

*The Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) hosted the Tribal Advisory Committee (TAC) Meeting and 15th Biannual Tribal Consultation Session, August 2–3, 2016, at Harrah's Rincon Conference Center in Valley Center, California. During the course of the two-day meeting, 10 TAC members heard presentations from and held discussions with CDC and ATSDR representatives. Additional presenters included representatives from the following tribes and tribal organizations:*

- *Indian Health Council, Inc.*
- *La Jolla Band of Luiseño Indians Avellaka Program*
- *Native Women's Resource Center*
- *Navajo Nation Tribal Epidemiology Center*
- *Strong Hearted Native Women's Coalition, Inc.*
- *The Scripps Research Institute*

*Topics discussed during the TAC meeting included CDC's budget, CDC's workforce resources in Indian Country, intimate partner violence, opioid abuse prevention, and underage drinking prevention.*

Members present for the roll call:

- Alaska Area Delegate—President Alicia Andrew, Karluk IRA Tribal Council
- Bemidji Area Delegate—Representative Robert TwoBears, Ho-Chunk Nation of Wisconsin
- California Area Delegate—Secretary Adam Geisler, La Jolla Band of Luiseño Indians
- 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 – Vice Chairwoman Delia Carlyle, Ak-Chin Indian Community
- Portland Area Delegate—Business Council Member Travis C. Brockie Jr., Lummi Nation
- Tucson Area Delegate—Councilman Chester Antone, Tohono O'odham Nation
- Tribes-at-Large Delegate—Board Member Darcy Morrow, Sault Ste. Marie Tribe of Chippewa Indians

[Quorum Met]

Members absent:

- Tribes-at-Large Delegate—Vice President George Edwardson, Inupiat Community of the Arctic Slope
- Tribes-at-Large Delegate—Council Member Leslie Sampson Sr., Noorvik Native Community

Delegate Vacancies: Albuquerque Area, Billings Area, Nashville Area, and one Tribes-at-Large position

## CDC/ATSDR TAC Meeting

---

**Tuesday August 2, 2016**

### Welcome and Logistics

Councilman Chester Antone, TAC Chair, opened the meeting with introductions. Secretary Adam Geisler introduced Ms. Romelle Majel-McCauley, Chief Executive Officer, Indian Health Council, Inc. Secretary Geisler shared that the Indian Health Council, Inc. would host the next day's clinic visit. Ms. Majel-McCauley briefly welcomed attendees on behalf of the Indian Health Council, Inc. Secretary Geisler provided a brief history on the consortium of tribes that forms the Indian Health Council. He said the consortium had grown substantially—from having no established federal government health clinic to operating a full-fledged medical facility that provides medical, dental, behavioral health, pharmacy, and research services. Secretary Geisler also welcomed CDC/ATSDR staff from the California Area. He said the area was excited to have CDC/ATSDR staff and fellow TAC delegates as its guests for this meeting.

Dr. Ursula Bauer, Designated Federal Official and Director, National Center for Chronic Disease Prevention and Health Promotion, CDC, greeted everyone on behalf of Dr. Tom Frieden, CDC Director and ATSDR Administrator. Dr. Bauer thanked the TAC delegates for their attendance. She specifically acknowledged the newest delegates: Representative Robert TwoBears from the Bemidji Area and Business Council Member Travis C. Brockie Jr. from the Portland Area. Dr. Bauer welcomed members of the National Indian Health Board and National Congress of American Indians, as well as members of other operational divisions within CDC/ATSDR. Dr. Bauer concluded her welcome by recognizing CDC senior leaders present: Mr. John Auerbach, Acting Director, Office for State, Tribal, Local and Territorial Support (OSTLTS) and Associate Director for Policy; Captain Thomas (Tom) Hennessy, Director, Arctic Investigations Program, National Center for Emerging and Zoonotic Infectious Diseases; and Ms. Kathleen Ethier, Director, Program Performance and Evaluation Office.

Captain Carmen Clelland, Associate Director for Tribal Support, OSTLTS, CDC, recognized and thanked Ms. Sheri Daniels, Executive Director, Papa Ola Lokahi, and Sika Dedo, Health Resources and Services Administration, for her attendance at the meeting. All welcomes were concluded. The meeting proceeded to the first item of business on the agenda.

### TAC Business and Tribal Support Unit (TSU) Updates

Councilman Antone opened the meeting with an overview of the roles and responsibilities for. For those attending the meeting for the first time, he provided a brief background on the committee composition. He explained that the TAC was established 12 years ago to identify urgent public health needs in Indian Country. Currently, there are 16 members—12 members representing each of the Indian Health Service areas and 4 Tribes-at-Large members. The TAC meetings are held biannually: one meeting is held in Atlanta and one meeting is held in an Indian Health Service area.

Councilman Antone also provided an update from the US Department of Health and Human Services Secretary's Tribal Advisory Committee meeting held in June. He shared that the Great Plains region had experienced a loss of healthcare services because a hospital in the area closed. He said that Mr. Morgan Rodman, Executive Director, White House Council on Native American Affairs,

also attended the US Department of Health and Human Services Secretary's Tribal Advisory Committee meeting and discussed issues similar to those listed on that day's TAC agenda. Councilman Antone discussed the Substance Abuse and Mental Health Services Administration's draft Tribal Behavioral Health Agenda and stated that the Administration for Children and Families provided an update on child welfare issues. Councilman Antone concluded by saying that the compiled issues, along with recommendations from that meeting, were sent to the US Department of Health and Human Services for dissemination to its appropriate agencies for follow-up before the next Secretary's Tribal Advisory Committee meeting scheduled for September 2016.

Councilman Antone then shared that the CDC/ATSDR TAC wanted to create a transition document. Work on this document was underway. Councilman Antone explained that many of the advisory committees throughout the federal government are creating similar documents to report on current successes, as well as where opportunities for future gains exist. The intent was to assure continuity through the transition. Councilman Antone then invited Secretary Geisler to speak further about this topic. Secretary Geisler expressed the CDC/ATSDR TAC's desire to come to Atlanta in October to meet with Dr. Frieden and review the transition document. Secretary Geisler stated that the TAC members were willing to pay for their own travel if CDC could not accommodate travel in October's budget.

Councilman Antone then asked for delegates to volunteer to host the Summer 2017 TAC Meeting. LT Governor Jefferson Keel volunteered the Oklahoma Area. He stated that the area had ample facilities and space for accommodations.

Councilman Antone then called for a vote to elect the TAC chair and co-chair. He invited Captain Clelland to open the floor for nominations. Secretary Geisler nominated Councilman Antone to continue serving as TAC chair. LT Governor Keel then moved to close nominations for TAC chair. Delegates approved the motion to close the nomination. The vote was called. Captain Clelland concluded the TAC chair nomination process by stating that there was a unanimous vote in favor of Councilman Antone. Councilman Antone accepted his re-election as TAC chair. Next, LT Governor Keel nominated President Jonathan Nez as TAC co-chair. Secretary Geisler moved to close the nominations for TAC co-chair and called for the vote. The delegates approved a motion to close nominations, and the vote was called. The vote was unanimous in favor of Vice President Nez, who accepted the nomination. Voting was closed, and the newly elected chairs were congratulated.

Councilman Antone recognized the Public Health Associate Program by inviting Ms. Alleen Weathers, Public Health Advisor, OSTLTS, CDC, to speak. Ms. Weathers explained that she came to work for TSU through the Public Health Associate Program. During her Public Health Associate Program experience, she was placed in the Bronx borough of New York City. Her work focused on chronic health prevention and underage teenage pregnancy. After the program concluded, she was selected for a public health advisor position within CDC. She now serves American Indian and Alaska Native (AI/AN) people through her work with TSU. Ms. Weathers concluded by stating that she encourages young professionals to apply for the Public Health Associate Program.

Captain Clelland invited Ms. Annabelle Allison, Associate Deputy Director for Tribal Support, OSTLTS, CDC, to lead a discussion addressing feedback the TAC provided on the structure of the post-meeting "Issues and Recommendations" document TSU compiled. Ms. Allison opened dialogue

with ways to make the document more efficient and user-friendly for the delegates. She then opened the floor for comments. Secretary Geisler suggested that TSU have a facilitator to document what was said at the TAC meetings to reduce ambiguity. The compiled recommendations could be agreed upon at the conclusion of the meeting by the delegates and then moved forward to the agency for response. Secretary Geisler recommended that the response document be formatted like a book (i.e., a table of contents, an index, and appendices) and that it include supportive documentation to help delegates understand the agency's response. This structure would improve its navigability. Councilman Antone suggested that an explanation and supportive documentation accompany recommendations that the agency cannot support.

Councilman Antone stated that a policy around issues, such as cancer testing, needed to be specific and focused toward health equity. He thanked Dr. Bauer and her center for providing a policy that moves toward health equity. Board Member Morrow agreed with Councilman Antone and stated that cancer is prevalent in the AI/AN community. Board Member Morrow shared background on an incident in which a lack of early detection in cancer screening resulted in the death of a woman in her community. In conclusion, she stated that Indian Country had received funding for diabetes and that now it is facing the battle to get funding for cancer.

Secretary Geisler stated his concern about the approaching change in administration. He requested that the AI/AN community be included in the budget before an official change in administration. Ms. Allison responded by stating that there is a need for an annual report that highlights issues outlined by TAC members. Secretary Geisler agreed and expressed the need for a strategic document in the form of an annual report.

Dr. Bauer informed TAC members that the next fiscal year (FY) for budget planning is 2018. She also reminded delegates that CDC has requested \$15 million in President Barack Obama's FY17 budget to fund initiatives, such as prescription drug overdose, in Indian Country.

Captain Clelland asked the TAC to clarify if the document they wanted CDC to generate would be in the form of an annual report. Secretary Geisler stated that he believed two things were required: 1) an engagement policy developed by the agency and signed by Dr. Frieden followed by 2) an annual Indian Country needs assessment by the agency, along with a budget priority document from the agency's centers, institutes, and offices. The document would be produced in collaboration with the TAC.

LT Governor Keel expressed his concern about whether the recommendations from the TAC members were actually being heard by CDC. He stated that the document created should help the TAC and CDC fulfill the TAC's primary purpose of improving public health in Indian Country. Essentially, it should include TAC recommendations and the agency status on each identified issue. It should be a living document that the agency updates and maintains. He also urged that the document be routed as follows: 1) recommendations should go straight to the Office of the Director for review; 2) from the Office of the Director, recommendations should be disseminated to the centers, institutes, offices, and programs; 3) centers, institutes, offices, and programs would then be held accountable for carrying out the recommendations approved by the Office of the Director. He requested the agency's assistance to frame the TAC's recommendations so that the Office of the Director can drive them. Dr. Bauer stated that she could commit to a document, drafted by

October, that would include a list of accomplishments and unmet needs in Indian Country. This could be used to help delegates substantiate the priorities they identify for a transition document.

Secretary Geisler also suggested that agency policies that help to drive momentum toward increased funding to Indian Country be written and enacted to address the identified public health priorities. He also suggested that the supporting document being drafted by Dr. Bauer include what had worked already in Indian Country, along with battles that have not been won. Chairman Antone stated that such a document could then be used by the Office of the Director to give to the secretary of the US Department of Health and Human Services, who, in turn, could use it to brief President Obama.

