

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 16th Biannual Tribal Consultation Session, February 14–15, 2017, at CDC's Roybal Campus, in Atlanta. During the course of the two-day meeting, TAC members held discussions with CDC and ATSDR representatives.

Topics discussed during the TAC meeting included CDC's budget, tribal strategies for connecting cultural practices in competitive funding opportunities, tribal priorities for the National Center for Injury Prevention and Control (NCIPC) and National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), tribal capacity in emergency preparedness and response, and tribal workforce in surveillance and epidemiological data.

CDC/ATSDR TAC Meeting

Tuesday February 14, 2017

Opening Blessing, Welcome, and Introductions

Roll call taken by Priyanka Oza, Public Health Advisor, Tribal Support Unit (TSU), Office for State, Tribal, Local and Territorial Support (OSTLTS), CDC

Members present for roll call:

- Bemidji Area Delegate—Representative Robert TwoBears, Ho-Chunk Nation of Wisconsin
- Billings Area Delegate—President Lawrence Jace Killsback, Northern Cheyenne Tribe
- Great Plains Area Delegate—Chairman Robert Flying Hawk, Yankton Sioux Tribe
- Nashville Area Delegate—Principal Chief Patrick Lambert, Eastern Band of Cherokee Indians
- Navajo Area Delegate—Vice President Jonathan Nez, Navajo Nation
- Oklahoma Area Authorized Representative—Director Lisa Pivec, Cherokee Nation
- Phoenix Area Delegate—Vice Chairwoman Delia Carlyle, Ak-Chin Indian Community
- Tucson Area Delegate—Councilman Chester Antone, Tohono O'odham Nation
- Tribes-at-Large Delegate—Tribal Employee Byron Larson, Northern Cheyenne Tribe

[Quorum Met]

Members absent:

- Alaska Area Delegate—President Alicia Andrew, Karluk IRA Tribal Council
- Oklahoma Area Delegate—Lieutenant Governor Jefferson Keel, Chickasaw Nation
- Portland Area Delegate—Business Council Member Travis C. Brockie Jr., Lummi Nation
- 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
- Tribes-at-Large Delegate—Board Member Darcy Morrow, Sault Ste. Marie Tribe of Chippewa Indians

Delegate vacancies: Albuquerque Area, and one Tribes-at-Large position

Captain Carmen Clelland, Associate Director for Tribal Support, OSTLTS, CDC, opened the meeting with introductions. Next, Dr. José Montero, Designated Federal Official, CDC Deputy Director, and Director of OSTLTS, welcomed everyone and thanked them for their attendance. Chairman Robert Flying Hawk led the opening prayer, after which Commander Damion Killsback, Deputy Associate Director for Tribal Support, OSTLTS, CDC, reviewed emergency exit procedures and protocols for meeting etiquette. A detailed explanation of the committee's Federal Advisory Committee Act (FACA) exemption under the Unfunded Mandate Reform Act was read into the record for all in attendance. Appropriate protocol for the meeting to remain compliant with the exemption was explained to all present. All welcomes concluded and the meeting proceeded to the first item of business on the agenda.

Tribal Advisory Committee Business

As the first order of business, Captain Clelland invited the committee to review proposed dates for the Summer 2017 TAC and Winter 2018 meetings and to call for a vote to finalize the dates. After discussion and consulting schedules, the committee voted by quorum that the Summer 2017 TAC meeting take place August 8–9, 2017, in Oklahoma. The following Winter 2018 TAC will be held February 6–7, 2018, in Atlanta.

Captain Clelland then redirected the conversation towards highlights from TSU. He informed attendees that, in an effort to keep the length of the business meeting as short as possible and allow for the expanded tribal caucus time, their binder materials included a detailed narrative brief of the TSU update. In addition, members could also find, per the committee's request, a document titled, "Highlights of FY16 Tribal Support Activities," which showcases work in Indian Country across the entire agency.

Captain Clelland highlighted several of the activities from the Winter 2017 TSU Update Brief, including Zika trainings to tribes to increase the dissemination of up-to-date knowledge about the virus; provision of subject matter expertise at forums, conferences, and other venues; and participation in the Department of Health and Human Services (HHS) regional consultations and site visits. He shared a few details from several of these engagements, such as the National Tribal Forum in Spokane, Washington, where attendees had the opportunity to learn from the tribe that has attained public health accreditation.. He then shared about his site visit to Rapid City, South Dakota, where he participated in the Great Plains Behavioral Health Conference and enjoyed the collegial dialogue about behavioral health as a public health activity. He also related that working with the Tribal Epidemiology Centers (TECs) and the Tribal Public Health Workgroup to identify opportunities to strengthen CDC's engagement with tribes has resulted in increased partnerships.

In his update on the advisory committee recruitment activities, Captain Clelland relayed that that there are 14 seated members on the committee and 2 existing vacancies; 1 for the Albuquerque

Area Delegate and 1 for a Tribes-at-Large delegate. He requested members to identify and recommend potential tribal leaders to fill these seats.

Captain Clelland updated the committee regarding the October 5, 2016, engagement with Dr. Tom Frieden, former CDC director, and the “Tribal Priorities for Transition” documents subsequently adopted by quorum vote of the committee to serve as working committee documents. He advised that TSU has been working to implement activities suggested in the transition document. In follow up to the engagement, Dr. Frieden sent a letter to the tribal leaders with whom he had met. The letter included a list of action items that the agency is currently working on as a response to the identified priorities.

Lastly, Captain Clelland informed meeting attendees that TSU is conducting a formal evaluation of the revised TAC meeting structure to assess its efficiency and identify opportunities for improvements. TAC members were informed that they will be asked to do a brief interview with the evaluators during the meeting the next day. A sign-up sheet for preferred interview times was circulated by a member of the TSU support staff.

Captain Clelland concluded the session on TAC business and TSU highlights.

[Adjournment to Tribal Caucus \(Closed to non-Tribal members and CDC/ATSDR Staff\)](#)

Councilman Antone adjourned the public component of the meeting and tribal leaders broke into private tribal caucus sessions for the remainder of the day.

CDC/ATSDR Tribal Advisory Committee Meeting

Wednesday, February 15, 2017

Welcome, Opening Reminders, CDC Office of the Director Updates

Roll call taken by Priyanka Oza, Public Health Advisor, TSU, OSTLTS, CDC

Members present for the roll call:

- Alaska Area Authorized Representative—Ileen Sylvester, MBA, Vice President of Executive & Tribal Services, Southcentral Foundation, Native Village of Ekwok
- Bemidji Area Delegate—Representative Robert TwoBears, Ho-Chunk Nation of Wisconsin
- Billings Area Delegate—President Lawrence Jace Killsback, Northern Cheyenne Tribe
- Great Plains Area Delegate—Chairman Robert Flying Hawk, Yankton Sioux Tribe
- Nashville Area Delegate—Principal Chief Patrick Lambert, Eastern Band of Cherokee Indians
- Navajo Area Delegate—Vice President Jonathan Nez, Navajo Nation
- Oklahoma Area Authorized Representative—Senior Director of Public Health Lisa Pivec, MS Cherokee Nation
- Phoenix Area Delegate—Vice Chairwoman Delia Carlyle, Ak-Chin Indian Community
- Tucson Area Delegate—Councilman Chester Antone, Tohono O’odham Nation
- Tribes-at-Large Delegate—Tribal Employee Byron Larson, Northern Cheyenne Tribe

[Quorum Met]

Members absent:

- Alaska Area Delegate—President Alicia Andrew, Karluk IRA Tribal Council
- Oklahoma Area Delegate—Lieutenant Governor Jefferson Keel, Chickasaw Nation
- 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
- Tribes-at-Large Delegate—Board Member Darcy Morrow, Sault Ste. Marie Tribe of Chippewa Indians
- Portland Area delegate—Business Council Member Travis C. Brockie Jr., Lummi Nation

Delegate vacancies: Albuquerque Area, and one Tribes-at-Large position

Introductory remarks: Rear Admiral Anne Schuchat, MD, Acting Director, CDC, and Acting Administrator, ATSDR, briefly introduced herself and then introduced Dr. Montero as the new OSTLTS director. Dr. Montero provided brief comments and then Councilman Antone read the mandatory FACA exemption guidelines.

Roundtable Discussion with Senior Leaders: Tribal Engagement in Budget Planning and Tribal Direct Funding Strategies

CDC roundtable discussion participants included

- Rear Admiral Anne Schuchat, Acting Director, CDC, and Acting Administrator, ATSDR
- Dr. Ursula Baur, Director, NCCDPHP
- Dr. Debra Houry, Director, NCIPC
- Rear Admiral Stephen Redd, Director, Office of Public Health Preparedness and Response (OPHPR)
- Ms. Stephanie Dulin, Deputy Director, National Center for Birth Defects and Developmental Disabilities (NCBDDD)
- Dr. Donna Knutson, Deputy Director, National Center for Environmental Health (NCEH) and ATSDR
- Dr. Hazel Dean, Deputy Director, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)
- Captain Tom Hennesy, Director, Arctic Investigations Program, National Center for Emerging and Zoonotic Infectious Diseases (NCEZID)

Rear Admiral Schuchat started the roundtable discussion by providing updates from the Office of the Director (OD). Rear Admiral Schuchat explained that she is serving as Acting Director, an interim role, until the HHS Secretary is appointed and subsequently appoints a permanent CDC director. She said the OD shares former CDC director Dr. Frieden's concern and priority for strengthening health in Indian Country. Rear Admiral Schuchat then gave a brief overview of the listening sessions and other engagements that have occurred between CDC leaders and tribal leaders since the October 5, 2016, tribal engagement session. She acknowledged Dr. Ursula Bauer, Director, NCCDPHP, for her championship of tribal issues on behalf of the agency. Rear Admiral Schuchat concluded her portion of updates by highlighting the January 2017 issue of *Vital Signs* titled, "Native Americans with diabetes: Better diabetes care can decrease kidney failure." [The CDC *Vital Signs* monthly report includes a *Morbidity and Mortality Weekly Report* (MMWR) Early Release, a graphic fact sheet and website, a media release, and social media tools at www.cdc.gov/vitalsigns]. The MMWR article addressed diabetes control in eliminating end-stage renal failure in tribal communities. Rear Admiral Schuchat highlighted this as an example of using evidence-based approaches and cultural practices to achieve a positive public health outcome. She concluded by stating that she hopes to do as much as possible, within the current budget constraints, to decrease the burden of chronic disease and injury in Indian Country.

Councilman Antone presented Rear Admiral Schuchat with a letter that the committee members had written. The letter's contents were described as reaffirming the priorities expressed in the October 2016 engagement with the former CDC director and expressing a strong desire by the committee to strengthen the government-to-government relationship with the agency and tribes.

Councilman Antone went around the table addressing senior leaders and inviting them to introduce themselves to the committee and to share about their centers and the interactions with tribes. He invited Dr. Bauer to begin.

