

CDC/ATSDR Tribal Advisory Committee (TAC) Meeting

July 23, 8:00 am–5:00 pm

July 25, 8:00 am–12:00 pm

Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

The Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) hosted their Tribal Advisory Committee (TAC) Meeting July 23 and July 25, 2018, in Washington, DC. The meeting was open to the public. Twelve members of the public attended the first day, and nine attended the second day.

TAC Member Attendees

Councilman Chester Antone

Tohono O'odham Nation
Tucson Area Delegate

Wally Apland

Ho-Chunk Nation of Wisconsin
Bemidji Area Authorized Representative

Rhonda Beaver

Muscogee (Creek) Nation
Oklahoma Area Authorized Representative

Verné Boerner

Native Village of Karluk
Alaska Area Authorized Representative

President George Edwardson

Inupiat Community of the Arctic Slope
Tribes-at-Large Delegate

Chairman Robert Flying Hawk

Yankton Sioux Tribe
Great Plains Area Delegate

Byron Larson

Northern Cheyenne Nation
Billings Area Delegate

Councilwoman Lana M. McCovey

Yurok Tribe
California Area Delegate

Principal Chief Richard Sneed (TAC Co-Chair)

Eastern Band of Cherokee Indians
Tribes-at-Large Delegate

Representative Robert TwoBears (TAC Chair)

Ho-Chunk Nation of Wisconsin
Bemidji Area Delegate

Del Yazzie

Navajo Nation
Navajo Area Authorized Representative

Absent

Affiliation/Org/Tribal Area	Name	Title
Portland Area	Travis Brockie	Council Member
Tribes at-Large	Darcy Morrow	Board Member
Tribes at-Large	Bryan Warner	Councilor

CDC Attendees

Robert “Bob” Anderson, PhD

Branch Chief, National Center for Health Statistics (NCHS)

Lieutenant Commander Naomi Aspaas, BSN, RN

Navajo Nation

Lead Public Health Advisor, Center for State, Tribal, Local, and Territorial Support (CSTLTS)

David Baden

Deputy Chief Financial Officer, Office of Financial Resources

Lieutenant Commander Deron Burton, MD, JD, MPH

Team Lead, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)

Captain Carmen Clelland, PharmD, MPA, MPH

Cheyenne and Arapaho Tribes

Associate Director, CSTLTS

Elizabeth Dalsey, MPH

Health Communications Specialist, National Institute for Occupational Safety and Health (NIOSH)

Heidi Davidson, MPH

Public Health Advisor, CSTLTS

Mark Davis, MDiv

Branch Chief, Center for Public Health Preparedness and Response (CPR)

Stephanie Dulin, MBA

Deputy Director, National Center on Birth Defects and Developmental Disabilities (NCBDDD)

Wendy Holmes, MS

Senior Public Health Advisor, CSTLTS/OTASA

Lieutenant Commander Jason Hymer, REHS, MPH

Environmental Health Specialist, NCIPC

Melissa Jim, MPH

Epidemiologist, NCCDPHP

Janet Kennedy

Management Analyst, CSTLTS

Pam Meyer, PhD, MSPH

Health Scientist, OTASA/CSTLTS

José Montero, MD, MHCDS

Federal Moderator
Director, CSTLTS

Georgia Moore, MS

Associate Director for Policy, CSTLTS

Sam Notzon, PhD, MS, MPA

Director, International Statistics Program, NCHS

Dagny Olivares, MPA

Associate Director for Communications, CSTLTS

Captain David Espey, MD

Medical Officer, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

Commander Mary “Molly” Evans, MD, MPH

Medical Officer, National Center for Injury Prevention and Control (NCIPC)

Donata Green, PhD, MA

Acting Deputy Associate Director, National Center for Environmental Health (NCEH)/ATSDR

Kimberly Hart, MPH

Public Health Analyst, CSTLTS

Captain Thomas Hennessy, MD, MPH

Director, National Center for Emerging and Zoonotic Infectious Disease (NCEZID)

Delight Satter, MPH

Confederated Tribes of Grand Ronde
Senior Health Scientist, OTASA/CSTLTS

Gregory Smith, MPA

Public Health Advisor, CPR

Rachel A. Kossover-Smith, MPH, RD

Public Health Analyst, NCIPC

Jeffrey Walker, MPH

Public Health Advisor, CSTLTS

Mitch Wolfe, MD, MPH

Acting Director, CDC Washington

Public and Other Federal Attendees

Robert (Bob) Ahern

Basa Amon

Alejandro Benavidez

Vickie Bradley

Michele Connolly

Kimberly Fowler

Carolyn Hornbuckle

Joshua Hudson

Tyler LaPlant

Jeffrey McCollum

Laura Platero

Kristine (Kris) Rhodes

Simental (Sy) Francisco

Opening Blessing, Welcome, and Introductions

- Captain Carmen Clelland welcomed everyone to the Summer 2018 CDC/ATSDR TAC Meeting and led the opening blessing.
 - TAC meetings are typically held in Atlanta, Georgia, or in Indian Country. However, this TAC meeting was held in Washington, DC, to enable staff from other Health and Human Services (HHS) agencies to attend.
- Dr. José Montero introduced himself and welcomed the group to the meeting.
- Lieutenant Commander Aspaas conducted the roll call. A quorum was present to conduct necessary business.

TAC Business

Facilitator

- **Chester Antone** (*Tohono O’odham Nation*) Councilman; Chairman, TAC

TAC Business Opening

- The CDC/ATSDR TAC is Federal Advisory Committee Act (FACA) exempt.
- Captain Clelland read the FACA exemption language.
- Captain Clelland read TAC members’ roles and responsibilities.