Captain Clelland informed the TAC that there are regularly scheduled meetings with Dr. Frieden to discuss priorities and issues in Indian Country. Dr. Bauer explained that the TAC must strategize to develop the document, which should include concrete recommendations that Dr. Frieden can address. Councilman Antone stated that a collaborative approach is required to develop the recommendations and priorities, particularly as they are applied to budget development. Mr. Auerbach explained that the budget involves a very complicated, yet collaborative, process. He explained that rules are established as to what centers, institutes, and offices can request in their budgets. The Congressional oversight committees set strict parameters. Mr. Auerbach stated that the clearer the priorities, the easier it is for Dr. Frieden to champion them and to strategically identify where the priorities can be aligned with the budget guidance for the centers, institutes, and offices. Mr. Auerbach concluded by assuring the TAC that CDC can help it strengthen its requests so that they are framed within the context of the agency's organizational structure and culture. Secretary Geisler concluded this discussion by stating that the TAC appreciated Dr. Frieden's work. Secretary Geisler stated that the TAC will need access to data from the agency in order for the TAC to clarify its priorities.

Captain Clelland then redirected the conversation toward the issues and recommendations document format. He asked TAC members if they wanted to see something different in the issues and recommendations document structure and asked for guidance to make the document more constructive. Councilman Antone asked where TAC members could find more information about the parameters of what CDC can and cannot do. The TAC seeks a more collaborative response that demonstrates what the agency can do, why it can do it, what barriers prevent a more robust response, and whether these barriers could be removed by changes in policies. He used fecal occult blood screenings for colon cancer as an example. CDC cannot fund screenings because they are considered "medical testing." However, this is the standard the American Cancer Society recommended for early detection of colon cancer. That is a public health screening campaign that CDC should be able to support. CDC policy, or maybe statutory language governing CDC's budget, does not appear to support the achievement of the end goal—cancer prevention. When a barrier exists, the TAC needs to know why it exists and what type of actions would be required to change it. He cited the funding increases that Dr. Bauer has accomplished in the National Center for Chronic Disease Prevention and Health Promotion and requested that other centers be as strategic.

Captain Clelland responded that TSU will work on a version of the document that addresses the TAC's wants and needs. Secretary Geisler affirmed that the TAC appreciated this discussion. He stated that the TAC needed to be able to track its requests of the agency statistically and also

required data to support its requests. He assured meeting attendees that the TAC would do the legwork, but the TAC had struggled previously to frame the suggestions in a relevant way. Increased collaboration will help accomplish this goal. Captain Clelland thanked the TAC for the frank discussion.

Captain Clelland introduced the last discussion topic of the TAC business session by inviting Lieutenant Commander Jessica Damon, Public Health Analyst, OSTLTS, CDC, to give an overview of the TSU website. Lieutenant Commander Damon indicated changes to the website, which included a rotating carousel of images on the homepage and a landing page to showcase AI/AN contributions to public health. Other changes were the launch of 10 new pages that serve as a gateway to information and tools located across the agency that address health issues in Indian Country. These new page launches resulted from recommendations the TAC provided during the Winter 2016 TAC Meeting. She described the internal strategies for ongoing improvement and development. Additionally, she requested that TAC members use the website features highlighted as well as direct communication with TSU staff to make further suggestions for improvements, requests for additions to the new “Resources” page, and submissions of Native American public health contribution stories. Secretary Geisler commended TSU on the improvements to the website.

## Opening Blessing

Councilman Antone formerly opened the meeting at 10:00 am with a welcome message. Secretary Geisler introduced himself and expressed appreciation that, for the first time in 21 years, the TAC meeting was hosted in California. He provided a brief history on the blend of Native and Spanish culture that comprises California’s landscape. Secretary Geisler introduced his grandmother, Ms. Viola Geisler, who, at age 96, is the eldest member of her tribe. Ms. Geisler provided a blessing and expressed her gratitude that her health had allowed her to come and speak. Councilman Antone introduced the first panel of the day. Panelists spoke on intimate partner violence programs.

## Innovative Programmatic Work in Domestic Violence

Ms. Beth Turner, Director, Health Promotion Services, Indian Health Council, Inc., introduced the topic of domestic violence. She shared domestic violence stories. She thanked CDC for its work in ending the cycle of violence, and she stated that more work still needs to be done. Ms. Turner introduced the panelists. She said they had been assembled to share about their services, provide information on partnerships in place, and highlight ongoing unmet needs. Ms. Turner explained that she would serve as the panel’s facilitator. A video feed of a public service announcement from Peace Between Partners, an Indian Health Council program for victims of domestic violence that aired on REZ Radio, was played for the audience. Ms. Turner explained how all programs are victim-centered and comprehensive and therefore, provide a range of resources, including food, shelter, legal guidance, education, counseling, and support. She concluded by showcasing reservations in San Diego County, which has more reservations than any county in California. Ms. Turner welcomed Ms. Keeley Linton, Operations Director, Strong Hearted Native Women’s Coalition, Inc., to present next.

Ms. Linton explained that many domestic violence programs are very small—one to four staff members per program. Programs, such as the Strong Hearted Native Women’s Coalition, collaborate through strategic partnerships to maximize funding. The Strong Hearted Native

Women’s Coalition uses this funding to organize conferences and host events, such as a Sexual Assault Awareness Walk. The Strong Hearted Native Women’s Coalition partners with several tribes and programs to conduct these awareness events. Ms. Turner thanked Ms. Linton and then invited Ms. Wendy Schlater, Director, La Jolla band of Luiseño Indian’s Avellaka Program, to present.

Ms. Schlater provided an overview and history of the program. She stated that the Avellaka Program provides legal services and a 24-hour connection to crisis resources. It also establishes partnerships to increase community members’ connections to ongoing resources. In addressing domestic violence, the program strives to maintain tribal sovereignty. The Avellaka Program was developed under the leadership of Yvonne Peck and Adam Geisler in 2009. A primary struggle during the beginning of the program was remaining mindful of tribal members’ unique needs in the healing process. Ms. Schlater explained that the La Jolla Band of Luiseño Indians applied for a US Department of Justice grant and received funding to start the Avellaka program. Currently, the program is looking for formula funding because it is difficult for small tribes to compete successfully for funding. The Tribal Law and Order Act was established to protect victims of domestic violence, as well as to support tribal sovereignty. As a people, AI/ANs are still recovering from historical trauma, which has contributed to present-day issues in AI/AN communities. Ms. Schlater presented statistics that showed high rates of domestic violence and highlighted the issue of underreporting. Ms. Schlater stated that the program’s message is to empower women and remind them that they are natural advocates for their children. She concluded by emphasizing that AI/ANs face an unmet need in terms of culturally relevant material for recovery. Ms. Turner thanked Ms. Schlater and then turned the panel back to Ms. Linton to talk about the Kiicha project—a southern California Native women’s village.

Ms. Linton stated that there are many restrictions and rules in non-Native shelters and that the Native communities need a center that supports Native culture. The Strong Hearted Native Women’s Coalition became a nonprofit that provides money and housing while partners of the program provide counseling and support. The funding stream is formula funding, meaning that the program has to re-apply each year for each participating tribe. The Kiicha program helps place victims in the shelters. Unlike non-Native systems, Kiicha includes family members living in the home and transitions the entire family into the shelters. Non-Native shelters too often do not honor the family-centered values of AI/AN culture and do not provide shelter to family members of victims of domestic violence. This prevents Native women from accessing help. Ms. Linton concluded by stating that, outside of tribal specific funding, shelter/transitional housing grants are highly competitive. This makes funding sources very limited. Ms. Turner expressed gratitude for this overview and then welcomed Ms. Shyanne Boston, Domestic Violence Director, Native Women’s Resource Center.

Ms. Boston introduced the issue of scarcity of emergency shelter needs for victims of domestic violence. She expressed that the Native Women’s Resource Center does have hotel shelters, but they are temporary. When custody issues are involved, sometimes victims are restricted to the county and cannot leave. The shortage of shelters often causes so much stress for the victim that it deters them from leaving their abusive circumstances. Ms. Schlater stated that La Jolla has reversed the system. It prioritizes women and children by forcing the perpetrator, rather than the victim, to leave the house. Ms. Linton added that last week she met with the US Department of Housing and

Urban Development and National Indigenous Women’s Resource Center. There was much discussion about how to change the funding source structure to match the La Jolla model to support the removal of the perpetrator, rather than the victims, from the home. Non-Native service providers are starting to reference these tribal models for shelter services. Ms. Turner thanked Ms. Boston and Ms. Linton and then invited Ms. Bonnie Salgado, Cultural Arts Specialist, Indian Health Council, Inc., to speak as a survivor of domestic violence.

Ms. Salgado shared her story of domestic violence. She explained that her husband returned from Vietnam with post-traumatic stress disorder and developed an addiction to alcohol. Her first shelter experience was in Oklahoma City, Oklahoma. The shelter was all inclusive and efficient, allowing her to receive the necessary support services and intervention methods needed to recover successfully. A case manager oversaw her intervention and helped her find her way. The case manager was a critical component because it is difficult to make decisions after a trauma. The facility also provided transportation support. Shelter staff members were critical in its success. It is imperative to invest in the programs—with the appropriate subject matter experts—so they are steady and longstanding. Ms. Salgado concluded by stating that if the center is not equipped with the necessary resources and staff, it decreases a victim’s chances for a successful recovery. Ms. Turner thanked Ms. Salgado for sharing her personal experience. Ms. Turner then invited the TAC delegates to participate in a question-and-answer discussion with the panel.

Secretary Geisler thanked the presenters. He then invited the TAC delegates to discuss collaborative methods for tribal leaders and federal agencies to begin effective domestic violence prevention programs, such the Native Women’s Resource Center, in all Native communities. He shared the La Jolla challenges in addressing domestic violence.

LT Governor Keel stated that the current culture in AI/AN tribes is to “accept the violence.” He explained that this culture has resulted from the public embarrassment tribal members face when members reveal that they are victims of domestic violence. The impulse is to deny or hide the incident. The Violence against Women Act and the Tribal Law and Order Act have exposed this fact already. LT Governor Keel is encouraged that tribes now operate safe houses and resource centers, but he said that tribes have a long way to go to reverse the cultural normalization of violence. LT Governor Keel expressed gratitude that domestic violence programs protect the victims by removing the perpetrator, especially because the perpetrators are not always sent to jail. He suggested that CDC help tribes assess the extent of the trauma inflicted on children exposed to domestic violence. He said that interagency collaboration was required to fully address the issue. LT Governor Keel concluded by emphasizing the need for one agency to take the lead on a collaborative response.

Vice Chairwoman Delia Carlyle thanked the presenters for their courage and shared her community’s hope to have a safe house one day. In the meantime, her community has collaborated with a neighboring county shelter access. Vice Chairwoman Carlyle noted that domestic violence also affects men. She questioned how to give these men a voice. Her tribe has banned a perpetrator from the reservation until he addresses his violence issues, with the stipulation that he may return after the issues are addressed. If the perpetrator fails to do this, he will remain banned. Vice Chairwoman Carlyle is encouraged by the cultural relevancy integrated into these programs and especially by the cultural teaching of familial roles within Native communities.



Board Member Morrow thanked the panelists, adding a request for more information about how to remove the perpetrator and leave the victimized family members in the homes. Board Member Morrow commended La Jolla on this practice and would like to implement these ideas and policies in her community.

Ms. Linton advocated for perpetrators' unmet needs. She acknowledged that it is hard to get people to invest in this, but investment is crucial. She emphasized that resources must be found for perpetrators to receive care so that they can re-enter their tribes and communities successfully.

