



**Department of Health and Human Services  
Centers for Disease Control and Prevention  
Agency for Toxic Substances and Disease Registry**

**Tribal Advisory Committee (TAC) Meeting and  
13th Biannual Tribal Consultation Session**

**August 4–5, 2015  
Airway Heights, Washington**

**Meeting Minutes**

The Centers for Disease Control and Prevention (CDC) and Agency for Toxic Substances and Disease Registry (ATSDR)'s TAC Meeting and 13<sup>th</sup> Biannual Tribal Consultation Session was held August 4–5, 2015, at the Northern Quest Hotel, in Airway Heights, Washington. Over the course of the two-day meeting, 12 TAC members heard presentations from and held discussions with CDC/ATSDR staff, as well as presenters working with the Oglala Sioux Tribe, the White Mountain Apache Tribe, and the Substance Abuse and Mental Health Services Administration (SAMHSA). Topics discussed during the TAC meeting included CDC's budget, marijuana use, tribal accreditation support, the Public Health Associate Program, an update on chronic disease prevention and health promotion in Indian country, and suicide prevention in Indian country.

## Tuesday, August 4, 2015

### Welcome

To begin, Councilman Chester Antone (TAC Chair/ Tucson Area Delegate) informed CDC/ATSDR that during the earlier tribal caucus, the TAC nominated and selected a TAC Chair and Co-Chair. Lt. Governor Jefferson Keel (Oklahoma Area Delegate) nominated Councilman Antone for TAC Chair; the vote for Councilman Antone to remain as the TAC Chair was unanimous. Lt. Governor Keel nominated Vice President Jonathan Nez (Navajo Area Delegate) as Co-Chair; the vote was also unanimous. Councilman Antone brought the Winter 2015 TAC minutes to a vote for approval. The TAC members voted and approved the Winter 2015 TAC Meeting minutes.

Councilman Antone provided Health and Human Services (HHS) tribal meetings highlights. He opened the floor to other TAC members to provide updates on the various federal agency committees on which they serve. Lt. Governor Keel, who serves on the Health Research Advisory Council (HRAC) committee, provided the committee's update. Councilman Antone listed the issues mentioned during the morning's tribal caucus. TAC members discussed the following:

- Tribal set-asides, perhaps in the form of a block grant, in which each of the Centers, Institutes, and Offices (CIOs) would have a specific line item related to work in Indian country
- Need for a strategic plan for the TAC
- Preparedness and Strategic National Stockpile (SNS) agreements, mainly where the SNS agreements exist
- Funding
  - CDC's and ATSDR's budgets for Fiscal Year (FY) 2017
  - Direct funding to tribes from all CIOs with potential to address public health concerns, including environmental health issues, in Indian country
  - Need to increase funding for the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)
  - Loss of funding to address colorectal cancer in Indian country
- Increase awareness of zoonotic infections, such as Rocky Mountain Spotted Fever, hantavirus, and Africanized honey bees, in Indian country
- Workforce development in Indian country
  - Trainings for medical and public health professionals
  - Need for recruitment mechanisms for medical and public health professionals
  - Assignment of CDC and ATSDR personnel

The TAC discussed clarifying the TAC's Charter and recommended that the protocol for selecting an authorize representative should be revised. Councilman Antone conveyed that the Intergovernmental and External Affairs (IEA) requested that HHS operating divisions (OpDivs) use the Secretary's Tribal Advisory Committee's (STAC) rules of order. Lt. Governor Keel added that IEA asked all OpDivs to adopt standard language in their charter. He explained how a unified charter format might become problematic because every OpDiv's focus is different. An OpDiv's tribal advisory committee charter should be specific to that OpDiv and not necessarily mimic one for the STAC.

### Tribal Support Unit Updates

Captain (CAPT) Carmen Clelland, Associate Director for the Tribal Support Unit (TSU), gave an overview of the work that TSU performs and highlighted the work completed since the last TAC meeting, including two Working Effectively with Tribal Governments course trainings. He provided a list of meetings and site visits, including a visit to the Eastern Band of Cherokee Indians in North Carolina, attended by TSU staff over the past six months. In addition, CAPT Clelland informed the TAC about staff changes within TSU and that currently, all TAC seats were filled. After completing the TSU Updates portion of the agenda, CAPT Clelland yielded his time, giving TAC members a chance to discuss any questions concerns and or suggestions for CDC.

Councilman Antone started this portion of the meeting by asking about studies done on e-cigarettes and CDC's recommendations regarding e-cigarettes. Dr. Gillian Schauer, contractor with the Office on Smoking and Health (OSH), shared that CDC is currently conducting surveillance studies on e-cigarettes. Dr. Ursula Bauer, Director of NCCDPHP, said that she would be happy to provide additional information on this topic during her session the following day. Councilman Antone then asked Ms. Annabelle Allison, Deputy Associate Director for TSU, about the National Tribal Environmental Health (NTEH) Think Tank. Ms. Allison gave an overview of the NTEH Think Tank and described its goals, which included establishing a strategic plan for priority areas regarding environmental health.

Secretary Adam Geisler (California Delegate) shared his frustrations about CDC's progress with the budget compared to where it was when it left off at the Winter 2015 TAC Meeting in February. He stated that one of the questions asked of the CDC during the February meeting was "are you including Indian country directly in that budget?" He said that he did not see any slides that outlined a recommendation for funding, and he did not see the analysis or breakdown in funding that tribes are eligible for and funding they are not. He wanted CDC to compile a document on specific diseases and outbreaks in Indian country. Tribes would be able to bring that document, equipped with the CDC logo, to Congress to better advocate for direct funding to tribes.

Council Member Andrew Joseph, Jr. (at Large Delegate) spoke about a situation in his tribe, Confederated Tribes of the Colville Reservation in Washington, dealing with the H1N1 outbreak. Vaccines went to the states and down to the counties; the county did not provide his tribe the vaccines that they needed. He explained how people had to go across the river to a neighboring county to get the H1N1 vaccine. He used this example to illustrate the importance of direct funding to tribes and working directly with tribes. He added that states and counties include tribal populations for numbers in reporting, but do not share any of the resources with them.

Vice President Nez asked if the public health success stories CDC are developing were by region or by tribe and if the success stories are based on tribes volunteering. He would like to see some of the success stories

in a concrete manner, such as digital stories. He added that tribes need information from the success stories to share with Congress. Vice President Nez said that discretionary funding is not working in Indian country and funding needs to be mandatory. He went on to say tribes and tribal-serving organizations would appreciate grant-writing support. He added that he would like to raise awareness for the youth suicide epidemic in Indian country and increasing funding towards suicide prevention.

Lt. Governor Keel also discussed the budget cycle, adding that the TAC had missed the cycle and as a result now has no idea what the budget will look like until it is released. He said tribal leaders are left to fend for themselves and need to get ahead of the budget cycle. He suggested that sometime between August 2015 and February 2016, a group should be convened or a meeting should be assembled where tribal leaders can come together and state their needs for FY 2017.

Councilman Antone asked, “What can the Office for State, Tribal, Local and Territorial Support (OSTLTS) recommend for the budget?” Ms. Georgia Moore, Associate Director for Policy (ADP) for the Office of the Director (OD) in OSTLTS, shared that a new budget initiative around foundational building was proposed and OSTLTS is constantly reminding CIOs to consider tribes for funding eligibility. In addition, OSTLTS is supporting tribes through the National Indian Health Board (NIHB) for public health accreditation. Dr. Bauer shared that NCCDPHP’s current budget could decrease in the House and Senate proposed budgets but a continuing resolution would keep NCCDPHP budget consistent. Secretary Geisler said that it was concerning to hear that the majority of the dollars that tribes are getting from CDC are slated to be reduced. In addition to funding eligibility challenges, tribes are competing against counties and/or states with more robust surveillance data systems. Secretary Geisler added that the trust responsibility to tribes is being neglected.

### **CDC Tribal Budget Updates**

Dr. Debra Lubar, Director for Appropriations, Legislation and Formulation Office, and Ms. Moore presented on CDC’s tribal budget updates. Ms. Moore, started the presentation by showing (in charts) the funding and contracts that have been awarded to tribal entities, noting that there had been an increase from 2012 to 2014. Dr. Lubar gave an overview of the timeline for the Office of Management and Budget (OMB)’s budget formulation process. She talked about how the majority of funds come from Congress and how the budget was a negotiation process between CDC, HHS, OMB, and the White House. Councilman Antone asked CDC’s perspective on the reasons for decreases within the budget. Dr. Lubar said for FY 2016, CDC was able to propose an increase to its budget. In the President’s budget proposal, the Administration proposed a budget for CDC, but Congress decides CDC’s actual funding. Congress considered CDC’s priorities, the White House’s proposals, and other interests before making budget decisions.