Dr. Bauer welcomed everyone to Atlanta. She relayed that NCCDPHP's tribal priorities include the following issues: commercial tobacco use, poor nutrition, physical activity, alcohol abuse, reproductive health, and oral health. She explained that NCCDPHP's operating procedure is to fund tribes and tribal-serving organizations directly. Dr. Bauer then stated that her center has requested \$15,000,000 for the expansion of the Good Health and Wellness in Indian Country (GHWIC) program. Dr. Bauer informed the committee that the presidential budget has not been finalized and that CDC may witness a series of continuing resolutions until a budget is affirmed. Dr. Bauer expressed her optimism towards receiving funds for the GHWIC budget. She explained that her center has been engaging with the committee on how to expand and increase the programmatic allocation to GHWIC. NCCDPHP is drafting a funding opportunity announcement (FOA) in the event that additional dollars will be allocated. She acknowledged the seven key strategies identified by the tribal convenings, which connect public health outcomes to tribal cultural practices, will be incorporated into the FOA. These strategies include: 1) family and community activities that connect cultural teachings to health and wellness; 2) seasonal cultural and traditional practices that support health and wellness; 3) social and cultural activities that promote community wellness; 4) tribal, intertribal, governmental, and nongovernmental collaborations that strengthen well-being; 5) intergenerational learning opportunities that support well-being and resilience; 6) cultural teachings and practices about traditional healthy foods to promote health, sustenance, and sustainability; and 7) traditional and contemporary physical activities that strengthen well-being.

Next, Dr. Donna Knutson, Deputy Director, NCEH/ATSDR, spoke about the center's tribal engagement. She stated that areas in which her center and tribes are working together include: the Navajo Birth Cohort Study, the Gold Key Mine study, and clean water initiatives across Indian Country. In addition, her center is currently working on a climate change initiative, exploring the effect on health for asthma prevention. She concluded by stating that NCEH/ATSDR has worked closely with tribes in Michigan and has regional staff that are able to address community health concerns.

Ms. Stephanie Dulin, Deputy Director, NCBDDD, spoke on behalf of the NCBDDD Director, Dr. Coleen Boyle. She explained that NCBDDD has a diverse portfolio that encompasses multiple populations across a lifespan. As an example, she discussed NCBDDD's birth defects surveillance program that is population-based towards infants. In addition, NCBDDD has a neural tube defects program that supports activities to prevent birth defects. Ms. Dulin provided the example of the center's efforts to fortify corn masa flour with folic acid to prevent neural tube defects among infants. She concluded by stating that additional priorities of NCBDDD include fetal death

syndrome, autism, children's mental health issues, attention deficient disorder, and blood disorders.

Dr. Debra Houry, Director, NCIPC, provided an update on the center's priorities and budget. She stated that NCIPC's focus is on fall prevention, motor vehicle injuries, opioid surveillance, sexual violence, and suicide prevention. Dr. Houry reported that their budget and activities reflect the priorities expressed by committee members from the previous year. She concluded by stating that based on feedback from committee, NCIPC's activities have included:

- A program that provides tribes funding and technical assistance for rape prevention education under the block grant for rape prevention education
- Working with the Association of American Indian Physicians to prevent childhood violence
- A federal highway assistance program through the Federal Highway Administration (FHA)
- Provision of funding to three TECs to gather data on opioid misuse/abuse, suicides, and motor vehicle injuries

Captain Tom Hennessy, Director, Arctic Investigations Program, NCEZID, spoke on behalf of Dr. Rima Khabbaz, Acting NCEZID Director, about tribes and funding. He explained that NCEZID does not fund tribes directly, but does provide support to tribes for center priorities. Captain Hennessy conveyed examples of NCEZID's support to tribes which included Hantavirus prevention and surveillance support, Rocky Mountain Spotted Fever activities in New Mexico, and an ongoing collaboration with the Indian Health Service (IHS) to gather data on tribal facilities that can further analyze disease burden disparity.

Rear Admiral Stephen Redd, MD, Director, OPHPR, shared that OPHPR is the office that serves as the home of CDC's Emergency Operations Center and is responsible for providing assistance for public health emergencies. He stated that his staff has been brainstorming which type of emergencies CDC needs to be prepared to address. He explained that preparation activities vary depending on the type of emergencies (e.g., weather-based; geological; intentional or human caused; and emerging conditions, such as Zika and Ebola viruses). He stated that his center mainly responds to natural emergencies [natural events such as communicable disease outbreaks and hurricanes]. Rear Admiral Redd stated that OPHPR has a sizeable cooperative agreement, the Public Health Emergency Preparedness (PHEP) grant, which currently does not provide direct funding to tribes. However, in 2018, there will be a reauthorization of the Pandemic and All Hazards Preparedness Act, which is the act under which this funding mechanism exists. Rear Admiral Redd concluded by stating that OPHPR is focusing on learning how to better support local health departments and tribes who receive funding through sub awards by the states.

Principal Chief Lambert introduced himself and stated he would be speaking on how tribes view funding and ways in which CDC can work with tribes. He proposed that CDC's budget expenditure in

Indian Country is disproportionate to its population size and health disparities. He stated that while a total of 2% of the US population is Native American, only about \$15,000,000 out of CDC's total budget of \$6,000,000,000 is allocated to Indian Country. He clarified by saying that ideally, 2% of CDC's budget should be allocated to Indian Country, which is roughly equivalent to \$120,000,000. Principal Chief Lambert stated that treating tribes equitable to states is the appropriate approach. He went on to say that tribes have a great relationship with IHS, but IHS takes care of immediate health concerns of tribes, not the public health concerns. According to Principal Chief Lambert, CDC can assist Indian Country with prevention and community-based approaches to improving health. Principal Chief Lambert held up the mission of the agency which is to "protect and improve" public health for all persons. A failure to fund tribes appropriately is a failure to carry out the agency's mission. He concluded that listening without action is not enough. He said that the ideal to fund programs equitably and to accomplish CDC's mission needs to be a shared ideal. He recognized that a cookie-cutter funding model will not work to effect change. Every tribe is unique and has unique health concerns and practices. Dr. Schuchat thanked Principal Chief Lambert for his comments and assured him that CDC has leaders that will take the tribes' budget concerns seriously.

Next, Vice President Nez thanked Rear Admiral Schuchat for serving as CDC's Acting Director and spoke about the letter presented to Rear Admiral Schuchat by tribes. Vice President Nez suggested that a few tribal leaders be able to participate in the interview and vetting process for the agency's two top positions. He stated that, by doing so, it would help educate the new appointees on tribal issues. Vice President Nez reminded the agency that Native Americans are dealing with a lot of issues; their culture is under attack. In the Navajo language the word that translates as "monster" is used to describe disease states. He said, "We picture each burden as a monster; the *monster* of suicide, the *monster* of opioid addiction, or the *monster* of obesity. CDC provides the tools that we use as weapons to fight these *monsters*. These tools are empowering and the Navajo people. Thank you." But, he cautioned that the Native American people as a whole are shortchanged when compared to the states. They do not receive substantial weapons to fight. So, the request for direct funding to tribal nations remains. He recommended that a 101 [an introductory level training, targeted toward a broad audience] be developed and implemented for all CDC leaders on tribal sovereignty and the federal trust responsibility, as well as cultural sensitivity training. Vice President Nez closed by giving thanks to the agency for the technical assistance provided to Navajo Nation with the Hanta virus, Zika virus, and Rocky Mountain Spotted Fever.

As Rear Admiral Schuchat prepared to leave the session to attend another high-priority meeting, President Killsback requested that she remain for just a moment longer, so that other key points could be addressed. He stated that funding is supposed to follow data, which is not occurring with regard to Native American healthy disparities and disease burden. He emphasized the need for CDC to make a stronger effort to fill the gap between primary care services provided by IHS and community prevention and public health required to achieve genuine health equity. He stated that

disease prevention is a concept model intuitively understood by Native persons. It fits well into the holistic view of health found rooted in cultural beliefs and practices. He would encourage that the funds awarded to states be accountable to the identified disparities and burdens in the state population. He explained that the biggest “*monster*” facing tribes is institutional racism. Cultural sensitivity training from the “boots on the ground” up to senior leaders is one strategy to help combat this.

Rear Admiral Schuchat replied by thanking President Killsback for his helpful comments and stated CDC is looking into funding measures to improve health disparities in tribal communities. She assured those assembled that their suggestions and the contents of the letter would be shared with the incoming agency leadership and all who make decisions about the direction of the agency.

Mr. Byron Larson, Tribes-at-Large delegate, thanked the TAC, OSTLTS, and the National Indian Health Board (NIHB) for their leadership in arranging the Winter 2017 TAC meeting. He added two additional points for consideration. First, he expressed a desire for the agency to try harder to elucidate mechanisms by which they could further fund/support tribes, such as supporting the prevention programs of the Indian Self-Determination and Education Assistance Act (Public Law 93-638) tribes, the Indian-serving organizations that work tirelessly on prevention strategies across Indian Country, and the area Indian Health Boards. Second, he suggested partnering with tribes and with the committee to be more innovative in tailoring the response strategies as the goals for health equity are shared goals.

Principal Chief Lambert invited CDC leadership to a site visit to Eastern Band of Cherokee approximately 2.5 hours north of Atlanta. He encouraged all who are interested in gaining a better understanding of Indian Country to contact him directly and offered to provide transportation. He also continued to address funding for tribal nations. He asked the following questions:

- How does CDC hold states accountable to fund and provide assistance to the pocket areas that CDC does not directly fund?
- Is there some sort of formal statement from CDC that holds CDC accountable to provide funding to those communities?

Principal Chief Lambert explained that tribes do not have the same capacity or funds to build infrastructure as states have. As an example, he stated that Eastern Band of Cherokee signed a Memorandum of Understanding (MOU) with the United States Department of Agriculture (USDA) that USDA would directly fund tribes. Principal Chief Lambert expressed that CDC should be informed on legal processes to break through such barriers for tribal funding.

Dr. Bauer thanked Principal Chief Lambert for his comments. In response to his request to allocate 2% of CDC’s entire budget to tribes, she clarified that for her center, NCCDPHP, 2% of their budget would equal \$20,000,000 whereas NCCDPHP currently has \$30,000,000 invested in Indian Country.

She acknowledged that in more ways than one, \$30,000,000 is still not enough. However, NCCDPHP does reach a few dozen tribes with the \$30,000,000 investment. Dr. Bauer candidly explained that her center does not expect state health departments to work with tribes. Going into further detail, Dr. Bauer stated that over the last several years, NCCDPHP has worked instead with tribal-serving organizations and area Indian health boards to reach tribes more directly with the funds allocated. She also informed the committee that NCCDPHP has requested a \$15,000,000 tribal budget line item in CDC's budget. Dr. Bauer acknowledged that although \$15,000,000 may not be a large amount, a consistent budget line for tribes will emphasize a moral obligation to support tribes and that the dollar value investment could be grown. She concluded by requesting input from the committee on this matter.

Ms. Ileen Sylvester, Alaska Area Authorized Representative, provided her comments on the CDC budget. She stated that funding for colorectal cancer screening was a funding area that worked well for the state of Alaska. The money was used to create an innovative approach to providing cancer screenings. She explained that tribes used the funding to make cancer screenings more affordable as they were able to provide them without needing a medical doctor to sign the order. Ms. Sylvester thanked Captain Hennessy for his center's partnership in providing colorectal cancer screenings to Indian Country.