CDC/ATSDR TAC Meeting

July 23 & 25, 2018—Summary

TAC Chairman Election

- Representative Robert TwoBears was nominated for chair. The motion was seconded and approved unanimously.
- Principal Chief Richard Sneed was nominated for co-chair. The motion was seconded and approved unanimously.
- Councilman Antone, previous TAC chair, was appreciated for his guidance over the years.
- Del Yazzie, *Navajo Nation* was representing Vice President Nez, previous TAC vice-chair, was appreciated for his support over the years.

TAC Charter Review

- Historically, the TAC reviews the TAC Charter every three years.
- During a previous discussion, TAC members expressed interest in adding another at-large member, changing the composition of the committee from 16 to 17 members.
- The TAC proposed a draft charter three years ago. The draft charter includes the proposed language tabled for a future TAC meeting. Captain Clelland will share the language and share the current charter.
- The current charter is posted on www.cdc.gov/tribal.
- A subcommittee will review the language and charter and will make recommendations to TAC members.
- TAC Chairman TwoBears asked for volunteers. Captain Clelland said the draft charter needs to be ready by the next TAC meeting (the winter meeting, in February 2019). A request was made to review the charter for needed changes by July 25, 2018, while members were still in town.
- By a unanimous vote, Chairs Robert TwoBears, Richard Sneed, and Mr. Larson volunteered to review the language and update the charter.

Meeting Logistics

- Members of the public signed in for the meeting.
- Emergency procedures and location of restrooms and cafeteria were explained.

Tribal Data Discussion

Presenter

- **Robert “Bob” Anderson, PhD**, Branch Chief, NCHS, CDC

Death Certificate Data

- Data quality continues to be a topic of discussion, especially listing American Indian and Alaska Native (AI/AN) heritage accurately on death certificates.
- The flow of data and information from the state and local level to federal level is as follows:
 - Death certificate data originate from two sources: funeral directors who provide personal and demographic information, and physicians or coroners who provide the cause of death. Most of this is done electronically, although some funeral directors still file paper death certificates.
 - When a death certificate is filed, it is sent to and processed at the state vital records office. It is then sent to CDC, where it’s compiled and coded into a national data file.
 - State- and county-level information is provided.
 - Ultimately, NCHS will have a data file for every death that is registered in the United States. This is essential to calculate statistics on small groups or unusual death causes.

Data Quality

- The quality of the information reported (i.e., race, ethnicity) affects the ability to draw meaningful conclusions from the data.
- Many times, funeral directors provide the information they observe, so it's subject to error.
- Ideally, funeral directors should ask the decedents' next of kin to identify the decedent's race.

Data Misclassification

- Misclassification is high for the AI/AN population—
 - Underreporting is about 30% nationally.
 - Reporting varies by region and areas. However, reporting is better where there are large concentrations of AI/ANs. When funeral directors work in the community, they report race more accurately than in areas where there are small concentrations of AI/ANs in the area.
- The latest information for Hispanic and Pacific Islander misclassification is 5%.

Opportunities for Linkages

- The National Longitudinal Mortality Study links pre-death sample survey data to death certificates.
- In AI/AN groups, only a small number end up in these linkages studies, so it is difficult to get any detailed data on these populations.
- Indian Health Service (IHS)-based studies are working on linkages too, but this will only provide data for those populations receiving IHS services.
- Captain David Espey linked mortality and cancer data with IHS data to improve accuracy of AI/AN racial classification and rates. Several studies that used this method are reported in a [2014 American Journal of Public Health supplement](#).

TAC Questions and Discussion

Questions from Mr. Sneed: How can we improve classification, and how does it benefit tribes?

Answers (input from multiple people):

- Improving data quality provides better information with which to make decisions. Tribes can use better data in grant applications to demonstrate need.
- If individual tribes would share their tribal roster, those could be linked with health data to improve data quality and help public health understand how and who is receiving health services. Better data will give tribes a more accurate picture of what's happening in their tribes.
- Most tribes have contributed to the core IHS database. Northwest Tribal Epidemiology Center (NWTEC) shares their tribal registry with the state registrar to improve data quality.

Questions from Dr. Montero and Mr. Larson: How can we improve this process with the states? How do we improve primary data collection efforts?

Answers (input from multiple people):

- The current strategy is to educate funeral directors to improve data collection (e.g., seek information from family members instead of guessing). The challenge is accurately capturing data on those who die outside of a tribal community.
- Each state health department, with leverage from CDC, may improve data quality collection within their own state.

- NCIPC heard concerns about racial misclassification, so in cooperative agreements (co-ags) for tribal epidemiology centers (TECs) has asked TECs to look at the issue and work with states in doing so. NCIPC left co-ag language broad so TECs could tailor activities to their specific needs.

Question from Councilwoman McCovey: For multi-ethnic classifications, how do we pull out the AI/AN affiliation when more than one is listed?

Answers (input from multiple people):

- NCHS acknowledged that correctly documenting indigenous populations is an issue in many countries.
- In New Zealand, the most successful approach was through linkages between death records and census data, but linkages are expensive and unsustainable.
- It is important to work individually with states, but working state-by-state can be difficult and time intensive. There are far easier ways to go about this, through the National Death Index and possibly having tribes strengthen the IHS patient registration database with their own rosters.
- Improving the data is the beginning of addressing health disparities.
- The best approach is to improve the quality of primary data collection conducted at the time of death. When a coroner or medical examiner is involved, collection can be enforced through licensing or regulation.
- There is a lot of potential for information to get lost because of a lack of a centralized database.
- Funeral directors often reach out to the Social Security Administration to stop payments once a person dies, so this may be a potential avenue for improved reporting.