Councilman Antone asked about the budget for NCCDPHP and if CDC determines the priorities within that line item. Lt. Governor Keel mentioned that immunizations have been proposed for a reduction of \$50 million and that the health departments in Oklahoma are now charging people, including American Indians and Alaska Natives (AI/ANs) for immunizations, which is money that the state previously received from CDC. He asked if CDC could make an exception in charging for immunizations to make up for the short fall. Dr. Lubar responded Congress had not cut the budget for immunizations but changed “who” is eligible to receive federally funded vaccines. Ms. Moore indicated that she would follow up with Lt. Governor Keel on the immunizations issue.

Ms. Kate Grismala (Nashville Authorized Representative) asked upon what data or information Congress makes its funding decisions. Dr. Lubar responded Congress considers various sources of information. In the past, Congress also listened to constituent groups in order to help set priorities which comes down to values and interests.

Secretary Geisler asked about CDC's efforts to impact epidemics in Indian country based on the data CDC has and if CDC is making recommendations to the President, OMB, and HHS for tribal-only set-asides. Dr. Lubar responded that CDC has some programs (Chronic most recently) addressing ways to eliminate disparities in Indian country. She mentioned that CDC is legally not allowed to discuss the proposed federal budget until it is publicly released; however, the public can directly influence the budget during an emergency. For example, the Ebola budget went through as an administrative proposal. Dr. Lubar told the TAC members that tribes should utilize the STAC and other groups expressing their needs directly to OMB and Congress. Secretary Geisler stated that tribes are not a special interest group; the tribal governments are sovereign nations and the federal government has a trust responsibility to uphold. Secretary Geisler requested more specific tribal programs be included in the FY 2017 proposed budget.

Vice President Nez expressed to Dr. Lubar and Ms. Moore the TAC would like to provide CDC with recommendations for the FY 2017 and future budget formulation discussions in order for tribal recommendations to reach OMB. Dr. Lubar replied the CDC would absolutely be open to this and that CDC utilizes TAC budget proposals. Although CDC cannot share internal discussions with external entities, CDC still welcomes the information.

CDC's Performance Office holds internal consultations with CDC CIOs on certain funding opportunity announcements (FOAs). Recently TSU has been invited to internal FOA consultations to encourage project officers to include tribal-eligibility when drafting FOA language. For FY 2016, OSTLTS and NIHB will develop and conduct a public health survey in Indian country to help characterize the public health system and gain input into the needs and challenges. These data, along with stories, will be helpful tools to inform the federal government of Indian country's needs.

Many times much of the funding that CDC awards to states does not reach Indian country, especially if it is funded to the counties. Oftentimes, tribal governments whose boundaries span multiple jurisdictions have not always worked with and received resources from the states or counties in which their government extends. However, the jurisdictions will use tribal demographics in order to compete for funding. By not requiring, the funding awarded to state and/or counties to go to the tribes, the tribes are excluded. Lt. Governor Keel remarked the TAC discussed the problems seen in Indian country, in particular the lack of tribal leader involvement in the budget formulation process. The TAC can offer Dr. Judith Monroe, CDC Deputy Director and Director of OSTLTS, input and recommendations about how the TAC can get more involved in that process. He stated CDC does not understand nor address the lack of public health infrastructure in Indian country. The lack of public health capacity causes many tribes to fail when competing with state, county, and large municipality health departments. Lt. Governor Keel discussed the difficulties tribes encounter when competing for funding. Ms. Moore acknowledged the recommendation about noncompetitive status for tribes and more block grants for tribes. She said the CDC would look for alternative delivery mechanisms for funding. She shared that during lunch CDC leadership and some TAC members discussed strategies to make public health more integrated with medical facilities within Indian country.

Councilman Antone asked Ms. Moore if she is involved in determining line items. Ms. Moore explained that she held a meeting with the other Associate Directors for Policy (ADPs) across the CDC and ATSDR to show them tribal data from the funding profiles and explained to the ADPs how NCCDPHP has stepped up to provide direct funding to tribes and tribal-serving organizations. She asked ADPs to go back to their respective CIOs to discuss how they can make funding for tribes more available. Ms. Moore said she will work on educational materials to orient CIOs on 1) ways to utilize discretionary and dedicated funds, 2) how to write the tribal specific FOAs, and 3) a list of public health issues in Indian country.

Councilman Antone stated that NCCDPHP's, the CIO currently providing the most funding to Indian country, funding is decreasing in the proposed FY 2016 budget. He asked what priorities caused the Center's funding decrease. Ms. Moore responded saying it is hard to pinpoint those priorities because changes could have been made at the OD level, and the CIO level. It takes time for CDC to get final budget numbers. Ms. Moore advised tribes to come back once CDC has its final budget numbers to have a conversation about how tribes can be included. She offered OSTLTS' help connecting tribes to these conversations. Dr. Lubar suggested that tribes start drafting outlines of projects they would like funded. In the event that more money becomes available, tribes will be able to 1) apply for FOAs quickly and 2) advocate for funding to be directed towards Indian country.

Dr. Bauer clarified that there are modest reductions to NCCDPHP's budget in the President's budget. She said there are bigger reductions in the House and Senate budget versions. CDC does not know what will happen when Congress convenes to pass the FY 2016 budget. If tribes see proposed reductions, tribes have an opportunity to work with the States' delegations to get desired changes. Dr. Lubar continued saying the House increased CDC's bottom line by \$140 million. However, within that \$140 million overall increase some CIOs and programs are being reduced.

The Senate cut CDC's budget substantially by about \$315 million. The Racial and Ethnic Approaches to Community Health (REACH) program, which provides funding and resources to tribes, is slated for elimination. Currently, Congress is debating additional cuts to other program areas. There is hope that more funding will become available, allowing budget cuts to be reversed in the final FY 2016 budget. At the staff level, there are four people responsible for negotiating the final numbers within the proposed budget—the Clerks of the Majority and the Clerks of the Minority in the House and Senate.

As for the FY 2017 budget formulation process, CDC has submitted its priorities to HHS on Memorial Day. Dr. Frieden has advocated for the proposed budget to the Secretary's Budget Council in July. CDC and HHS will negotiate and agree on what to submit to OMB, normally around Labor Day. Then, HHS advocates for its proposed budget to OMB. OMB questions the proposed budget heavily and formally returns the budget back to HHS stating, "This is what we want you to include in your proposal". This usually happens in early December. The final decisions on what to include in the President's budget proposal are normally released the first Monday in February. Geisler points out that since February 2016 is in the middle of an election cycle, the presidential influence will not matter as much. In that scenario, Congress always relies on the Departments and OpDivs. Thus, CDC is consulted on many things throughout the year. The TAC says it will provide FY 2017 budget recommendations to CDC and ATSDR at the end of the Summer 2015 TAC Meeting.

## The Changing Face of Marijuana: Policies, Practices, and Public Health Considerations

Dr. Schauer started her presentation addressing “how we got to where we are today”. One of the things changing policy may have to do with change in public perception. In 2012, Washington and Colorado voted to legalize recreational marijuana; Alaska, Oregon, and the District of Columbia voted to legalize recreational marijuana in 2014. In spite of states changing their policies, marijuana is still illegal in the United States, with enforcement priorities in eight different areas including preventing distribution to minors and driving under the influence of marijuana. Since marijuana policy discussions can be a contentious issue, Dr. Schauer stated the CDC does not provide an opinion or recommend one policy over another but rather provides an overview of marijuana products and the benefits and hazards of marijuana use.

Dr. Schauer explains tetrahydrocannabinol (THC) is responsible for the majority of psychoactive (mind-altering) properties. Since cannabidiol (CBD) does not have the same mind altering properties, scientists are exploring a number of potential medical properties. CBD has been shown to have some properties that reduce the mind-altering properties of THC, making the ratio of THC to CBD important. In the past couple of decades, the marijuana plant has been bred for higher levels of THC, while levels of CBD potency has remained the same. Marijuana is more potent because of the THC to CBD ratio.

Combustible products are still the most popular, which includes joints, bongs, bowls, spliffs, and blunts. Since legalization, modern generation vaporizing devices for marijuana have emerged. These are different from vaporizing devices used in the 1960’s and 70’s that vaporized dried plant matter. The new generation vaporizers, which look more like electronic cigarettes, vaporize concentrated hash oil, which can be high in THC. Edibles, which can include candy, cookies, cakes, and brownies, have been discussed recently in mainstream media. These products can also have high concentrations of THC because of the dose and the time it takes to metabolize marijuana in edible form. Overdoses (typically acute psychotic episodes) have been documented from edibles. Marijuana can also be consumed in drinks; however, effects of mixing marijuana and alcohol are unknown. Finally, a method of use known as dabbing has raised some unique concerns. Butane or other solvents are used to extract pure THC into concentrated wax and a bong-like device is used to inhale the substance. These concentrated waxes used for dabbing are very potent and contain up to 90% THC.