Dr. Bauer replied by stating that her center, NCCDPHP, understands the different health system structure in Alaska. She also explained that the colorectal cancer grant highlighted a problem with the way CDC competes for certain types of funding. For example, this opportunity was "open competition," meaning tribes competing for these funds competed openly against far more competitive applicants, making it very challenging for tribes to qualify high enough in the scoring system to be selected and awarded the funds. Dr. Bauer proposed the solution to differentiate allocating funds in the opportunity announcement. She shared that there is the opportunity to explicitly state that a certain amount of funds will be awarded to states, another amount to locals, and another amount to tribes. This created competitive categories within the open competition and promotes the likelihood that a tribe can successfully compete for the funding. She concluded by stating that the difficulty tribes have while competing for funding is an issue CDC is working to solve.

Captain Hennessy stated that he is not aware of the requirements CDC has to fund awards directly to states and ensure states interact with tribes. Typically this is simply "encouraged" without any actual accountability. This makes the actual tracking of disbursements to the states down to tribes almost impossible. He suggested that embedding tracking requirements into the opportunity could help the agency to improve accountability and reporting. He also championed the technical assistance form of support as a way for the agency to give time and expertise to Indian Country and advance the impact of work in situations where funding may not be available.

Next, President Killsback invited Dr. Bauer, as well as all present, to explore his culture by participating in the Northern Cheyenne marathon. He then responded that accountability vehicles, like MOUs with tribes, are a powerful tool. He suggested that the agency establish a standard across the centers for this type of mechanism. Tribes can also create resolutions that will facilitate and prioritize state-tribal relationships, while depoliticizing the health of Native persons.

Mr. Larson, extended an invitation to those assembled to visit the Urban Indian Health Institute epidemiology center, before requesting that each center, institute, and office representative speak about their individual strategies for improving funding to tribes.

Dr. Hazel Dean, Deputy Director, NCHHSTP, stated that a lot of NCHHSTP's programs now follow an open competition format. Dr. Dean agreed to work with Dr. Bauer to include more sections to fund tribes in NCHHSTP's funding announcements.

Dr. Donna Knutson stated that a lot of tribes applied for NCEH's safe water grant. Unfortunately, none of tribes were funded. Dr. Knutson agreed that perhaps CDC needs to earmark monies to tribes within the opportunity announcements. She strongly encouraged those assembled to reach out to the center for technical assistance as needed for the center responds to 100% of all technical assistance requests.

Councilman Antone acknowledged that CDC is moving in the right direction to improve funding for tribes. He advised of the upcoming break before the next session. He reminded those present of the photo opportunity and the evening dinner at the Buckhead Diner.

TAC Chairman, Councilman Chester Antone concluded the session.

Roundtable Discussion with Senior Leaders: Tribal Strategies for Connecting Cultural Practices to Evidence-Based Interventions to Promote Tribal Practices in Competitive Funding Opportunities

CDC roundtable discussion participants included

- Dr. Ursula Baur, Director, NCCDPHP
- Dr. Debra Houry, Director, NCIPC
- Dr. Patrick Breyse, Director, NCEH and ATSDR
- Captain Tom Hennesy, Director, Artic Investigations Program, NCEZID

Ms. Sylvester started the discussion by stating that healthcare for AI/AN should focus on spiritual, physical, and mental dimensions of health and that there is a need to focus on what is important to an individual. She shared the metaphor of getting a bird on target and expressed that when a change is made in an individual that causes a change in the family, which causes a change in the

state, which ultimately causes a change in population. Ms. Sylvester acknowledged that some cultural practices may not align with evidence-based measures. She requested CDC/ATSDR partner with Indian Country to align their practices with evidence-based measures. She believes that increased site visits by the agency may improve understanding of Native American culture and provide the opportunity to evaluate cultural practices. She also expressed that trauma plays a role in chronic issues and in order to have the best outcomes it is critical to identify strengths within the community and build upon them. She relayed that surveillance is being conducted at TECs on wellness and protective factors for positive health.

Chairman Robert Flying Hawk started off by thanking CDC for allowing him to share the ways of [his] people. He affirmed his belief in health and wellness. Policy integration was expressed as the ultimate acceptance of tribal way of life. He shared that, historically, tribes have a healthy way of life yet there has been a surge of non-communicable diseases like cancer, diabetes, and heart disease. He asked that CDC/ATSDR recognize tribes as human beings and to honor their ways. Chairman Flying Hawk shared that the medical community now recognizes Native American traditions. He also expressed that water protection is a form of prevention health strategy. For example, the Yankton Sioux tribe's water is being contaminated causing a concerns over how this will impact health.

Dr. Bauer shared that her center is taking a holistic approach to tracking protective factors. She also stated that programs based on increasing resiliency can be evaluated and shared around the country.

Dr. Houry stated that her center observes many conditions being deeply intertwined—for example, opioid abuse, domestic violence, and suicide. Protective factors are a critical component of a solution. She believes that the Native programs that promote resiliency could greatly benefit both Native and non-Native communities. She would appreciate the opportunity to evaluate and promote those which show demonstrated evidence of success as models of prevention.

Councilman Antone shared that each tribe has its own creation story, gender roles, and ceremonies, however federal grants do not capture this cultural wisdom. He requested HHS evaluate cultural practices and value the government to government partnership. He said the Tribal Behavioral Health Agenda (TBHA) recognizes cultural wisdom and is built upon ancient practices to advance health and promote healing. Colonization destroyed Native American culture, but it is possible bring back what was taken. The TBHA preserves and honors culture. He also stressed to CDC/ATSDR that three years is an insufficient period of time for a grant that focuses on resiliency. Five years would allow more time to connect traditional practices to evidence based practices.

Chairman Flying Hawk acknowledged the Substance Abuse and Mental Health Services Administration's work on youth suicide prevention known as, Helping Our People Endure. He expressed regret for the discontinuation of the traditional foods program which was effective. He

understands that CIO directors allocate programming funds, therefore a letter has been sent to Dr. Schuchat.

Ms. Sylvester asserted that culturally relevant language should be incorporated into FOAs. She asserted that every funding opportunity should lend value to the applicability of cultural wisdom in addressing public health issues. She recommended that when CDC does a project there should be an evaluation by a cultural evaluation specialist. She requested that CDC develop and support evaluators with this expertise. In addition, Ms. Sylvester requested that funding opportunities have longer project periods, beyond five years, with a non-compete clause for long-term sustainability. She shared with those present that Native communities have many unique intervention strategies—such as talking circles and storytelling—that are pillars of family-based interventions. Community runs (e.g., 5k, 10k, marathons) are another common way of connecting with health and history as these are held on ancestral homelands and there is much ceremony around these events. Lastly she shared that tribal leaders must be approached before engaging in any form of research. Ms. Sylvester asked for examples of tribal strategies that have translated into evidence.

Dr. Bauer mentioned pages 24–25 of [“CDC and Indian Country Working Together”](#) as examples of evidence-based tribal practices and strategies. She shared that language from this document will be included in future FOAs. She highlighted that the GHWIC cooperative agreement used tribal evaluators for monitoring and reporting. Dr. Bauer acknowledged the traditional foods program is no longer directly funded however her center did make an attempt to incorporate traditional foods under this cooperative agreement.

Chairman Flying Hawk asked for a risk assessment plan to identify hazards associated with pipeline malfunctioning. Dr. Patrick Breysse, Director, NCEH/ ATSDR, replied to Chairman Flying Hawk’s concern. He shared that ATSDR is involved in municipal water break investigations and would be happy to assist with preparing ways to identify and mitigate environmental risks in Indian Country.

Vice President Jonathan Nez shared success stories of tribes that are reclaiming their food system (i.e., food sovereignty). He also advised that language, tradition, and way of life are essential to the survival of native people, stating that Navajo Nation would like to bring elder practices into the 21st century. For example, by focusing on gardening and hunting, Navajo people bring health and wellness into the community and promote intergenerational teaching. Navajo Nation challenged the cultural appropriateness of retail supermarkets in Indian Country and the retailers are providing native foods.

President Killsback stated the resurgence of our culture is the strongest weapon to fighting disease. Tribal liaisons to coordinate communication and tribal-specific grants to limit competition are essential to administering programs for tribes. However, he noted trends in eliminating programs that benefit tribal communities.

Captain Hennessy discussed the importance of the trifecta of human-animal-environment. He shared CDC uses this approach to look at infectious diseases in Alaska. He mentioned the CDC Alaska One Health workgroup that shared environmental observations, which he believed was an effective method to monitor environmental effects.

In closing, Ms. Sylvester gave two recommendations. Her first recommendation was to develop an open items list that is periodically shared in the form of status reports during TAC meetings. The second recommendation was to create equitable scoring for culturally appropriate practices within FOAs.

TAC Chairman, Councilman Chester Antone concluded the session.

Roundtable Discussion with Senior Leaders: Tribal Priorities for the National Center for Injury Prevention and Control

CDC roundtable discussion participants included

- Dr. Debra Houry, Director, NCIPC
- Ms. Amy Peeples, Deputy Director
- Ms. Angela Marr, Acting Director, Division of Analysis Research and Practice Integration (DARPI), NCIPC
- Ms. Rachel A. Kossover, DARPI, NCIPC
- Captain Holly Billie, Division of Unintentional Injury Prevention (DUIP), NCIPC
- Ms. Lindsey Culp, DUIP, NCIPC
- Ms. Reshma Mahendra, DUIP, NCIPC
- Ms. JoAnn Yoon-Kang, DUIP, NCIPC
- Dr. Asha Ivey-Stephenson, Division of Violence Prevention, NCIPC

The cross-sectional panel was introduced by Dr. Houry as she addressed the TAC with greetings and a sincere appreciation for the opportunity to update them on activities of interest across the center. Panelists received a copy of the advisory committee's briefing document for the discussion session and collaborated to respond to the questions therein.

Captain Holly Billie fielded the first inquiry regarding the center's intention to continue its motor vehicle crash-related work with tribes. Captain Billie shared that there have been two historical rounds of direct funding to tribes, the first from 2004–2009 and the second from 2010–2014. While this work was conducted directly with 12 individual tribes, the outcomes of the work were successfully assimilated into a best practices guide by CDC and other agencies involved in this work. This guide was a direct request from Indian Country and was released in November 2016. Now that the guide has been in the field for several months, the focus will shift toward evaluating the adoption and implementation of the guidelines across Indian Country. Additionally, the team is working on a collaborative project with FHA in which CDC will fund three positions within FHA that will serve as technical advisors/facilitators for tribes. It is anticipated that these positions will reach approximately 37% of all federally recognized tribes.

Dr. Houry continued the center's response to identified priorities, reporting that NCIPC is currently funding three TECs for the purpose of national violent death and injury reporting across many domains, including (but not limited to) opioid overdose, traumatic brain injury, and suicide. The state of Alaska released its National Violent Death Reporting System (NVDRS) report with specific AI/AN population data. NVDRS uses police department reports, medical examiner reports, and death certificates, which is critical in assisting with the identification of the causes that lead to violent death.

With regard to opioid abuse, Dr. Houry announced that the center has released its guidelines for prescribing opioids and that IHS had modified the guidance for their prescriber base. As the opioid abuse prevention program is very new, the program desires input regarding cultural messaging across Indian Country. There is also a desire to collaborate in the identification of opportunities to increase data surveillance around opioids in tribal communities. Currently, there is ongoing effort to identify and expand direct funding opportunities around opioid abuse prevention in Indian Country. Within this context there is effort being made to ensure each pilot has representation in its composition from at least one IHS tribal region.