Discussion

- President Edwardson reported that someone in his community dies from colon cancer every three days.
 - It was suggested that CDC collect and evaluate the data to describe what is occurring in the community.
- CDC is working to make linkages less expensive. States charge because they need money to support their linkage activities. One way to make linkages less expensive is to accurately classify a condition when purchasing data.
- CDC has a contract with each state's vital statistics office.
- Resources were redirected to Alaska because rates of colon cancer is greater in Alaska. It is important to work with the state, but it is time-intensive.
- It would be beneficial if IHS strengthened the AI/AN database. The states can use the information to report more details.
- Linkages work well, but they require many resources.
 - The data are provided under contracts and other conditions. The data are put on a file and can be shared. CDC can pay the states to do the linkage.
 - To make it less expensive, CDC has to find funding for the state vital statistics offices. Currently, the state vital statistics offices fund themselves by selling birth and death certificates.
- Captain Clelland provided the following information from previous TAC meetings, local consultations, and regional consultations.
 - There is a lack of communication with funeral directors.
 - There is a lack of outreach with local entities among tribes.
 - Some tribal leaders do not want to talk about personal practices during a death event. There are cultural considerations when preparing the body which don't allow much space for questions and inquiries.
 - There is a default of using Hispanic, rather than AI/AN, when classifying ethnicities.

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- There should be linkages with the Bureau of Indian Affairs. Large gaps exist because of the lack of a comprehensive database.
- In Arizona and New Mexico, mortality data are captured by providing zip codes within the nation and border towns with AI/AN populations.
 - The challenge is that definitions need to be created for Navajo identity.
 - AI/AN zip codes must be provided.
 - Tribal variables or options on death certificates vary from state to state.
- It is critical for tribes within a county to obtain tribal-specific data.
- It is also important to collect contributing factors of death and manner of death.
- There will be a small tribal surveillance meeting hosted by the Council of State and Territorial Epidemiologists in Albuquerque, July 30–August 3; data sharing and other surveillance data issues are on the agenda.
- Tribes could consider having their data linked. The tribes could put their tribal roster in an electronic format, allowing the tribe to have control of the data on laptops and can link millions of records.

Question from Chairman TwoBears: Some tribes still practice traditional culture and religion. Is there a box for tribes to check if they don't want to indicate the cause of death?

Answer (Dr. Anderson): There is not an option on a standard death certificate that is used as a model. I can't speak to specific state certificates.

Discussion:

- Michele Connolly, the co-chair of the International Group for Indigenous Health Measurement (IGIHM), spoke about some of the group's activities. She is Native American, from Blackfeet. Sam Notzon is also co-chair.
- Currently, IGIHM is drafting a publication (scheduled to publish March 2019) about indigenous health.
 - The papers in the publication will center on health topics (e.g., socio-demographics of the populations in New Zealand, Australia, Brazil, Canada, United States).
 - IGIHM will work with the various countries and the United Nations.
 - IGIHM is looking at death rates for AI/ANs, and they want to gather input from the TAC. Tribal elected officials will join the IGHM subcommittee.
 - IGIHM will share a copy of the publication when it is released.
 - There are plans to present at the International Statistical Institute.
 - IGIHM is open to having tribal elected officials on this group.

Question from Captain Hennessy: Are there any proposed mechanisms for tracking progress on underreporting of AI/AN mortality? When linkages are made you can correct for that, but is there a way to compare one state to another at the national level?

Answer (Dr. Anderson): NCHS has done some tracking at the national level. Comparing states becomes problematic because most of the linkages are survey linkages. Theoretically, surveys can produce state-level estimates, but the numbers are very small for the AI/AN population, and that is a big challenge. We'd like to do ongoing follow up based on census data. Typically, there isn't much missing information on death certificates. The need for imputation for missing information is roughly half a percent.

Question from Ms. Moore: Is the call for papers for the IGIHM open or closed?

Answer (Ms. Michele Connolly): The journal will have planned papers, which have gone out. The call for unplanned papers should be available soon. The draft will go for printing at the end of November or the

beginning of December 2018. The publication date is set for March 2019.

Office of the Surgeon General Priorities

Presenter

- **Vice Admiral (VADM) Jerome M. Adams**, MD, MPH, United States Public Health Service (USPHS); US Surgeon General for HHS

Opening Remarks

- He reviewed the history and purpose of the USPHS and the locations of Public Health Service (PHS) officers.
- He discussed the issues and needs that PHS addresses, including some areas of priority for AI/AN populations.
- VADM Adams explained the importance of understanding cultural legacies and communicating a pathway to health that resonates among the population that needs it most.
- VADM Adams is planning to visit Alaska to learn more about the public health challenges the AN community faces, and he hopes to visit other communities to expand his knowledge.
- He explained how Congress sets priorities and that jobs and the economy are the first priorities.
- VADM Adams's strategy is to focus on health to allow people to work and contribute to the economy.
- The purpose of the USPHS reorganization is to ensure that staff placements are appropriate and effective. Numbers of placements may increase or decrease.
- Reimagine HHS is a part of a proposed effort recently released by the White House to right size the Commissioned Corps (CC). The CC has been around for more than 200 years. Dr. Brett Giroir, HHS assistant secretary of health, is onboard and has dedicated over a million dollars to show the value of the CC.