The highest prevalence of marijuana use in the U.S. is among young adults ages 18-25. This trend does not appear to have changed over time at a population level. The CDC values any data sources tribes have that may help with determining marijuana use in Indian country. In youth, CDC sees that alcohol and tobacco use are declining nationally, while marijuana use is steadily increasing. She stated that the trend might be different in Indian country.

Dr. Schauer mentioned the most promising indications for medical use, which include pain relief, nausea relief and appetite stimulations. She said states have authorized uses for medical marijuana that may be determined politically, or by a state review committee. She notified the TAC that there is not a lot of research about medical marijuana use and diabetes. A few animal studies suggested a link between marijuana and insulin resistance. However, some case reports suggested just the opposite. CDC did not have enough well-designed studies to recommend use of marijuana in diabetes prevention or control. Recommending marijuana without appropriate evidence might distract people from using proven methods to prevent or control diabetes, like weight management, or dietary change.

Adverse health effects of short-term marijuana use may include impaired short-term memory and coordination, altered judgment and decision-making, and acute paranoia and psychosis. Long-term health risks may include addiction linked to heavy continual use, altered brain development (particularly concerning for adolescents), poor educational outcome/dropout, cognitive impairment (reductions in IQ), diminished life satisfaction and achievement, symptoms of chronic bronchitis, increased risk of chronic psychotic disorders, and an unclear relationship to lung cancer. Because of the variety of marijuana strains and variations in use, researchers find it difficult to identify any health benefits solely attributable to marijuana use. Dr. Schauer stated that 70% of adult marijuana users also use tobacco products, further complicating researchers understanding of the health implications due to marijuana.

Dr. Schauer stated a number of public health areas that may be impacted by marijuana legalization, including:

- chronic disease prevention;
- burden on vulnerable populations, namely pregnant/breastfeeding women (crosses barrier exposed to fetus, in breast milk) and young children (i.e., marijuana infused gummy bears);
- injury prevention;
- environmental health in terms of second-hand smoke;
- substance abuse and mental health; and
- lab quality and safety of products.

In the case of federal- or state-level policy change, tribes should engage in certain public health functions (e.g. monitoring and evaluation, health communication, assurance, and epidemiological studies). Dr. Schauer said legalization of marijuana may protect individual rights, enable regulations, and provide economic benefits; however, harms are also possible. She further stated that considering both sides of the equation is important and collaborating to prevent unintended public health consequences from policy changes is paramount. She ended her presentation asking the TAC “how can CDC be helpful as tribal governments have discussions on whether to legal marijuana use within their communities?”

According to Secretary Geisler, marijuana interest and farming groups have approached numerous California Area tribes. Many tribes see this as a potential for economic development in their communities. Secretary Geisler states his tribe, the La Jolla Band of Luiseño Indians, is looking at the impact of legalizing and producing CBD. The La Jolla Band of Luiseño Indians and other southern California tribes expect marijuana to be used medicinally to prevent and/or treat certain health outcomes. Although Indian country is not formally requesting funding from CDC for research on CBD, the tribes ask for subject matter experts (SMEs) and a platform to conduct a legitimate medical study on the holistic medicinal benefits of CBD. The tribes are focusing on any beneficial health outcomes in diabetic and pre-diabetic AI/ANs.

Dr. Schauer stated that the National Institute on Drug Abuse (NIDA), National Institutes of Health (NIH), and the SAMHSA are involved in CBD research. She and Dr. Bauer explained that until the federal government legalizes marijuana, CDC could only provide tribes with technical assistance. Tribal Board Member Darcy Morrow (at Large Delegate) requested specific data on youth addiction. Dr. Schauer stated that marijuana addiction is well documented with recent additions noting that symptoms like withdrawal are possible. She added addiction occurs in a smaller proportion of marijuana users compared to many other drugs. However, because marijuana use is more prevalent than other drug use, the number of people who have marijuana abuse or addiction could be higher.

Vice President Nez mentioned several negative connotations surrounding the use of marijuana among Navajo Nation. The portions of the Navajo Reservation in Arizona and New Mexico would allow the use of

marijuana for medical purposes only; however, Navajo Nation residents living adjacent to Colorado are open to the use of marijuana for recreational purposes. Dr. Schauer inquired if there are any groups advocating for legalization in Navajo Nation. Vice President Nez replied the tribal council leaders have been talking about medical use but there are challenges discussing a marijuana policy because the Navajo word for “marijuana” has negative meaning. He added that educating Navajos about the health benefits of marijuana and diabetes may be important. Dr. Schauer clarified that evidence is unclear and there is no recommendation for using marijuana in diabetes prevention or control.

Council Member Joseph Jr. said since Washington approved the use of marijuana, if a non-tribal member is caught with possession and/or using marijuana on the Colville Reservation, his/her charges will be dropped. However, it is still an offense for tribal members. He stated prior to legalization, marijuana was the top drug of choice on the Reservation; now, it is heroin. Council Member Joseph Jr. stated more studies need to be conducted on the use of medical marijuana for cancer patient recovery. He said the federal government needs to regulate medical marijuana to ensure the safety of people, especially the ones using it for medicinal purposes.

Ms. Grismala highlighted the following CDC resources tribal leaders would find beneficial to use in their discussions with their communities:

- Formal document of health facts on marijuana
- Policy recommendations
- Labeling and packaging recommendations as they relate to tribal public health
- Tribal surveillance data (the Tribal Epidemiology Centers [TECs] would like to partner with CDC to create a Behavioral Risk Factor Surveillance System [BRFSS] or a Youth Risk Behavior Surveillance System [YRBSS] of tribal data only)

### **Tribal Accreditation Support Initiative**

Ms. Valeria Carlson, Public Health Analyst in the Division of Public Health Performance Improvement (DPHPI) within OSTLTS, presented on the Tribal Accreditation Support Initiative (ASI). She provided an overview of Public Health Accreditation Board (PHAB) and the accreditation process. In 2014, the Tribal ASI project was launched. She informed the TAC that three tribal public health departments have applied for accreditation. She also provided a summary of funding for accreditation support. OSTLTS worked with NIHB to provide funding to assist tribes with the accreditation process.

Mr. Robert Foley, Acting Director of Public Health Programs and Policy for NIHB, highlighted Tribal ASI’s successes. In 2014-2015, thirteen tribes applied for the funding with five tribes receiving approximately \$10,000 each. Mr. Foley described the areas on which awardees focused activities, including gathering and developing the required accreditation documentation. NIHB provided tribal grantees with technical assistance, learning communities, webinars, and monthly phone meetings. Tribal grantees were required to participate in the monthly phone meetings and the learning community calls. Other tribal-serving organizations, such as TECs, were also invited to participate in the learning community calls. Mr. Foley said NIHB adapted a strategy to measure tribal public health department accreditation readiness. Tribal grantees were interviewed on 36 questions that were divided into 6 critical dimensions or areas. The results of the interviews allowed NIHB to place each tribal public health department within a stage on a 9-stage accreditation readiness scale. Mr. Foley noted the scale is specific to readiness and not an indication of program success. Tribal grantees completed pre- and post- interviews and scores were grouped by

dimension. Tribal public health departments scored very high in resources related to accreditation but universally low in the dimension on community knowledge of accreditation.

Ms. Carlson stated that accreditation work often occurs in silos. For example, staff in one program (i.e. tobacco control) were working on documenting what they do for accreditation purposes and staff in another program (i.e. oral health) were documenting their own efforts; however, the two programs were not communicating with each other about what information they were gathering for accreditation purposes or how they were documenting it. Once public health department leadership support for accreditation had been established, it tended to remain very strong and consistent across time. Tribal public health departments greatly valued peer networks and learning communities. Strong positive outcomes were tied to continued support (monetary and technical). Most importantly, small amounts of funding had large impacts on improving accreditation readiness.

At the national level, NIHB needs to use lessons learned and the framework built for other accreditation processes in order to better support tribal public health departments seeking accreditation. There should be a continued push for building on existing resources and developing new ones. At the tribal leadership level, there needs to be strong cases made for why a tribal public health department should become accredited. Finally, at the community level, communities need to be educated about what public health accreditation is and how it will be beneficial to the community. Applications for the 2015-2016 funding cycle are due to NIHB by August 31, 2015. Tribal public health departments funded in the 2014-2015 cycle may apply again. NIHB plans to fund at least five tribal public health departments.

Ms. Carlson presented the following questions for discussion with the TAC:

- What are the best ways to talk about public health accreditation with tribal communities? What should be key messages?
- What more would the TAC like to know about the Tribal ASI project and its outcomes?

