ms. Sebag stated that the audience should take away the following two points:

- Organizations should have a food service contract that offers food products that fulfill basic human needs.
- Organizations are encouraged to review their Fitwel score card to determine if individual aspects can be incorporated in your office space that can encourage positive health outcomes.

Councilman Chester Antone thanked the built environment panel members for their time and concluded the session.

## Association of American Indian Physicians

Panel participants

- Jamie McDaniel, MS, Program Manager, Million Hearts: Hypertension Control Improvement in Indian Country, AAIP
- Gary Lankford (Cherokee Nation): Program Director, Advances in Indian Health Care Student Programs, AAIP

Mr. Lankford shared that through the Data Into Action Project, two consultants from University of Oklahoma's College of Public Health implement three workshops each year, with each including between 20 and 25 attendees. Workshop leaders use a hand-on approach to show participants strategies to find good data sources and types of data that might be helpful for different programs. Workshops have been held in Oklahoma City, Oklahoma (twice); Albuquerque, New Mexico; Denver, Colorado; Oakland, California; and Phoenix, Arizona. To date, they have reached approximately 200 attendees. In addition, a hands-on grant writing workshop aims to help attendees write strong grant proposals. The evaluation ratings for the Data Into Action workshop and the grant writing workshop have been positive. In 2018, AAIP will offer three more workshops in the eastern US region, possibly focusing on tribes in North Carolina, the New England area, or the Great Lakes region.

Ms. McDaniel presented more details on AAIP's grant writing workshop. AAIP worked with June Strickland, PhD, RN, professor at the University of Washington, to develop the grant writing workshop curriculum and to implement it in tribal communities. She developed several training modules in a train-the-trainer style, which are now available online. Dr. Strickland implemented in-person workshops in Oklahoma City and at the University of Washington. They learned that a

one-day training was not enough time to go through the intensive training process. Post-workshop evaluations revealed that although people were gaining knowledge, the period was still too short for the attendees to grasp the concepts for developing effective proposals.

In response, AAIP partnered with the Agency for Healthcare Research and Quality's Office of Minority Health (OMH) Resource Center to provide facilitators who had already developed a curriculum geared towards tribal communities. Their program is called "Vision, Design and Capacity," and it incorporates several group exercises that are aimed at different components of a grant proposal. AAIP offered a 2½ day grant writing workshop in conjunction with the recent HHS Region 6 Tribal Consultation Session in May 2017. It reached twice as many attendees from tribes and tribal organizations. The topics included an overview of problem statements, the components of logic models, how to write SMART (specific, measurable, achievable, results-focused, time-bound) objectives, and resources for finding funding opportunities. The facilitators also encouraged attendees to look at "cycles of funding" so their activities and funding amounts are consistent and steady. The post-workshop evaluations were very positive with a few recommendations to shorten the course length to two days.

Ms. McDaniel described the Healthy Active Native Communities Project for which AAIP is partnering with tribal health departments and tribal organizations that have an interest in preventing obesity. The project adapts CDC's evidence-based strategies to improve nutrition and increase physical activity for tribal communities.

With a focus on policy systems and environmental changes, eight communities have been funded to incorporate ten strategies to increase fruit and vegetable consumption and ten strategies to increase physical activity. As one example, the Absentee Shawnee Tribe used AAIP funding to incorporate two 10 to 15-minute breaks in the course of a workday and add a social support component. The tribe had an existing physical activity policy, which allowed tribal employees to use three hours paid leave to either use the tribe's fitness facilities or a preapproved offsite facility, but interest eventually dwindled over time. As indicated in CDC's Winnable Battles initiative, programs with a participant support component are more effective. At Absentee Shawnee, the employees turn in walking logs, and have monthly incentives and awards ceremonies. The tribe also modified the policy language from "exercising for fitness" to "exercising for health," which survey responses indicate is more favorable.

A village in Alaska enhanced its exercise facilities through community buy-in and participation. They reached out to elders to help name the facility in the Yupik language and incorporated symbols for marketing purposes. They included community members to repaint the facility and set up the exercise equipment, and they held a grand opening. They also implemented a five-week fitness challenge. The village found that community members equated using the facility with "If you're healthy, you can fish more, and you can enjoy outdoor activities when your body is in a better physical condition." The physician who visits periodically also encourages its use for rehabilitation purposes.

The Indian Child and Family Preservation Program is an Urban Indian program based in California. It conducts work related to Indian Child Welfare Act compliance and supervised visits. The program also does outreach activities using an intergenerational approach, including working with an education and development program to develop three acres of land for community gardening and a recreational facility. They worked with elders to impart knowledge about traditional plants, to share their histories with families, and to convey the importance of physical activity.

The Oklahoma Indian Clinic, an Urban Indian program, is providing a space for children to be more physically active. The space was primarily designed for people ages 13 and up, but when they found that children visiting the clinic were either obese or overweight, they decided to modify the space to make it suitable for children too. Pediatricians refer the children and individuals who work at the clinic staff the space and lead individual and group sessions. They also offer nutrition classes.