NCIPS is also currently working with seven tribes in South Dakota and Indiana to fund rape prevention. Additionally, the center is preparing to launch a sexual violence prevention technical package and requests assistance from the advisory committee to review and provide feedback. Dr. Houry raised the concern that diligent effort was made to include tribes in the funding announcement opportunity language and this action did not prove effective as no tribes made the cut to receive funding. While the cooperative agreement will run for another four years before it is re-competed, project officers are working with the states to strongly encourage tribal engagement and inclusion. For example, Oklahoma has done a phenomenal job in including tribes. However, before the next round of funding is released, Dr. Houry stated that there is more that can be done to revise the funding opportunity to ensure that it is more effective in allowing successful tribal competition. Many opportunities to improve were already identified in the center's senior leadership discussion lead by Captain Billie after the awards were made. These have been recorded and will be used to guide the next funding opportunity development.

Council Member Carlyle addressed the CDC participants asking what CDC can do to work with IHS in its prescription drug monitoring program. She further asked about how to connect IHS reporting to local private reporting and inquired if there is any way that CDC can assist. She described the anecdotal risks that she has observed within the Ak-Chin Indian Community, such as pill bottles within easy reach of minor children. She explained that IHS does not have pain management specialists in house and must use limited Purchase and Referred Care funds to outsource for pain management. This prevents IHS providers from being able to manage the root cause of many patients chronic pain. This exacerbates opioid dependency and the cycle of dependence acts as a contributing factor to the suicide rate in Indian Country. Council Member Carlyle concluded by stating that there is an evident need for interagency collaboration around opioid abuse prevention.

Dr. Houry responded to Council Member Carlyle's concerns stating that the initial steps for CDC are well underway, including the published prescribing guidelines for all providers, the training curriculums in medical schools, continuing education requirements for licensed providers, development of patient support materials, and the incorporation of prompts in many electronic health record systems that facilitate safe practices that align with the recommended prescribing guidelines. Providers are strongly encouraged to check the state prescription drug monitoring programs but Dr. Houry acknowledged that she was aware of technical issues being worked through with the states.

Ms. Reshma Mahendra shared that CDC is working to identify the barriers to tribes with entering into the state prescription drug monitoring programs and determining which steps are required to address and remove these. Captain Billie has been reaching out to the tribes and the states to identify the specific barriers and is continuing to do so. Captain Billie reported that one recurrent barrier has been that the federal provider at the IHS facility is not required to register as a provider in the state. Lack of registration with the state has prevented access to the monitoring systems. Captain Billie also shared that the Division of Unintentional Injury Prevention will be watching carefully as IHS stands up its own prescription drug monitoring program.

President Killsback expressed his thanks to the discussants for the information shared thus far. He relayed that for his region and more specifically for his tribe, Eastern Band of Cherokee, they have identified injury prevention as a tribal priority. With regard to the center's funding of the TECs. President Killsback implored the center to please consider funding not just three, but all, TECs. He stressed that the centers are relatively new and need appropriate funding and technical assistance in order to develop long term capacity.

In addition, President Killsback remarked that domestic violence prevention messaging within tribes and across Indian Country is insufficient to fully address the needs. He stated that he would like to see an investment by the agency through a grant vehicle which could support the legal infrastructure within tribes to use policy in addressing domestic violence prevention. Within the Eastern Band of Cherokee tribe, a comprehensive law/policy approach is currently under review. He asks that CDC align with tribal goals by helping tribes to better share their successes in injury prevention with other tribes as well as non-tribal communities who could learn from Indian Country. In addition, he asked that the agency continue to share identified best practices and he expressed that there is a vast need for public health teaching in native communities. President Killsback requested that an effort be made to facilitate this learning. He shared that his own tribe desperately needed the IHS five-year funding around health promotion and disease prevention but missed the application window. As such, the tribe has had to invest its own funds into the critical work and seek out administrative support.

Mr. Larson, acknowledged CDC for participating in the TBHA. He expressed that he would like to see this partnership expand and not stall. In addition, he championed the strategy of a multi-agency approach and supported the use of this strategy to combat other areas of concern in public health. He also wanted to advocate for increased funding for and assistance to TECs. He made attendees aware that Congress recognized the TECs as being official public health authorities, responsible for the performance of the 10 critical public health functions for Indian Country. Through supporting them more, the entire native public health infrastructure is strengthened.

Principal Chief Lambert yielded a minute of his time to Ms. Kate Grismala, assistant director for the United South and Eastern Tribes Tribal Epidemiology Center. Ms. Grismala explained that the center represents 26 tribes and covers the largest regional area of all the TECs nationwide. She thanked NCIPC for its robust presentation. She shared that the TECs provide both data and services. For example, many tribal nations use the Resource Patient Management System Electronic Health Record. Of the 26 tribes her center serves, 19 are using this system. The center has access to this data source and can extract data as needed to help explore a public health concern within a particular tribe or across several tribes. However, there are three areas in which the center struggles and could use the agency's assistance:

- 1A. The absence of a desperately needed "magic button" which would create an interface between the Resource Patient Management System and the Prescription Drug Monitoring Program(s). Essentially there is the need for a software bridge but IHS lacks the resources to build it at this time.

1B Another challenge with prescription drug monitoring programs is with tribes whose boundaries sit on or cross state borders. Eastern Band of Cherokee is one such tribe. They volunteered to serve as a pilot for a solution project, which has also been suspended due to budget constraints.

2. The TEC did a “mini-pilot” around suicide data. They taught providers and medical record coding staff to use the suicide reporting form. Funds are desperately limited to expand this pilot project, but technical assistance is still requested. The center would very much appreciate an opportunity to expand the pilot work.

3. Provision of culturally appropriate, cross-departmental techniques is needed to address opioid abuse prevention. Use of a model such as the Talking Circles program used in Alaska could prove an effective approach to this serious public health issue.

Chairman Flying Hawk shared many thanks for the center’s participation in the discussion. He expressed that help from NCIPC is deeply desired at the Great Plains Area Tribal Epidemiology Center and for the health directors of the clinics in the region. Many of the health directors lack public health knowledge and experience and yet their patients could greatly benefit from public health prevention strategies. Subject matter expertise and technical assistance from NCIPC and CDC could have far reaching impact in the Great Plains Area.

Ms. Pivec shared a word of caution with those assembled. She stressed that CDC needs to be aware that not all TECs are the same. In fact, they are wildly diverse in their capabilities and resources as well as in the type of work that they do within their respective regions. Because of this, it is not recommended that the agency only fund TECs. It is necessary to afford funding opportunities to the centers, to individual tribes, and to other tribal serving organizations.

Councilmember Carlyle shared that slips, trips, and fall prevention is an ever increasing need for many tribal nations as they continue to age. She also asserted that in funding opportunities where money must go to the state and not to the tribe, CDC needs to make certain that there is accountability for the funds passed from the state to the tribes. She requested that the agency build and monitor these accountability mechanisms into all current and future FOAs.

Dr. Houry thanked the committee. She concluded by stating that NCIPC appreciated the opportunity for partnership that the committee has presented.

TAC Chairman, Councilman Chester Antone concluded the session.

Break for Lunch

Tribal Priorities for the National Center for Chronic Disease Prevention and Health Promotion

CDC roundtable discussion participants included

- Dr. Ursula Baur, Director, NCCDPHP
- Dr. David Espey, NCCDPHP

Panelists received a copy of the advisory committee’s briefing document for the discussion session and collaborated to respond to the questions therein.

Dr. Bauer started the discussion by providing a brief history of the activities of the center and its engagements and investments in Indian Country. She stated that in the past 25 years, NCCDPHP has funded tribes in a “scattershot way,” through multiple programs, such as tobacco, cancer and diabetes. The GHWIC program was developed to create a mechanism that could bring together funding from multiple programs and focus on cross-cutting strategies to address disease prevention. She stated that currently 3% of NCCDPHP’s budget is going to Indian Country. However, she expressed that there is room for improvement. Dr. Bauer further explained that NCCDPHP has very specific budget lines in terms of what diseases and programs it is authorized to fund and that the language attached to the funding is very detailed and specific. One program effort which she highlighted was the Division of Population Health’s Behavioral Risk Factor Surveillance System (BRFSS). She explained that through BRFSS, her center has worked with Indian Country to do tribal specific surveillance surveys. Dr. Bauer assured the committee that NCCDPHP can look to partner more of their investments in the BRFSS.

Dr. Bauer stated that the Prevention and Public Health Fund (PPHF) was funded at approximately \$1,000,000,000 under the Affordable Care Act (ACA). Congress is currently working to repeal and/or replace the ACA, which could potentially eliminate PPHF. She explained that 35% of her center’s programs are funded through PPHF. She concluded by stating that NCCDPHP is committed to continuing GHWIC and that her center’s priorities will focus on bringing funding together to address health disparities in a holistic manner.

Councilman Antone asked about the requirements for working with the IHS Special Diabetes Program for Indians and CDC’s National Diabetes Prevention Program. Dr. Bauer replied by stating that NCCDPHP is working with IHS to align the programs and expedite the enrollment process. She stated that her center has received input from IHS that Medicare reimbursement is a very big financial lift for their agency. Her center is hopeful that Medicaid reimbursement for ages 40-65 can eventually be achieved as well. NCCDPHP hopes to work with the Center for Medicare and Medicaid on this issue in the upcoming years.

Councilman Antone asked about Dr. Bauer’s comments to the recommendations handed to her at the beginning of session by the committee.

Dr. Bauer explained that in terms of recommendations, NCCDPHP does not have a formal policy to allocate 2–4% of their total budget to tribal health. However, NCCDPHP does have a 25-year commitment to improving tribal health. She asked tribes for guidance on how to proceed with their recommendation to have a colorectal cancer program in each tribal region. NCCDPHP's comprehensive cancer program funds a total of \$21,000,000 to seven tribal grantees, at 7% of that program's total budget. Dr. Bauer explained that while she would be glad to meet the 2–4% Chief Lambert proposed, in certain scenarios such as this one, 2–4% would not be a sufficient percentage. She stated her support of funding tribes directly as well as reaching additional tribes through consortia, tribal serving organizations, and TECs. Dr. Bauer asked the committee for guidance on finding a funding formula that does not limit a larger reach in Indian Country. Councilman Antone replied that the committee would get back to her on this matter.

Ms. Pivec highlighted the issue of tribes and accreditation. She stated that tribes are focusing more on building infrastructure and planning for public health accreditation. She explained that by doing so, tribes hope to make themselves more competitive for FOAs. Dr. Bauer stated that this is a standard in all of the center's FOAs. It states that an awardee may dedicate \$5,000 or 5% (whichever is more) of the award towards efforts to achieve accreditation.

Ms. Pivec imparted that having been the first tribe to achieve accreditation, she is keenly aware of what types of activities can best help an awardee to ready themselves for the accreditation process. However, she expressed concern that many awardees would not know how to begin. She felt that the activities should be more clearly exemplified in the language of the funding opportunity which authorizes the dedication of the 5% or \$5,000, so that more tribes would take advantage of this little understood opportunity. Dr. Montero also shared that there is a group within OSTLTS dedicated to identifying barriers around the accreditation process. The group also strategizes on ways to address these barriers.

