21st Biannual CDC/ATSDR Tribal Advisory Committee (TAC) Meeting

February 3, 2021
1:00–7:00 pm (EST)
Virtual Zoom Platform

The Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) hosted their TAC Meeting on February 3, 2021.

Table of Contents

21st Biannual CDC/ATSDR Tribal Advisory Committee (TAC) Meeting 1
- CDC/ATSDR TAC Meeting Participants and Attendees 3
  - TAC Member Attendees 3
  - Absent TAC Members 3
  - CDC Attendees 3
  - Nonfederal Attendees 10
- 1:00 pm—Opening Blessing, Welcome, and Introductions 10
- 1:20 pm—TAC Business 10
  - Facilitator 10
  - Nominations for TAC Co-Chair 10
  - Fall 2021 TAC Meeting 10
  - Fall 2021 TAC Meeting Discussion 10
  - CDC/ATSDR TAC Charter 11
  - CDC/ATSDR TAC Charter: Discussion 11
  - CDC/ATSDR October TAC Letter to CDC 11
  - CDC/ATSDR October TAC Letter to CDC: Discussion 11
- 2:10 pm—National Institute for Occupational Safety and Health (NIOSH) Worker and Safety Health Strategic Plan Update 12
  - Presenter 12
  - Opening Remarks 12
- 2:30 pm—CDC/ATSDR Updates 12
  - Presenter 12
  - Opening Remarks 13
  - TAC Questions and Discussion 13
- 3:00 pm—Technical Assistance Discussion 13
  - Presenter 13
  - Opening Remarks 13

TAC Questions and Discussion 14
3:30 pm—COVID-19 Response Update and Discussion 15
Presenters 15
Opening Remarks 15
TAC Questions and Discussion 15
5:20 pm—Tribal Testimony 17
6:30 pm—Summary, Closing Prayer, and Adjournment 18
Presenters 18
Closing Remarks 18
Appendices 19
Appendix A: Tribal Testimony 19
Appendix B: Acronym List 25
Appendix C: Roster (As of February 3, 2021) 27

CDC/ATSDR TAC Meeting Participants and Attendees

TAC Member Attendees

President Alicia L. Andrew
Native Village of Karluk
Alaska Area Delegate

Legislator Connie Barker
The Chickasaw Nation
Tribes At-Large Delegate

Secretary Vickie Bradley, MPH, BSN, RN
Eastern Band of Cherokee Indians
Tribes At-Large Authorized Representative

Secretary Doreen Fogg-Leavitt
Inupiat Community of the Arctic Slope
Tribes At-Large Delegate

Jill Jim, PhD, MHA/MPH
The Navajo Nation
Navajo Area Authorized Representative

Trinidad Krystall
Torres Martinez Desert Cahuilla Indians
Tribes At-Large Delegate

Councilman Stephen Kutz, RN, BSN, MPH
Cowlitz Indian Tribe
Portland Area Delegate

Byron Larson, MHA
Northern Cheyenne Nation
Billings Area Delegate

Councilwoman Teresa Sanchez
Morongo Band of Mission Indians
California Area Delegate

Representative Robert TwoBears (TAC Chair)
Ho-Chunk Nation of Wisconsin
Bemidji Area Delegate

Deputy Principal Chief Bryan Warner (TAC Co-Chair)
Cherokee Nation
Oklahoma Area Delegate

Absent TAC Members

***Affiliation*/Tribal Area**	**Name**	**Title**
*Ute Mountain Ute Tribe/*Albuquerque Area	Selwyn Whiteskunk	Tribal Councilman
*Eastern Band of Cherokee Indians/*Tribes At-Large	Richard Sneed	Principal Chief
*The Navajo Nation/*Navajo Area	Myron Lizer	Vice President
*Mandan, Hidatsa, and Arikara Nation/*Great Plains Area	Monica Mayer	Councilwoman

CDC Attendees

Ronnesha Addison, MPH
Public Health Advisor, Health Department Program Branch (HDPB), Division of Program and Partnership Services (DPPS), Center for State, Tribal, Local, and Territorial Support (CSTLTS)