The Sacramento Native American Health Center, an Urban Indian Center, is implementing community and home gardens. They are focusing on young families, and patients with diabetes and hypertension. Their activities include hosting a series of workshops that involve growing your own food, and vouchers for the farmers market. The health center has found that participants developed their own health goals and had questions for their health providers or health educators. This presented an opportunity to combine medical services with social services, which had never been done previously.

A common theme across participating tribes and tribal organizations is that partnerships were crucial to the success and sustainability of the projects. AAIP's technical assistance to the sub-grantees, along with buy-in from leadership and the community to sustain the programs either through memoranda of agreement, memoranda of understanding, policies, etc.

Councilman Antone opened the floor for questions.

One attendee asked if the Grant Writing Workshop is in a "train the trainer" format.

Presenters answered that the first modules were in a train-the-trainer format, but since AAIP started partnering with the Office of Minority Health, the training is in a more direct training format. The web-based train-the-trainer modules are still available.

Councilwoman Carlyle asked if the tribes in Arizona work with the Inter-tribal Council of Arizona TEC, and if presenters know if anyone from that organization has attended the grant writing trainings.

Presenters responded that AAIP is planning to offer two or three more trainings before funding ends in 2018, so those interested can make a request to have a training in their area.

Councilman Antone concluded the session.

## Tribal Partnerships for Enhanced Emergency Preparedness

### Panel participants

- Jeff Morris, MPH, Institutional Environmental Health Officer, CNDH
- Mendy Spohn, MPH, Administrative Director for Health Departments, Oklahoma State Department of Health

Ms. Spohn started the panel by stating that three years ago the Oklahoma State Department of Health collaborated with the Chickasaw Research and Population Health program on a community-wide project to reduce the incidence of influenza hospitalizations and deaths. The project helped identify roles and responsibilities, data storage, and definitions. Because the outbreak occurred on Trust Lands, it involved several health departments, school systems, and employee worksites, and it taught an important lesson about who to reach out to during an outbreak. Because of a learning curve regarding how to coordinate efforts best across several organizations, infectious disease nurses from Chickasaw and the Oklahoma State Health Department now regularly meet to ensure tracking and effective communication of potential health issues.

In addition, Ms. Spohn shared that to continue building their skills, her department is working in Carter County, Oklahoma, on a full-scale exercise on mass immunization and prophylaxis. Oklahoma State Health Department has been practicing and training on such topics across the state for the past 15 years. Ms. Spohn stated that her department is now capable of setting up a clinic within an hour. However, they are concerned about setting up an incident management system.

In addition, Oklahoma State Department of Health is working to increase risk communication capabilities by creating or designating liaisons between incident command and hospitals, city and county governments, and school systems. Ms. Spohn explained that this creates a channel for communications on a local, regional, or national level to manage any potential outbreaks or the need for medicine or vaccine distribution, and builds a broader and more accessible public information platform. Ms. Spohn concluded by emphasizing that building relationships and remaining active in daily activities is the core to providing effective preparedness and response.

Dr. Montero commented that it was great to learn about a model where tribal, state, and local health departments are working together. He asked panel members to specify what makes their collaborative efforts successful.

Mr. Morris responded by stating that the Oklahoma State Health Department and CNDH have established personal relationships and intentionally broken down social barriers by training together and sharing information.

Dr. Montero asked the panel members how CDC could institutionalize a program such as theirs.

Ms. Spohn responded by stating the following tactics:

- Establishing policies
- Creating a plan that is easy to follow regardless of who holds different roles
- Building an MOU to help institutionalize programs
- Defining the urgency of issues at hand and working to address them effectively

She went on to recommend developing relationships early to set up the infrastructure, so it will carry on. Emergency management or response is not just about inspecting damaged buildings or public health infrastructure, it is about people.

Dr. Montero asked what CDC could do beyond funding to support efforts like this, or to step aside.

Ms. Spohn suggested that CDC build flexibility in program guidelines or grant applications, and be less prescriptive with requirements like forms. She went on to suggest CDC focus on what the ultimate goal is, such as for communities to be ready—to be able to access the Strategic National Stockpile, get medications to the right people within 48–72 hours, document and track that distribution in case there might be a recall on the medications or something, and communicate risk well. Looking back 15 years, Ms. Spohn remarked that having funding opportunities and the training really helped, and that flexibility—however that can be done—is good.

Navajo Area Authorized Representative Del Yazzie, Acting Director, Navajo Epidemiology Center commented that Navajo Nation, with three state borders (New Mexico, Arizona, Utah), has made strides in building relationships with those states and the counties within them. Navajo Nation is working to coordinate on public health emergencies, communicable diseases, environmental health assessments, and outbreaks. He asked if the presenters have a flow chart for communications for how different cases could be managed. He went on to say that at Navajo Nation, responding to emergencies in a coordinated fashion is a challenge, and that they need protocols for samples that are sent to the state health departments and/or CDC. Navajo Nation has tried to develop a flow chart based on what a patient would go through.