Lt. Governor Keel conveyed there is a need to convince tribal leaders across Indian country that 1) accreditation is beneficial in order to improve public health within their communities and 2) funding to assist in accreditation readiness is limited. He asked how NIHB intends to assist all tribal public health departments in the accreditation process, if NIHB can only award five tribal public health departments annually. Mr. Foley responded that NIHB would try to pick one component, versus the entire process, in which a tribal grantee needs financial support to move towards accreditation. Mr. Foley mentioned CDC and NIHB welcome TAC suggestions on how to make accreditation more appealing to tribal public health departments.

## Wednesday, August 05, 2015

### CDC Leadership Updates

Rear Admiral (RADM) Robin Ikeda, CDC Deputy Director and Director for the Office of Noncommunicable Diseases, Injury, and Environmental Health (ONDIEH), updated the TAC on tribal activities in the National Center for Injury Prevention and Control (NCIPC) and the National Center on Birth Defects and Developmental Disabilities (NCBDDD). She notified the TAC that NCIPC plans to release the manual for best practices on ways to reduce motor vehicle accidents in late 2015. The Work@Health® Training and Technical Assistance Portal (TTAP) is an online information-sharing platform meant to enhance collaboration and ongoing learning while assisting in the sustainability and replication of successful worksite health and wellness best practices. To date, this website has provided 207 tribes in 10 states with technical assistance and training to promote workplace wellness.

RADM Ikeda updated the TAC on NCBDDD's work to prevent fetal alcohol spectrum disorders in AI/AN communities. NCBDDD previously worked with IHS and the Oglala Sioux Tribe in South Dakota to support the tribe's implementation of CHOICES, an evidence-based intervention designed to prevent alcohol exposed pregnancies by addressing high-risk alcohol use in women of childbearing age who are not currently pregnant and increasing effective contraceptive use. The success of this work prompted the National Organization on Fetal Alcohol Syndrome (NOFAS) to assess the feasibility of implementing CHOICES more broadly with AI/AN women. Last year they released a report titled, "Implementing CHOICES in clinical settings that service AI/AN women of childbearing age".

The report serves as a resource guide for those who are interested in implementing CHOICES in clinical settings serving AI/AN women. There are a number of best practices from stakeholders included in the report. For example, the importance of engaging the community at the onset of the project's implementation; using a multigenerational approach; and incorporating cultural traditions, such as developing a talking circle version of CHOICES. NOFAS is working to disseminate the report via the National Indian Health Board and the National Indian Welfare Association. NCBDDD is currently working to build further upon this work through provision of training and technical assistance.

RADM Ikeda reiterated that CDC understands the importance of suicide prevention in tribal communities. For example, Alaska had been working with the Alaska Native Tribal Health Consortium (ANTHC) to capture AI/AN deaths data using the National Violent Death Reporting System (NVDRS). RADM Ikeda mentioned the progress with prescriber guidelines for pain medication and both the House and Senate proposed budgets increase funding to address prescription drug overdose. If CDC received that funding, ONDIEH would welcome discussions with tribes and tribal-serving organizations about the areas of critical need in Indian country.

Secretary Geisler recommended that CDC expand the TTAP since many of the tribes in California lack funding to address transportation and highway safety. He recommended that TTAP evolve to have a "boots on the ground" approach, since many California Area tribes first want to understand how TTAP can assist tribes in understanding the issues. RADM Ikeda told Secretary Geisler she would share his feedback with CAPT Holly Billie and others working in the program.

Tribal Board Member Abramson stated that many Bemidji Area tribes are concerned about the pipeline that goes under the Mackinac Bridge. There was a leak and the owners of the pipeline are responsible for cleaning the leak; however, it has taken years. She asked RADM Ikeda how the tribes within that area could get assistance. Dr. Dennis Lenaway, Acting Deputy Director of the National Center for Environmental Health

(NCEH)/ ATSDR, replied that the Environmental Health Services Branch in his division could assist through Epi-Aids.

In the Nashville Area, two adolescent substance abuse treatment facilities had been under-utilized mainly because of transportation costs to get the adolescents and families to the treatment facilities. Ms. Grismala asked if CDC had any funding available to help reduce transportation costs. She noted that motor vehicle accidents were one of the leading causes of death among Nashville Area tribes. She recommended CDC reinstate funding to tribes for the successful child safety seat program. RADM Ikeda asked Ms. Grismala if tribes could develop and share success stories with CDC, HHS, and OMB leadership as a demonstration on how that funding added tribes in reducing death in motor vehicle accidents.

Council Member Joseph Jr. shared with RADM Ikeda how a public health intervention increased seatbelt usage on the Colville Reservation. Council Member Joseph Jr. notified CDC about the misconception surrounding funding for emergency services on the Colville Reservation. The Indian Health Service (IHS) was only responsible for providing ambulatory services from the IHS clinic to the Grand Cooley Dam hospital, which covers only 18 miles of the entire Reservation. The first responders to motor vehicle accidents were the Bureau of Indian Affairs (BIA) funded police departments, which are heavily underfunded. Council Member Joseph Jr. recommended that CDC look into funding tribes for preventions measures like seatbelt campaigns.

Vice President Nez stated that unintentional injury is the leading cause of death on the Navajo Reservation, based on 2006-2009 Arizona data. He mentioned that during the NIHB meeting on August 3, 2015, the CDC's budget was discussed and unintentional injury prevention programs comprised only 2% of CDC's overall budget with no proposed increase. Based on the health data from Navajo Nation, Vice President Nez recommended that CDC fund more unintentional injury prevention programs in Indian country to aid tribes in reducing the high numbers of injuries and deaths.

Dr. Lenaway updated the TAC on NCEH's and ATSDR's budget negotiations. One of the main priorities for NCEH and ATSDR was safe drinking water. He stated safe water issues disproportionately affect tribal lands. He was interested in hearing how NCEH and ATSDR can support tribes in ensuring they have access to safe drinking water. Dr. Lenaway highlighted how NCEH and the National Center for Emerging and Zoonotic Infectious Diseases (NCEZID) are collaborating to address Rocky Mountain Spotted Fever (RMSF). He stated that he did not realize until preparing for this presentation that tribal lands have 100 times the national incidence rate for RMSF. NCEH and NCEZID piloted a dog collaring and vaccination project to reduce the exposure in the population.

Dr. Lenaway highlighted the Navajo Birth Cohort Study (NBCS), a multi-million dollar study with the Navajo Nation tracking how toxic exposures during pregnancy affect the mother and child during the pregnancy, post-partum, and into childhood. Over 20 Navajo medical and public health professionals were hired to help conduct the study. Dr. Lenaway mentioned the Environmental Health Tracking program, a robust environmental health surveillance system in the United States. The Great Lakes Inter-TEC (GLITC) piloted the program with Wisconsin's and Minnesota's tracking programs to figure out gaps in tribal environmental health data and ways to address them. The main question stemming from the pilot was "can researchers take the information about contaminants and exposure and conduct a quality epidemiology study to show the health impacts on tribal lands?" Dr. Lenaway informed the TAC that the environmental health surveillance system's funding will be reduced in the upcoming budget. He mentioned the Maternal Organics Monitoring Study (MOMS), led by ANTHC, is investigating the association of contaminants with 1) pregnancy outcomes, 2) the risk of infectious disease, and 3) growth and development outcomes in a child's first year of life.

Council Member Joseph Jr. cited examples of environmental hazards in Indian country such as the dumping of slag in the Columbia River and a uranium mine waste leaching into soil and well water near Spokane's tribal lands. He notified the CDC that there has been an increase in cancer rates within that area. He requested grant funding to conduct studies on the various types of factory and mine wastes on these tribal lands and how it is affecting the health of the people living on those lands.

CAPT Thomas Hennessy, Director of the Arctic Investigation Program, NCEZID, provided an update on three health initiatives CDC supporting affected Alaska Natives through the Arctic Council. First, RISING SUN is an initiative sponsored by NIH, with CDC support, that is developing consensus around metrics for mental health among AI/AN communities in the Arctic region. Their scientific advisory committee is meeting in Anchorage on Sept 19-20, 2015 with tribal input. These meetings occur throughout the next two years. The second initiative includes assessing the status of water and sanitation in Arctic communities and promoting initiatives to improve service. The third initiative promotes Arctic One Health, an approach to link human, zoonotic, and environmental health activities to address emerging infections and climate-related concerns.

To round out this session, Dr. Monroe provided updates on behalf of other CIOs. The Office of Public Health Scientific Services' Center for Surveillance, Epidemiology and Laboratory Services (OPHSS/CSELS) focused on CDC's surveillance strategy, which should increase accessibility to more robust data for TECs. She stated that OPHSS/CSELS was not able to mobilize funding for TECs. The National Center for Immunizations and Respiratory Diseases (NCIRD) produced a recent update of human papillomavirus materials specific to AI/AN communities. The National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP) saw an improvement in hepatitis vaccination rates.