Romana Allison, MPH
Public Health Advisor, Office of the Director (OD), CSTLTS

Dayna Alexander, DRPH, MSPH
Health Scientist, Epidemiology Branch, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

Annabelle Allison
Public Health Advisor, OD, Division of Population Health (DPH), NCCDPHP

Brittany Anderson
Public Health Advisor, OD, CSTLTS

Brittany Argotsinger, MPH
Associate Service Fellow, Performance Development, Evaluation and Training Branch (PDETB), Division of Performance Improvement and Field Services (DPIFS), CSTLTS

Danielle Arellano, MPH
Public Health Advisor, State, Local and Tribal Support Team (SLTST), Program Implementation and Evaluation Branch (PIEB), Division of Injury Prevention (DIP), National Center for Injury Prevention and Control (NCIPC)

Gustavo Aquino, MPH
Senior Public Health Advisor, OD, CSTLTS

Coretta Bailey
Public Health Analyst, Office of Appropriations (OA), OD, Office of Financial Resources (OFR), Office of the Chief Operating Officer (OCOO)

Famata Barrie
Operational Support Specialist, Infant Outcomes Monitoring, Research and Prevention Branch (IOMRPB), Division of Birth Defects and Infant Disorders (DBDID), National Center on Birth Defects and Developmental Disabilities (NCBDDD)

Gregory Bautista, MPH
Health Scientist, OD, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)

James Beck
Information Technology Specialist, OD, CSTLTS

Herlynn Benoit, MPH
Communications Specialist, Emergency Preparedness and Response Branch, Division of Preparedness and Emerging Infections (DPEI), National Center for Emerging and Zoonotic Infectious Diseases (NCEZID)

Leann Bing
Environmental Health Scientist, Central Section, Office of Community Health Hazard Assessment (OCHHA), Office of the Associate Director, OD

Dimple Bhat, MPH
Oak Ridge Institute for Science and Education (ORISE) Fellow, OD, Division of Overdose Prevention, NCIPC

Patrick Breysse, PhD
Director, OD, National Center for Environmental Health (NCEH), Deputy Director for Non-Infectious Diseases (DDNID)

Michael Bruce, MD, MPH
US Public Health Service (USPHS), Medical Epidemiologist, Arctic Investigations Program, DPEI, NCEZID

Joan Brunkard, PhD
Epidemiologist, Waterborne Disease Prevention Branch, Division of Foodborne, Waterborne and Environmental Diseases, NCEZID

Sharunda Buchanan, PhD
Director, OD, NCEH, DDNID

Rebecca Bunnell, PhD, MEd, ScD
Director, OD, Office of Science, Deputy Director for Public Health Science and Surveillance

Tonia Burk, PhD
Environmental Health Scientist, Associate Director for Science, OCHHA, Office of the Associate Director

Rachel Burke, PhD, MPH
Epidemiologist, Division of Viral Diseases (DVD), National Center for Immunization and Respiratory Diseases (NCIRD)

Ashley Busacker, PhD
Field Assignee, Field Support Branch, Division of Reproductive Health (DRH), NCCDPHP

CDR Renee Calanan, PhD, MS
USPHS, Office of the Director, NCEZID

Kimberly Cantrell
Public Health Advisor, OD, CSTLTS

Russ Cantrell, MPA
Director, OD, DPIFS, CSTLTS

Sarah David Carrigan, MPH
Health Communications Specialist, OD, DRH, NCCDPHP

Karla Checo
Public Health Advisor, National Partnership Branch, DPPS, CSTLTS

Karen Cobham-Owens, MPA
Public Health Advisor, HDPB, DPPS, CSTLTS

CAPT Amanda Cohn, MD
USPHS, Medical Officer, OD, NCIRD

Anne-Marie Coleman, Contractor (CTR)
HDPB, DPPS, CSTLTS

Elizabeth Conrey, PhD, MS
Senior Service Fellow, Field Support Branch, DRH, NCCDPHP