Ms. Spohn replied that mind mapping software is a good tool, and that it's helpful to think about the public health message, and if it gets complicated, to start scheduling meetings with partners to figure out roles and responsibilities and top issues that need to be addressed immediately. She has some logic models that she would be happy to share.

Mr. Morris also responded that disseminating accurate information is key. He recommended establishing a unified command and use media e.g., radio, TV) to get messaging out.

Councilman Antone added a response to Dr. Montero's questions, stating that funding to tribes and allowing for flexibility is important. Whether funding goes directly to tribes or through states, it is important to know what the expectations are and where the accountability is. Even if Congressional language restricts funds to certain entities, tribes might still be able to obtain some of that funding; however, restrictions can also hurt tribes too. He stated that hearing from the tribes today, it is not about money—it's about changing policy. The CDC Director or HHS Secretary might have broad authority to implement Memoranda of Understanding (MOUs) that help to get the funding and other resources to tribes.

Councilman Chester Antone concluded the session.

## Oral Tribal Testimony

Mr. Yazzie presented the first tribal testimony. He thanked CDC representatives for addressing Navajo Nation's concerns and needs. Mr. Yazzie requested that written testimony to be imported into the meeting minutes. As a result, all written testimonies are included as appendices to this document.

Mr. Yazzie noted that Navajo Nation applied to be a CDC PHAP host site and hopes to get their first PHAP in October 2017.

Chickasaw Nation Representative, Judy Goforth Parker, Secretary of Health for Chickasaw Nation, provided a testimony. She thanked CDC and ATSDR staff for their presence and support at the Summer 2017 TAC Meeting. Secretary Parker stated that her background is in nursing and teaching public health, and that tribal public health accreditation is one of Chickasaw Nation's priorities. She addressed a question regarding preparedness activities and state and tribal relations. Secretary Parker emphasized the role of the tribal liaisons within various departments in Oklahoma. Tribal liaisons answer questions for states on behalf of tribes and vice versa. The relationship between states and tribes depends on the communication carried out by the tribal liaisons. She emphasized that continuous, bidirectional outreach in a professional relationship is extremely beneficial in attaining goals. She concluded by highlighting the following items from Chickasaw Nation's written testimony:

- Make funding to tribes secure and sustainable—ensure funding streams to tribes, even if it takes Congress to make this happen.
- Increase tribes' access to compete for funding. For example, identify where a tribe can have direct eligibility and facilitate their competitiveness in the application process.
- Ensure a tribal voice in the larger CDC system by better understanding the role of OSTLTS and TSU.
- Report on CDC funding streams that are restricted through legislative language.

- Remain cautious on specificity in grant opportunities.
- Acknowledge the Tribal Behavioral Health Agenda, which empowers Chickasaw Nation to do great things in integrating services for our nation.
- Understand Chickasaw Nation shares common concerns, goals and visions in public health and behavioral health.

Chairwoman Andrews-Maltais provided testimony on behalf of her tribe. She reiterated the need for direct funding, and specifically requested additional funding or assistance to combat Lyme disease. Chairwoman Andrews-Maltais explained that there are no natural predators to the deer population in her area. In addition, her tribe has seen many false negatives when testing for Lyme disease, and improved diagnostic testing is needed. Some individuals in her tribe are identified as having Lyme disease 15–20 years after contracting the illness. She requested that CDC conduct an island-wide survey or study of Lyme disease. She concluded by stating that we need to be able to learn more about treatment process and CDC guidelines, and that follow-up to this request will impact IHS and Purchase/Referred Care dollars.

President Edwardson stated that he has pursued building a hospital for 18 years, and that his clinic cannot treat cancer patients. He stated that among eight communities, his tribe lost on average one member to cancer every three days consecutively for a year and eight months, a significant loss for a population of only 13,000. He explained that he would like to add an entire floor as a treatment clinic.

In addition, the Inupiat community has two contaminated rivers that cause fish to die, making it hard for villages that rely on fishing as a source of food to feed themselves. President Edwardson listed the following additional issues:

- Arrival of foreign ships is creating a risk to the national security of the community
- Assistance in protecting the North American salmon in the arctic as fish are killing the salmon

President Edwardson concluded that his biggest request is the third-floor construction of a cancer treatment clinic. The Mayo Clinic is willing to provide his community with staff to treat the patients if a building is available for them to work in. He reiterated that his community is in dire need of this assistance because people are dying.

Ms. Fourkiller thanked Dr. Bauer for taking an additional day to visit and for visiting Indian Country in general. She reiterated what TAC members previously said about funding mechanisms, and that activities proposed in NOFOs are highly beneficial but will not be executed if tribes lack funds to do so. Ms. Fourkiller also emphasized the need to develop a long-term plan for developing such activities in Indian Country.

She stated that with the help of a small team in Oklahoma, NIHB is developing a public health capacity scan. The following themes recur in discussions regarding the scan:

- Tribes request data on tribal and federal resources invested in public health
- Tribes are hesitant to report financial data

Ms. Fourkiller recommended that NIHB remove financial questions from the scan to ensure a greater response from individuals in Indian Country.