Priorities

- Focus on leading with the science—
 - Reframe the way we talk about health. So much of what we talk about is rooted in our failure to address health in a way that fits in with cultural beliefs, and the solutions are sensitive to cultural beliefs and desires.
 - Understand cultural legacies because our mission is to better health through better partnerships.
 - Prioritize community health and economic prosperity.
 - A Gallup poll shows that American voters do not prioritize health. Health usually does not make it into the top 10 priorities.
 - Americans' priorities are jobs and the economy.
 - Bring an awareness of economic health and health in our communities. For example, reframe that having a healthy environment with policies conducive to lower smoking rates helps promote exercise and physical activity and leads to increases in economic prosperity.
 - Dr. Ursula Bauer, former director of NCCDPHP, now works with the Office of the Surgeon General. She is committed to addressing AI/AN issues. She will prepare a report on community health and prosperity.
- Health and national security—

- Many people can't pass the fitness and security checks needed to serve in the military.
- We need to invest in the communities to improve the health of potential recruits from day one of life (and before during pregnancy/preconception).
- The opioid epidemic is affecting all sectors of the population—
 - Ensure that programs and resources are focused on all communities in an equitable way and that data are available to support and inform efforts effectively.
- Adverse childhood events (ACEs), trauma-informed care, and resilience—
 - There is a need to raise awareness about ways to mitigate the negative effects of ACEs, to prevent these traumatic events from resulting in long-term negative health outcomes.
 - ACEs affect AI/AN populations at a much higher rate. We need to prevent them first and mitigate their effects if prevention is not possible.

AI/AN Health Statistics as Presented

- 1-in-4 AI/AN pregnant women smoked during pregnancy.
- 52% of AI/AN people reported wanting to quit smoking compared to >70% among other populations.
- 45% of AI/AN people reported ever having used tobacco compared to 11% of other populations.
- Heart disease, diabetes, cancer, and unintentional injuries are AI/AN leading causes of death and affect AI/AN populations disproportionately.
- 15–20% of health is health care, and 80–85% is the environment and the choices we make.
- If we focus only on health care, we can't address the underlying issues.
- The interconnectedness of a tribal community provides a lot of opportunities to successfully conduct pilot programs across health issues.

TAC Questions and Discussion

- Tribal leaders want to share stories and develop priorities.
- VADM Adams believes it is also important to talk about positive things occurring in Indian Country.
 - Infant deaths have declined by 67% in the past 20–30 years.
 - Stroke deaths have declined.
 - Diabetes has declined by 54%.
- Tribes are model places to implement programs.
- VADM Adams developed the first surgeon general advisory on Naloxone.
- Mr. Larson appreciated the comment about economics because Cheyenne communities are economically disadvantaged.
 - IHS is mandated through the Affordable Care Act to support tribal self-governance. Therefore, IHS controls the resources to do self-governance. Clinical services are the biggest priority in Cheyenne.
 - When tribal nations are given the opportunity to execute service delivery in public health, the constituents can make the change.
- VADM Adams stated that health care was rapidly approaching a quarter of the US gross domestic product. Every dollar going towards health care is a dollar that could have been used towards poverty reducing programs, education programs, etc.
- The issues in the Navajo Area are motor vehicle crashes, chronic diseases, and infectious diseases.
- People who suffer from ACEs are more likely to experience chronic disease and unintentional and intentional injuries, etc.

- President Edwardson stated that people in his community (in Alaska) are diagnosed with cancer at high rates, and they begin treatment too late. Every three days in the past three years, someone in his community has died from cancer; there are 13,000 people in his area. He believes most cancers can be cured if they are diagnosed earlier.
- VADM Adams is interested in doing the following:
 - Using PHS officers.
 - Making sure places with rates of disease as high as President Edwardson described have strike teams to assess the situation, complete screenings, and perform primary prevention.
- Principal Chief Sneed stated that Naloxone is an important drug, and he appreciated VADM Adams’s priorities around this issue because resources are stretched in rural communities.
- VADM Adams wants to ensure the following happens:
 - People get the treatment they need.
 - They receive recovery support services after treatment (or, the cycle will continue because it is a symptom of a broken system.)
 - They share more recovery stories.
- Rhonda Beaver stated that AI/AN communities continue to fight substance abuse.
 - There have been challenges because of the way opioid data are documented.
 - Police document substance abuse as drug use, social workers document it as child abuse and neglect; it is never documented as opioid use.
 - In doctors’ offices, it is recorded as drug use.
 - She appreciated that VADM Adams talked about childhood ACEs because obesity is on the rise.
- Chairman Robert Flying Hawk stated that the PHS reorganization is concerning. Tribes are doing everything they can to stop the reorganization.
 - The Office of the Surgeon General is looking at efforts to improve and right size the CC.
 - Dr. Giroir, HHS Secretary Alex Azar, and VADM Adams are making sure that the reorganization does not harm the commitment to AI/AN populations.
 - VADM Adams and Dr. Giroir want to continue to improve the current level of support for IHS.
- VADM Adams stated that a request for information is coming out in their community report in August.
 - He encouraged people to share examples of their work.
 - He asked for the tools to help him report on the issues in the community.