Meredith Cooney
Public Health Associate, Field Services Branch, DPIFS, CSTLTS

Julie Cox-Kain
Public Health Analyst, HDPB, DPPS, CSTLTS

James B. Crockett, MPA
Deputy Division Director, OD, DPPS, CSTLTS

Elizabeth Dalsey
Health Communications Specialist, Western State Division (WSD), National Institute for Occupational Safety and Health (NIOSH)

Shivani Dama, MPH
Public Health Analyst, Office of Planning and Evaluation, OD, NCCDPHP

Teresa Daub, MPH
Public Health Advisor, HDPB, DPPS, CSTLTS

Gabrielle Davidheiser
Public Health Associate, Field Services Branch, DPIFS, CSTLTS

Alyson Davis, MPH
Public Health Analyst, Program Development and Services Branch, Division of Heart Disease and Stroke Prevention, NCCDPHP

Heather Dennehy, MPP
Public Health Analyst, Meeting and Advance Team Management Activity, OD, Office of the Chief of Staff

Yvette Diallo
Emergency Management Specialist, OD, Division of Emergency Operations, Center for Preparedness and Response (CPR)

Sonal Doshi, MPH, MS
Health Scientist, Evaluation Team Lead, PDETB, DPIFS, CSTLTS

Jillian Doss-Walker, MPH
Public Health Advisor, Program Operations Branch, Immunization Services Division, NCIRD

Audrey Dowling, MPA, MRE
Public Health Analyst, Budget Performance and Evaluation Team, Office of Policy Partnerships, and Planning (OPPP), OD, NCEH

Grisy Escoto, BSHA
Program Specialist, OD, CSTLTS

David Espey, MD
Director, Healthy Tribes Program, NCCDPHP

CDR Molly Evans, MD, MPH
USPHS, Medical Officer, HIV Care and Treatment Branch, Division of Global HIV and TB, Center for Global Health (CGH)

Taleria Fuller, PhD
Health Scientist, Field Support Branch, DRH, NCCDPHP

Sundak Ganesan, MD
Health Scientist, Program Implementation Branch (PIB), Division of State and Local Readiness (DSLR), CPR

Cynthia Garcia
Public Health Associate, Field Services Branch, DPIFS, CSTLTS

Dave Goodman
Lead Health Scientist, Maternal and Infant Health Branch, DRH, NCCDPHP

Amy Groom, MPH
Public Health Advisor, OD, DPH, NCCDPHP

Nancy Habarta, MPH
Branch Chief, PDETB, DPIFS, CSTLTS

Keira Hall
Public Health Analyst, IOMRPB, DBDID, NCBDDD

Mary Hall, MPH
Health Scientist, OD, DPH, NCCDPHP

Amy Watson Hardnett, PhD, MS
Senior Service Fellow, Emergency Response Branch, Division of Laboratory Sciences, NCEH

Veda Harrell, MPA
Public Health Advisor, HDPB, DPPS, CSTLTS

Tara Ramanathan Holiday, JD, MPH
Public Health Analyst, OA, OD, OFR, OCOO

Margaret Honein, PhD, MPH
Director, Division of Congenital and Developmental Disorders, NCBDDD

CDR David Hunter, MPH, MSW
USPHS, Branch Chief, PIB, DSLR, CPR

Stacey Hurst, MPH
Associate Service Fellow, Women's Health and Fertility Branch, DRH, NCCDPHP

Tracy Ingraham
Associate Director for Communication, OD, CSTLTS

Ikovwaiza Irune (CTR)
OD, CSTLTS

Mica Jamison
Management Analyst, OPPP, OD, NCEH

Stacey Mattison Jenkins, MPH
Director, OD, DPPS, CSTLTS

Heather Jones, DrNP, MN
Nurse Consultant, Prevention and Response Branch, Division of Healthcare Quality Promotion, NCEZID