Ms. Schlater explained that when their work first started, they did not have their tribal policies in place. So when they confronted perpetrators, tribe members did not have solid standing. Having their council look to their creation stories to develop their policies has had great impact.

Councilman Antone thanked all who shared their stories, program narratives, and policies. He cautioned that, despite having laws in place, tribal leaders still do not "own" domestic violence as an issue in their tribes. When tribal leaders engage in the issue, AI/AN communities do better. He confirmed that creation stories—roles of women, roles of men, celebration of life, and celebration of children—should govern how tribes address all behavioral health issues. For example, if a man marries a woman with children, the children become his children. Councilman Antone explained that many domestic violence issues start because AI/AN men do not know their roles and responsibilities. He complimented and applauded the presenters for their wonderful model to address domestic violence issues.

Secretary Geisler said that addressing behavioral health and historical trauma issues require flexibility in tribal funding, stating that tribes benefit from the ability to hire personnel to assist with policy and law development. He also thanked the panelists and then dismissed the panel and concluded this session.

Councilman Antone called for Ms. Georgia Moore, Associate Director for Policy, OSTLTS, CDC, to speak about CDC's budget.

### CDC Budget Updates

Ms. Moore presented a federal budget update. Ms. Moore shared that, in response to a TAC request, OSTLTS had launched a new "Budget, Grants, and Funding" section on the tribal support website ([www.cdc.gov/tribal/budget.html](http://www.cdc.gov/tribal/budget.html)) to share information about funding.

She also shared that experts were predicting that the FY17 Labor, Health and Human Services, Education and Related Agencies appropriations bill, which contains CDC's budget, would not pass by the September 30, 2016, deadline and that a continuing resolution would be necessary. Therefore, CDC expected a continuing resolution in October. The length of the continuing resolution was under debate. Some members of Congress wanted a continuing resolution through December 2016; others wanted it through March 2017. Ms. Moore discussed what happens during a continuing resolution, including that the Office of Management and Budget would use a formula to allocate funding to federal agencies to cover the continuing resolution period only. In addition, federal agencies under a continuing resolution could continue activities authorized and conducted in the previous year but could not start new programs unless those programs were specified by Congress in the continuing resolution. The only exception was that Congress could write changes into an omnibus, although these changes were typically few.

Ms. Moore provided an overview of the top-line Senate and House FY17 budget marks for CDC (e.g., the House mark is \$7.8 billion, an increase of \$605.4 million over CDC's FY16 program level; the Senate mark is \$7.1 billion, a decrease of \$118.3 million compared to CDC's FY16 program level). The differences in the bills provided areas for negotiation and resolution regarding the budget mark variations between the House and Senate. An example of an initiative that still needed to be negotiated in Congress was the Racial and Ethnic Approaches to Community Health program. The House had a decrease in program funding, while the Senate favored eliminating it.

Another important budget process matter was that bills in 2017 that had not been passed at the time of the administration change would be reviewed by the new administration. These would be passed or rejected based on the new administration's priorities. For recently passed bills, there would be an opportunity for the new administration to make amendments. Ms. Moore mentioned that there was room to negotiate until the bill was passed into law. She added that it was wise to be familiar with Senate and House committee reports.

In response to a question about an opportunity to influence the agency's budget, Ms. Moore explained how to use the committee reports to recommend priorities to the agency. She suggested the following strategy:

- Identify opportunities
- Look at where the money is increasing or decreasing
- Identify potential impacts and quantify them, if possible
- Tie the recommendation back to what the jurisdiction would do if it had more resources
- Describe the actual plan if the funding needed was appropriated
- Support the recommendation by highlighting what has been accomplished under a deficit in funding

She explained that many national organizations have an analysis already completed. These reports can be accessed and feedback provided to the agency.

Another opportunity to influence the agency's budget was to monitor the grants forecasting section of the [www.Grants.gov](http://www.Grants.gov) website. The forecasting section can help guide input to projected funding opportunities. The US Department of Health and Human Services forecasting portal, under "opportunity status," lists grants that the agencies speculate they will offer the following year. Ms. Moore suggested that delegates visit the project purpose page to find contact information and ask questions about the proposals. She encouraged tribal members to tell OSTLTS if they wanted OSTLTS to help connect them to programs.

Secretary Geisler requested examples of how others successfully obtained funding, as well as how they receive and submit feedback about forecasted grants. Ms. Moore shared that, pre-Zika, she had started developing a package of examples for the TAC. She reminded Secretary Geisler to email specific questions to OSTLTS and also to attend Capitol Days. She suggested that TAC members read the published budget priorities of national organizations, similar to that created by the National Indian Health Board. Ms. Moore and TSU staff invited the TAC to engage in routine conversations with OSTLTS. Because CDC does not have a budget structure that resembles that of the Indian Health Service, the agency must use a different approach. In discussing the budget process, Ms. Moore suggested organizing teleconference calls—by center and topic—for TAC members. Secretary Geisler stated that the TAC remained flexible and open to suggestions. TAC members

were willing to work within CDC's parameters to increase the agency's comfort in committing dollars to improve the public health of Native communities.

Ms. Moore shared that OSTLTS anticipated the results of the public health survey in Indian Country. The survey would help the agency better understand the existing public health infrastructure. In turn, the survey would provide additional insight into how the agency could best support the TAC's priorities.

Captain Clelland reported that TSU had been speaking with the Indian Health Service about that agency's budget consultation process to determine where similarities may exist. CDC may be able to create a similar process so that it is a familiar one. One stark difference between the agencies is that the Indian Health Service has a budget formulation workgroup from the field. TSU has looked at the feasibility of CDC developing something similar. He explained that the Winter 2017 TAC Meeting in Atlanta would be an opportunity to conduct a pilot, but there must be a way for all tribes to attend or call in to give feedback. The agency is willing to discuss structures that are adaptable from the Indian Health Service. CDC does not have a base funding level or recurring dollars. However, the process could be modified to accommodate these foundational differences.

Councilman Antone asked Ms. Moore about a more accurate estimate of agency spending in Indian Country. At the last TAC meeting, it was reported that 1% of CDC funding goes to tribes. However, if one removed the recurring funding items, such as Vaccines for Children Fund dollars, the remaining percentage would be a more exact reflection of funding that reaches Indian Country to address other public health issues. He asked if the agency could calculate this and report back to the TAC. Ms. Moore stated that this could not be generalized. It had to be answered by budget year. That information for 2015 could be shared. She explained that an analysis of the budget could be conducted as 2016 came to an end. That information could then be shared with the TAC.

LT Governor Keel expressed that tribal leaders have had very little input or influence on the proposed agency budget. Tribal leaders have tried to coordinate an opportunity to see the budget with the Office of Management and Budget but have not had success. He suggested that the TAC get involved in developing requests of CDC on public health issues affecting Indian Country in time for 2018 budget formulation. He stated that true consultation occurs before a concrete decision is made. If the TAC and CDC come together and consult in February 2017, the priorities and action items need to be clarified in a way that works within existing statutory language, or the TAC needs to identify statutory language barriers.

Ms. Moore stated that CDC usually does not start the budget process from scratch. She suggested that the TAC review the prior year's budget to start budget planning. In addition, TAC members could examine the agency director's priorities and then work to align their priorities with the agency. This would give additional weight to the requests and ensure an easier adoption by the agency. She concluded by stating that there were many points in the budget planning process where TAC members could get a good idea of what budget items were being planned.

Dr. Bauer shared information on how CDC deploys funds. Fund deployment is an additional place where the TAC can apply influence. These dollars are line items, but the deployment of the dollars is not always set in stone.

Ms. Moore stated that TAC members should watch for funding opportunity announcements that are about to close. One year before the close of a funding opportunity announcement, planning occurs for the next version of the announcement. The TAC can influence the language of the next iteration.

Mr. Auerbach confirmed the information both Dr. Bauer and Ms. Moore shared, and he encouraged TAC members to explore these key opportunities. He stated that the agency could help with these opportunities. He explained that planning for new programs during a transition year can be delicate. He advised that CDC and the TAC work aggressively to ensure that important programming is identified as an agency priority. He emphasized that losing funding for key programs would be a huge setback.

Secretary Geisler concluded by emphasizing that the TAC should follow Mr. Auerbach's advice.

## Lunch (On Your Own)

### Highlighting CDC Workforce Resources to Indian Country

Councilman Antone welcomed everyone back from lunch and reopened the meeting. He greeted the next panel, which highlighted the successful workforce partnerships between tribes and the agency. Panelists were Dr. Pierre Rollin, Deputy Branch Chief, and Mr. Craig Manning, Health Communications Specialist, both from the Viral Special Pathogens Branch, Division of High-Consequence Pathogens and Pathology, CDC, along with Mr. Del Yazzie, Director, Navajo Epidemiology Center. The panelists introduced themselves to those assembled, giving personal and professional backgrounds.

Mr. Yazzie gave a brief overview of the Navajo Epidemiology Center. There are 12 tribal epidemiology centers in the nation. A collective website was launched on August 1, 2016. The site provides more information about the work of tribal epidemiology centers. All tribal epidemiology centers are tasked with the investigation of disease and disease outbreak. Navajo Nation has had historical issues with hantavirus outbreaks. While much has been accomplished, it is important to recognize that the work continues. Mr. Yazzie expressed that much is done at the center, including work on Good Health and Wellness in Indian Country. The center also has CDC funding from the Navajo Birth Cohort Study to monitor the impacts of uranium exposure on health. He explained that the area surrounding his Sedona, Arizona, home had been affected by uranium mining. The people there say that their illness is "due to uranium," regardless of the illness type. Through the center, he hopes to conduct research about uranium mining and its correlation to various illnesses. Additionally, the center is currently looking at opportunities to address the Zika virus. A major role of the center is initiating the research of outbreaks. Through epidemiologic assistance, the center works collaboratively with CDC to conduct these types of investigations. Vice President Nez initiates these requests to CDC when they are required.

Dr. Rollin assumed the role of presenter and provided a historical perspective of hantavirus in Navajo Nation. Dr. Rollin shared that, in 1993, a hantavirus outbreak occurred in the Four Corners area of the country (southwestern corner of Colorado, southeastern corner of Utah, northeastern

corner of Arizona, and northwestern corner of New Mexico). At that time, the cause of the disease was unclear. Ways to intervene and prevent the spread of the disease also were unclear. Because successful intervention in hantavirus relies on awareness of the disease's signs and symptoms to respond quickly with treatment and prevent death, physicians in areas where outbreaks are likely to occur need training in the identification of disease. Initial signs and symptoms are very subtle, and delayed treatment can be fatal. Providers can go their entire careers without encountering a single hantavirus case. Education and awareness, not experience, are the best tools to help providers with appropriate identification and timely intervention.

Mr. Yazzie mentioned that the disease has surfaced every year in Navajo Nation since 1993. There is no good treatment, and there is not a vaccine for the disease. So, prevention of transmission is critical. The best form of successful prevention is to keep the rodent population outdoors and away from the humans living indoors.