CDC/ATSDR Updates and Listening Session

CDC Presenters

- **Rear Admiral Mitch Wolfe, MD, MPH**, Acting Director, CDC Washington
- **José Montero, MD, MHCDs**, Director, CSTLTS

CDC Discussants

- **Captain David Espey, MD**, USPHS; Medical Officer, NCCDPHP
- **Commander Mary “Molly” Evans, MD, MPH**, USPHS; Medical Officer, NCIPC
- **Lieutenant Commander Jason Hymer REHS, MPH**, USPHS; Environmental Health Specialist, NCIPC
- **Mark Davis, MDiv**, Branch Chief, CPR
- **Gregory Smith, MPA**, Public Health Advisor, CPR
- **Elizabeth Dalsey, MPH**, Health Communications Specialist, NIOSH
- **Captain Thomas Hennessy, MD, MPH**, USPHS; Director, NCEZID

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- **Stephanie Dulin, MBA**, Deputy Director, NCBDDD
- **Lieutenant Commander Deron Burton, MD, JD, MPH**, USPHS; Team Lead, NCHHSTP

Priorities of the CDC Director Presented by Rear Admiral Wolfe

- Dr. Robert Redfield was recently in Uganda observing some of the programs overseas.
- Dr. Redfield's priorities are—
 - Global health security
 - Opioids in public health (high priority)
- Core CDC work that affects AI/AN communities is in outbreak control. Dr. Redfield is committed to CDC detecting and preventing outbreaks. For instance, he wants to control HIV/AIDS, non-communicable diseases, etc.
- Mr. Larson asked that CDC not lose sight of other issues occurring in AI/AN communities, such as behavioral health issues and co-occurring disorders. He suggested that CDC leverage resources that are more categorical across all funding mechanisms.

CSTLTS Restructuring Presented by Dr. Montero

- While the organization is restructuring, there is still emphasis on how knowledge and resources can be leveraged across diseases and programs.
- CSTLTS is working to provide resources and build close partnerships with Indian Country through several channels, including OTASA, the Public Health Associate Program (PHAP), and funding to support tribal public health priorities through co-ags.
- CSTLTS will continue to support work done in Indian Country through programmatic support, co-ag funds, and legal support; over the last year, CSTLTS has changed the approach to make the support of tribal partners more systematic, effective, and efficient.
- **CDC's Four Communities of Practice**
 - Public Health Services
 - Center for Global Health
 - CPR
 - CSTLTS
 - Office of Minority Health and Health Equity
 - Public Health Science
 - Office of the Associate Director for Science
 - Office of Associate Director for Laboratory Science and Safety
 - Center for Surveillance, Epidemiology, and Laboratory Services
 - NCHS
 - All infectious programs are together
 - NCEZID
 - NCHHSTP
 - National Center for Immunization and Respiratory Diseases
 - All non-communicable diseases are together
 - NCCDPHP
 - NCBDDD
 - NCIPC
 - NCEH/ATSDR
- **Change from Office to Center**
 - Under this structure, OSTLTS will no longer be an office; it will be a center.
 - Dr. Montero works with a systems approach.

- Quality improvement
 - Performance improvement
 - State and public health
 - The Tribal Support Unit is being changed to the Office of Tribal Support and Strategic Alliances
 - Created an Office of Insular Affairs (US Virgin Islands, Puerto Rico, Guam, and the Freely Associated States)
- PHAP is a successful program. There are currently 23 associates in Indian Country.
- OTASA coordinates and provides representation at the regional meetings.
- **Funding**
 - There is a lack of proper mechanisms to provide funding to tribes.
 - There is a new umbrella tribal cooperative agreement that allows 25 tribes to apply for funding. (We cannot yet announce the names of the tribes that are being funded.)
 - Another funding mechanism is to provide funding to other national organizations that engage with Indian Country.
 - CDC funding decisions are directed by Congress and appropriations.
 - NCIPC will have opioid funds for surveillance.
 - CSTLTS will continue to support tribes through performance improvement, PHAP placement, fiscal/financial mechanisms created through notices of funding opportunities (NOFOs), the Office of Public Health Law Services and its many support programs.
 - CSTLTS is currently supporting AI/ANs through CPR to help with emergency funding and to develop internal resources. CSTLTS and CPR hope to make this more systematic. The mechanism will serve all of CDC.
 - Over the last year, CSTLTS has changed its approach to make the support of tribal partners more systematic, effective, and efficient.
- Regarding discretionary funds and legislative restrictions, Councilman Antone suggested that the TAC should consider visiting the new CDC director. They had met with Dr. Fitzgerald, but she left CDC soon after that. They should pool resources, combining different agencies' funds that contribute to the same issues.
 - Dr. Montero noted the need for variety in funding options: identify different funding sources and coordinate within the right levels of HHS to funnel the money to create capacity within the tribes.
- Mr. Yazzie recognized Dr. Bauer's support of tribal traditional practices and her efforts to identify funding to support tribal work addressing chronic diseases. He questioned what will happen to that funding now that Dr. Bauer is in a new position. How will these efforts continue?
 - Dr. Montero responded that Dr. Bauer will be able to continue support of tribal work in her new position in the Surgeon General's Office.

Injury Presented by Dr. Evans, Mr. Hymer, and Ms. Smith

- NCIPC received money to add a supplement to their Tribal Epidemiology Centers Public Health Infrastructure (TECPHI) NOFO. They are also working with CSTLTS on the umbrella NOFO that is available for 25 tribes and added an opioid part.
- Other priority projects for NCIPC include the following:
 - Providing training and technical assistance to tribes to reduce injuries
 - Improving availability and quality of data in tribes

- Working with IHS to implement a fall prevention program
- Addressing motor vehicle crashes in Indian Country (child restraint and seatbelt use)
- Improving injury-specific data in tribal communities (funding to produce injury atlases)
- Partnering with IHS on fall prevention
- NCIPC formed a tribal workgroup to address tribal issues.

Emergency Preparedness Presented by Mr. Davis and Mr. Smith

- Public Health Emergency Preparedness (PHEP) is a program that helps the entire nation prepare for and respond to made-made or natural disasters, such as hurricanes and wildfires, influenza, and Zika.
 - It is a large and comprehensive program with funding flowing to tribes through states.
- Currently, the Center’s Division of State and Local Readiness operates at a high level programmatically and will begin executing at a more granular level.
- The Center requires states to provide more information on how they interact with tribes.
- The Center has developed a mechanism to get money out of the door quickly, if emergency funds become available.
- The Center provides support to tribes for the annual application process to receive funds.
- The Center started a pilot program this month (July) in Navajo Nation. It placed a field-based tribal liaison on site to build bridges between state health departments. They will be able to build a toolbox to make sure they can respond to public health emergencies. The Center will expand to tribes and other CDC centers if the program is successful.