Shaakira Jones, MPH
Public Health Analyst, Office of Policy, Performance, and Communications, OD, OFR, OCOO

Sherry Jones, PhD, JD, MPH
Health Scientist, School-Based Surveillance Branch, Division of Adolescent and School Health, NCHHSTP

Marisa Kanemitsu
ORISE Fellow, SLTST, PIEB, DIP, NCIPC

Julia Kibunja, MPH
Public Health Analyst, EPB, Influenza Division, NCIRD

Alison Kelly, MPIA
Director, Office of Appropriations, Office of the Director, Office of Financial Resources

Samantha Kessler, JD (CTR)
Health Marketing/Communication Specialist, OD, CSTLTS

Stephanie Koh, MPH, MPA
Associate Service Fellow, OD, CSTLTS

Laura M. Mercer Kollar, PhD
Behavioral Scientist, Division of Violence Prevention, NCIPC

Rachel Kossover-Smith, MPH
Public Health Analyst, SLTST, PIEB, DIP, NCIPC

Tamara Lamia, MPH
Health Scientist, OD, CSTLTS

Jessie Legros, EdD, MPH
Public Health Educator, Field Services Branch, DPIFS, CSTLTS

Karina Lifschitz, MPH, MAIA
Public Health Analyst, OD, CSTLTS

Kelsey Linzell
Public Health Associate, Field Services Branch, DPIFS, CSTLTS

Gerda Louizi
Grants Management Specialist, OD, Office of Grants Services (OGS), OFR, OCOO

Katherine Luce
Public Health Advisor, Office of Tribal Affairs and Strategic Alliances (OTASA), CSTLTS

Victoria McBee, MPH
Grants Management Specialist, HDPB, DPPS, CSTLTS

Donna McCree, PhD, MPH
Associate Director for Health Equity, OD, Division of HIV/AIDS Prevention-Intervention Response and Support (DHPIRS), NCHHSTP

Temet McMichael, PhD
EIS Officer, Epidemiology Workforce Branch, Division of Scientific Education and Professional Development, Center for Surveillance, Epidemiology, and Laboratory Services (CSELS)

RADM Jonathan Mermin, MD
USPHS, Director, NCHHSTP

Nancy Messonnier, MD
Director, OD, NCIRD

Erika Meyer, MPH
Health Scientist, Polio Eradication Branch, Global Immunization Division, CGH

CDR Jenna Meyer, MPH, RN
USPHS, Acting Director, OTASA, CSTLTS

Lydia Mezenghie, MPH (CTR)
Public Health Analyst, OTASA, CSTLTS

Jessica Miller, MA, MPH
Public Health Advisor, OTASA, CSTLTS

José Montero, MD, MHCDS
Director, CSTLTS

Georgia Moore, MS
Associate Director for Policy, OD, CSTLTS

Mitch Morris
Public Health Advisor, HDPB, DPPS, CSTLTS

Karen Mumford, MEd, PhD
Behavioral Scientist, OD, CSTLTS

Ranell Myles, PhD, MPH
Epidemiologist, OD, NCHHSTP

Stephanie Neitzel
Lead Public Health Advisor, OD, CSTLTS

Stephanie Nguyen (CTR)
OD, CSTLTS

Joanne Odenkirchen, MPH
Public Health Advisor, OTASA, CSTLTS

William Kerry Osborne (CTR)
OD, CSTLTS

Matt O'Shea, MPH
Public Health Advisor, HDPB, DPPS, CSTLTS

Eli Painter, PhD, MBA
Public Health Analyst, Office of Policy, OD, NCIRD

CAPT Monica Parise, MD
USPHS, Medical Officer, OD, Division of Parasitic Disease Malaria (DPDM), CGM