Councilwoman Carlyle shared that the Phoenix Area consists of 42 tribes across the states of Arizona, Nevada, and Utah. Councilwoman Carlyle stated that the Nevada TEC sends information out via the Inter Tribal Council of Arizona (ITCA). Using surveys that reach tribal communities, the ITCA shortlisted a few priorities, including ACA and the IHS National Community Health Program. Several tribes have developed a community-based action plan to assess the effectiveness of community public health programs. A top priority in the Phoenix area is to serve all AI/AN individuals, and avoid limiting community health services to those who do not live on reservations. Additional priority areas include mental health, oral health, urban health, and the sanitation facilities construction.

Councilwoman Carlyle elaborated on the survey sent out to tribal communities. The survey included questions about data quality improvement and community profiles of health statistics.

Councilwoman Carlyle concluded by recommending that CDC address and respond to each priority by collaborating with tribes to collect data. She stated that although there will never be enough funding, accurate data has the power to increase tribal health funding.

President Andrew stated Alaska Area priorities: substance abuse, unintentional injury, adverse childhood experiences (ACE), cancer prevention and control, diabetes prevention and access to clean water. President Andrew explained that Alaska's main issue is that the state does not recognize the tribes, creating a barrier to accessing accurate tribal health data. She concluded that the CDC can assist the Alaska area by providing TECs with access to data.

Ms. Pivec started her testimony by stating that CDC can continue to fund and utilize the TAC to its fullest potential. Ms. Pivec suggested:

- Holding an annual, in-person meeting between the CDC director and TAC members
- Assigning a tribal liaison position within each CDC CIO
- Creating a dedicated and formal tribal seat at the CDC EOC
- Including TAC members and tribal leaders in the internal budget process
- Formalizing a tribal budget formulation process

In addition, Ms. Pivec emphasized the need for public health services that are tailored for tribal communities. She expressed concern about the current public health capacity scan, explaining that it will not provide more information than we already know, which is that tribal communities need more public health infrastructure. Ms. Pivec concluded by stating that Cherokee Nation is committed to working with CDC and NIHB to build public health infrastructure.

Councilman Antone provided his testimony by reiterating the following past requests made to CDC:

- Allocate 2% of each CIO's budget to Indian Country
- Improve language that can be used for legislative appropriations and explore how public health services can be provided with language that CDC is responsive to

Councilman Antone also stated that OSTLTS could proactively educate each CIO as well as the CDC director on tribal priorities. He suggested that OSTLTS could facilitate a meeting for TAC members to discuss tribal priorities with the new CDC director, Dr. Brenda Fitzgerald, within her 90-day review period. He acknowledged that Dr. Fitzgerald would consider requests from OSTLTS and other CIOs. Councilman Antone also supported the idea of OSTLTS continuing to support the TAC by holding an annual meeting with the CDC director. Regarding public health infrastructure, Councilman Antone requested that the new CDC Director use maximum discretion when it comes to tribal funding.

He acknowledged that the GHWIC grant has an evaluation component and emphasized the importance of analyzing evaluation results. In response, Dr. Montero stated that he would check and see if University of South Dakota is in charge of the evaluation results.

Councilman Antone stated that Arizona is having issues with their state legislature submitting the Sunrise application due September 1, 2017. Arizona's Sunrise review process provides a mechanism for healthcare professionals to request regulation or expansion in scope of practice.

Lastly, Councilman Antone reminded participants that Zika virus is still affecting tribal communities. CDC and tribal communities should continue to be mindful of the impact of the Zika virus.

Representative TwoBears gave the final tribal testimony. He acknowledged that the Bemidji Area has been consulting with the federal government for a while. He stated that Ho-Chunk Nation of Wisconsin has an organization called the Midwest Alliance of Sovereign Tribes (MAST), which includes tribes in the states of Minnesota, Iowa, Michigan and Indiana. He stated that MAST needs a technical advisor to assist with issues such as health disparities, chronic diseases, and diabetes. In a recent regional consultation, the top issues in the Midwest were opioid use and heroin overdose. Representative TwoBears stated that the issue is that tribes are relatively new to addressing such issues and may not always know how to address them. He reiterated that his tribe and area are looking for advice and assistance in addressing public health concerns, and added that some tribes do not have the means to travel to meet with technical advisors.

## Closing prayer/Adjournment

Dr. Montero thanked Councilman Antone for running the meeting and thanked everyone for his or her input, recommendations, and ideas. He stated that CDC has been continuously improving the way it manages TAC meetings, and that it will continue to do that to make the most of TAC delegates' time.

Captain Clelland thanked the Chickasaw Nation hosts for their gracious hospitality. He also instructed those on federal travel orders to send their receipts to Tyece Marshall by Friday August 18, 2017. CDC's Winter TAC will be Feb 6–7, 2018.

Councilman Antone thanked the state of Oklahoma and tribes.