Secretary Geisler reiterated the TAC membership needed to review the current TAC Charter and tribal consultation policy to figure out how the TAC could provide input during the budget formulation process. He suggested that CDC work with the TAC to create a schedule of when tribal consultation can occur during budget formulation process so that Indian country could look at the areas of funding fluctuations and compare that to tribal public health issues. Dr. Monroe asked the TAC what would be the best way to communicate budget information to tribes throughout the year. In response, Councilman Antone initiated a vote to go into a tribal caucus with fellow TAC members to discuss the matter privately. Secretary Geisler agreed, adding the TAC Charter has to be amended in order to allow the TAC the opportunity to convene in-person more than twice a year. Tribal Board Member Abramson seconded going into tribal caucus. The TAC compiled budget recommendations for CDC and ATSDR leadership.

### **CDC Public Health Associate Program in Indian Country**

Ms. Heather Duncan, Director of the Public Health Associates Program (PHAP), informed the TAC that PHAP is a two-year competency based training program which places early career public health professionals into field assignments. Since 2007, PHAP grew exponentially and the largest class will begin in October 2015. Ms. Duncan stated the program provides valued added service, different levels of expertise, skill building, and education for PHAP associates. She provided a list of characteristics for the "best fit" host site and one for "best fit" candidates:

#### *Characteristics of a "best fit" host site*

- Capacity to develop and implement a work plan for an early career public health professional
- Willing and able to pay for associate's local travel and training costs
- Able to assign a host site supervisor who will be actively involved in the associate's work activities

- Provide work space, telephone, internet access, computer, and other necessary work supplies for the duration

#### *Characteristics of a “best fit” candidate*

- Recent graduate with bachelor’s or master’s degree obtained less than two years before starting PHAP
- Proven record of academic success (3.0 or higher GPA)
- Limited public health work experience, but potentially interested in public health as a career
- Able and willing to relocate anywhere in the U.S. and its territories for the two-year assignment
- U.S. citizen or permanent resident

PHAP’s goals for its AI/AN outreach and engagement efforts has been to identify and match “best fit” AI/AN candidates and host sites to establish and sustain a long-term system to support the tribal public health workforce. PHAP is piloting two efforts targeting Indian country: the “Best Fit” Candidate Pilot Project and the “Best Fit” Host Site Pilot Project. Beginning in FY 2015, PHAP will 1) work with five tribal colleges and/or universities (TCUs) for the FY 2016 application process to increase the number of AI/AN applicants and 2) provide support to tribal entities to develop quality PHAP training experiences.

Ms. Grismala stated that the United South and Eastern Tribes TEC applied to be a host site but was not selected. She asked for information on how to attract a match. Ms. Duncan stated that the program had begun asking for the applicants’ regional preferences since geography is a big factor in whether associates accept a match or take a position. For the class of 2015, PHAP had been able to match about 90% of associates to their regional preferences. With the class of 2016, PHAP specifically asked during the interview if associates are interested in a tribal field assignment.

Council Member Joseph Jr. mentioned when health providers come to the Colville Reservation, providers compare the remoteness of the Reservation to tribes in Alaskan native villages. He stated that harsh living conditions make it less appealing to get personnel stationed in Indian country. He suggested CDC should highlight some of the things associates and providers will not have to deal with such as traffic jams (½ hour or less commute to work), more time with families, etc. Vice President Nez continued saying that housing is something lacking in Indian country. Tribes have tried to advocate amending laws on development of homes and apartments in tribal communities in order to provide housing for providers.

### **Chronic Disease Prevention and Health Promotion in Indian country**

Dr. Bauer updated the TAC on the Good Health and Wellness in Indian country grant. The Navajo Nation grantee worked on integrating commercial tobacco cessation into the healthcare setting; standing up and strengthening delivery of breastfeeding education; and developing tools to improve health literacy. In the Albuquerque Area, grantees worked with public health practitioners and healthcare providers on chronic disease prevention training. The California Rural Indian Health Board (CRIHB) collaborated with 43 area tribes to assist in completing community health assessments; redesigned health tools to make them more culturally appropriate; and built partnerships to share best practices to improve health outcomes. Dr. Bauer said NCCDPHP needs to assess tribal communities’ public health issues, form and strengthen coalitions, and help facilitate collaboration between tribes and different partners working in public health.

School Board Member Beverly Coho (Albuquerque Delegate) added that the Albuquerque Area consists of multiple nations, Pueblos, and tribes. The Good Health and Wellness in Indian Country grantee worked to

spread the funding widely and to link tribal communities that are interested in similar public health interventions.

NCCDPHP has invested an additional \$1.8 million into addressing commercial tobacco use. The goal for the additional funding is to strengthen activities involving persons affected by second-hand smoke and smoking cessation programs. Some awardees are sub-granting their funding to tribes in the area.

Dr. Bauer informed the TAC that the GLITC is hosting a resource meeting in Detroit, Michigan later in August. Recently, Mr. Robert McSwain, IHS Acting Director, and Dr. Frieden discussed ways to increase federal field assignments in Indian country. Both have committed to meeting the next time Dr. Frieden is in Washington, DC to further identify goals and work together in partnership to bolster the workforce.

At the last TAC Meeting in February 2015, the TAC requested that CDC reach out to traditional practitioners for help in developing more culturally appropriate health and wellbeing programs for Indian country. In response to this request, Dr. Bauer convened a group of traditional healers and tribal public health practitioners on August 3, 2015. The convening's objective was for CDC to learn more about traditional healing practices so that tribes and CDC could work better together to improve health and wellness in Indian country. The traditional practitioners proposed having follow-up meetings and will work on recruiting representatives from the Alaska and Phoenix Areas to ensure tribes within those Areas are heard.

TAC members who attended the tribal convening provided feedback to the TAC and CDC. Tribal Board Member Abramson said the meeting was "a dream come true" because CDC and tribal representation from various tribes came together to discuss commonalities in tribal practices. Chairman Robert Flying Hawk (Great Plains Delegate) said he sensed the positive energy as he entered the meeting. He appreciated the room's circular set-up and the regionally appropriate tribal symbols displayed in the center of the room. Chairman Flying Hawk said that unlike other meetings he has attended, the convening was focused on true collaboration among AI/AN communities. He saw the convening as the beginning of true discussion and action on how to address the current health of Indian country and make it better for the future generations. Councilman Antone said the convening had been a long time coming. Tribal communities in the Tucson Area kept asking him why there is not more consideration for traditional healing practices; the focus seems only on western methodology at the meetings he attends. Councilman Antone told the TAC that tribes in the Tucson Area developed a project incorporating traditional medicine and the grant evaluators/project officers would not fund the activities because they did not understand the methods. As a result, some tribes stopped applying for non-tribal grants. He recommended that future CDC and ATSDR FOAs focus on tribal commonalities with added flexibility in evaluation requirements to allow for traditional healing practices.

Council Member Joseph Jr. elaborated on the importance of traditional foods in fetal development and throughout early childhood. Activities rooted in traditional practices have been misunderstood by evaluators but were/are the most beneficial for tribal communities. For example, the Confederated Tribes of the Colville Reservation used funding to access traditional food gathering sites and to train the youth on how to cultivate the tribes' traditional foods. During the hunting and gathering process, community elders taught youth respect and honor. Council Member Joseph Jr. said not only did the act of hunting and gathering increase physical activity and provide access to healthier food options but the mentoring provided by elders made the youth feel valued and helped to prevent youth suicides and other destructive behaviors.

Ms. Lisa Pivec (Oklahoma Authorized Representative) expressed some concerns on behalf of Lt. Governor Keel and the Oklahoma Area. She stated that the money going into Indian country might not yield the

outcomes that CDC wants at the end of the grant, such as more robust tribal public health infrastructure and accredited tribal public health departments, and will be redirected from Indian country to another area. CDC misunderstands which activities will work best in Indian country because CDC is not familiar with those activities. Ms. Pivec restated the Oklahoma Area's concern that "people will say we have put \$10 million into Indian country and there is nothing to show for it".

Dr. Bauer said that NCCDPHP is working with TECs and the Urban Indian Health Institute to craft culturally appropriate evaluation methods. Ms. Pivec continued saying that tribal grantees spend the majority of their funds attempting to meet the evaluation requirements and are left with little money to conduct activities. Similar to what the Tucson Area, tribes and tribal-serving entities in the Oklahoma Area have started to become discouraged from participating and applying for grants in the future because of the rigid definition of what qualifies as an "evidence-based strategy".