Stacy Parker, MPH
Health Marketing Specialist, OD, CSTLTS

Chelsea Payne, MPH
Management Officer, OD, CSTLTS

Amy Peeples, MPA
Deputy Director for Management and Operations, OD, NCIPC

Chandra Pendergraft, MPA
Public Health Analyst, OD, CSTLTS

Laquetta Peters
Grants Management Specialist, OD, OGS, OFR, OCOO

Victoria Phifer, MPH
Public Health Analyst, OD, CSELS

Celeste Philip, MD, MPH
DDNID, OD

Lori Phillips, MPH
Health Scientist, OTASA, CSTLTS

Lindsay Prescod, MS
Public Health Advisor, OD, CSTLTS

Gemille Purnell, MPH
Public Health Associate, Field Services Branch, DPIFS, CSTLTS

Karen Remley
Distinguished Consultant, OD, NCBDDD

Nicole Richardson-Smith, PhD, MA
Health Communication Specialist Lead, OD, CSTLTS

Steve Reynolds, MPH
Deputy Director, OD, CSTLTS

Davie Rickenbacker (CTR)
Public Health Analyst, OTASA, CSTLTS

Tekerri Rivers
Public Health Advisor, HDPB, DPPS, CSTLTS

LCDR Shannon Saltclah, PharmD, CPH
USPHS, Healthy Tribes Program, NCCDPHP

Delight Satter, MPH
Senior Health Scientist, OTASA, CSTLTS

Anne Schuchat, MD
Principal Deputy Director CDC, OD

Julia Simon
Deputy Associate Director for Communication, OD, CSTLTS

Karen Simon, MPA (CTR)
HDPB, DPPS, CSTLTS

Sabrina Shivji
ORISE Fellow, OD, DVD, NCIRD

Nathaniel Smith, MD, MPH, MA
Deputy Director of Public Health Service and Implementation Science, OD

Gregory Smith, MPA
Public Health Advisor, PIB, DSLR, CPR

David Sullivan
Public Health Advisor, STLTS, PIEB, DIP, NCIPC

Celeste Smalls Sumpter
HR Specialist, Customer Staffing Activity 2, Client Services Office, Human Resources Office, OCOO

Alice Sutcliffe, MS
Biologist, Entomology Branch, DPDM, CGH

Leigh Swaim
Public Health Advisor, Parasitic Disease Branch, DPDM, CGH

Craig Thomas, PhD, MS
Division Director, OD, DPH, NCCDPHP

Hope Thompson
Analyst, OD, Office on Smoking and Health, NCCDPHP, DDNID

Stacy Thorne, PhD, MPH
Public Health Advisor, PIB, DSLR, CPR

Ana Maria Toro
Public Affairs Specialist, OD, Division of Public Affairs, Office of the Associate Director for Communications

Rhea-Lanee Lansang Tran, MPH, CHES
Public Health Advisor, OD, CSTLTS

Melissa Victor
ORISE Fellow, DBDID, NCBDDD

Rochelle Walensky, MD, MPH
CDC Director/ATSDR Administrator

Jessica Washington
ORISE Fellow, Environmental Epidemiology Branch, Division of Toxicology and Human Health Sciences, OD

Nicole Wachter, MPH
Public Health Advisor, OD, CSTLTS

Charisse Walcott
Public Health Advisor, PDETB, DPIFS, CSTLTS

Alleen Weathers, MEd, MPH
Public Health Advisor, HDPB, DPPS, CSTLTS

Paul Weidle, PharmD, MPH
Research Officer, OD, DHPIRS, NCHHSTP

Seh Welch, PhD, MBA
Public Health Analyst, Strategy, Policy and Communications Branch, Division of Global HIV and TB, CGH