Principal Chief Lambert stated that in his tribe there is an issue of hepatitis C in a specific area, known as a cluster. Dr. Bauer explained that NCHHSTP would be able to assist with this and she would gladly connect Principal Chief Lambert.

Mr. Larson stated that there exists an opportunity to share "mutual technical assistance" between tribes and the agency. He stated that a mechanism to do this needs to be developed so that cross collaboration can occur. He offered his tribe to work with TECs and area Indian health boards to develop a workgroup, which could address public health issues in partnership with the agency.

Dr. Bauer asked for the committee's recommendations for ensuring the continuity of GHWIC and for additional input on a potential tribal liaison position which was requested for her center in the committee's priority briefing. Ms. Lisa Pivec, yielded her seat to Mr. Robert Foley, Chief Program Officer for NIHB. Assuming the seat, Mr. Foley stated that this recommendation has been suggested to each center, institute and office. He explained that the liaison position would serve in a variety of outward and inward facing roles. An example of an inward facing role would be to serve as a direct liaison to TSU. In addition, each tribal liaison officer would work with the center to help build

capacity in Indian country and could serve as a project officer to tribal grantees. Mr. Foley yielded the seat back to Ms. Pivec. Ms. Pivec thanked Dr. Bauer for making her center such a great model.

Dr. Bauer acknowledged the recommendation, but informed the committee that CDC cannot create a field office (another of the recommendations from the briefing document). However, she stated that HHS did have this authority. She explained that it has been difficult to recruit tribal members to an Atlanta-based office. Dr. Bauer suggested that perhaps the Albuquerque office can help with this. Addressing the next recommendation in the briefing on improving tribal access to data, Dr. Bauer stated that the center has a Youth Risk Behavior Surveillance System (YRBSS) and a National Program of Cancer Registries, but that there are a multitude of other registries across CDC. She shared that her center spearheads the data linkages project to ensure that AI/AN data is complete. She committed to working harder to ensure that there is access to these resources.

Next, Dr. Bauer asked about guidance from the committee regarding social media and marketing for Native Americans. She cited the successful and innovative work of the Tips from Former Smokers campaign with two participants being Native American. She stated that the advertisements were well received. Ms. Pivec stated that her tribe does not have the funding or resources to produce quality campaigns like CDC, and expressed her hope that the agency would continue to develop these cultural relevant outreaches in collaboration with Indian Country.

Principal Chief Lambert asked Dr. Bauer how the idea for GHWIC came to be. Dr. Bauer explained that in 2014 she put together chronic disease funding to develop programs to address specific tribal needs that she had become aware of throughout her years of attending TAC meetings. She advised TAC members to remain vigilant when opportunities arise, so that when one program sunsets, another may rise.

Ms. Pivec thanked Dr. Bauer for educating the TAC on her center's challenges.

Mr. Larson acknowledged the need for capacity building in Indian country and thanked Dr. Bauer for the efforts put forth by NCCDPHP.

Captain Clelland contributed by stating that under Dr. Montero's leadership, OSTLTS has provided guidance to strengthen state, tribal, local, and territorial support through various subcommittees. He concluded by stating that he is working towards building capacity and improving infrastructure through a variety of opportunities, such as orientation and trainings for new tribal health officials and a concept paper on tribal health diplomacy.

Councilman Antone closed the session and ceded the chairman position for the remainder of the meeting to the Vice Chairman, Vice President Johnathon Nez.

Tribal Public Health Capacity in Emergency Preparedness and Response

CDC roundtable discussion participants included

- Gregory Smith, Division of State and Local Readiness, OPHPR

Mr. Smith received a copy of the advisory committee's briefing document for the discussion session and collaborated to respond to the questions therein.

Mr. Smith thanked the committee for having him present at the discussion. He opened by reiterating the information provided in the senior leadership discussion session on budget by OPHPR director, Rear Admiral Redd. He stated that the Pandemic and All-Hazards Preparedness Reauthorization Act will be up for review in 2018. While OPHPR does not have the statutory authority to directly fund tribal nations at this time, this review will be a strategic opportunity in which tribal nations can voice their desires for direct funding in the reauthorization.

Mr. Smith began with a brief statistical overview for the committee stating that 34 states funded by the PHEP cooperative agreement had tribes residing within their state borders. Of these 34, only 23 currently fund tribes through a sub-award under the agreement. Historically, the office has strongly encouraged states to be inclusive of tribes. The new agreement language further strengthened this by incorporating requirements that encourage routine reporting on tribal engagement efforts and outcomes. Yet there remains opportunity even without direct funding to ensure more robust engagement. Opportunities discussed include having states work with tribes to establish MOUs and submit these along with their applications; creating and reporting established points of contact between the tribe and the state; reporting on jurisdictional risk and hazard vulnerability; and identifying what the needs are to ensure public health emergency readiness for tribes within the state. Mr. Smith acknowledged that there are still more strategies to promote the state accountability to tribes around emergency preparedness. While such activities may not be a substitute for direct funding, they can certainly help to ensure that states are more diligent in funding tribes.

Mr. Larson yielded his seat to Dr. Jennifer Giroux, member of the Tribal Public Health Work Group and Medical Epidemiologist with the Northern Plains Tribal Epidemiology Center. Dr. Giroux shared that under the administration of Dr. Julie Gerberding (former CDC director), tribes saw, for the first time, language requiring states to work with tribes in the state. While this language has worked in some instances, in many others it has been less effective. Some states, in lieu of funding, placed a career epidemiology field officer in Indian Country and this action, where it occurred, was extraordinarily effective for the public health capacity development of tribes. Many tribes still need this type of expertise within their region so that they can successfully develop emergency preparedness plans and strategies. She highlighted the Navajo Nation and stated that, for several tribes, the coordination of resources is highly complex and is unlikely to be manageable by an individual with less experience. Dr. Giroux stated that career epidemiology field officers would cost the agency approximately \$200,000 per officer for annual salary, but she strongly suggested that funding to place an officer in each of the 13 regions be explored as a capacity building solution strategy. Dr. Giroux then returned the seat to Mr. Larson.

Mr. Smith shared that the Navajo Nation is the only tribe to have completed “Receive, Stage and Store” training, a critical training for emergency response using the Strategic National Stockpile. In addition, the nation has garnered strong support from the state of Arizona which currently funds the tribe at the highest rate of any state in the country. This proactive work by the tribe and the engagement by the state is raised up as a model for what an effective relationship should look like and needs to be replicated across the United States.

Principal Chief Lambert asked Mr. Smith to identify the specific statutory barrier in the direct funding of tribes under the Pandemic and All-Hazards Preparedness Reauthorization Act. Further he inquired as to why the act was written in a way that would be exclusionary to tribes. Addressing the tribal nations present at the meeting, Principal Chief Lambert encouraged them to be vocal with their congressmen, so that the act is amended in 2018 to specify that tribes can be directly funded if they are able to meet the necessary requirements.

Mr. Smith concurred that the only influence the agency has at this juncture is in the strengthening and clarifying of the language of the FOAs. The FOA language cannot conflict with statutory language, but it can define the parameters of funding enactment. Principal Chief Lambert again addressed the tribal audience stating that the National Congress of American Indians, as well as groups like the United South and Eastern Tribes Impact Group, could really do some substantial work on getting tribes recognized for direct funding. Principal Chief Lambert requested that Mr. Smith please share the actual statutory language as well as the current FOA language with him so that he could initiate momentum toward this objective. He shared that the irony is that the Eastern Band of Cherokee actually funds their state in preparedness activities, so there is clearly a need to work together for the betterment of society. However, this can only happen if tribes have equal opportunity to achieve national preparedness goals.

Mr. Larson, concurred with Principal Chief Lambert’s assessment.

Vice President Nez requested that the information shared by Mr. Smith, be shared with the entire committee and he offered to do this.

Vice President Nez yielded his seat to Mr. Del Yazzie, authorized representative for the Navajo Nation and Acting Director for the Navajo Nation Epidemiology Center. Mr. Yazzie wanted to follow up on Dr. Giroux’s request for career epidemiology field officers at each TEC. The expertise and capabilities of a career epidemiology field officer would greatly augment the capacity of each center to respond to infectious disease threats like Zika, Ebola, and Hanta viruses, as well as to contaminations and spills and other such disasters which impact public health. Their knowledge could be shared within the TEC to increase the skill of the workforce in general. Mr. Smith agreed to bring this suggestion to his senior leadership. Mr. Yazzie returned the seat to Vice President Nez.

Mr. Larson yielded his seat to Ms. Carolyn Hornbuckle, Director of Public Health Policy and Programs for NIHB. Ms. Hornbuckle relayed that direct funding to tribes is crucial to ensuring the preparedness of Indian Country to respond in a disaster or outbreak and that this need has to be prioritized. She affirmed that it is a critical component of the federal trust responsibility to tribes. Mr. Smith expressed that his office appreciated the engagement of NIHB within the Zika response. He shared that the board has been funded by his office and that the work contributed has been impressive. He also shared that the board is one of the first tribal organizations to ever be funded by his office. Mr. Smith affirmed that the opportunity to partner has been welcomed. Ms. Hornbuckle expressed thanks for the role the board has been able to play in the response activity. Ms. Hornbuckle returned the seat to Mr. Larson.

Principal Chief Lambert expressed that upholding tribal sovereignty is a responsibility of the federal government as well. He stressed that this is another factor in the need to directly fund tribes as many tribes cross state lines and are therefore forced to coordinate with multiple states for funding. He asked if, with regard to additional Zika dollars, there is a plan in place to work toward the direct funding of tribes. Mr. Smith reaffirmed that Congress has not yet appropriated this funding and therefore the agency does not know the mechanism contained within the appropriation and cannot fully respond to this inquiry at this time.

As there were no further inquiries by the committee, Vice President Nez closed this session.

Tribal Public Health Workforce in Surveillance and Epidemiological Data

CDC roundtable discussion participants included

- Umed A. Ajani, Division of Health Informatics and Surveillance, Center for Surveillance, Epidemiology, and Laboratory Services (CSELS)
- Captain Kristine Bisgard, CSELS

Panelists received a copy of the advisory committee's briefing document for the discussion session and collaborated to respond to the questions therein.

Vice President Nez opened the session and welcomed the panelists. Captain Bisgard and Mr. Ajani stated that they did not have a formal presentation and they asked the committee how they should proceed. Vice President Nez advised that the panelists respond to the briefing document presented.

Going in order through the briefing document, Captain Bisgard addressed the committee regarding the EIS program. She reported that while the program's total numbers are down there remain approximately 70 EIS officers. EIS officers are a diverse group in order to meet a wide range of needs. The program for EIS officers is two years in length and requires the commitment of a supervisor with the appropriate experience and background in epidemiology at the host site location. In order to place an officer into a TEC, there would need to be strong supervision. The

current mix of EIS officer backgrounds is approximately 50% physician and 50% PhDs or veterinarians. Currently, the program has one EIS officer in Indian Country located at the North West Portland Area Health Board.