## Participants

### Tribal Advisory Committee Members

- **Alicia Andrew** (Karluk IRA Tribal Council): President, Karluk IRA Tribal Council; Alaska Area Delegate
- **Robert Flying Hawk** (Yankton Sioux Tribe): Chairman, Yankton Sioux Tribe; Great Plains Area Delegate
- **Robert TwoBears** (Ho-Chunk Nation): Legislative District V Representative, Ho-Chunk Nation; Bemidji Area Delegate
- **Jonathan Nez** (Navajo Nation): Vice President, Navajo Nation, Co-Chair, Tribal Advisory Committee; Navajo Area Delegate
- **Lt. Governor Jefferson Keel** (Chickasaw Nation): Lt. Governor, Chickasaw Nation; Oklahoma Area Representative
- **Delia Carlyle** (Ak-Chin Indian Community): Councilwoman, Ak-Chin Indian Community; Phoenix Area Delegate
- **Travis Brockie** (Lummi Nation): Council Member, Lummi Nation; Portland Area Delegate
- **Chester Antone** (Tohono O’odham Nation): Councilman; Tohono O’odham Nation, Chair, Tribal Advisory Committee; Tucson Area Delegate
- **George Edwardson** (Inupiat Community of the Arctic Slope): President, Inupiat Community of the Arctic Slope; Delegate-At-Large
- **Byron Larson** (Northern Cheyenne Tribe): Tribal Employee, Northern Cheyenne Tribe; Delegate-At-Large
- **Bryan Warner** (Cherokee Nation): Tribal Councilor, Cherokee Nation; Delegate-At-Large

### CDC and ATSDR Senior Leaders

- **Ursula Bauer, PhD, MPH**: Director, NCCDPHP, CDC
- **Stephanie Dulin, MBA**: Deputy Director, NCBDDD, CDC
- **José T. Montero, MD, MHCD**: Deputy Director, CDC; Director, OSTLTS, CDC

### CDC and ATSDR Participants

- **Captain Carmen Clelland, PharmD, MPA, MPH**: Associate Director for Tribal Support, OSTLTS, CDC, *(Cheyenne and Arapaho Tribe)*
- **Commander Damion Killsback, PharmD, MPH**: Deputy Associate Director for Tribal Support, OSTLTS, CDC, *(Northern Cheyenne Tribe)*
- **Gregory Smith, MPA**: Tribal Liaison Officer, Program Services Branch, Division of State and Local Readiness, OPHPR, CDC
- **Joel Kimmons, PhD**: Health Scientist, Division of Nutrition, Physical Activity and Obesity, NCCDPHP, CDC
- **Georgia Moore, MS**: Associate Director for Policy, OSTLTS, CDC
- **Jillian Doss-Walker, MPH**: Public Health Advisor, IHS Immunization Program Field Assignee, CDC

- **Victoria Phifer, MPH:** Public Health Analyst, Office of Public Health Scientific Services Office, CDC

# Appendices

(Click to open each .pdf file to read the full report)

## Alaska Area Delegate, Area Report

### CDC/ATSDR Tribal Advisory Committee (TAC) Area Report

TAC  
Member: Alicia Reft  
Area or National  
Organization: ALASKA TRIBES  
Timeframe: \_\_\_\_\_  
TAC  
Meeting: August 8/9, 2017

How have you been able to disseminate and share information about CDC to your Area Health Board, Area Tribal Consortia, and other tribes or tribal organizations?

With whom have you communicated? (Check all that apply)

Area Indian Health Board  
Tribal Consortia  
Other \_\_\_\_\_

Tribal Organizations  
Tribal Leaders

Describe your Service Area. Include tribal composition, and public health areas of greatest concern. (2 paragraphs).

The Alaska Tribal Health System (ATHS) provides comprehensive *statewide* health services to Alaska Native and American Indian people. Alaska has 229 tribes that span a geographic area of 586,412 square miles of land predominantly off the road system. In 2015, there were approximately 158,674 Alaska Native and American Indian people using the Alaska Tribal Health System. Alaska is the only state in which over 99 percent of health programs are managed by tribes and Native organizations. Such a large



**CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.**

Submitted via e-mail to: TribalSupport@cdc.gov

July 7, 2017

Captain Carmen Clelland  
Associate Director, Tribal Support Unit  
Office for State, Tribal, Local and Territorial Support  
Centers for Disease Control and Prevention  
4770 Buford Highway N.E.  
Mail Stop: E-70  
Atlanta, GA 30341-3717

**Re: Tribal Consultation Session Testimony**

Dear Captain Clelland:

I write today on behalf of the California Rural Indian Health Board (CRIHB) to present testimony about Tribal health issues during the Centers for Disease Control and Prevention (CDC) /Agency for Toxic Substances and Disease Registry (ATSDR) Tribal Advisory Committee (TAC) Meeting and 17th Biannual Tribal Consultation Session.

As authorized by the Indian Self Determination, Education, and Assistance Act (ISDEAA), CRIHB is authorized to provide ISDEAA services to seven Public Law 93-638 contracted Tribal Health Programs (THPs), with another five THPs as associate members. CRIHB serves twenty-six Tribes under the ISDEAA contract, with an additional seven other Tribes as associate members. CRIHB's network of 17 Tribal Health Clinics provide health care services to more than 19,000 patients eligible for Indian Health Services. CRIHB is authorized to represent our member Tribes in health policy/ advocacy matters for purposes of government-to-government consultation.