Emerging and Zoonotic Infectious Disease Presented by Captain Hennessy

- NCEZID activities include the following:
 - Technical assistance for infectious diseases
 - Surveillance (e.g., lab-based surveillance in Navajo Nation)
 - Analysis of algal blooms in the Great Lakes area
 - Provision of nosocomial investigation training and two-day prevention and control training for tribes
 - Analysis of hepatitis rates using IHS data—
 - Tribes could partner with NCEZID to track other conditions because some of the IHS data are outdated (going back to 2001).
 - Work with tribes on Rocky Mountain Spotted Fever (RMSF)—
 - There is a section in the NOFO that provides direct support to tribes to control RMSF.

Birth Defects and Disabilities Presented by Ms. Dulin

- NCBDDD programs don’t have large co-ags, but they do have other resources to share.
- The “Saving Babies” program is the center’s first presidential initiative to protect mothers and babies.
 - This model is used in Zika responses to get real-time data to support intervention efforts.
 - It can also be used in the opioid epidemic with mothers who use substances during their pregnancy.
- NCBDDD provides a lot of technical assistance and collaboration.
- The “Learn the Signs Act Early” program helps parents and childcare workers recognize birth defects and development milestones and problems. The earlier parents can identify developmental abilities, the earlier they can address them.
- NCBDDD is working on improving health disabilities data, using the Behavioral Risk Factor Surveillance System.
 - AI/AN who are aged 18+ years have the highest rate of disability (38%).
- NCBDDD is also working to identify impacts of fetal alcohol syndrome, opioids, and other teratogens.

Occupational Injuries and Diseases Presented by Ms. Dalsey

- NIOSH focuses on health, and the Occupational Safety and Health Administration is regulatory.
- NIOSH is conducting site visits to tribes in different regions to learn about their occupations and to develop partnerships.

TAC Questions and Discussion

Questions from Councilman Antone: How are funds restricted legislatively? How can CDC manage funds with and without legislative restrictions?

Answers:

- We need to look at the discretionary authority from Secretary Azar. The TAC was told legislatively they cannot, but the TAC is uncertain whether it is the final answer or if lobbying is an option.
- In the past, the TAC's concerns were relayed to the CDC director (i.e., Dr. Tom Frieden and Dr. Brenda Fitzgerald).
- The TAC and CDC are concentrating on ways to fund tribes.
- It is worth speaking with Dr. Redfield, the current CDC director, because the former CDC director, Dr. Fitzgerald, left two weeks after the discussion with the TAC.
- The TAC needs assistance with identifying funds that have legislative restrictions.
- It is beneficial to combine different agencies' funds that contribute to the same issues.
- Dr. Montero agrees that there should be synergy across agencies so there are complementary approaches rather than divergent approaches to funding.

Questions from Mr. Yazzie: How can tribes continue the work in Good Health and Wellness in Indian Country (GHWIC), TECPHI, and the recent traditional practices promoting health and wellness? How can tribes continue these efforts and will funding continue?

Answers (Input from multiple people):

- There is no reason to believe funding will stop or that the co-ags will end early. Our role is to continue community engagement. The three awards mentioned (i.e. GHWIC, TECPHI, and Traditional Practices) go beyond prevention of chronic disease. When we talk about injury prevention, these awards are fundamental to address opioids, suicides, ACEs, etc.; they are not mutually exclusive of obesity, diabetes, or heart disease. All of these things are connected because they are about a healthier lifestyle.
- There is a possibility for additional funding in the FY19 budget from the US House of Representatives to support Indian Country work, as well as continued support for existing programs. For clarity, below is an overview and update on the three co-ags:
 - GHWIC is a \$16 million a year, five-year program that funds 12 individual tribes and 11 individual organizations. It is approaching year four, with one year remaining. Most of the work has been on policy systems and environmental changes at the tribal level. The reach of the funds was vastly increased with the component 2 (c2) model where the organizations funded by CDC could then fund others. We are preparing for GHWIC 2. We are currently in the process of concept clearance before the development of a full NOFO.
 - TECPHI is an \$8.5 million a year, five-year program launched in 2017. It was created in response to feedback CDC received at TAC meetings that TECs try to help tribes better fulfill their role of public health support at the area level. The goal of TECPHI is to create more infrastructure and capacity to address chronic disease prevention and broader concerns in a specific IHS area. This is in year one.

- Tribal Practices for Wellness in Indian Country is a \$5 million a year, three-year program launched in May 2018 in response to three listening sessions in 2015 and 2016 that gathered input from tribal cultural leaders and community members to better understand cultural and traditional teachings and practices. The language and the evaluation approach were discussed, and the seven strategies were the heart of the NOFO. This funds 21 tribes and tribal organizations supporting tribes and 15 urban Indian health centers. It is the first time CDC has funded urban Indian health centers.
- A moderate number of tribes responded in 2014 for GHWIC, but for tribal practices, CDC received more than 100 applications. NCCDPHP has recruited two project officers (one is a Navajo pharmacist).
 - The center provides support in other ways, too. For instance, there are three assignees to Albuquerque, New Mexico, working on topics related to cancer.

Overview of Joint TAC Session

- A motion to go straight in to tribal caucus passed.
- Captain Clelland then adjourned the TAC meeting so that tribal leaders and delegates could meet for the tribal caucus.