Mr. Manning then presented on the start of the current collaborative work with Navajo Nation to address needs specific to the hantavirus. The intent of the presentation is to demonstrate how a collaboration developed into a successful delivery and a potential ongoing partnership. Mr. Yazzie said the request began when he was in Atlanta for the 2016 Winter TAC Meeting and raised the issue of hantavirus. Initially, Mr. Manning believed that undergraduate students studying public health communication strategies could develop messaging around hantavirus for Navajo Nation. However, the timeframe for the expressed need by Navajo Nation was short, and the undergraduates were involved in writing about other public health issues already. So, Mr. Manning and the team from the Viral Special Pathogens Branch adjusted their initial thinking in order to better address the hantavirus messaging request. Accomplishments from the partnership included

- Updating hantavirus information on Navajo Nation's website
- Developing and producing radio public service announcements in Navajo for broadcast
- Conducting a live radio show with a call-in question-and-answer format
- Deploying a CDC official to update Navajo Nation surveillance and tracking systems for cases and to conduct case analyses

Mr. Manning said few challenges were encountered during this collaboration. Perhaps, the biggest challenge was to fully understand the specific needs of Navajo Nation. By working to define and refine the request, CDC's Viral Special Pathogens Branch also mitigated Navajo Nation's concerns regarding media outreach, which uniquely involved a media "overreach" from outlets outside of Navajo Nation.

Vice President Nez invited the audience to discuss this.

Secretary Geisler commented positively on how quickly CDC responded. He inquired about the the agency's approximate cost to respond. Mr. Manning stated that the cost was \$15,000 in direct funds, not including salaries. Vice President Nez also responded to Secretary Geisler that there were many in-kind exchanges and emphasized that this partnership has saved lives. In addition, Vice President Nez requests that Mr. Manning and his group return to Navajo Nation and speak on the radio again—this time, to address the Zika virus. He said translating Zika concerns into Navajo would be challenging.

Vice President Nez thanked CDC, Mr. Manning, and Dr. Rollin. Much was accomplished with few available resources. Epidemiologic assistance was not required this time. People used the information provided and took care of their health and their households. Currently, the community is plugging holes where mice come into their homes. He stated that Navajo Nation has been fortunate to have had Dr. Rollin's expertise. He thanked the agency for the strong and effective collaboration.

In addressing requests, Dr. Rollin emphasized that CDC should identify, in explicit detail, the tribe's precise need. The agency requires the tribe's assistance to clearly express the issue and describe the desired activities to resolve it. Once defined, it is easy to move forward and link the request to the appropriate outreach. Mr. Auerbach shared that OSTLTS can be contacted when issues needing clarification arise. He asked if it would be helpful for OSTLTS to develop a webinar for tribes about how to reach out for technical assistance. Vice President Nez said tribes and other tribal epidemiology centers could certainly use this type of webinar.

Dr. Bauer re-emphasized that Dr. Rollin described the agency barrier of identifying a clearly defined request very well. She praised the Navajo Nation Epidemiology Center for being a true rising star in Indian Country.

## Reducing Opioid Dependence and Overdose in Indian Country

Councilman Antone welcomed the next panel, stating that they would address opioid abuse prevention strategies. The panelists introduced themselves to the TAC, providing brief biographical information. All presenters were from the Indian Health Council, Inc. Presenters were Dr. Daniel Calac, Chief Medical Officer; Dr. Elaine Davidson, Family Medicine Physician (and coordinator for the center's chronic pain management program); and Mr. Tony Luna, Project Coordinator on the Pill Take Back Projects.

Dr. Calac introduced the Indian Health Council's multidisciplinary approach to addressing opioid use and abuse in local communities. There is a general misunderstanding about how communities use excess opioids. CDC cites 107 deaths per day associated with drug therapies. At Indian Health Council, the chronic pain management team looked at a lot of data. That data revealed that the rural environment is inherently at higher risk. In part, this is because the remote environment made the redistribution of opioids easier within communities. He presented detailed community demographics for the center's program, stating that the overall geographic area is quite large. The Indian Health Council is a managed twenty-first century healthcare system with two facilities. The Rincon facility serves about 3,800 people, with a smaller satellite facility in the mountainous region approximately 25 miles away. Data about the community was obtained from the sheriff's department. Different reservations had varying numbers, but when reviewed in detail, the actual drugs involved in incidents were methamphetamine and oxycodone. The chronic pain management program targeted its approach toward prescribed opioids. The program examined what could be done to influence prescribed opioid misuse or abuse within the community and developed a multipronged response approach.

Dr. Davidson introduced the chronic pain management program at the Indian Health Center clinics. The program was initiated in 2008. There was a serious issue then, but the magnitude was not fully understood. Initially, a simple pain agreement was implemented for all patients receiving

prescription opioids for chronic pain management. In 2010, the program realized that the pain agreement was not enough because it addressed only the prescribed pain relief. Despite misperceptions around it, chronic pain is real for patients. The program then began to explore how to structure itself to hold both patients and providers accountable for prescribed opioid use. The program emphasized incorporating improved communication across the care center and partnering with all facets of the clinic's programming. Dr. Davidson referred the audience to the trifold in the bags that had been distributed to attendees. She stated that the center combined all of its resources to improve patient outcomes in the management of pain and to engage everyone involved in the system of care to be part of the process.

Initially, the program looked internally at center data by reviewing all charts of patients enrolled in a pain agreement. Then, the program took the same people and looked for psychiatric diagnoses. Of those people, 76% had a diagnosed psychiatric disorder. Years later, these statistics remain essentially unchanged. With that data in hand, a policy and procedure for the treatment of chronic pain was created. The program developed an initial assessment tool and planned appropriate interventions. Although they educated patients about the center's services, only 5% took advantage of the robust assistance available. This new data informed the program's next steps. A comprehensive pain clinic was created to allow patients to see the physician last in a sequenced multidisciplinary appointment. Unfortunately, when the program re-analyzed its data, it recognized that many of the patients were still getting too many pills. So, the program enacted a maximum prescribable amount of no more than 200 of any opioid pills per month. The program established daily morphine equivalency and set the dose maximum of 200 milligrams, with a target therapeutic goal of 80–120 milligrams.

Metabolism rates varied from patient to patient, based on a variety of health factors. The clinic uses urine screens with blood and hair sample confirmation testing to monitor compliance with prescribed opiate therapy. The clinic checks the state drug registry to ensure that patients are not getting opioid medications elsewhere. These checks are performed before every visit. Patients complete a pain questionnaire that includes a pain scale and is conducted on the initial patient visit and every six months thereafter. Patients also use an opioid abuse risk tool to self-report. All medical and dental providers have been educated about CDC's safe-prescribing guidelines. Additionally, the clinic removed Soma from the formulary to help support the other prescribing changes. In part, this was because the drug is a muscle relaxant, but when the drug is metabolized, it works on the central nervous system. This activity was creating an increase in emergency department visits because patients were much more likely to overdose on their prescribed opioids when also taking Soma. Instead, the clinic now prescribes other well-tolerated muscle relaxers, as needed.

All controlled substance prescribers are registered in the Controlled Substance Utilization Review and Evaluation System (CURES), California's prescription drug monitoring system. The pharmacy department follows the prescribing physician and performs a secondary CURES check before distributing medications. The program has aligned with the community's county task force. Most recently, the program has focused on benzodiazepines. The program is weaning patients off these drugs because benzodiazepine use increases the risk of opioid abuse.

Since implementation of a system-wide approach, a few patients have still managed to “slip through the cracks,” despite the high level of care. Routine record reviews help the center to identify when patients are prescribed an opioid medication but do not have a pain agreement in place. Those patients are weaned off the opioids, unless opioid treatment is appropriate. In the latter case, people are transitioned into the chronic pain management program. Based on provider capacities, the administration has a limit of 90 total enrollees at a time. Patients who cannot be brought below the 200 milligram morphine equivalent dose target in the course of the program are sent to the pain specialist for further management. The program’s staff is striving to get Naloxone kits into the pharmacy. Staff members also hope to get Suboxone.

Mr. Luna introduced the the center’s Pill Take Back Project and mentioned that it follows the ideals of the Indian Health Service and the National Prescription Drug Take Back Day events. He explained that the center’s goal expands on this foundation and explores interventions that create convenient options for community members to reduce the availability of non-prescribed pain medications. The program also tailors interventions, working to establish a routine, safe disposal mechanism within the community.

The project has both research and outreach parts. In the research part, the team conducted a community survey to look at attitudes and perceptions toward prescriptions to treat pain. Data obtained, thus far, has aligned with national data, although some of it is still being analyzed. The other part of the program is outreach and education. The Indian Health Council has looked at ways to engage various groups on this topic. For example, in the younger age group, the outreach is more interactive and less didactic. The program has collaborated well with seven different after-school programs for the past couple of years. Department personnel rotate through topics in the seven tribal after-school programs. It has also partnered with the Valley Center High School. Additionally, the program works with older age groups and strives to promote responsible pain pill management. One tool is “pill pots.” Mr. Luna passed around a pill pot for attendees to examine. He explained that a pill pot is similar to a lock box and is used to prevent young children or teens from accessing prescribed opioids. To date, 149 pill pots have been distributed within the community. A few different models have been tested. A user preferences survey was conducted on the current version.

Implementing a pill take back program requires collaboration, and this is done at various levels: in the Indian Health Council prevention department, within the Indian Health Council clinics, and within the county served. Six drug take back events had been held so far. Four of these required collaboration with the sherriff’s office. Additionally, the program has worked with tribes within the consortiums that have law enforcement. The program partners with these law enforcement offices at other events to normalize the engagement and promote change. (Note: Secretary Geisler stated that, in California, coordination with local law enforcement is required for pill take back events.) Mr. Luna concluded by discussing the partnership with the San Diego County Drug Abuse Taskforce. For the upcoming year, the program plans to establish a permanent drop box within the centers’ pharmacy departments. The California State Board of Pharmacy had been resisting, but it seems that the momentum is changing, and this may be authorized as early as the end of 2016. A drop box in the pharmacy department carries less stigma than one in a sherriff’s office.



Dr. Calac thanked the audience and directed its attention to bags that had been distributed to attendees. He explained the bags' contents and concluded the panel presentation. He stressed the importance of partnering with the community to make intervention relevant and culturally sound. Dr. Calac then invited the TAC to ask the panelists questions.

Councilman Brockie commented that the movement toward Narcan in pharmacies had saved lives in his community. Eleven overdoses were intercepted. Last year alone, although two lives were lost, nine lives were saved. In response, Dr. Calac demonstrated the simplicity of the Narcan pen and explained how Narcan functions. Dr. Davidson shared that the clinic pharmacy at her center now has the nasal spray form. All of the providers have been trained how to use it. The next objective is to market this resource to the patients when they come in. Dr. Davidson believes this is will save lives.

Dr. Calac discussed the New Paths kits and shared one with the TAC.

LT Governor Keel discussed health promotion disease prevention history and asked if CDC could purchase lock boxes, similar to those demonstrated in this presentation, under its opioid prevention dollars and route these to Indian Country. He asked about integrating chiropractic and acupuncture techniques in the clinic. He stated that the Indian Health Service has difficulty incorporating these techniques across the country. He wondered how this had been accomplished at the Indian Health Council. In addition, he asked if CDC could support these techniques by funding solutions that involve them. Dr. Calac stated that the community has embraced these non-traditional services. He was aware that Dr. Bauer has been looking at incorporatong tribal health practices in health and wellness. It would be extremely helpful if CDC could support the use and dispensation of these techniques as valued interventions. Mr. Orvin Hanson, Chief Financial Officer, Indian Health Council, addressed the question about incorporating non-traditional techniques. He explained that the clinic studied its own board of directors to see which methods it could incorporate into its clinics. The idea was to use the Indian Health Service's purchased and referred care, as well as third-party revenue, to fund their incorporation.

Mr. Auerbach interjected to say that the Substance Abuse and Mental Health Services Administration is the established lead agency on the issue of opioid abuse prevention. He explained that CDC is involved in tracking and monitoring data and in conducting some research activities around monitoring.