Indian country focuses more on qualitative data and puts more value in talking to people. Tribal grantees are currently trying to compile data that Indian country finds valuable with the quantitative data needed to meet the evaluation requirements for CDC. In the Nashville Area, this is challenging, especially when tribal grantees are unable to meet CDC's evaluation requirements or the quantitative data does not strongly show the intended change desired. As a result, funding decreases or disappears from Indian country. For example, funding for the Tobacco Control program for tribes has been reduced. Ms. Pivec attributes this to people who managed the funds and reviewed the data from Indian country, and determining the program was not producing the results the CDC wanted. However, Indian country feels the programs were helpful and saw significant decreases in commercial tobacco use.

Council Member Joseph Jr. stated that the federal government is trying to regulate how third-party revenue can be spent. He said the Confederated Tribes of the Colville Reservation would like to spend some of the third-party revenue on traditional practices that have worked on certain medical conditions. He said traditional foods and medicines should be eligible for third-party money and included as part of acceptable preventive health tools.

Ms. Pivec also inquired as to what happened to the funding for the Diabetes Program. Dr. Bauer responded that HHS (and IHS) redistributed the funding. Ms. Pivec commented that the funding will more than likely end up in direct services, not in preventative care.

## **Suicide Prevention in Indian Country**

Lieutenant Commander (LCDR) Asha Ivey-Stephenson, Behavioral Scientist for NCIPC, provided data on the leading causes of death by age and ethnicity, highlighting how the rate of suicides in AI/AN communities compares to other populations. LCDR Ivey-Stephenson informed the TAC that suicide is the second leading cause of death for individuals 10-29 years old in Indian country, preceded by unintentional injuries. She explained how the public health approach to prevention is used to address self-directed violence. She defined an Epi-Aid, which is short-term assistance for urgent public health problems requiring predominately epidemiologic methodology.

Requesting an Epi-Aid must come from a public health authority (in the case of tribes, this would be a tribal leader) for the purpose of an Epidemic Intelligence Service (EIS) officer to assist in an investigation of infectious or non-infectious diseases, natural or manmade disasters, or other public health emergencies (e.g. suicide). The inviting authority usually leads the Epi-Aid investigation. All data are owned by the inviting state, tribe, local, military, or international public health authority. An Epi-Aid team consists of an

EIS officer and other CDC staff as needed, and a CDC Subject Matter Expert (SME) who supervises them. The team joins local staff in the field to assist the public health authority in that jurisdiction and focuses on making practical recommendations to mitigate the problem. An Epi-Aid normally lasts 1-3 weeks but can be extended depending on the circumstances. The public health authority may request an extension through continued collaboration in data analysis, report writing, presentation preparation, or follow-up studies.

LCDR Ivey-Stephenson went on to explain reasons to request Epi-Aid for non-infectious public health problems, such as environmental health concerns, injuries, and chronic disease. LCDR Stephenson reviewed the protocol for how to request an Epi-Aid:

- Contact the CDC SME directly or contact the EIS office anytime via email at [epiaid@cdc.gov](mailto:epiaid@cdc.gov).
  - EIS Office phone number during business hours (8:00am – 4:30pm ET) is 404-498-6110.
  - After business hours, call the CDC Emergency Operations Center at 770-488-7100.
- CDC SME and EIS program communicate to discuss the Epi-Aid request. If CDC can support the Epi-Aid, the CDC SME notifies the requesting public health authority.
- Requesting public health authority sends a formal letter of invitation to their CDC contact.
- EIS program approved the Epi-Aid and works with public health authority on the logistics.

The public health authority provides overall leadership, clearances, and approvals on the ground to facilitate a smooth transition. This is not an investigation where CDC comes to “solve the problem” or “take over the investigation”. An Epi-Aid does not always equate to immediate “boots on the ground”. CDC typically presents the preliminary findings on the last day in the field and provides the public health authority a thorough final report of the Epi-Aid. The public health authority owns all data and CDC may not publish or present the data without prior approval and clearance from the public health authority.

LCDR Ivey-Stephenson provided the TAC with an example of an Epi-Aid on youth suicides in Delaware. CDC provided recommendations for strategies to address suicides. The community decided to implement some of the recommendations and the Governor of Delaware proposed a \$3 million increase in youth services, including mental health and suicide prevention. LCDR Ivey-Stephenson acknowledged not all public health authorities want (and in some situations) do not warrant an Epi-Aid. In these cases, CDC could provide time-limited technical assistance and brief phone/email consultation.

Ms. Jennifer Irving, Project Coordinator for the American Indian Scholars Initiative of the American Indian Institute for Innovation (AIII), provided an overview of AIII activities. AIII began to look at ways to address the increasing number of youth suicides on South Dakota Reservations. Since schools are hubs of communication and community on many reservations, AIII decided to work with schools as an avenue to address youth suicide. The schools, with guidance from AIII, developed and trained a response team; created standard operating procedures for pre-attempt/completion (intervention), after event, and prevention; trained, educated, informed, and provided outreach to the student and tribal communities; conducted surveillance activities; and evaluated the standard operating procedures and outreach methods. AIII informed the tribal community that suicide is a public health problem and should not be treated as isolated events.

Ms. Irving explained that AIII’s efforts are not grant funded, but are carried out by utilizing local community resources. In the past few months, AIII shifted its view to look at “connection” and address the following questions:

- Is there a way to incorporate certain activities without the negative labeling?

- How can schools utilize the insights of students to help reduce youth suicides and make this assistance inclusive?
- What information do schools need to utilize students to help in reducing youth suicides and make this assistance inclusive?
- How does the community share information and data with each other about suicide?

AllI started to include other protocols (i.e., staff education, parent education, media plan, and screening referrals). AllI provided schools with examples of how to include youth in community activities. Examples include expanding the variety of schools activities such as movie nights, student art shows, cultural nights, and traditional storytelling nights.

Ms. Francene Larzelere-Hinton, Director of the Native American Research Centers for Health (NARCH), and Ms. Novalene Goklish, Senior Program Coordinator of Celebrating Life, stated suicide is taboo within the White Mountain Apache Tribe. In 1993, the White Mountain Apache Tribe received funding for a program called Ghost Busters. From 1993-1998, Ghost Busters responded during any time of suicided behavior. There was a decline in suicide rates until 2001 when there were 11 deaths by suicide in a 6-month period. Members of the community went before the tribal council and requested tribal action. In 2002, the White Mountain Apache Tribe passed a mandate and started a suicide prevention task force. The tribe contacted Johns Hopkins University for assistance to implement the tribe's suicide surveillance system and to partner in applying for funding to combat suicide within the community. The funding allowed for development of a web-based computerized surveillance system. Non-suicidal self-injury and binge drinking were later added to the surveillance system due to the high incidence of these events and the likelihood of suicidal behaviors occurring after such an event.

Based on reports from the system, the Tribe initiated a suicide program focusing on intervening prior to a suicide attempt/completion. The multi-faceted program targeted all members of the community. Tribal mandate allowed the program to go into schools and talk to students with parental permission. The program trained elders to provide outreach to at-risk youth. Even though there are 500-1000 referrals annually, rates of suicide attempts/completion have not increased. Ms. Larzelere-Hinton and Ms. Goklish said this might be due to more awareness in the community about mandated reporting.

Mr. David Dickinson, SAMHSA Regional Administrator for Region 10 (Alaska, Idaho, Oregon, and Washington), stated that it is important to recognize the difference between suicide and behavioral health disorders. He listed SAMHSA's five major suicide prevention components: 1) National Suicide Prevention Lifeline, 2) Garrett Lee Smith State and Tribal Suicide Prevention Grant Program, 3) Garrett Lee Smith Prevention Campus Grant Program, 4) Suicide Prevention Resource Center, 5) and Native Aspirations. He mentioned SAMHSA's [suicide prevention application](http://store.samhsa.gov/apps/suicidesafe/) (found at <http://store.samhsa.gov/apps/suicidesafe/>), which is a great tool for healthcare providers and potentially public health practitioners.

The [National Suicide Prevention Lifeline](http://www.suicidepreventionlifeline.org/) (found at <http://www.suicidepreventionlifeline.org/>) or toll-free call number is 1-800-273-TALK [8255]) is manned 24 hours/day, 7 days/week. There are 163 crisis centers within the network across the U.S. The National Suicide Prevention Lifeline provides counseling and mental health referrals. For the Garrett Lee Smith State and Tribal Suicide Prevention Grant Program, 124 grants have been awarded since 2005 (37 were to Tribes). Currently, there are 55 grants with active funding; 26 of those grantees are tribes. The 124 grantees have trained or educated over 250,000 people and screened nearly 43,500 youth. For the Garrett Lee Smith Campus Suicide Prevention Grant Program, there have been 114 three-year grants awarded to 99 campuses since 2005. Currently, there are 43 grantees receiving

funding. Since 2005, over 3.5 million college students have been exposed to mental health and suicide awareness messages and campaigns.