Wednesday, July 25, 2018

Opening Remarks

- Chairman TwoBears called the meeting to order.
- Roll call was taken and quorum established.
- Chairman TwoBears noted two changes in the agenda.
 - Captain Clelland acknowledged Damion Killsback in his new role at HHS and thanked him for his service to the TAC.
 - Elizabeth Dalsey provided NIOSH updates, beginning with an overview of the center.
 - In 2015, NIOSH hosted a partnership workshop to bring tribal partners together to share resources and foster collaborations. NIOSH plans to host another workshop and is conducting site visits to tribes to learn more about occupational safety health issues in Indian Country.
 - NIOSH currently maintains a tribal email distribution list for sharing resources; anyone who is interested can be added to the listserv.
- Chairman TwoBears then called the meeting back to agenda.

CDC Budget Initiative Discussion

Presenters

- **David Baden**, Deputy Chief Financial Officer, OFR, CDC
- **Georgia Moore**, MS, Associate Director for Policy, CSTLTS, CDC

Overview of CDC Appropriation Structure

- CDC has one of the most complex budget and accounting structures in the federal government.
- CDC receives money to carry out programmatic work from Congress and multiple other agencies, as well as gifts from the CDC Foundation. This results in a complex budget and accounting structure.
- Most of CDC's funds are disseminated to partners via co-ags and contracts.

- CDC also funds research, which is dependent on the programmatic goals of the CDC centers, institutes, and offices (CIOs).
- Mr. Baden’s office focuses closely on congressional funding sources, which give more direction on how money should be spent (including programmatic directives and how money is to be redirected, such as through co-ags).
- Money going out from CDC can originate from multiple programs at CDC; this structure has both benefits and challenges.
- In the last several budget cycles, there has been a disconnect between what the president wants and what Congress appropriates, leading to communication challenges with grantees.
 - One area that has been proposed is a rapid response fund. The House is proposing that CDC have funds for rapid response to infectious diseases. Any emerging infectious disease issue can quickly deplete existing programmatic budgets (e. g., Zika, Ebola).
- Both the US House of Representatives and Senate are proposing increases to CDC’s budget for the 2019 fiscal year.
- In chronic disease, the House has proposed to double the funding for GHWIC, where the Senate has proposed level funding.
- In birth defects, a new initiative is being considered to understand and enhance surveillance activities for Zika; the House has proposed more in funding than the Senate.
- In the 2017 fiscal year, \$34.9 million went directly to tribes, an increase of \$9.1 million from the previous year.
 - Any given tribe was eligible for more than 70% of funding provided.
 - Sometimes eligibility is limited, but even with restrictions many tribes are eligible to apply.
- CDC worked closely with states to include tribes in a more substantial way; however, eligibility limitations don’t account for why some tribes don’t apply.
- CDC is working with tribes to be aware of and apply for more funding, including new opportunities for emergency preparedness and response funding (which can cover wide range of emergencies including the opioid epidemic).
 - CDC needs to advertise opportunities more effectively and support tribes wanting to apply.
- In CSTLTS, there are new umbrella co-ags available to tribes and tribal agencies: 1) national partners to support the field during an emergency response, 2) tribal public health capacity building umbrella co-ag, and 3) national partner organizations to protect the nation’s health through partnerships.
 - Phase one recipients of the tribal public health capacity building umbrella co-ag are eligible to apply for phase two awards that are offered under that umbrella co-ag.
 - The funding source and scope of programmatic activities are not limited, so many CIOs can participate.
 - This allows the CIOs to work more closely with tribes through a more direct mechanism and allows for more extensive relationships between tribes and the CIOs.
 - This can result in more tribal-specific data, and can help to understand public health needs in Indian Country and measure progress, and can allow for public health in Indian Country to be incorporated into national programmatic planning efforts.
 - It is important to note that some tribes don’t have opportunities to apply because their numbers are too small. There should be opportunities for smaller tribes to apply for grants.
 - CDC has formed key relationships with tribal partners to do sub-granting to smaller tribes.

Questions from Mr. Yazzie: Can you share more about CDC Foundation and how they serve tribes? The Special Pathogens Branch has worked with Navajo to address Hantavirus on the reservation for many years. Can the CDC Foundation help purchase materials to rodent-proof homes in selected communities?

Answers (Input from multiple people):

- CDC Foundation is statutorily established by Congress; the Hantavirus work may already be too far down the path from project initiation; however, the CDC Foundation may be able to work with Navajo on this need and request.
- CSTLTS is engaging with the CDC Foundation to see how it can support work done in Indian Country.

Question from Councilwoman McCovey: Was the TAC involved in the creation of the tribal umbrella co-ag and selection of recipients?

Answer (Dr. Montero): The TAC provides recommendations that may include priorities for funding, but it cannot make budgetary decisions or select grantees. The number of tribes funded depends on the availability of funds.

NCEH—Looking Ahead and Strategic Planning

Presenter

- **Donata Green**, PhD, MA, Acting Deputy Associate Director, NCEH, CDC/ATSDR

Overview of Environmental Health Programs and Initiatives, and History of ATSDR and the Agency's Activities and Roles

- Funding priorities are—
 - Clean water in Indian Country (testing and monitoring)
 - Working with tribes to address environmental health concerns
 - Supporting tribes through technical assistance, training, and staff support
- Dr. Montero noted climate change, weather patterns, food chain contamination, and impact of mining as topics to bring before the TAC to identify support needed from CDC (data, technical assistance, funding).

Question from Councilwoman McCovey: There is an issue with *E. coli* (from feces and growers) getting on marijuana plants. Is it possible for NCEH to train water safety? Monitors?