Dr. Bauer added that CDC has existing mechanisms wherein the pill lock box might be similar to a prevention effort, such as the distribution of a blood pressure monitor. She said that agency cannot fund prescriptions such as Narcan.

Dr. Calac stressed the importance of assessing community need. He also stated that this assessment requires substantial work. Assistance in conducting these assessments is needed.

Secretary Geisler thanked the panel presenters. He stated that the TAC realizes that the Substance Abuse and Mental Health Services Administration has the designated lead role in addressing this public health issue, but he questioned whether CDC would be the responsible party in the event of an "epidemic." He emphasized the need for a mechanism to create flexibility for the tribes to

receive assistance from CDC, the Substance Abuse and Mental Health Services Administration, or other federal government organizations. Secretary Geisler concluded by stating that intervention is needed in Indian Country, and it seemed that CDC should be the lead for intervention on an epidemic.

President Alicia Andrew expressed her frustration at being told at the Winter 2016 TAC Meeting that CDC can provide methods and resources for prevention but not treatment. She questioned why CDC does not provide interventions for treatment in the name of prevention. She also stated that she and other TAC members might not be fully aware of what CDC does. She stated that the TAC and CDC go around circles about this question; meanwhile, people are dying.

Dr. Bauer explained that CDC is involved in prevention efforts. CDC implements policies and system prevention mechanisms. The only difference is that CDC does not engage in direct patient care. Dr. Bauer concluded by stating that agencies, such as the Indian Health Service and the Substance Abuse and Mental Health Services Administration, provide direct patient care, but CDC does not.

Dr. Roderick McClure, Director, Division of Analysis, Research and Practice Integration Research, National Center for Injury Prevention and Control, CDC, addressed the comments. He informed the TAC that CDC does have a prescription drug overdose program funded by Congress currently in place. Supply restriction is the prescription drug overdose program's current focus. Dr. McClure explained that CDC and the Substance Abuse and Mental Health Services Administration have communicated to define their individual roles in the prescription drug overdose program. He stated that Dr. Frieden is using discretionary funds to look at demand management. Dr. McClure applauded all panel members' work. He acknowledged that the frustration over CDC's role in prevention/intervention is a valid and complex issue that needs addressing. He stated that opioid abuse is increasing, despite work being done. Dr. McClure concluded by stating that CDC would be more than willing to work with the TAC members to be more responsive to the problem.

Mr. Auerbach expressed the need to skillfully understand how federal agencies work together on a response. He stated that CDC wants to maximize the degree to which these medications—those to which the TAC have referred—are paid for by insurance agencies, rather than with public health funds. He asked where the gaps existed. He also asked how CDC and the TAC can collaborate to fill them. He said statutory language places certain restrictions on CDC; however, CDC can work with other agencies.

Board Member Morrow stated that tribal communities have distinct data needs to measure the epidemic in their communities.

Captain Clelland said that he has heard some of the desperate need, referencing President Andrew's statements. He reminded the TAC that within the parameters of its charter, members can establish a subcommittee to develop a meaningful and collaborative response. Dr. Bauer referred to the previous panel with Mr. Yazzie and the Viral Special Pathogens Branch, stating that the collaboration yielded a big advantage. She suggested that President Andrew contact CDC experts to explore opportunities. Together, they might be able to develop a solution and a strategy that could be shared with the TAC.

Vice Chairwoman Carlyle thanked the panel for its presentation. She stated that such issues have been going on for a long time. She said she was happy to see the focus placed on educating the providers to change their prescribing behaviors. President Andrew stated that the plea is for help. She is open to the idea of convening a special group to address intervention. She was disappointed that CDC did not have a way to assist someone desperate for treatment to get help. She concluded by stating that, if CDC and Indian Country convene experts, then maybe we really can find a solution.

LT Governor Keel thanked the panel for its informative presentations. He reminded everyone that discussions around these issues open a dialogue to bring resources together, which promotes collaboration among federal agencies. He asked how to gather all of the agencies with the “real” decision-makers to make the important decisions. He requested an afternoon to speak with people within the US Department of Health and Human Services umbrella to create a plan and get a true commitment. He concluded that his vision was to get the experts and the people with the resources in the same room to talk to each other.

President Andrew reiterated that a single death in a small community can affect the entire community and can be a massive impact, regardless of how many lives are lost. In fact, the magnitude can be more substantial.

Councilman Antone stated that it is about changing the environment. He asked whether CDC could assign someone to attend the Tribal Behavioral Health Agenda meeting in December. He clarified that, although the Substance Abuse and Mental Health Services Administration may be taking the lead, it is still a collaboration. Councilman Antone stated that many answers lie within the tribal people themselves. He applauded Dr. Bauer for recognizing the importance of incorporating tribal practices. Councilman Antone concluded by emphasizing the need to act swiftly.

Councilman Antone welcomed the next panel to speak about underage drinking prevention.

### Underage Drinking Prevention

Panelists introduced themselves. Dr. Roland Moore, Center Director and Senior Research Scientist, Pacific Institute for Research and Evaluation, introduced the topic by stating that the Indian Health Council, a consortium of nine tribes, has higher rates of alcohol misuse, along with use of tobacco, marijuana, and other drugs, than other demographic groups. This is the result of institutional trauma, racism, and many other factors. At the Indian Health Council, the consortium has developed multipronged programming to address these numbers and make impactful change. The team examined pre- and post-intervention timeframes, studied the data collected, and demonstrated that the intervention strategies employed had measureable impacts on behaviors. To understand the issue and design an intervention strategy, they used survey development, motivational interviewing, etc., to conduct 70 ethnographic interviews and 200 anonymous youth surveys.

Dr. David Gilder, Senior Staff Scientist, Department of Molecular and Cellular Neuroscience, The Scripps Research Institute, shared that a study was conducted within the program to compare motivational interviewing against psychoeducation trials on affecting behaviors. Evaluations of the intervention strategies were conducted pre-program, immediately post-program completion, and

one year later. Of 112 students who received the program intervention, 85 were available for follow-up. Improvement in behavior was observed for both strategies, although the motivational interviewing technique was slightly superior.

Ms. Jennifer Geisler, Research Coordinator, Preventing Underage Drinking Project, Indian Health Council, shared that after reviewing the data and talking with the children, the children's transparency was surprising. They actually shared where they were getting/buying the alcohol within a 10-mile radius of the reservation. To conduct a study of this information, the team implemented a Reward and Reminder Underage Drinking Prevention Program. They sent young people into the community stores to try to buy alcohol. If they were carded, the establishment was thanked; if they were not carded, then the establishment was issued a reminder. This effort was repeated before important events, such as proms and pow-wows. Initially, there was a 60% compliance rate with carding. Today, there is 100% compliance when the program surveys are conducted. These results have been publicized. During the past five years, five tribal resolutions have been passed to support underage drinking prevention. Additionally, tribal leader and parent nights are held to promote awareness and prevent underage drinking. Letters of support from schools and businesses committing to prevention efforts have been obtained. The program also worked with young people to collectively design a two-sided billboard on the reservation. Many interactive activities are available for young people of all ages. The team recently has been re-funded for another five years of work. The strategies are becoming embedded in the community and are creating change by developing new cultural norms. The team is now looking to document these strategies so that other tribes can replicate them.

Secretary Geisler remarked on the La Jolla Band's work with children and the amazing candor of these young people. Tribal leaders used this information to educate parents. Before parents are allowed to enroll their children in after-school programs, they must participate in an awareness night. At the awareness night, they are taught prevention and intervention strategies. If parents did not attend these sessions, they were not allowed to enroll children in the after-school programs. This was a serious approach because the tribe considered underage drinking a serious issue. Secretary Geisler invited the TAC to provide comments and feedback to the panelists to help the team map the next five years of the program.

Councilman Antone stated that most of the efforts are within the rural communities, and he inquired about the possibility of looking at efforts within an urban population. Dr. Moore affirmed that some programs look at underage drinking in the urban areas. Also, there are unique situations where children are on "dry reservations." He said the best way to get the information in various environments is to ask the children because they will tell you everything. He suggested that tribes consider their policies carefully because tribes have the power to determine their own alcohol policies and to publish these in the Federal Register. He reminded those present that bootleggers do not ask for identification—period.

Secretary Geisler expressed concern that California is considering legalization of recreational marijuana use. He stated that to date, there are no studies in Indian Country about the impacts to youth from legalization of marijuana. He suggested the opportunity to explore this.

Vice Chairwoman Carlyle stated that her own tribe is small, and it sells liquor on the reservation. At one time, the tribe did not permit liquor sales. However, tribal members were being killed in automobile accidents because they were commuting to the nearby counties to purchase liquor and driving back to the reservation at night while intoxicated. So, the tribe decided to allow liquor sales on the reservation again. These are some of the special circumstances various tribes face when addressing drinking prevention.

Vice Chairwoman Carlyle shared that there is a smoke shop near the daycare center on the reservation. She does not feel that proximity is wise. She thanked CDC for the presentation about the impacts of electronic cigarettes, commonly known as e-cigs, at the Winter 2016 TAC Meeting to better inform her on this issue. She also said her tribe had legalized marijuana—for medicinal use only—at this time but has not yet legalized it for recreational use. Dr. Moore urged tribes to think about zoning and redistricting in reference to issues such as having a smoke shop near a daycare center.

Councilman Antone closed the discussion by stating that he believed it is important to explore the impacts of legalizing marijuana on young people in Indian Country. While some marijuana would make it through any border controls, he cautioned against growing it on tribal reservations, stating that the drug cartels ultimately control the drug and that this invites many other issues. He applauded the panelists for the amount of data that they had collected. He stated that their research demonstrated and justified the request for assistance on underage drinking prevention. Their strategies are also a new way of thinking and were really good to hear.

Councilman Antone announced that a video with Dr. Frieden would be next. He turned the video introduction over to Mr. Auerbach.

### Fireside Chat with Dr. Frieden

Mr. Auerbach introduced the 10-minute video. He explained that Dr. Frieden regretted that he was unable to attend the TAC meeting that day but that he wanted to address a few relevant questions and assure the TAC that he is engaged with the group. He said he looked forward to being briefed on the work that took place those two days.

The video played for the TAC. (A transcript is available upon request.)

### Wrap-Up

Captain Clelland closed the presentations and discussions for the day with thanks. He gave special acknowledgement to Ms. Geisler for her presence and to the site hosts for the upcoming cultural enrichment activities.

Secretary Geisler advised that there were some schedule changes to the cultural enrichment activity that had to be accommodated. He instructed those present to meet outside tomorrow, immediately after the meeting wrap-up. He stated that Valley View Casino is expecting attendees for its buffet luncheon and site tour from 12:30 to 2:30 pm. He described this as a world-famous buffet. He said the group would proceed to Rincon to visit the Indian Health Council's facility after the lunch and tour.

Secretary Geisler suggested that the TAC members informally gather the next day at 7:00 am to talk about what it would take to walk through the process of moving a priority through CDC to get funding that would support change. He stated that the TAC could select a representative project and step through it with CDC personnel.

Echoing Secretary Geisler, Mr. Auerbach expressed a desire to focus on what can be supported in the upcoming year. He suggested focusing on existing funds. He felt that informally gathering to create clarity of purpose was a wise idea.

Councilman Antone asked who should be present for this discussion.

Secretary Geisler requested a working session to clarify purpose so that the TAC and CDC depart with a good starting point for further efforts.

LT Governor Keel asked if a tribal caucus would still occur at 8:00 am, or whether the TAC would use this time period to extend the informal work session.