Regarding laboratory services, Captain Bisgard stated that there is a separate division that does training and lab services, but that is not an area of expertise represented on today's panel. She advised that she will make sure these questions get back to the appropriate division for a response to the committee

Mr. Ajani responded to the concerns regarding the Nationally Notifiable Disease Surveillance System (NNDSS), stating that while CSELS plays a critical role in collecting the clinical data, not all the data comes through their center. He explained that the process is complex. For example, a given condition becomes reportable when a state or jurisdiction decides that the condition is to be designated as reportable and/or notifiable. At this juncture the condition is given a case definition. Agreeing to a case definition is the first hurdle that must be overcome in order to coordinate a national system. And once the case definition is agreed to, the definition itself can change as new scientific knowledge is acquired. An epidemiology work group must then approve the final case definition. CSELS publishes the overall reports yearly in the MMWR. In addition, they are made available online at data.cdc.gov and wonder.cdc.gov. Responding to a question about how CSELS ensures that the designation of AI/AN is properly documented, Mr. Ajani shared that it was his understanding that there are jurisdictional reports, which include this characteristic, that are submitted within the jurisdiction and/or state.

Vice President Nez stated that there are Native American health care facilities (IHS, Self-Determination Tribes, and Urban Indian Centers) and non-Native health care entities throughout the nation and that many health care workers do not check the AI/AN box. The impact of this is that when the information goes to the state, it is never counted at the tribal level. Getting data that is accurate is a really challenging problem for tribal nations. He asked the panelists how to go about training these facilities on the criticality of appropriately completing forms to identify AI/AN, especially down to the associated tribal level where possible. Mr. Ajani stated, that having worked with AI/AN data in the past, he does understand the concern. One thing that comes to mind is that CSELS could work with other organizations. CSELS serves as the subject matter expert but the boots on the ground assistance is what is required to improve the quality of the data reported.

Mr. Larson yielded the floor to Dr. Giroux. Dr. Giroux shared that at Great Plains Area Indian Health Service, in the past one and a half years, there has been a turnover in the TEC director seven times. She shared that the center covers a four state region, approximately 70,000 people, with 17 different tribes. She reported that the lack of stability detrimentally affects public health capacity. She asked about the potential to assign career epidemiology field officers (CEFOs) to the TECs. She shared that professionals with that level of training could exponentially increase capacity and

prepare the center to be better able to make use of the many other CDC trainings and resources that are available. However, the constant state of change with no continuity has been damaging to the TEC's ability to establish knowledgeable infrastructure. For example, in the area the rates of gonorrhea and chlamydia among the local population are already at 40–50%. Dr. Giroux stated that Great Plains Area has some of the worst disparities in the country. Dr. Giroux also made a response to the NNDSS discussion. She explained that in South Dakota, there is one health care worker who has been diligently dedicated to ensuring that missing AI/AN data is reported on all forms. She has single-handedly completed over 800,000 forms. Whereas, across the border in North Dakota, 40–60% of all forms are submitted without the AI/AN data properly completed. There are many examples already at CDC that have improved data linkages such as the collaboration with IHS on immunizations. There are lessons in these successes that can be extrapolated and applied to the NNDSS concerns. Mr. Ajani shared that both the Council of State and Territorial Epidemiologists and the Association for Territorial and State Health Officials are partners of CSELS. CSELS can engage further with these partners to identify possible tools and strategies to address the data concerns.

Dr. Giroux reported that the biggest barrier is always the small “n” (i.e., the small population numbers in many tribes). For example, on a single reservation there may be four out of five counties. Within each separate county, the tribal “n” is too small to report. However, if the counties could be collapsed to identify the tribal “n,” then that collapsed number could be reported back to the tribe. She asserted that there is previous work around this concept. Dr. Giroux ceded the seat back to Mr. Larson. Mr. Ajani stated that these models can be examined.

Vice President Nez opened the floor for discussion.

Principal Chief Lambert, expressed that he understood that a portion of the center's efforts revolve around the collection of data and he asked the panelists if there is direct collaboration with the United States Census Bureau and their population surveys. Mr. Ajani mentioned that only a very small portion of the work within CSELS is on data collection. However, he was aware of collaboration with the Census Bureau for the National Health and Nutrition Examination survey (NHANES) within the National Center for Health Statistics, which is a separate center from CSELS.

Principal Chief Lambert asked if there were efforts being made to bring young AI/AN people on board through the center. Captain Bisgard responded that that the Public Health Associate Program under OSTLTS is one such effort. Also, she shared that the EIS program is another opportunity. She informed the group that regional presentations are done to diverse audiences and that local tribes are invited to these presentations. The participants are MD, PhD, and DVM-level practitioners and tribes are strongly encouraged to send one participant. The next presentation will be in Arizona.

Dr. Montero spoke on behalf of Public Health Associate Program, stating that there are currently eleven students placed at AI/AN site locations. He suggested that there be exploration into a collaboration between PHAP and the career epidemiology field officer program to explore

opportunities to partner and place both a career epidemiology field officer and a public health associate at a shared location in Indian Country.

Principal Chief Lambert invited Dr. Montero to come visit the Eastern Band of Cherokee facilities, meet the students from the community, and see if it would be a place with the appropriate programmatic and supervisory components for a PHAP host site.

Ms. Pivec stated that her tribe has young students that are still in high school who could start preparing now to enter college with a plan to apply to the PHAP program post-graduation. She asked CDC how to initiate this type of relationship. Dr. Montero replied that OSTLTS could certainly start working with Cherokee Nation to collaborate around this goal. Dr. Montero concluded by assuring Ms. Pivec that he would reach out to her after the meeting.

Captain Bisgard mentioned that CSELS has a program called Science Ambassadors, designed for middle and high school teachers where training is provided to the teachers to take back to their communities. The objective is to promote interest in science for young persons

Vice President Nez stated that there exists an opportunity through these types of strategies to “grow our own,” meaning that investing now in continued learning through programs like PHAP and EIS targeted in Native communities is a developmental opportunity to grow the workforce skill sets to improve public health capacity. The Navajo Nation hosts one of the eleven PHAP students currently working in Indian Country. Many tribes invest heavily in scholarship funding but only rarely do the students return to work long term in tribes. It was advised that tribes need to think more strategically about supporting such workforce skill building programs for degreed students.

Vice President Nez yielded his seat to Mr. Yazzie, who asked the panel if they could describe more about how the EIS opportunity came about in the Portland area as he understands that the supervision component was challenging. Captain Bisgard stated that the Northwest Portland Area Indian Health Board had a position occupied by a person with a master’s degree in public health who had completed the two-year placement as an EIS officer. After completion of the EIS officer training, this individual was recruited to supervise a new EIS officer to be placed at his site location. To be approved, he was required to commit to supervising the officer for the duration of the officer’s two-year training period. This commitment was critical in gaining the approval as an individual with a master’s or doctorate level degree and demonstrated, extensive epidemiology experience must supervise each placement. As a side note, prior to placement, Captain Bisgard shared that a site visit is conducted.

Vice President Nez, thanked the panelists and closed the session, opening the floor for oral tribal testimonies.

Tribal Testimony

Eastern Band of Cherokee Indians: Oral testimony entered into record by Principal Chief Patrick Lambert.

Principal Chief Lambert stated that health care is a component of the US government's federal trust responsibility to AI/AN tribes. Health promotion and disease prevention are included in the overarching concept of health-care. He stated that AI/ANs comprise approximately two percent of the total population. He asserted that AI/ANs suffer disproportionately from chronic diseases, the causes of which are influenced by multiple generations of historical trauma.

For these reasons it is reasonable to assume that AI/ANs should receive significant attention and support from CDC for public health activities. However, based on historical funding allocations, this is clearly not the case. Aside from the recent allocation to Indian Country from NCCDPHP, there is very little else CDC has done to support public health and wellbeing of tribal citizens.

Some of the overarching questions from the Eastern Band of Cherokee include:

- How many more tribal citizens must die from often preventable diseases like diabetes, commercial tobacco use, second hand smoke, birth defects caused by drug use during pregnancy, unintentional injuries, cancer, poor immunization rates, Hepatitis C, and HIV?
- How many tribal citizens must contract infectious diseases such as Zika, Avian Flu, and West Nile virus?
- How many more tribal children must lose parents from the effects of drug overdoses, suicide, HIV and Hepatitis C following unintentional injuries and effects originating initially from appropriately prescribed opioids?
- At what point will the CDC step up and fulfill its responsibility to Indian Country to provide support through direct funding to tribes and TECs to provide public health services including health promotion and disease prevention activities?

The mission of CDC is a treaty obligation, as these are primary to health care. IHS treats illness but is woefully underfunded and therefore the job and mission of CDC on prevention and wellness is even more critical and important to tribes.

Native Village of Ekwok: Oral testimony entered into record by Ms. Ileen Sylvester, Vice President of Executive & Tribal Services, Southcentral Foundation.

Ms. Sylvester stated that she was in attendance at this same meeting three years ago and that the revised format has been very useful. Based upon what occurred this week, she shared that she is going to stay involved. She suggested that the committee maintain an open items list and that the agency update the committee on these items on monthly calls. She expressed appreciation for the cross pollination of ideas between the CDC center directors in attendance. She stated that she was hopeful that the discussions here will effect change. As mentioned earlier about her tribe's holistic

approach to health and wellness, she shared that this was done by asking a lot of questions. The tribe and other associated tribes focused on what was important to native peoples. The tribes examined these issues and explored what was working and then began to model this elsewhere. She expressed her thanks to the agency and stated that she was looking forward to things being tracked.

Cherokee Nation: Oral testimony entered into record by Ms. Lisa Pivec, Director Community Health Promotion.

Ms. Pivec stated that she had just a few brief comments. First, she too wished to remind the agency about the federal trust responsibility in the building and sustaining of the public health infrastructure. She advised that the agency needs to help build the figurative bridge between clinical healthcare delivery and public health. She asked that the agency keep cancer screening and diabetes prevention programs on their radar. She also mentioned that the agency has a responsibility to connect cultural practices and evidence-based interventions and that they could examine the linkage through exploring the many long-standing youth-to-elder programs in various tribes. Lastly, she shared that her tribe is doing a lot on its own dime, like with YRBSS. She closed by saying that the tribe asks that all of these ideas and requests remain on the table.

Yankton Sioux Tribe: Written testimony received entered into record by Chairman Robert Flyinghawk. (See Appendix A)

Navajo Nation: Oral and written testimony received and entered into record by Vice President Jonathon Nez. (See Appendix B)

Vice President Nez stated that tribal leaders must show their tribal members how to embrace health and wellness by “walking the walk” of eating well and exercising. He recounted his personal story of health transformation. He stressed that the traditional wisdom of the Navajo can be used to fight the “monsters.” He encouraged all tribal leaders assembled to share that great things are happening within Indian country. He asked that all leaders not speak from a mindset of “poor, poor me,” but rather from a place of resiliency and self-reliance. He stated that each tribal nation has a story of overcoming and these stories can add immense value to all programmatic interventions around public health. He shared that he was encouraged by the meeting and was pleased to return home and share what a great meeting it had been.