Mr. Dickinson spoke about the Native Aspirations component. Native Aspirations was designed to work with AI/AN communities to develop prevention efforts to address youth violence, bullying, and suicide. It represented a departure from the federal model towards an emphasis on community-guided and community-specific solutions. Forty-nine AI/AN communities accepted the invitation to participate. By the end of Native Aspirations, 65 AI/AN communities will have developed a prevention plan using cultural-, evidence-, or and/or practice-based interventions, as well as, a sustainability plan to continue the efforts. Communities noted a reduction of stigma associated with youth violence; an increase in referrals; and an increase in awareness regarding effective strategies to reduce youth violence, bullying, and suicide.

Dr. Iris PrettyPaint, Director of The Training and Technical Assistance, Kauffman and Associates, Inc., said she came into this work after the Red Lake shooting in 2005. She transferred suicide theories she researched for her dissertation into SAMHSA's Native Aspirations. The project was based on how AI/ANs built relationships within their families, communities, and with tribal, state, local, and federal governments. When first entering a tribal community, Native Aspirations focused on helping tribal leadership understand suicide. Once tribes recognized the denial, the next step Native Aspirations undertook was planning. Dr. PrettyPaint said the first skill a community loses (because of oppression) is the ability to plan. She expressed that there are "beautiful approaches and ways of doing things" and it is not feasible to expect a model developed in Pueblo Country to work in the Great Plains Area because of the great diversity and uniqueness of tribes in those areas. Dr. PrettyPaint informed the TAC she has been involved in nine suicide clusters ranging up to 24 suicides. The most alarming was a suicide cluster of 19 young males in three months. In her work, Dr. PrettyPaint calculated more young men committing suicide than young women. Because of this, she indicated there needs to be gender specific approaches in suicide prevention programs. She conveyed that cultural-based interventions have been the most successful throughout Indian country.

The Suicide Prevention Center, in conjunction with SAMHSA, provides training to project officers. It is important to teach sovereignty and that prevention and primary care services should be combined. For example, if someone goes in for substance abuse treatment, he or she should also be treated for suicide and vice versa. With new grantees, like the Oglala Sioux Tribe, Native Aspirations has an optional program component, Native Connections, consisting of over 150 hours monthly of virtual strategic action plans, community readiness assessments, and service delivery assessment via the Training and Technical Assistance Center. Any federally recognized tribe seeking training and/or technical assistance is eligible to contact the Center.

Council Member Joseph Jr. commented that one of the most effective non-clinical practices is traditional practices (e.g., weaving, beadwork, fishing, etc.) which has helped many on the Colville Reservation deal with suicidal ideologies. Vice President Nez commented that it is a taboo even to be associated with a topic such as suicide and thanked the panel for their commitment to saving lives. He said their efforts were evident from their presentations. He conveyed that he has raised this topic to HHS' Secretary Burwell and they discussed the current AI/AN data on suicide and how to raise awareness in Indian country. He stated that it is a challenge with HHS to convene a workgroup of tribal leaders and professionals to develop a comprehensive approach based on tribal cultures. He proposed an intergenerational program concept in which elders work with young people to bridge the language gap and stated the need for funding to support intergenerational programs.

## Tribal Testimony (Recommendations and Requests for CDC and/or ATSDR)

### Albuquerque Area (School Board Member Beverly Coho)

There was a federal promise to provide health services a long time ago. Trust responsibility for health goes beyond health services. The Albuquerque Area provided the following recommendations and requests to CDC:

- Recommend CDC NCIPC develop an FOA similar to Good Health and Wellness in Indian country to address persistent disparities in accident and unintentional injury mortality
- Re institute programs aiming to raise HIV prevention and treatment capacity
- Place a Career Epidemiology Field Officer in the Albuquerque Area to support regional expertise in increasing targeted programmatic response/management to complex public health challenges
- Expand public health surveillance to include AI/AN specific data for oversampling in national public health databases, such as the BRFSS and the YRBSS
- Invest in Adverse Childhood Experiences (ACE) studies in Indian country to improve efforts towards prevention and recovery

### Bemidji Area (Tribal Board Member Cathy Abramson)

CDC should engage TAC on how CDC can move forward on federal trust responsibilities. The Bemidji Area offered the following recommendations and requests to CDC:

- Identify and build the evidence and capacity for the solutions that already exist within tribal communities
- Facilitate a strategic planning session with tribal representatives to establish a blueprint for equitably and fully integrating Indian country into the US public health system
- Create an internal policy requiring a percentage of funding from CIOs that can potentially impact tribal public health to be dedicated solely for AI/AN projects
- Request CDC allocate resources to build/strengthen the public health capacity and infrastructure of tribes throughout Indian country
- Continue and expand preventive health and health services block grants in Indian country to allow tribes to directly allocate funds to address pressing public health priority areas, including infrastructure growth and support

### California Area (Secretary Adam Geisler)

Secretary Geisler articulated that most of the tribes in southern California are not accustomed to writing things down. When trying to determine tribal issues, anecdotal data is valued more than other types of data. The California Area presented the following requests and recommendations to CDC:

- Allow three delegates from the California Area (north, central, and south) on the TAC since California has the most number of tribes and the largest urban Indian population
- Conduct research on marijuana because tribal leaders need to understand the health effects
- Consider the following funding recommendations
  - Provide and increase block grant funding
  - Re institute funding to NCIPC for motor vehicle injury prevention
  - Cease creating stop gap funding for Indian country
  - Create permanent funding to federally recognized tribes

- Coordinate in person TAC Meetings and Consultation Sessions more than biannually, instead of weekly or monthly conference calls

### **Nashville Area (Ms. Kate Grismala)**

The Nashville Area provided the following recommendations and requests to CDC:

- Create a strategic plan for CDC and ATSDR's work and relationship with Indian country
- Mandate a percentage of each CIO's, with the potential to address tribal public health issues, discretionary funds be allocated to Indian country
- Request block grant funding for disease prevention and health promotion
- Collaborate with SAMHSA to bridge the funding gap and combine resources to address social determinants of health
- Provide direct funding to tribes and TECs to enhance tribal data surveillance
- Distribute TAC Meeting minutes and any follow up items sooner than previous meetings

### **Navajo Area (Vice President Jonathan Nez)**

The Navajo Area offered the following recommendations and requests to CDC:

- Increase direct and noncompetitive funding to tribes
- Update the CDC/ATSDR strategic plan to improve the mechanisms for tribal input on CDC's and ATSDR's budget formulation processes
- Update the CDC/ATSDR TAC Charter to include the use of tribal caucuses, which provide the opportunity for tribal leaders to discuss issues in Indian country face-to-face as a formal way to identify issues and directions for the TAC

### **Oklahoma Area (Ms. Lisa Pivec)**

Ms. Pivec yielded her time to other TAC members since she submitted a hardcopy of her Tribal Testimony. The Oklahoma Area presented the following recommendations and requests to CDC:

- Invest in strengthening tribal public health infrastructure including but not limited to:
  - Providing appropriately-trained public health practitioners
  - Working with TECs to build more robust surveillance and monitoring systems
  - Creating a Tribal-level public health policy development
- Increase direct funding to tribes for:
  - community health and population based prevention programs such as the Partnerships In Community Health and Comprehensive Cancer Control
  - hepatitis C prevention and treatment
- Requests technical assistance on survey design, implementation, and analysis, as well as, identifying data sources for sample populations and determining a proper sample size

### **Tucson Area (Councilman Chester Antone)**

Councilman Antone stated that in previous TAC Meetings, he felt like CDC and ATSDR were placing Indian country as a low priority, that many recommendations and requests from Indian country did not receive a response from CDC or ATSDR. Now, requests are being addressed.

Moving forward, even if CDC or ATSDR cannot address an issue, Indian country needs to be informed because it helps tribal governments determine what direction to take. When Indian country does not receive a response, the tribes become frustrated and it causes tension between Indian country (TAC) and

CDC and ATSDR. The Tucson Area provided the following requests and recommendations for CDC and ATSDR:

- Develop a behavior health agenda for Indian country
- Provide more direct and noncompetitive funding to tribes
- Review CDC's budget at every TAC Meeting
- Increase fetal alcohol spectrum disorder prevention efforts

#### **At Large Area (Council Member Andrew Joseph Jr.)**

Prior to giving his recommendations and requests, Council Member Joseph Jr. (Co-Chair of the IHS Budget Committee) stated that many tribes are severely underfunded. The overall budget of IHS should be at least \$31 billion; however, the OpDiv receives approximately \$6 billion. When IHS received an increase in the past, it was a decrease due to inflation. Council Member Joseph Jr. stated he would hate to see the same thing happen to CDC and ATSDR. He offered the following recommendations and requests to CDC:

- Provide direct funding to tribes as opposed to funneling funds through states and counties because many of the larger tribes have to provide safety and healthcare to their entire population as well as non-tribal members living on or near tribal lands.
- Conduct studies and provide evidence to regulatory agencies so these agencies revise and enforce regulations that protect tribes' way of life
- Allow traditional practices to be fundable grant activities
- Conduct studies on the health impacts of toxic waste from mines and marijuana use

#### **Closing/Adjournment**

Prior to adjourning the meeting, Tribal Board Member Abramson informed the audience that NIHB drafted a list of recommendations for CDC and ATSDR. Mr. Foley asked the TAC members to send him a list of their Areas' recommendations so he could compile a formal document for CDC and ATSDR. Secretary Geisler reiterated the CDC/ATSDR TAC Meetings should move from biannual to quarterly, like the HHS STAC meetings.