Councilman Antone said that the TAC could do whatever it decided was most suitable. LT Governor Keel suggested a two-hour working session that would start at 7:00 am. He suggested forgoing the tribal caucus.

All TAC members agreed.

Councilman Antone confirmed the change in the agenda and closed the meeting.

## Adjournment

## CDC/ATSDR Tribal Advisory Committee Meeting

---

**Wednesday August 3, 2016**

### Welcome

Councilman Antone provided brief opening remarks and turned the floor over to Captain Clelland for a few logistical updates.

### CDC Office of the Director Updates

Dr. Bauer stated that she would share the timeframe with her colleagues, Mr. Auerbach, Captain Hennessy, and Mr. Gregory Smith, Tribal Liaison Officer, Program Services Branch, Division of State and Local Readiness, CDC.

Dr. Bauer stated that she had two specific updates relative to the National Center for Chronic Disease Prevention and Health Promotion. First, Dr. Bauer provided a brief update on the Tribal Practices that Promote Health & Well-Being convenings.

The first convening was in Spokane, Washington, in August 2015. It focused on what the federal government was doing to understand the importance of tribal health practices. CDC heard from the attendees that these types of health and well-being activities have not been recognized or allowed

as “evidence-based” public health interventions, although tribes have seen health improvement through these activities. The workgroup developed the overarching theme of connection to culture and connection to community to drive health and wellness and identified practices and activities related to culture and community.

At the second meeting in Chandler, Arizona, in December 2015, the group drafted language to describe these activities and discussed how funding opportunity announcement language could be modified to include tribal health practices. The group categorized the activities into the following seven sub-themes:

- Family and community activities that connect to culture
- Seasonal and cultural traditional practices
- Social and cultural activities
- Intertribal and nongovernmental organization collaborations
- Intergenerational learning opportunities
- Cultural teachings and practices about traditional health
- Traditional and contemporary physical activities that strengthen well-being

A third convening is currently scheduled for later this August in Atlanta, Georgia, to finalize standardized funding opportunity announcement language. Dr. Bauer stated that her center is hopeful to attach new funding opportunities to this language in FY17 but that the center will be including this language in all funding opportunity announcements moving forward.

Secondly, Dr. Bauer wanted to discuss Good Health and Wellness in Indian Country. In the FY17 Presidential Budget Initiative, an additional \$15 million was proposed to enhance the existing work of Good Health and Wellness in Indian Country. (The FY16 funding level was \$15 million.) Doubling the funding would allow the center to maintain the original 12 direct tribal awardees and to fund 12 new tribes. In addition, there would be an expansion of funding awarded to tribal health organizations, with a focus on support, via sub-awards to tribes in the Alaska and California areas. Urban Indian health centers would be added. There is increased funding outlined for tribal epidemiology centers to continue building out their capacity to support tribes. The possibility exists for creating a baseline amount of \$1 million each to strengthen the tribal epidemiology centers. The expansion of Good Health and Wellness in Indian Country would open the potential to move further upstream on issues, such as strengthening resilience, improving social wellness to support suicide prevention efforts, and behavioral health. Because these items were written into President Obama’s budget initiative, CDC can provide education on the initiative. The proposal made it through the House budget markup, but was not in the Senate budget markup. However, there is no known opposition to its inclusion. The House increased President Obama’s proposal by \$5 million, making the proposal’s approval appear promising. Dr. Bauer stated that the administration change would make this a very challenging budget year. If this budget is put in place, it would be a critical opportunity to include the new funding opportunity announcement language about tribal practices.

Mr. Auerbach introduced himself and stated that he would provide updates about OSTLTS, the Office of the Associate Director for Policy, and the Zika virus. Mr. Auerbach reported a definitive increase in travel-associated cases of the Zika virus. Florida was the first state to show laboratory-

confirmed local cases of transmission, totaling 14 cases to date. Regarding tribes and tribal engagement in the Zika response activities by the agency, a tribal point of contact was established within the State Coordination Task Force and has been critical in a seamless engagement response. He acknowledged that OSTLTS supports the establishment of a permanent tribal seat within the response to assure that tribes were routinely engaged early with every response activity. Standard operating procedures for this had been drafted during the Zika response and can be used to solidify the seat. Recently, \$130,000 in Zika-related AI/AN-specific funds were awarded to the National Indian Health Board for the development of culturally appropriate communication materials around the virus. The National Indian Health Board is currently developing a work plan for this project. More information would be forthcoming.

Mr. Auerbach turned his attention to updates for OSTLTS. He said OSTLTS was in the process of identifying a permanent director and expected the decision to be finalized very soon. Mr. Auerbach said that his experience in serving as the acting director's role had been very rewarding. He added that he planned to remain engaged with the TAC in the future through CDC's Office for Policy. Mr. Auerbach updated the TAC on the Public Health Associate Program and its progress toward increasing tribal public health capacity. He noted that each year, the program doubles the number of Native host sites. Two years ago, there were only two tribal host sites. Today, there are 13 for the October class. He reminded the TAC to encourage young Native graduates to apply to the program.

Mr. Auerbach reported that the Public Health Accreditation Program had increased tribal applications through a partnership initiative with the National Indian Health Board. Through the National Indian Health Board, \$10,000 grants are available to assist tribal sites in the preparatory activities for accreditation (five in Year 1; six in Year 2; and nine in Year 3). Four prior grant recipients are currently in the active accreditation process. The Public Health Law Program has been deeply engaged with tribes, having provided 30 opinions on tribal inquiries in 2016 to date. Mr. Auerbach reminded the TAC members that having legal experts with specialization in tribal public health law is valuable.

Mr. Auerbach then shifted his attention to the work in the Office of the Associate Director for Policy. He shared that Dr. Frieden specifically asked the Office of the Associate Director for Policy to strengthen the relationship between the public health sector and the health care delivery system. An example of this is CDC's *6/18 Initiative*, in which six costly public health issues were identified and for which 18 specific evidenced-based interventions could be leveraged to affect change in the healthcare system. One important outcome of this work has been developing billable activities for public health work with the Centers for Medicare & Medicaid Services. This has been rolled out to large commercial payers, but the Office of the Associate Director for Policy is looking to identify a tribal pilot site to launch this also. Additionally, there is CDC's *HI 5*, an initiative developed as a tool for states to take a health issue in a population and make high-impact change in five years or less to improve population health. This tool can be good for tribal public health officials to share with elected officials because there is a certain measure of confidence with these definitive strategies—in impact on both health and cost.

Captain Hennessy addressed the TAC next, focusing on the Arctic activities of most importance to tribes in Alaska. Captain Hennessy relayed that the Interagency Arctic Research Policy Committee, established by the federal government, has published its proposed Arctic Research Plan 2017–2021.



The plan is available in the Federal Register and open for public comment. It outlines interagency research plans, with the first chapter focused on health-related topics that may be of interest to tribal health organizations. Input is encouraged. Captain Hennessy also reported on the Arctic Council, a multinational organization comprised of eight member nations and six indigenous organizations which include Alaska Native membership. The council has developed several health initiatives that may be of interest. One such initiative is the upcoming International Conference on Water and Sanitation. It is intended to address the 20% of Alaskans who do not have appropriate water and sanitation in their homes. The meeting will occur in Anchorage, Alaska, September 18–21. Additionally, the Arctic Council is addressing suicide in indigenous communities through the project, RISING SUN, and will soon report on a series of measurements assessing commonly used interventions. Another Arctic Council initiative is *One Health*, a network that uses local environmental observers to monitor changes in the environment through observing human, animal, and environmental impacts and reporting these threats to a shared network that involves tribal, state, and federal agencies. Captain Hennessy stated that this program is a direct result of the skilled work of a single public health associate from the Public Health Associate Program. Captain Hennessy concluded his update with another reminder to provide feedback on the Arctic Research Plan mentioned in his opening.

Minor discussion occurred after Captain Hennessy's update. The floor was opened to permit this exchange.

Mr. Auerbach commented that, regarding the suicide work by the Arctic Council, the incoming president of National Association of County and City Health Officials is the state health official for Alaska. The president has selected two issues as his focus: suicide and mental health.

Councilman Travis Brockie commented that his tribe has concerns about local dairy farming and fecal coliform bacterial contamination of the water supply. He asked about CDC's role in collaborating with the Environmental Protection Agency to review these types of concerns. Captain Hennessy asked if the tribe had contacted CDC for technical assistance with water quality to initiate the process of mitigating his concerns. Councilman Brockie responded that decreased water quality affects sustainability, which feeds into historical trauma and the impacts this has on health and wellness for his tribe. Captain Hennessy replied that if there were gaps in understanding how to move the process forward, he could place Councilman Brockie in touch with people to assist him. He volunteered to speak further with Councilman Brockie after the session.

Mr. Smith addressed the TAC regarding the Public Health Emergency Preparedness grant program. He stated that the Division of State and Local Readiness funds states through the Public Health Emergency Preparedness grant. Of the 33 states with tribes within their boundaries, 22 issue sub-awards, commonly referred to as "Tribal PHEPs," directly to tribes. The issue is that the previous funding opportunity announcement contained only minimal language for states with regard to tribal engagement. In collaboration with TSU, the Division of State and Local Readiness has drafted improved language in the FY17 funding opportunity announcement to strengthen state engagement with tribes. It also has included accountability mechanisms to improve the success of the sub-awards. Mr. Smith said that he would be available for the remainder of the day to answer questions about the Public Health Emergency Preparedness grant program.

Councilman Antone concluded this session and opened the floor for tribal testimonies.

## Tribal Testimonies

**Alaska Area (President Alicia L. Andrew, Karluk IRA Tribal Council):** President Andrew relayed the following verbal testimony:

“For our area, I will speak to the little guys. When I look at the report for the TPHWG, a lot of this goes back to childhood trauma. Our children are lost! There is a horribly vicious cycle of hopelessness at work. Our population may be small and therefore be largely ignored, but a loss of one has a greater magnitude in a small community. My plea is for support. We need more counselors immediately on hand with a cultural knowledge of historical trauma. For us, a priority is the heroin overdose issue, and we need intervention. We need counseling to address the issue. We need a mechanism to get the appropriate response in place.”

President Andrew then ceded the remainder of her time to Dr. Gary Ferguson, Senior Director of Community Health Services, Alaska Native Tribal Health Consortium.

Dr. Ferguson stated that, “We need to work with our communities to develop methods and ways that are effective in our communities. Our strategies need to resonate. We need to use the practice-based evidence that exists in our communities in order to develop these strategies.”

In Alaska, the issue of the tribal health workforce development negatively affects many cross-cutting public health concerns. Dr. Ferguson highlighted that tribes in Alaska believe that their culture is a form of prevention. Children who experience culture have a decidedly lower risk for many adverse health behaviors. In addition, they experience improved outcomes when treated for existing issues. Dr. Ferguson stated that addressing historical trauma and adverse childhood experiences is a key strategy. He stated that tribes need to look internally and learn from their own stories of resilience. Dr. Ferguson stated that the Alaska tribes resonate with CDC’s desire to measure the burden and capacity of tribal public health infrastructure through survey.