CRIHB appreciates this opportunity to speak openly about the public health issues affecting our member Tribes, including priorities for the CDC/ATSDR, public health capacity in Indian Country, American Indian and Alaska Native (AI/AN) public health concerns, budget and funding opportunities, and programmatic issues. CRIHB offers the following testimony:

**I. General Questions and Recommendations**

1. **How is CDC responding to the President's 2018 Budget Request?**
  - i. **Will CDC work to ensure that all existing AI/AN programs under CDC continue to be funded at their current level or above? AI/AN organizations have documented the effectiveness of these programs and CDC needs to maintain them.**
2. **CRIHB recommends that CDC include language in its Funding Opportunity Announcements that recognizes the value and applicability of cultural and traditional practices as viable grantee activities.**
  - i. The intent of this recommendation is to address the existing barriers that Tribes experience when seeking to implement or incorporate traditional and cultural practices and activities. Tribes are frustrated when they have to explain and defend the benefit of their cultural practices and the positive



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**Office of the Chief**

**Bill John Baker**  
Principal Chief  
P.O. Box 4550 • 904  
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**S. Joe Chillemead**  
Deputy Principal Chief  
P.O. Box 4550 • 904  
W.P.A. Dtd'VA 0-280-00

July 24, 2017

Brenda Fitzgerald, MD  
Director, Centers for Disease Control and Prevention  
Administrator, Agency for Toxic Substances and Disease Registry  
1600 Clifton Rd  
Atlanta, GA 30333

Dear Dr. Fitzgerald:

On behalf of the Cherokee Nation, I am pleased to offer comments in response to your Dear Tribal Leader letter requesting testimony for the Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry (CDC/ATSDR) Summer 2017 Tribal Consultation. Acknowledging the trust responsibility of the United States to provide health care to American Indian/Alaska Natives and understanding the important role the CDC/ATSDR in protecting and promoting the public health of all American Indian/Alaska Natives, I submit the following priority issues and recommendations.

**1) Solidify Direct Funding Streams to Tribes:**

CDC/ATSDR funding and resources to Tribes have been limited historically. The Agency should review the budget to determine current allocations with active strategies to increase budgets and resources as they relate to American Indian / Alaska Native (AI/AN) public health. As Tribes do not have a local tax base to support local public health activities, as a states do, and the lack of direct funding negatively impacts tribal public health operation. Currently, the lack of funding dedicated to Tribes prohibits implementation of effective prevention and health promotion activities, opportunities for sustainability, and the construction of a solid public health infrastructure at the Tribal level. To rectify this situation CDC/ATSDR should:

- Adopt policy that directs Centers, Institutes, and Offices to allocate 2-4% of their total budgets to direct funding of Tribes for public health infrastructure development.
- Ensure equal funding opportunities for Tribes as those that are open to only Tribal Epidemiology Centers (TECs). While TECs may provide the best avenue for funding in some areas it is not a method that is successful in the Oklahoma Indian Health Service Area. TECs are not governments and the funding often goes to build the infrastructure of the TEC and not the Tribes in the Area.
- Adopt policy that creates a process for proactive review of CDC/ATSDR funding opportunity announcements to ensure Tribal inclusion.

## Written Testimony of Chickasaw Nation

**CENTERS FOR DISEASE CONTROL/AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY  
TRIBAL ADVISORY COMMITTEE MEETING AND 17<sup>TH</sup> BIENNIAL  
TRIBAL CONSULTATION SESSION  
AUGUST 8-9, 2017**

**TESTIMONY  
JUNE 30, 2017**

### **INTRODUCTION OF CHICKASAW NATION PUBLIC HEALTH:**

Although public health crosses several divisions within the Chickasaw Nation, the Chickasaw Nation Department of Health has formalized public health within the Division of Research & Population Health. The Division is actively involved in Community Based Participatory Research with Universities and other partners based on tribal priorities. The Chickasaw Nation's Public Health priorities are obesity, commercial tobacco use, prescription drug use and misuse, behavioral health and public health literacy. Programs have been developed or are in development addressing these priorities. Some of the programs will be presented during this important meeting.

Chickasaw Nation Department of Health is currently reviewing the feasibility of Tribal Public Health Accreditation. The Division of Research & Population Health has received three grants, two from the National Indian Health Board and one from the Accreditation Support Initiative for completion of the pre-accreditation requirements of a Community Health Assessment, Community Health Improvement Plan and a Strategic Plan. Although capacity is there, the infrastructure needs development and funding. Community Health is a focus for the Chickasaw Nation with active and actionable partnerships from both sides with the Oklahoma State Department of Health through our public health nursing immunization projects as one example.

A priority is to facilitate collaboration and integration between medicine and public health to ultimately improve population health.