Closing prayer/Adjournment

Vice President Nez reminded the agency of the letter submitted to Dr. Schuchat regarding tribal consultation in the selection of leadership under the new administration. He asked that

responsibility for consultation remain with OSTLTS and TSU to ensure that the letter is championed with new agency leadership. Regarding CDC/ATSDR TAC recruitment, he stressed that there remains a need to fill vacancies. The current number of vacancies is the lowest that it has been in recent years but we need the committee to be full. He advised that TSU should use the TAC Strategic Priorities document from October to steer their work and should develop a tracking document with a routine reporting cycle. He urged the agency as a whole to continue to increase the investment in tribal public health infrastructure and for TSU and OSTLTS to continue their work in this area. Lastly he shared that as the CDC/ATSDR TAC has grown in its capacity in recent years, it has proven itself to be a visible investment in the agency's executing of the federal trust responsibility. He championed OSTLTS and TSU to promote its continuation.

Vice President Nez gave the closing prayer and adjourned the meeting.

Participants

Tribal Advisory Committee Members

- **Chester Antone** (Tohono O'odham Nation): Councilman, Tohono O'odham Nation; Chair, Tribal Advisory Committee; Tucson 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
- **Lawrence Jace Killsback** (Northern Cheyenne): President, Northern Cheyenne Tribe; Billings Area Delegate
- **Patrick Lambert** (Eastern Band of Cherokee Indians): Principal Chief Eastern Band of Cherokee Indians; Nashville Area Delegate
- **Byron Larson** Employee of Northern Cheyenne Nation; Tribes-at-Large Delegate
- **Jonathan Nez** (Navajo Nation): Vice President, Navajo Nation; Co-Chair, Tribal Advisory Committee; Navajo Area Delegate
- **Lisa Pivec, MS** (Cherokee Nation): Senior Director of Public Health, Cherokee Nation; Oklahoma Area Authorized Representative
- **Robert TwoBears** (Ho-Chunk Nation): Legislative District V Representative, Ho-Chunk Nation; Bemidji Area Delegate
- **Ileen Sylvester, MBA** (Native Village of Ekwok): Vice President of Executive & Tribal Services, Southcentral Foundation; Alaska Area Authorized Representative

CDC and ATSDR Senior Leaders

- **Ursula Bauer, PhD, MPH**: Director, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention
- **Patrick Breyse, PhD, CIH**: Director, National Center for Environmental Health, Centers for Disease Control and Prevention; Director, Agency for Toxic Substances and Disease Registry

- **Coleen A. Boyle, PhD, MSHyg:** Director, National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention
- **Hazel D. Dean, ScD, DrPH (hon), FACE:** Deputy Director, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB, Centers for Disease Control and Prevention
- **Stephanie Dulin, MBA:** Deputy Director, National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention
- **Debra Houry, MD, MPH:** Director, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
- **Rear Admiral Robin M. Ikeda, MD, MPH:** Deputy Director, Centers for Disease Control and Prevention; Director, Office of Noncommunicable Diseases, Injury and Environmental Health, Centers for Disease Control and Prevention
- **Donna Knutson, PhD:** Deputy Director, National Center for Environmental Health, Centers for Disease Control and Prevention; Deputy Director, Agency for Toxic Substances and Disease Registry
- **José T. Montero, MD, MHCD:** Deputy Director, Centers for Disease Control and Prevention; Director, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention
- **Rear Admiral Stephen C. Redd, MD:** Director, Office of Public Health Preparedness and Response, Centers for Disease Control and Prevention
- **Rear Admiral Anne Schuchat, MD:** Acting Director, Centers for Disease Control and Prevention; Acting Administrator, Agency for Toxic Substances and Disease Registry

CDC and ATSDR Roundtable Discussion Participants

- **Umed A. Ajani, MBBS, MPH:** Associate Director for Science, Division of Health Informatics and Surveillance, Center for Surveillance, Epidemiology, and Laboratory Services, Centers for Disease Control and Prevention
- **Captain Holly Billie, MPH:** Expert Consultant, Division of Unintentional Injury Prevention, Centers for Disease Control and Prevention
- **Captain Kristine Bisgard, DVM, MPH:** Epidemiologist, Center for Surveillance, Epidemiology and Laboratory Services, Centers for Disease Control and Prevention
- **Captain Carmen Clelland, PharmD, MPA:** Associate Director for Tribal Support, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention
- **Lindsey Culp, MPH, JD:** Public Health Analyst, Division of Unintentional Injury, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
- **David Espey, MD:** Medical Officer, 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
- **Damion Killsback, PharmD, MPH:** Deputy Associate Director for Tribal Support, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention

- **Rachel A. Kossover, MPH:** Public Health Analyst, Violence and Injury Prevention Team, Division of Analysis, Research and Practice Integration, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
- **Angela Marr, MPH:** Acting Director, Division of Analysis Research and Practice Integration, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
- **Reshma Mahendra, MPH:** Deputy Branch Chief, Health Systems & Trauma Systems Branch, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
- **Amy Peeples, MPA:** Deputy Director, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
- **Gregory Smith, MPA:** Tribal Liaison Officer, Program Services Branch, Division of State and Local Readiness, Office of Public Health Preparedness and Response, Centers for Disease Control and Prevention
- **Asha Ivey-Stephenson, PhD, MPH:** Behavioral Scientist, Surveillance Branch, Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
- **JoAnn Yoon-Kang, JD:** Team Lead, Policy and Partnership, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

Appendices

A. Written Testimony of Yankton Sioux Tribe

Tribes in the northern plains experience some of the worst health disparities in the nation. For example, In South Dakota, Tribes have some of the highest rates of infant mortality in the nation and the world. American Indian rates aggregated at the state level are greater than 12 infant deaths per thousand live births. For some individual tribes in SD, the infant mortality rate is twice the aggregated American Indian state rate.

On the other end of life, South Dakota epidemiologists, Christensen and Kightlinger, published an article in the American Journal of Preventive Medicine in 2013 that demonstrated American Indians in SD have the highest premature mortality rates of any racial or ethnic group in the United States. They demonstrated that 70% of American Indians in South Dakota die before the age of 70; while 70% of non-natives live beyond the age of 70.

These tragic infant and premature mortality disparities have been occurring for decades. The Department of Health and Human Service's initiative was to eliminate racial ethnic health disparities by the year 2010.

Question: I ask the public health leaders at the Center for Disease Control and Prevention, "Why is this? What can you do?"

Dr. Camara Jones, former President of American Public Health Association, encourages us to examine the potential effects of racism in causing race associated differences in health outcomes. She defines types of racism, one type being institutionalized racism.

Dr. Jones defines institutional racism as differential access to the goods, services and opportunities of society by race. She describes institutionalized racism, as being normative, sometimes legalized and often manifests as inherited disadvantages. It is structural having been codified into our institutions of custom, practice and law, so there need NOT be an identifiable perpetrator. Indeed, institutionalized racism is often evident as inaction in the face of need.

When we look at the development of the United States Public Health System, it is defined by systematic and functional relationships between federal (CDC), state, and local/county public health partners. Historically, the inclusion of Tribes the national public health system was overlooked. This is institutionalized racism: "differential access to the goods, services and opportunities of society by race." We ask for action in the face of need.

Robert Flying Hawk, Chairman Yankton Sioux Tribe
February 15, 2017

B. Written Testimony of Navajo Nation

THANK YOU FOR THE CDC/ATSDR PARTNERSHIP

- Thank you for your partnership and recognition of public health needs on Navajo Nation and Indian Country.

CURRENT CDC SUPPORT FOR NAVAJO NATION

1. Good Health & Wellness in Indian Country

- The Navajo Nation and Navajo Epidemiology Center appreciate the leadership and efforts of Dr. Ursula Bauer recognizing the health needs to address chronic diseases (i.e., diabetes, heart disease, stroke, etc.).
- Navajo Epidemiology Center has used the funds to complete the Navajo Nation Health Survey Project (also known as the Tribal Behavioral Risk Factor Surveillance System Survey):
 - This is the first ever such survey conducted on Navajo Nation to help identify priority health concerns.
 - Completed over 2,500 surveys covering all of Navajo Nation.

- Data analysis is currently in progress.
- Report will be available in summer 2017.
- Navajo Epidemiology Center is also using the funds to assist Navajo Nation Chapters develop community wellness plans in partnership with the Healthy Dine Nation Act Project (Junk Food Tax).

2. Viral Special Pathogens Branch

- The Navajo Nation and Navajo Epidemiology Center appreciate the leadership and efforts of Dr. Pierre Rollin, Mr. Craig Manning, Dr. Barbara Knust, Dr. Annabelle De St. Maurice, and Ms. Elizabeth Ervin in assisting us address Hantavirus disease.
 - Developed Navajo Nation Hantavirus surveillance report covering years 1993-2016.
 - Developed prevention education materials (brochure, website, radio PSAs/forum, and video).
 - Working on a home-based rodent exclusion pilot project currently in concept phase.
 - Continuing the education of clinicians on Hantavirus disease.

3. Injury Prevention

- The Navajo Nation and Navajo Epidemiology Center appreciate the leadership and assistance provided by Ms. Debra Houry and the Injury Prevention Team in the development of the Navajo injury atlas.
 - Motor vehicle injuries
 - Elderly falls
 - Suicide
 - Violence
 - Substance abuse
 - Traumatic brain injuries

4. Public Health Associate Program (PHAP)

- The Navajo Epidemiology is appreciative of the PHAP Associates that assist us in building our public health capacity.
- The Navajo Epidemiology Center has applied to be a host site in 2017.
- The focus is on infectious disease surveillance development.
- We are looking forward to hosting a CDC PHAP candidate.
- We are aiming to submit future applications to focus on other areas of health concerns.

5. Navajo Birth Cohort Study

- The Navajo Nation and Navajo Department of Health appreciate the continued funding.
- The project is a study on the effects of uranium exposure and its health effects on Navajo Nation residents, including mothers and their infants, living near abandoned uranium mines.
- The support allows us to continue to provide survey administration, community education, training, and outreach.

6. Navajo Breast and Cervical Cancer Prevention Program

- The Navajo Nation and Navajo Department of Health appreciate the support.
- Cancer is the second leading cause of death on Navajo Nation according to Navajo Mortality Report, 2013.
- Breast cancer is the most commonly diagnosed cancer among Navajo women, followed by colorectal, uterine and kidney cancers (Navajo Cancer Report, 2013).
- Prostate cancer is the most commonly diagnosed cancer among Navajo males, followed by colorectal, kidney, and stomach cancers (Navajo Cancer Report, 2013).
- Additional funding and support from CDC is imperative for the Navajo Nation.

7. Navajo Public Health Emergency Preparedness and Response

- Currently partnering with NM and AZ for funding and conducting emergency preparedness and response activities.
- Developing Navajo Nation Joint Information Center to coordinate emergency response activities.
- Direct funding from CDC to Navajo Nation is requested.

HEALTH PRIORITIES & RECOMMENDATIONS**Injury Prevention and Control**

- Continued funding and support is imperative for the Navajo Nation.
- Motor vehicle injury is the #1 cause of mortality on the Navajo Nation.
- Suicide—BUILDING COMMUNITIES OF HOPE—ONE VOICE, ONE NATION—PROTECT LIFE
 - The Navajo Nation Office of the President/Vice President in partnership with tribal programs visited schools and communities focusing on Navajo youth to provide suicide prevention education.
 - National campaign and summit to address suicide prevention.
- Adverse Childhood Events (ACE)

- There is under reporting of ACE on the Navajo Nation. There is a shortage of health professionals to help address ACE. This is a multifaceted issue and involve the DOJ, Public Safety, Social Services, Education and parents.
- Focus on funding of long-term familial support and early intervention to address and prevent adverse childhood events.