Dr. Ferguson read into the record these key comments and recommendations from the Alaska Area to CDC:

- Intimate partner domestic violence—Research has shown a higher rate among Alaskans than in the general population. This is feeding an increased drug and alcohol dependency as a means of coping. Alaska tribes would like to advocate for a comprehensive prevention approach that utilizes education and system strategies.
- Cross-cutting recommendations to CDC
  - Interagency plan to address adverse childhood experiences and bringing together a summit on the topic
  - Culturally relevant tool development
  - US Senator Dan Sullivan of Alaska is convening a meeting on opioid abuse and the tie to historical trauma; it was suggested that CDC be actively involved in this work

- Better data to understand the opioid epidemic is requested of the agency
  - Improved death registry quality regarding the effect on opioid abuse is also requested
- Requests that the agency address the roots of the challenges that Alaska tribes face and focus on their innate resilience on how to develop those into successful culturally relevant intervention strategies
- Colorectal cancer population screening, via CDC—Under a previous CDC funding mechanism, tribes had patient navigators who were able to substantially improve screening rates. The need for funding still exists. Alaska tribes continue to have 2.5 times the rate of colorectal cancer. Screening rates, despite current efforts, remain below the national average, which evidences that more support is needed.

President Andrew thanked CDC for working to improve AI/AN health.

**Tribes-at-Large (Board Member Darcy Morrow, Sault Ste. Marie Tribe of Chippewa Indians):** Board Member Morrow opened her testimony with points of pride for her community. She stated that community members are proud of their culturally competent healing programs, which include tribal health practices. She shared that the community is developing capacity for tribal health for the following priority areas of concern: addiction, cancer, and access to care.

The Sault Ste. Marie Tribe of the Chippewa Indians made the following recommendations for CDC:

- Sovereignty
  - Understand and respect tribal sovereignty. Outreach should always include the tribal elders. They are revered for their wisdom and should be incorporated.
  - Understand that our tribe lacks trust. As much as possible, CDC needs to help regain the trust of all tribes.
- Cancer
  - Funding for cancer prevention, which includes screening programs, should be a priority for the agency.
- Community health
  - Funding for prevention should address infrastructure, economy, childcare transportation, and access.
  - Funding for healthy activities for young people should be prioritized.
  - CDC grant requirements do not fit tribal communities. Please consult with the TAC for advice before releasing grants. Grants must include funding for food at gatherings. Food and eating together are a cultural essential of practice.
  - Grants that include the agency's dictated models of care diminish outcome in tribal environments.
- States
  - Mandate state health departments to include tribal data in their reports.
- Intimate partner domestic violence
  - Rates are high within the tribe. There is an association with alcohol and drug use and the perpetrators are usually male.
  - Culturally relevant interventions, such as early treatment for alcohol and substance abuse, are required to address the issue.

- Underage drinking prevention
  - The average age of first alcohol use for the tribe is 12. The tribes request support for activities that delay first use.
- Alcohol and drug use rates
  - Alcohol and drug use rates, in general, are high. The tribe needs programs and funding to improve access to care. This includes treatment programs and halfway houses.
- Opiate addiction
  - Opiate addiction is increasing within the tribe. The tribe requests that the agency expands marketing and outreach services to address the blanket acceptance of this lifestyle, as it need not become a social/cultural norm. The tribe needs increased options for care, such as support/funding for Medical Assisted Therapy, CERT access, and harm reduction through Narcan programs.

Board Member Morrow suggested that the agency consider the following recommendations for future meetings:

- She suggested a panel topic on a cancer prevention and treatment that uses innovative, culturally tailored interventions.
- She reported that the TAC appreciates having access to the tribal public health advisors and would like to hear more from them.
- She recommended that the agency arrange for TAC members to receive materials in advance—not a day before the meeting. She requested that the agency please include this in strategic planning and develop a blueprint for equitable sharing.

**California Area (Secretary Adam Geisler, La Jolla Band of Luiseno Indians):** Secretary Geisler began his testimony by listing the top health priorities for his tribes and the action requested of the agency to support work in these areas. Secretary Geisler stated that the tribes understand the relationship between behavioral health and historical trauma, but they are requesting greater efforts from the agency on establishing linkages and developing strategic prevention and intervention efforts to address the negative impacts. In his tribal testimony, Secretary Geisler identified the additional challenges facing the La Jolla Band:

- Injury prevention—For injury prevention, the tribe is requesting further discussion with the agency regarding the impacts of drinking and driving, in general, and within the tribe, as well as a focus on underage drinking and driving. The tribe also is interested in the impacts of seat belt use on injury prevention and the survival rates in adults and children, specific to injury-related accidents on tribal lands.
- Mental health—One specialist serves a population of more than 5,000 people. This is clearly insufficient and affects the capacity of the tribe to execute adequate prevention strategies. Increasing the capacity of mental health professionals is critical to improving outcomes in many areas for the tribe.
- Heroin and opioid abuse prevention—This is a national epidemic, but it disproportionately affects Indian Country. Issues around addiction and overdose affect

- entire families and, in many cases, entire communities. He requests that the agency investigate strategies to broadly address the issue across all of Indian Country.
- Zika virus—Secretary Geisler commented that the example of Navajo Nation and the collaboration with hantavirus should help inform CDC about how best to support engagement around infectious disease in Indian Country. California would like to see a more robust engagement in education and awareness around the Zika virus.
  - Emergency planning and preparedness—The tribe lacks resources for adequate emergency preparedness. Funding is needed for tribes to have effective response capabilities. Federal agencies need to be involved in pre-planning efforts for mitigating the impacts of disease outbreaks for all tribes.
  - Aftercare for behavioral health issues—CDC often states that it does not fund clinical care services, but CDC is in the business of prevention. Prevention of the recurrence of behavioral health issues involves funding programs that mitigate housing challenges and provide long-term services.
  - Marijuana industry—Currently, there are no Indian Country studies on general use or potential health impacts of cannabinoids. With industry legalization, growers are pressuring tribes to allow for cannabis farming on tribal lands. In addition, the heightened rates of community exposure to our young people could have long-term impacts to their health. California tribes would like to see further exploration of possibly piloting specific projects regarding the effect marijuana legalization has on AI/AN young people and AI/AN populations.

Secretary Geisler also suggested some important policy fixes for CDC. These include

- Funding opportunity announcement language—In the development of new funding opportunity announcement language, please allow an opportunity for tribal review and engagement before finalization and release.
- Dedicated funding—Support CDC’s various centers, institutes, offices, and programs in a flat-rate increase dedicated to AI/AN prevention or intervention. If the National Center for Chronic Disease Prevention and Health Promotion can do it through a population-based formula, so can others. California tribes applauded Dr. Bauer’s work, and they advocate for the Good Health in Indian Country model.
- Capacity building—Tribal epidemiology centers need increased support for capacity development. This will enable tribal leaders and clinical directors to better understand how epidemics occurring in tribal communities can be addressed.

In closing, Secretary Geisler thanked Dr. Frieden, Dr. Bauer, Mr. Auerbach, the OSTLTS team, and all the boots-on-the-ground personnel responsible for putting this event together. He highlighted that, through advising CDC, the TAC had no intention of “throwing stones” or creating problems. Instead, comments were made in a way that was a goodwill effort to solve problems collectively.

**Portland Area (Councilman Travis Brockie, Lummi Nation):** Councilman Brockie opened his testimony by sharing that opioid abuse is wreaking havoc on the Lummi Nation. The effects trickle down through the entire community. He shared the following statistics:

- The overdose rate was 6 times the national average in 2015.

- Reversals are tracked only by law enforcement, not by people in the community who have the Naloxone kits.
- 30% of people in county jail are tribal.
- 100 out of 101 cases are related to drugs.
- Of 103 babies born, 15 were born addicted.

Councilman Brockie stated that methamphetamine manufacture also has substantial effects on the community. During the past two months, 30 homes were evacuated. More recently, five more were evacuated because of toxic levels of manufacturing methamphetamine in these homes.

The Lummi Nation requested a methamphetamine/heroin/opioid tribal summit involving experts gathered together to address the crisis.

Creative funding and technical assistance are desperately needed to address the complex issue. He stated that it all came down to one word: action. Action is needed in tribal communities. The administrator of the Substance Abuse and Mental Health Services Administration is being a leader. We need other agencies to support this work. The US Department of Health and Human Services will expand funding through a recent bill signed by President Barack Obama. He asked if CDC could access this increased funding to address the crisis.

**Phoenix Area (Vice Chairwoman, Delia Carlyle, Ak-Chin Indian Community):** Vice Chairwoman Carlyle said, “Ditto,” in response to all that had been said and added the following concerns and requests to the growing list.

- **Suicide**—Vice Chairwoman Carlyle stated that the children of the Ak-Chin Indian community and the other tribes of the area are talking about suicide, and the communities do not have the adequate resources to address the issue. Access to tele-behavioral health services is needed desperately.
- **Methamphetamine abuse**—Understand that young adults are losing their homes because of methamphetamine laboratory operations. When young adults lose homes, their children lose shelter. While tribes attempt to shelter the children within the community, a lack of suitable options sometimes prevents them from doing so.

The Inter Tribal Council of Arizona, Inc. Tribal Epidemiology Center is providing substantial technical assistance in health planning and data management analysis to local tribes. It has begun work on the Youth Risk Behavior Surveillance System project.

In closing, Vice Chairwoman Carlyle stated that tribes must continue working toward eliminating the issues of suicide and methamphetamine abuse in Indian Country so as to preserve culture for the future generations.

**Navajo Area (Vice President Jonathon Nez, Navajo Nation):** A written testimony was distributed to attendees. Vice President Nez opened his testimony by thanking CDC and ATSDR for their partnership. He also thanked members of his staff who attended and supported him in the development of his testimony. He thanked Dr. Bauer for visiting the field and for advocating for

Good Health and Wellness in Indian Country. He affirmed that Navajo Nation supports funding mentioned in President Obama’s budget for Good Health and Wellness in Indian Country and will advocate for it.

Navajo Nation broached the following requests for the agency to address:

- Navajo Birth Cohort Study—Continuation of this study is critical to observe and document the effects of uranium mining.
- Gold King Mine spill—Navajo Nation requests the long-term monitoring of people exposed to the Gold King Mine spill.
- Zika response—Navajo Nation requests direct funding for Zika.
- Public health emergency preparedness—Navajo Nation requests direct funding for Zika.
- Increase radio announcement collaboration with CDC on a variety of health priorities.

Navajo Nation identified the following health priorities:

- Suicide prevention resources—*One Nation One Voice Protect Life Initiative* by Navajo Nation is a culturally competent strategy. While it is taboo to talk about death, it is culturally appropriate to talk about the greatness of life. Suicide surveillance in Indian Country needs to be increased through the tribal epidemiology centers. Funding is requested to accomplish the infrastructure/capacity building to do this.
- Chronic disease prevention—Here is a cultural tip for the agency: Our culture understands the idea of going into battle against “monsters.” This is how the culture conceptualizes disease. Using this concept in strategies for prevention and intervention will yield better success.
- Zoonotic diseases—Navajo Nation requests ongoing hantavirus and Zika virus collaboration.

Vice President Nez closed with thanks and recognition of a movement toward greater collaboration. He also volunteered to use the lobbying arm of Navajo Nation to assist other areas and tribes.

**Tucson Area (Councilman Chester Antone, TAC Chair, Tohon O’odham Nation):** Councilman Antone opened his testimony and provided the following health priorities and agency requests:

- Zika virus—Initially, his area and tribe were told that there was little risk, based on vector mapping of the carrier mosquito. But he stated that the area does have people arriving from other countries, leaving the tribe concerned about transmission. The tribe is addressing this through public service announcements on radio stations.
- Rocky Mountain spotted fever—The area continues to have issues with incidence of disease. They are continuing to make public service announcements. So far, there have been no deaths.
- Zoonotic disease (in general)—There appears to be an increase in diseases affecting animals and humans. He suggests that the agency remain mindful that there are likely contributing environmental factors to this increase. He suggested that CDC look at this more closely for the contributing factors. There is a need to reiterate the importance of funding to carry out this type of monitoring.