### **CHICKASAW NATION PUBLIC HEALTH PRIORITIES:**

The Centers for Disease Control (CDC) has come a long way in fostering a partnership with tribal nations. Chickasaw Nation Lieutenant Governor, Jefferson Keel, serves on the Tribal Advisory Committee (TAC) to CDC. On October 19, 2016, the Tribal Leaders submitted a document which outlined the Tribal Priority Areas for the CDC. The document contained a Vision of "Tribes and Tribal organizations operate a robust, capable, and independent public health system." The two major goals outlined to fulfill this vision was: 1) Make funding to tribes secure and sustainable; and 2) Ensure a tribal voice in the larger CDC system.

These two goals reflect the Chickasaw Nation's public health priorities and we respectfully request that CDC leadership ensure the goals are instituted in CDC operations and full implementation of the recommendations.

## Written Testimony of Navajo Nation

August 2017

### Navajo Nation Briefing Document – CDC TAC Meeting

Thank you for CDC's partnership and support in addressing our public health concerns and needs on the Navajo Nation. We appreciate the funding support and technical assistance provided for the following Navajo Nation programs and projects:

1. **Good Health & Wellness in Indian Country** – The Navajo Epidemiology Center (NEC) is using the funding support to focus on reducing rates of chronic diseases on NN (i.e., diabetes, heart disease, stroke, etc.). The funding support has allowed NEC to conduct community health assessments on the NN (also known as Navajo Nation Health Survey and Tribal Behavioral Risk Factor Surveillance Survey). This was the first ever such health assessment was conducted on NN to help identify priority health concerns. The survey data has been analyzed and the report will be available in September 2017. The NEC is also using the funds to assist NN Chapters develop community health and wellness plans in partnership with the Healthy Dine Nation Act Project (Junk Food Tax).
2. **Injury Prevention** – The Navajo Epidemiology Center has established the Navajo Injury Prevention Coalition and is using the funding support to develop an injury atlas for NN looking at unintentional and intentional injury morbidity and mortality that describes magnitude, trends, and patterns of motor vehicle injuries, elderly falls, suicide, violence, substance abuse (including opioid) and traumatic brain injuries.
3. **Viral Special Pathogens Branch Technical Assistance Support** – The Navajo Epidemiology Center appreciates the technical assistance provided addressing infectious diseases including Hantavirus. The NEC also appreciates the proposed funding support to implement a home-based rodent exclusion project focusing on reducing risk of Hantavirus exposure.
4. **Public Health Associate Program (PHAP) Opportunity** – The Navajo Epidemiology appreciates the PHAP opportunity to assist with building our public health capacity. The NEC has applied to be a PHAP host site and its application has made the final phase and look forward to hosting a PHAP candidate in October 2017. We will encourage other NN tribal programs to seek this great opportunity.
5. **Navajo Birth Cohort Study** – The Navajo Community Health Representatives (CHR) Program is using the funding support to study the effects of uranium radiation exposure and its health effects among Navajos, including mothers and their infants living near abandoned uranium mines. The support allows us to continue to provide survey administration, community education, training and outreach.
6. **Breast and Cervical Cancer Prevention** – The Navajo Breast and Cervical Prevention Program appreciates the funding support to provide screening services for breast and cervical cancers. The program helps low-income, uninsured, and underinsured Navajo women gain access to breast and cervical cancer screening and diagnostic services. Additional funding to support colorectal cancer prevention activities is a great need.
7. **Public Health Emergency Preparedness and Response** – The Navajo Public Health Emergency Preparedness and Response Program is using the funding support to address public health emergency such as a natural disaster, act of terrorism, or disease outbreak in partnership with local, state and federal agencies.
8. **Request for continued and/or additional funding support:**
  - a. **Continued Funding for Good Health & Wellness in Indian Country** – to address reducing the rates of chronic diseases (i.e., diabetes, heart disease, stroke, cancer, etc.).

August 2017

- b. **Continued Funding for Injury Prevention** – motor vehicle injury is the #1 cause of mortality on the Navajo Nation and youth suicide is a priority health concern as well as opioid overdose.
- c. **Funding for Colorectal Cancer Prevention and Screening for Early Detection** – colorectal cancer is the #1 cause of cancer mortality on the NN.
- d. **Funding for Emerging and Zoonotic Infectious Diseases** – to establish infectious disease surveillance system and conduct investigation and outbreak activities.
- e. **Funding for Navajo Department of Health (NDOH) Public Health Accreditation** – to establish the accreditation of NDOH.
- f. **Continued Funding for Tribal Public and Environmental Health Think Tank** – since its inception in 2010, the Tribal Public and Environmental Health Think Tank has served as an information forum to seek visibility about the issues that tribes face with regards to environment and public health. The Think Tank membership have developed informative videos and outreach documents that have been shared with CDC and other partners. Funding to continue the Think Tank is not available and just want to convey that this initiative was doing good work and making inroads with partners.
- g. **Funding for Maternal and Child Health**
  - i. Tribal Pregnancy Risk Assessment Monitoring System (PRAMS) – to collect Navajo-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. PRAMS provides data not available from other sources. These data can be used to identify groups of women and infants at high risk for health problems, to monitor changes in health status, and to measure progress towards goals in improving the health of mothers and infants.
  - ii. Birth Defects Surveillance – to examine whether known risk factors for birth defects explain the higher prevalence of selected birth defects among Navajo newborns.
- h. **Funding for Healthy Dine Nation Act (Junk Food Tax) Project Evaluation** – Conducting a high-quality, review of the feasibility and impact of the HDNA among our Navajo people is essential to make informed decisions about the future of the tax. Capturing information on implementation, adherence and wellness projects is urgent, as implementation is already underway.
- i. **Funding for Navajo Tribal Behavioral Risk Factor Surveillance System (BRFSS) Survey** – The survey was conducted on the NN for the first time ever and the need to continue the survey activities is imperative so that health trends over time can be established. The BRFSS enables the NDOH, tribal health programs, and other entities to monitor risk behaviors related to chronic diseases, injuries, and death. It is an effective tool in preventing disease and promoting health.