Chronic Disease Prevention and Health Promotion—CANCER, HEART DISEASE, DIABETES

- The continued funding support from the Good Health and Wellness in Indian Country program is important in addressing heart disease, diabetes, cancer, etc.
- Continued funding and support is imperative for the Navajo Nation as cancer is now the 2nd leading cause of death according to Navajo Mortality Report, 2013.

Emerging and Zoonotic Infectious Diseases—HANTAVIRUS, ZIKA VIRUS

- Infectious diseases continue to be a threat and health burden on the Navajo Nation.

Public Health Preparedness and Response

- Technical assistance with conducting emergency response activities to ensure rapid, coordinated detection and response to outbreaks and to promote comprehensive surveillance and investigation.
- We would like to explore the placement of a Career Epidemiology Field Officer on the Navajo Nation/Navajo Epidemiology Center.

HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

- Need for funding of HIV/AIDS prevention and capacity building efforts.

Vice President Jonathon Nez

February 15th, 2017

C. Written Testimony of Kipnuk Tribe (Received January 13, 2017)

I am the tribal administrator for the community of Kipnuk. On behalf of the community of Kipnuk I would like to emphasize on our gravel roads. In our community we have sewage bins that are hauled to the sewage lagoon by a snow machine or an ATV. In the summer the sewage bins are hauled on the roads where the kids like to play on, and there are a lot of spills because of the bumpy roads. Onto the boardwalks, the boardwalks are not straight because of the pipes for our laundromat and the school. There is one area where the sewage haulers never miss to spill the bins and that is in front of a young couple with small children. One of their kids got real sick from this. This family is always getting sick, probably

from the spills right in front of their house, that is where the pipe system is for the laundromat and school is. Since this is the only route to the sewage lagoon we would really like to see another route to the sewage lagoon. I don't know if this is the kind of testimony you are looking for but I wanted to let someone know to help us and the kids of Kipnuk with our roads. Thank you very much for your time.

Shirley Fox, Tribal Administrator

D. Written Testimony of Leech Band Ojibwe

In response to letter dated December 19, 2016, regarding 2017 TAC Meeting and 16th Biannual Tribal Consultation Session

The Leech Lake Band of Ojibwe in north-central Minnesota is committed to the responsible operation of government, preservation of our heritage, promotion of our sovereignty, and the protection of natural resources for our elders and future generations, while enhancing the health, economic well-being, education, and our inherent right to live as Ojibwe People. Our tribal membership is approximately 9,500 citizens. Our reservation is made up of eleven communities within our external boundaries. Of our 864,158 original acres, nearly 300,000 acres are surface area of the three big lakes. Communities are geographically isolated, with a majority of tribal governmental services provided in one town on the west side of the reservation, Cass Lake. Health services are provided at an IHS hospital and clinic in the Cass Lake community, and seven Tribal Community Health Clinics across the reservation provide preventative, chronic, and urgent care. If care that is more extensive is needed, the hospitals in neighboring cities are used.

At Leech Lake, we have a number of public health issues on which we focus, and many issues that we wish to see improved. We feel that the CDC can assist tribal communities with improvements in the following areas:

Tribal-specific traditional approaches to improving mental health and decreasing substance abuse or suicide must be eligible for funding- though often are not, due to the requirement that they are “evidence-based” public health preventions or interventions. Often times we see improvement in community health through our specific Ojibwe culture-based practices, and we should be allowed to present those ideas for funded projects. FOAs should be constructed in a way that respects the path to the results. We are individual, unique tribes that practice individual, unique cultural practices – and we should be allowed to conduct funded projects that relate to our culture and community, without having to disclose those practices in detail, which is often against our tribe’s teachings. We can develop internal practices and processes that train our local practitioners, and we can report on results from

the interventive or preventive practices, without disclosing the details of community cultural events or ceremonies. Trust us to do the work that is appropriate to our communities, but may not be labelled “evidence-based.” It is not the CDC’s job to evaluate our ceremonies, but to measure improved health indicators. Processes appropriate to our community may not be appropriate to another community, but a process may inspire another community to consider how their community measures health indicators. The FOAs and awards should recognize that right.

We know that we have negative health indicators. Tribes need access to funding as timely as funding that is available for exotic emergencies, such as Zika. A 2% set-aside in funding at federal levels does not feel adequate to address the health disparities in Indian Country, and we must ensure that all of this funding goes out to Indian Country in an effective manner in ways that will be effective for us.

A sustainable public health system is not managed by 3-year or 5-year interventive grant projects that begin to show promise and then are de-funded or de-prioritized. Longitudinal or maintenance efforts that scaffold onto previous prevention strategies must be considered as we build capacity in Indian Country in order to see the increased health benefits to the projects that we undertake. Please consider how to build capacity on previous projects by providing ongoing funding past one single cycle of funding.

There is a concern over increased maternal opiate use and infant exposure. Please ensure that there are inter-agency ways to support us in Indian Country to address these issues, as much of the funding is moved out of the CDC into other agencies, we know that there are ways to address this that cross many lines.

We are concerned that Adverse Childhood Experiences (ACE) issues are increasingly identified, and much of our work currently is crisis-mode interventive. We would like to get ahead of this, and again, require capacity-building in order to do so. Preventing the negative health effects of ACE should be a priority, and we are concerned that there has been very limited public funding available in the last funding period, and even more limited tribal participation. Funding for ACE preventive measures or tribal-specific community pilot programs should be prioritized.

Increase Technical Assistance to tribes so that we are aware of pilot opportunities and consider reflexivity: tribal members can possibly participate in providing culturally-relevant training to CDC.

Ensure that cancer-screening efforts are increased or maintained.

Resources for child and teen health must be increased or maintained in this year's appropriation.

CDC must address a lack of tribal-specific data on public-health issues, which can be a Technical Assistance effort.

Over the past several years, the Leech Lake Band has worked on Public Health and Well Being through Pet Care for Tribal Communities: community and public health efforts that involve taking care of our pets in our community, which have been supported by volunteer efforts in the community, and which we believe to have serious consideration for expanded access for funding and research. Paying attention to animal welfare—particularly relating to dogs, which are the most common “problem animal” in Tribal communities—not only decreases animal suffering; it increases quality of life, social capital, and the economy. By resolving issues with animals and community safety improvements, there is less human-animal conflict at any level from dogs foraging in garbage to traffic accidents from roaming dogs and feral horses, community members experience less sadness about animal suffering and feel less helpless, and zoonotic disease concerns are alleviated. Pets also provide rich emotional support, recreation and enjoyment for many community members. As problems are resolved, social conflict over animal issues decreases. The community becomes more walkable, improving social relationships and health of community members. People feel more pride in their community, and can see that their efforts have an impact on the world, thereby fostering empowerment and agency. Community members begin to also experience more confidence in local institutions. Focusing on animal welfare can also improve a community's economy by reducing medical costs associated with zoonotic diseases in both people and livestock, increasing potential related business and employment opportunities, and reducing the economic costs associated with animal challenges.

Benefits

- Improving community safety and walkability.
 - Dog bite prevention through spay/neuter and access to behavior consultation veterinary services
- Reducing community conflict over dogs and other animals.
- Decreasing incidence of zoonotic diseases among humans and livestock.
 - Rabies and tick borne diseases, plus other zoonotic diseases. Regular vaccination and access to flea and tick prevention for dogs and cats can help decrease human exposure to diseases like Rabies and Lyme disease.
- Improved physical and mental health through positive interaction with dogs and other pets.

- Leveraging the social/cultural value of the human-animal relationship as a mechanism to advance educational programs around nutrition and exercise (cancer and heart disease prevention), smoking cessation (causes/contributes to cancer and asthma in dogs and cats), vaccination, and other wellness and injury and disease prevention programs that apply across species boundaries. It might be easier to start conversations about sensitive health related topics around a pet, but the same interventions can work for people.
- People often share the same stressors as a result of coping with mental health, domestic violence, instability, or other situations of household stress.
- Increasing employment opportunities directly related to animal services.
- There is a social justice aspect to the lack of available animal care services for tribes. Tribal communities deserve access to the same protections and the same quality care for their animals as other communities.
 - Currently many tribal nations lack the resources to fund animal care and population management services despite acknowledgement from federal agencies (see 2013 CDC report “Dog Bite Injuries among American Indian and Alaska Native Children,” [http://www.jpeds.com/article/S0022-3476\(12\)01421-7/abstract](http://www.jpeds.com/article/S0022-3476(12)01421-7/abstract)) that there are challenges with animal populations. (Generally, non-tribal municipalities use tax revenues to fund animal control services.)

Opportunities for CDC Interventions:

1. Access to data on dog bite injuries along with other health conditions where pets and people might both be affected (obesity, diabetes, asthma, etc.) to monitor effectiveness of any pet-based interventions.
2. Funding or Technical Assistance to set up a system to monitor and record the use of services that may lead to positive outcomes over time (computer setup, databases, data analysis capabilities), and/or opportunities to train tribal community members to be able to do these things on their own.
3. Dedicated research (full time fellowship position) on the public health impact of the lack of animal care and control services available at American Indian and Alaska Native communities for presentation to congressional decision makers for discussion of solutions.

Miigwech gaa-inendameg, Thank you for the consideration, and the opportunity to present our Leech Lake community’s public health opportunities.
Presented by LeRoy Staples-Fairbanks, District III Representative
January 12, 2016

Acronyms

AI/AN	American Indian/Alaska Native
ACA	Affordable Care Act
ATSDR	Agency for Toxic Substances and Disease Registry
BRFSS	Behavioral Risk Factor Surveillance System
CDC	Centers for Disease Control and Prevention
CSELS	Centers for Surveillance Epidemiology and Laboratory Sciences
EIS	Epidemic Intelligence Service
FACA	Federal Advisory Committee Act
FHA	Federal Housing Authority
FOA	Funding Opportunity Announcement
GHWIC	Good Health and Wellness in Indian Country
HHS	Department of Health and Human Services
IHS	Indian Health Service
MOU	Memorandum of Understanding
NCBDDD	National Center for Birth Defects and Developmental Disorders
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCEH	National Center for Environmental Health
NCEZID	National Center for Emerging and Zoonotic Infectious Diseases
NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, STD and TB
NCIPC	National Center for Injury Prevention and Control
NIHB	National Indian Health Board
NNDSS	Nationally Notifiable Disease Surveillance System
NVDRS	National Violent Death Reporting System
OD	Office of the Director
OPHPR	Office of Public Health Preparedness and Response
OSTLTS	Office for State, Tribal, Local and Territorial Support
PHEP	Public Health Emergency Preparedness (cooperative agreement)
PHPF	Public Health Prevention Fund
TAC	Tribal Advisory Committee
TBHA	Tribal Behavioral Health Agenda
TEC	Tribal Epidemiology Center
TSU	Tribal Support Unit
USDA	United States Department of Agriculture
YRBSS	Youth Risk Behavior Surveillance System