- Mental health—There is a connotation of being mentally unwell when mental health is addressed in many settings, but mental health is more a sense of emotional well-being. Tribes are responding emotionally to historical trauma. This is manifesting as mental health/behavioral health issues across Indian Country. However, resilience is prevention, and culture is a cure. For the agency, he stressed that strategies must focus on this concept for tribal interventions. When suicide prevention is addressed, it must be tied to culture. The work around suicide has partly driven the Tribal Behavioral Health Agenda being seen now. Behavioral modification can be taught. For example, everyone brushes and flosses daily. A similar ingrained response to mental wellness is needed.

### Bemidji Area (District Representative Robert TwoBears, Ho-Chunk Nation of Wisconsin):

Representative TwoBears introduced his testimony by sharing that he emailed his written tribal testimony to Ms. Weathers in TSU. Therefore, he wanted to speak off topic from that written testimony. He stated that it often seems like there is a pervasive “Us Versus Them” stance. He advised that there needs to be outreach and education to explain how vital this advisory committee is and to increase attendance at the meetings. He advised the TAC and the agency to better explain the work being done.

Speaking on behalf of the Ho-Chunk Nation, Representative TwoBears stated that the issues affecting the Ho-Chunk Nation, as well as the other tribes in his region, include the opioid epidemic. In 2014, his tribe implemented a Declaration of Emergency for drug abuse. They began outreach efforts that included block parties, neighborhood watches, and a 1-800 reporting line. The community has been deeply involved to make it a wrap-around programmatic effort. He stated that there are many microprograms in place but that a macroprogram is required. This level of technical assistance will require US Department of Health and Human Services collaboration. He stated that it is recognized that the various US Department of Health and Human Services agencies continue to work in silos because tribes and the TAC see the apprehension on the faces of CDC/ATSDR representatives when they attempt to push agencies out of their respective silos. Yet, this is what is required to make an impactful change.

Representative TwoBears also recommended that the agency have a wrap-around program for TAC members and tribal leaders. He stated that it should start with building collaborative spirit over a dinner before addressing the business at hand. He also said that meeting twice a year is not often enough. A webinar or a listserv is needed for resources, and the TAC needs to talk to the agency more often. In closing his testimony, Representative TwoBears agreed with other TAC members in saying that the workgroup preparing TAC members one day prior to a TAC meeting was ineffective.

## Wrap-Up

Councilman Antone closed the tribal testimony portion of the meeting and ceded the floor to Captain Clelland.



Captain Clelland reminded those in attendance of the reimbursement process for TAC member travel.

Secretary Geisler requested that all interested in attending the cultural enrichment event meet outside for departure, exiting via the courtyard to the left. He reminded attendees to gather at noon for departure from the hotel.

Captain Clelland said those attending the cultural enrichment activity would eat lunch at the buffet in the Valley Center Casino and then take a guided tour of the property, with a specific emphasis on the establishment and operation of a smoke-free gaming area. He said a tour of the Rincon Indian Health Council's clinic would follow before returning the hotel.

Ms. Weathers discussed the shuttle to the airport on Thursday morning. She said there would be 7:00 am and 8:30 am departures to the airport from the hotel lobby area just outside of the registration desk on the first floor. She said up to 18 persons could be accommodated in a shuttle group. She asked those riding to advise TSU.

## Closing Prayer and Adjournment

Councilman Antone thanked the participants. He closed the 2016 Summer TAC meeting with a prayer.

## Participants

### Tribal Advisory Committee Members

- **Alicia Andrew** (Native Village of Karluk): President, Karluk IRA Tribal Council; Alaska Area Delegate
- **Chester Antone** (Tohono O'odham Nation): Councilman, Tohono O'odham Nation; Chair, Tribal Advisory Committee; Tucson Area Delegate
- **Travis C. Brockie Jr.** (Lummi Nation): Councilmember, Lummi Indian Business Council, Lummi Nation; Portland Area Delegate
- **Delia M. Carlyle** (Akin Indian Community): Vice Chairwoman, Ak-Chin Indian Community; Phoenix Area Delegate
- **Robert Flying Hawk** (Yankton Sioux Tribe): Chairman, Yankton Sioux Tribe; Great Plains Area Delegate
- **Jefferson Keel** (Chickasaw Nation): LT Governor, Chickasaw Nation; Oklahoma Area Delegate
- **Adam Geisler** (La Jolla Band of Luiseño Indians): Secretary, La Jolla Band of Luiseño Indians; California Area Delegate
- **Darcy Morrow** (Sault Ste. Marie Tribe of Chippewa Indians): Board Member, Sault Ste. Marie Tribe of Chippewa Indians; Tribes-at-Large Delegate
- **Jonathan Nez** (Navajo Nation): Vice President, Navajo Nation; Co-Chair, Tribal Advisory Committee; Navajo Area Delegate

- **Robert TwoBears** (Ho-Chunk Nation): Legislative District V Representative, Ho-Chunk Nation; Bemidji Area Delegate

### CDC and ATSDR Senior Leaders

- **John Auerbach, MBA:** Associate Director for Policy and Acting Director, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention
- **Ursula Bauer, PhD, MPH:** Director, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention
- **Captain Thomas Hennessy, MD, MPH:** Director, Arctic Investigations Program, National Center for Emerging and Zoonotic Infectious Diseases, Centers for Disease Control and Prevention
- **Roderick McClure, MBS, PhD, FAFPH, FAICD:** Director, Division of Analysis, Research and Practice Integration Research, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

### Presenters/Participants

- **Annabelle Allison** (Navajo Nation): Deputy Associate Director for Tribal Support, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention
- **Shyanne Boston:** Domestic Violence Director, Native Women’s Resource Center
- **Daniel Calac, MD** (Pauma Indian): Chief Medical Officer, Indian Health Council, Inc.
- **Captain Carmen Clelland, DPh, PharmD, MPA** (Cheyenne and Arapaho Tribes): Associate Director for Tribal Support, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention
- **Lieutenant Commander Jessica Damon:** Lead Public Health Advisor, Tribal Support Unit, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention
- **Elaine Davidson, MD:** Family Medicine Physician, Indian Health Council, Inc.
- **Jennifer Geisler, RN** (Kumeyaay/Shoshone): Research Coordinator, Preventing Underage Drinking Project, Indian Health Council, Inc.
- **David Gilder, MD:** Senior Staff Scientist, Department of Molecular and Cellular Neuroscience, The Scripps Research Institute
- **Keely Linton:** (Íipay and Cupeno Native from the Mesa Grande Band of Mission Indians): Operations Director, Strong Hearted Native Women’s Coalition
- **J. Antonio (Tony) Luna, MA** (Tlingit/Chicano): Project Coordinator, Indian Health Council, Inc.
- **Georgia Moore, MS:** Associate Director for Policy, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention
- **Roland Moore, PhD:** Center Director and Senior Research Scientist, Pacific Institute for Research and Evaluation
- **Pierre Rollin, MD:** Deputy Branch Chief, Viral Special Pathogens Branch, Division of High-Consequence Pathogens and Pathology, Centers for Disease Control and Prevention

- **Bonnie Salgado** (Iipay Nation of Santa Ysabel): Cultural Arts Specialist, Indian Health Council, Inc.
- **Wendy Schlater** (La Jolla Band of Luiseño Indians): Director, La Jolla’s Avellaka Program
- **Gregory Smith, MPA**: Tribal Liaison Officer, Program Services Branch, Division of State and Local Resources, Office of Public Health Preparedness and Response, Centers for Disease Control and Prevention
- **Beth Turner, MPH**: Director, Health Promotion Services, Indian Health Council, Inc.
- **Del Yazzie, MPH** (Navajo Nation): Director, Navajo Epidemiology Center

## Acronyms

|          |  |
|----------|--|
| ACEs     | Adverse Childhood Experiences  |
| ACF      | Administration for Children & Families   |
| AIP      | Arctic Investigation Program   |
| ATSDR    | Agency for Toxic Substances and Disease Registry                                 |
| ANTHC    | Alaska Native Tribal Health Consortium   |
| AI/AN    | American Indian/Alaska Native  |
| AIP      | Arctic Investigation Program   |
| CDC      | Centers for Disease Control and Prevention                                       |
| CEO      | Chief Executive Officer  |
| CIO      | Centers, Institutes, and Offices   |
| CMS      | Centers for Medicare & Medicaid Services   |
| CoAg     | Cooperative Agreement  |
| CR       | Continuing Resolution  |
| CURES    | Controlled Substance Utilization Review and Evaluation System                    |
| DFO      | Designated Federal Official  |
| DHPP     | Division of High-Consequence Pathogens and Pathology                             |
| DOJ      | Department of Justice  |
| DSLRL    | Division of State and Local Readiness  |
| DV       | Domestic Violence  |
| EOC      | Emergency Operations Center  |
| EPA      | United States Environmental Protection Agency                                    |
| FOA      | Funding Opportunity Announcement   |
| FY       | Fiscal Year  |
| GHWIC    | Good Health and Wellness in Indian Country                                       |
| HHS      | Department of Health and Human Services  |
| HHS STAC | US Department of Health and Human Services Secretary’s Tribal Advisory Committee |
| HPDP     | Health Promotion and Disease Prevention  |
| HRSA     | Health Resources and Services Administration                                     |

|         |   |
|---------|---|
| IC      | Indian Country  |
| ICWA    | Indian Child Welfare Act  |
| IHS     | Indian Health Service   |
| NACCHO  | National Association of County and City Health Officials            |
| NCAI    | National Congress of American Indians                               |
| NCCDPHP | National Center for Chronic Disease Prevention and Health Promotion |
| NCEZID  | National Center for Emerging and Zoonotic Infectious Diseases       |
| NCIPC   | National Center for Injury Prevention and Control                   |
| NIHB    | National Indian Health Board  |
| NWRC    | Native Women’s Resource Center                                      |
| OADP    | Office of the Associate Director for Policy                         |
| OD      | Office of the Director  |
| OPHPR   | Office of Public Health Preparedness and Response                   |
| OSTLTS  | Office for State, Tribal, Local and Territorial Support             |
| PHLP    | Public Health Law Program   |
| PHA     | Public Health Advisor   |
| PHAB    | Public Health Accreditation Board                                   |
| PHAP    | Public Health Associate Program                                     |
| PHLP    | Public Health Law Program   |
| PHEP    | Public Health Emergency Preparedness (cooperative agreement)        |
| PPCU    | Program Planning and Communication Unit                             |
| PPEO    | Program Performance and Evaluation Office                           |
| PTSD    | Post-Traumatic Stress Disorder                                      |
| SAMHSA  | Substance Abuse and Mental Health Services Administration           |
| SCTF    | State Coordination Task Force                                       |
| SHNWC   | Strong Hearted Native Women’s Coalition, Inc.                       |
| STAC    | Secretary’s Tribal Advisory Committee                               |
| TAC     | Tribal Advisory Committee   |
| TBHA    | Tribal Behavioral Health Agenda                                     |
| TEC     | Tribal Epidemiology Center  |
| TPHWG   | Tribal Public Health Workgroup                                      |
| TSU     | Tribal Support Unit   |
| VSP     | Viral Special Pathogens   |
| USPHS   | United States Public Health Service                                 |