## Written Testimony of the Osage Nation



WahZhaZhi Health Center  
715 Grandview Ave, Pawhuska OK 74056

The Osage Nation is a federally recognized tribe located in Northeast Oklahoma. The county is the largest in the state and the original land purchased by the Osage and still regarded on the federal level as reservation land. The tribe has only a small amount of trust lands, which are interspersed with private and other federal lands, but by treaties made in the past, the minerals under the land are held in communal property of the Osage Nation. Bordered by Kansas on the north and other tribes surrounding the other three sides, the total area is 2,246 square miles. The total population was 47,917 in 2012. The percentage of the population reporting as Native American alone was 14.7% in 2014. Two hospitals exist within the Osage county area and both are rated as level III hospitals located in rural area. 59% of Osage County is rural, whereas 41% of the county is considered urban, in contrast with that of the entire state of Oklahoma, which is 32% rural. The largest town in Osage County/Osage Nation is Skiatook population of 7,788 and the county seat is Pawhuska with a population of 3,666. American Indian and Alaska Native children have parents who are, on average, less educated and poorer than the parents of non-Hispanic white children. Among older youth (ages 16 to 19), American Indians and Alaska Natives are more likely to be high school dropouts, jobless, and outside the civilian labor force more than non-Hispanic white youth.

The Osage Tribe has fairly recently compacted the Former IHS Pawhuska Indian Health Clinic in October 2015. The Health facility is now the WahZhaZhi Health Center, staffed by 53 dedicated employees. Other programs in our Health division are WIC, Elder Nutrition, Community Health Representatives, Prevention, Domestic Violence shelter, Fitness centers, and a program for drug and alcohol both outpatient counseling as well as an inpatient program. Presently the Osage Nation Health Authority Board of Directors has been tasked with developing a Strategic Plan that addresses moving the Division of Health and Wellness forward. Since early Fall 2016 members of workgroup have met in planning sessions to approve various data and assessment tools, (Community Needs Assessment, Employee Assessment, Program Assessment and Key Informant Assessment), review preliminary findings, and prioritize objectives. Data collection was the primary driver to assist with determining any potential Strategy Plan recommendations and resulted in the following activities.

The Osage Nation HAB approved a 31 question Community Health Survey, which was designed to collect various demographic data sets, rate and rank level of satisfaction of services, define

## Acronyms

AAIP	Association of American Indian Physicians
ACA	Affordable Care Act
AI/AN	American Indian/Alaska Native
ASI	Accreditation Support Initiative
ATSDR	Agency for Toxic Substances and Disease Registry
BMI	Body Mass Index
CDC	Centers for Disease Control and Prevention
CIO	Center, Institute and Offices
CNDH	Chickasaw Nation Department of Health
DRH	Division of Reproductive Health
EOC	Emergency Operations Center
FY	Fiscal Year
GHWIC	Good Health and Wellness in Indian Country
HHS	Department of Health and Human Services
IAA	Interagency Agreement
IHCIA	Indian Health Care Improvement Act
IHS	Indian Health Service
IRB	Institutional Review Board
ITCA	Inter-Tribal Council of Arizona
MAST	Midwest Alliance of Sovereign Tribes
MOU	Memorandum of Understanding
NAS	Neonatal Abstinence Syndrome
NCBDDD	National Center for Birth Defects and Developmental Disorders
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCIPC	National Center for Injury Prevention and Control
NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention
NIHB	National Indian Health Board
NPHII	National Public Health Improvement Initiative
NOFO	Notice Of Funding Opportunity
OPHPR	Office of Public Health Preparedness and Response
OSTLTS	Office for State, Tribal, Local and Territorial Support
PHAB	Public Health Accreditation Board
PHAP	Public Health Associate Program
PHPS	Public Health Prevention Service
QI	Quality Improvement
RPMS	Resource Patient Management System
SDPI	Special Diabetes Program for Indians
STAC	Secretary's Tribal Advisory Committee
TAC	Tribal Advisory Committee
TEC	Tribal Epidemiology Center

TSU	Tribal Support Unit
USZPR	US Zika Pregnancy and Infant Registry