Answer: Dr. Green will connect interested participants to the appropriate NCEH points of contact.

Question from Ms. Boerner: In Alaska, air and water currents pick up contaminants and deposit them on the circumpolar area. Also, the change in climate melts off permafrost. How can CDC help address these environmental issues?

Answer (Captain Hennessy): NCEH has an officer in Alaska (Jim Bermer) who handles some environmental questions, NIOSH has an assignee in Alaska, and the Alaska Native Tribal Health Consortium can help with some of the environmental issues. CDC encourages tribes to use local resources such as these to address issues.

Discussion:

- The Navajo cancer report is complete and is now on the Navajo website.
- There is a need to address high cancer rates among Navajo people as many communities on Navajo reservations have uranium mines.
- The Red Dog Mine is the largest zinc mine in the United States.

- Fish have lead from Red Dog Mine, the salmon population has decreased, and state environment and mining laws are not very strict.
- Climate change is causing pollutants to be released from the soil, leading to an increase in vector-borne diseases.
 - NCEH has a climate readiness initiative in Indian Country; there may be some funding for tribes to address this issue.
 - This is an area of great concern. The National Climate Assessment Report for 2018 is currently in review.
 - The report includes issues relating to AI/AN populations and adaptations and a series of regional reports.
- A fishing tribe representative recognizes a change in diet has occurred and is concerned about the effect of the diet change in the future in the Pacific Rim, North Sea, and Bering Sea.
- Dr. Green posed questions to the group and will compile feedback to share with leaders:
 - Thoughts on having a national tribal environmental health summit?
 - What topics should be discussed? Ideas for presenters?
 - What are current issues for consideration?

Tribal Testimony

Presenters

- **Byron Larson**, *Northern Cheyenne Nation*, Billings Area
- **Del Yazzie**, *Navajo Nation*, Navajo Area
- **Councilwoman Lana M. McCovey**, *Yurok Tribe*, California Area
- **Verné Boerner**, *Native Village of Karluk*, Alaska Area
- **President George Edwardson**, *Inupiat Community of the Arctic Slope*, Tribes-at-Large
- **Councilman Chester Antone**, *Tohono O'odham Nation*, Tucson Area

Testimony

- Byron Larson, *Northern Cheyenne Nation*, Billings Area—
 - Mentioned that Rocky Mountain TEC recently added a Canadian tribe split by the border
 - Acknowledged CSTLTS for becoming a center and extended appreciation for new funding opportunities for tribes, and the amount of work needed to complete activities
 - Stated that he knows everyone is working hard to recognize and honor tribal sovereignty but acknowledged that tribes are complaining that they want more, including
 - In all treaties, health care is to be included as a trust responsibility
 - Recognized all TAC members who donate their time to this group
- Del Yazzie, *Navajo Nation*, Navajo Area—
 - Acknowledged Sy Francisco and Teresa Galvin as fellow Navajo representatives
 - Thanked CDC for PHAP support, umbrella NOFO, and GHWIC
 - Acknowledged work with chronic disease and special pathogens work on Hantavirus, using lab screening methods to diagnose Hanta early in the development to increase survivorship, including
 - Planning to conduct some lab screening at a local college
 - Continuing the birth cohort study and breast and cervical cancer screening work
 - Requesting public health emergency response funding support directly from CDC instead of through the Arizona Department of Health Services

- Vice President Nez wishes to give a presentation on Navajo ongoing preparedness activities and revenue from junk food tax, including how it's being use for community wellness efforts.
- Regarding workforce development: PHAP is great, but it would be good to have CDC personnel with higher skillsets, such as Epidemic Intelligence Service officers and Career Epidemiology Field officers.
- There is a huge need to support PHEP efforts.
- There are currently no grant writers within the Navajo Health Department.
- Councilwoman Lana M. McCovey, *Yurok Tribe, California Area*—
 - Expressed that in California there is concern about having to wait for money to funnel down from CDC through the states to the tribes—
 - Whether it's pandemic flu, all-hazards preparedness, or hepatitis C, the money is not trickling down to the tribes.
 - CDC needs to determine the impact of current framework (maybe through a study).
 - It is important to know how much CDC dollars that go to states actually get down to the tribes when tribes are designated as a target community.
 - Tribes suffer some of the highest rates of health and socio-economic disparities.
- Verné Boerner, *Native Village of Karluk, Alaska Region*—
 - Workforce development is a priority in Alaska.
 - There's a concerted effort to recruit AI/ANs for staff, but recruitment needs to happen earlier since people aren't getting college educations.
 - Aspects that include high resiliency factors are part of the culture, but much needs to be done to plant those seeds of interest and hope.
 - Hoping to partner directly with CDC for funds and to run programs
- President George Edwardson, *Inupiat Community of the Arctic Slope, Tribes-at-Large Delegate*—
 - The last third of the world's fisheries are in the arctic, and the arctic polar ice is thinning (more than 63% gone). As a result, shipping will increase because of greater water access and migratory animals, and fish will leave because of too much traffic.
- Councilman Chester Antone, *Tohono O'odham Nation, Tucson Area*—
 - Asked which diseases qualify for the infectious diseases funds and how to use money provided to test and prevent Zika and RMSF
 - Mentioned that the border wall will affect water flows and migratory patterns of animals across the border

Closing Remarks

- Chairman TwoBears acknowledged Councilman Antone and thanked the committee members for the opportunity to serve as chair.
- Dr. Montero, on behalf of CDC, and Captain Clelland thanked everyone for participating and the planning team for facilitating the meeting.

Chairman TwoBears adjourned the meeting at 12:15 PM.