## Participants

### Tribal Advisory Committee Members

- **Cathy Abramson** (*Sault Ste. Marie Tribe of Chippewa Indians*): Tribal Board Member, Sault Sainte Marie Tribe of Chippewa Indians; Bemidji Area Delegate
- **Chester Antone** (*Tohono O'odham Nation*): Councilman, Tohono O'odham Nation; Chair, Tribal Advisory Committee (TAC); Tucson Area Delegate
- **Beverly Coho** (*Navajo Nation*): School Board Member, Ramah Chapter of the Navajo Nation; Albuquerque Area Delegate
- **Robert Flying Hawk** (*Yankton Sioux Tribe*): Chairman, Yankton Sioux Tribe; Great Plains Area Delegate
- **Shawna M. Shillal-Gavin** (*Confederated Tribes of the Umatilla Indian Reservation*): General Council Secretary, Confederated Tribes of the Umatilla Indian Reservation; Portland Area Delegate
- **Adam Geisler** (*La Jolla Band of Luiseño Indians*): Secretary, La Jolla Band of Luiseño Indians; Chair; California Area Delegate
- **Kate Grismala**: Assistant Director, Tribal Health Program Support, United South and Eastern Tribes (USET); Nashville Area Authorized Representative
- **Andrew "Andy" Joseph, Jr.** (*Confederated Tribes of the Colville Reservation*): Council Member, Confederated Tribes of the Colville Reservation; at Large Area Delegate
- **Jefferson Keel** (*Chickasaw Nation*): Lieutenant Governor, Chickasaw Nation; Oklahoma Area Delegate
- **Darcy Morrow** (*Sault Ste. Marie Tribe of Chippewa Indians*): Tribal Board Member, Sault Sainte Marie Tribe of Chippewa Indians; at Large Area Delegate
- **Jonathan Nez** (*Navajo Nation*): Vice President, Navajo Nation; Co-Chair, TAC; Navajo Area Delegate
- **Lisa Pivec, MS** (*Cherokee Nation*): Director, Community Health Promotion, Cherokee Nation; Oklahoma Area Authorized Representative
- **Alicia Reft** (*Native Village of Karluk*): President, Karluk IRA Tribal Council; Alaska Area Delegate

### CDC/ATSDR Senior Leadership

- **Ursula Bauer, PhD, MPH**: Director, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC)
- **CAPT Thomas Hennessy, MD, MPH**: US Public Health Service (USPHS); Director, Arctic Investigations Program (AIP), National Center for Emerging, Zoonotic, and Infectious Diseases (NCEZID), CDC
- **RADM Robin Ikeda, MD, MPH**: USPHS; CDC Deputy Director; Director, Office of Noncommunicable Diseases, Injury, and Environmental Health (ONDIEH), CDC
- **Dennis Lenaway, PhD, MPH**: Acting Director, Division of Emergency and Environmental Health Services, National Center for Environmental Health (NCEH), CDC
- **Judith Monroe, MD, FAAFP**: CDC Deputy Director; Director, Office for State, Tribal, Local, and Territorial Support (OSTLTS), CDC

### Presenters/Discussants

- **Annabelle Allison** (*Navajo Nation*): Deputy Associate Director for Tribal Support (TSU), OSTLTS, CDC
- **Valeria Carlson, MPH**: Public Health Analyst, Division of Public Health Performance Improvement (DPHPI), OSTLTS, CDC

- **CAPT Carmen Clelland, PharmD, MPA** (*Cheyenne and Arapaho Tribes*): USPHS; Associate Director for TSU, OSTLTS, CDC
- **David Dickinson, MA**: Regional Administrator, Region 10, Substance Abuse and Mental Health Administration (SAMHSA)
- **Heather Duncan, MPH**: Director, Public Health Associate Program (PHAP), OSTLTS, CDC
- **Robert Foley, MEd**: Acting Director of Public Health Programs and Policy, National Indian Health Board (NIHB)
- **Novalene Goklish** (*White Mountain Apache Tribe*): Senior Program Coordinator, Celebrating Life
- **Jennifer Irving, MPH** (*Oglala Sioux Tribe*): Program Coordinator, American Indian Scholars Initiative of the American Indian Institute for Innovation (AIII)
- **Francene Larzalere-Hinton** (*White Mountain Apache Tribe*): Director, Native American Research Centers for Health (NARCH), Johns Hopkins Center for American Indian Health
- **Debra Lubar, PhD**: Senior Advisor to the Appropriations, Legislation, and Formulation Office (ALFO), Office of the Chief Operating Officer (OCOO), CDC
- **Georgia Moore, MS**: Associate Director for Policy, OSTLTS, CDC
- **Iris PrettyPaint, PhD, MSW** (*Blackfeet Nation*): Director of Training and Technical Assistance, Kauffman and Associates, Inc.
- **Gillian Schauer, PhD**: Health Scientist, Office of Smoking and Health (OSH), NCCDPHP, CDC
- **LCDR Asha Ivey-Stephenson, PhD, MA**: USPHS; Behavioral Scientist/Epidemiologist, Surveillance Branch, Division of Violence Prevention, National Center for Injury Prevention and Control (NCIPC), CDC

## Acronyms

ASI	Accreditation Support Initiative
ATSDR	Agency for Toxic Substances and Disease Registry
ANTHC	Alaska Native Tribal Health Consortium
AIII	American Indian Institute for Innovation
AI/AN	American Indian/Alaskan Native
ADP	Associate Director of Policy
BRFSS	Behavioral Risk Factor Surveillance System
BIA	Bureau of Indian Affairs
CRIHB	California Rural Indian Health Board
CBD	Cannabinoids
CSELS	Center for Surveillance, Epidemiology and Laboratory Services
CDC	Centers for Disease Control and Prevention
CIO	Centers, Institutes and Offices
STAC	Department of Health and Human Service Secretary's Tribal Advisory Committee
DPHPI	Division of Public Health Performance Improvement
EIS	Epidemic intelligence Service
FY	Fiscal Year
FOA	Funding Opportunity Announcement
GLITC	Great Lakes Inter-Tribal Epidemiology Center (GLITC)
HHS	Health and Human Services
HRAC	Health Research Advisory Council
IHS	Indian Health Service
IEA	Intergovernmental and External Affairs
MOMS	Maternal Organics Monitoring Study
NCBDDD	National Center on Birth Defects and Developmental Disabilities
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCEZID	National Center for Emerging and Zoonotic Infectious Diseases
NCEH	National Center for Environmental Health
NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
NCIRD	National Center for Immunization and Respiratory Diseases
NCIPC	National Center for Injury Prevention and Control
NIHB	National Indian Health Board
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health
NOFAS	National Organization on Fetal Alcohol Syndrome
NTEH	National Tribal Environmental Health (Think Tank)
NVDRS	National Violent Death Reporting System
NARCH	Native American Research Centers for Health
NBCS	Navajo Birth Cohort Study
NN	Navajo Nation
OSTLTS	Office for State, Tribal, Local and Territorial Support
OMB	Office of Management and Budget
ONDIEH	Office of Noncommunicable Diseases, Injury and Environmental Health

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OPHSS	Office of Public Health Scientific Services
OD	Office of the Director
OSH	Office on Smoking and Health
OpDiv	Operating Division
PICH	Partnerships to Improve Community Health
PHAB	Public Health Accreditation Board
PHAP	Public Health Associate Program
REACH	Racial and Ethnic Approaches to Community Health
STLT	State, Tribal, Local and Territorial
SNS	Strategic National Stockpile
SAMHSA	Substance Abuse and Mental Health Services Administration
THC	Tetrahydrocannabinol
TAC	Tribal Advisory Committee
TCU	Tribal Colleges and Universities
TEC	Tribal Epidemiology Center
TSU	Tribal Support Unit
TTAP	Tribal Technical Assistance Program/Portal
YRBSS	Youth Risk Behavior Surveillance System