Corinne Wigington, MPH
Health Scientist, OD, CSTLTS

Craig Wilkins
Senior Advisor, OD, Office of Minority Health and Health Equity

Kelly Wilkinson (CTR)
Health Marketing and Communication Specialist, OD, CSTLTS

Yves Wilkerson
Grants Management, OD, OGS, OFR, OCOO

Rebecca Willis
Public Health Advisor, HDPB, DPPS, CSTLTS

Stacey Ann Willocks, MS
Behavioral Scientist, Evaluation Team, PIEB, DIP, NCIPC

Alison Winstead, MD
Medical Officer, Malaria Branch, DPDM, CGH

Ciera Woods
Public Health Associate, Field Services Branch, DPIFS, CSTLTS

Debbie Yembra
Health Scientist, Office of Planning and Evaluation, OD, NCCDPHP

Andrea Zekis MPS, MGIS, MS
Health Communications Specialist, OD, CSTLTS

Carlos Zometa, PhD, MSPH
Behavioral Scientist, PDETB, DPIFS, CSTLTS

Nonfederal Attendees

Andria Apostolou
Nicolas Barton
Nicole Barron
Rhonda Beaver
Stacey Bohlen
Bridget Canniff
Vanesscia Cresci
Tyler Dougherty
Julia Dreyer
Jessica Elm
Kimberly Fowler
Angela Haynes Ferere
Joshua Gregory
Kate Grismala
Candice Jimenez
Karrie Joseph
Andrew Kalweit
Alfred Koroma
Monique Martin
Nina Martin
Erin Morris
Kelly Njike
Travis Noland
Megan O'Neil
Gene Perry
Lisa Pivec
Laura Platero
Ellen Provost
Dean Seneca
Margaret Snead
Sharon Stanphill
Sunny Stevenson
Sue Steward
Annie Tran
Victoria Warren-Mears

1:00 pm—Opening Blessing, Welcome, and Introductions

- **Deputy Principal Chief Bryan Warner** provided the opening blessing.
- **José Montero, MD, MHCDS,** Director, CSTLTS, CDC, welcomed everyone to the 21st Biannual CDC/ATSDR TAC Meeting and introduced the new TAC members, nonfederal partner guests, and CDC leader attendees.
- **Commander Jenna Meyer, MPH, BSN, RN,** USPHS; Acting Director, OTASA, CSTLTS, CDC, conducted the roll call. A quorum was present to conduct necessary business.

1:20 pm—TAC Business

Facilitator

- **Representative Robert TwoBears** (Ho-Chunk Nation): Legislative Representative, Ho-Chunk Nation; Chair, TAC

Nominations for TAC Co-Chair

- Chairman TwoBears asked TAC members for nominations regarding new co-chairs.
- Two nominations were received: Deputy Principal Chief Bryan Warner and Councilman Stephen Kutz.
- Chairman TwoBears passed a motion to open the vote for TAC co-chair. Deputy Principal Chief Bryan Warner was confirmed as the new TAC co-chair position.

Fall 2021 TAC Meeting

- Representative TwoBears and Dr. Montero advised the TAC that, despite the uncertainty regarding the location of the next TAC Meeting, a TAC Meeting will still be held with an initial recommendation for the month of August.
- Representative TwoBears suggested the TAC will identify additional recommendations and dates for the Fall 2021 TAC Meeting and provide updates to CDC.

Fall 2021 TAC Meeting Discussion

Comment from Councilman Kutz:

- I would like to propose for the next TAC Meeting to occur in October 2021 for the possibility that CDC and the TAC could meet face to face.

Comment from Mr. Larson:

- I would like to thank CDC for hosting the TAC Meeting during the 2019 Novel Coronavirus Disease (COVID-19) pandemic. I agree with Councilman Kutz, to push the meeting back to October as this will also allow time for the TAC to reengage the workgroup.

Comment from Dr. Montero:

- CDC is aware of the request from the TAC to have a workgroup, and the agency is supportive of this. CDC staff are currently working with the National Indian Health Board (NIHB) regarding the workgroup.

Comment from Commander Meyer:

- Workgroup information was shared on the January 15, 2021, planning call with the TAC, and we will share it again following this meeting. I would expect any information following this meeting to come from NIHB.

Comment from Representative TwoBears:

- The TAC will work on gathering a recommendation for the next TAC Meeting time and date and follow up with CDC.

CDC/ATSDR TAC Charter

- Mr. Larson proposed the idea that a subcommittee would help TAC members develop input on the TAC charter and return concise comments back to CDC/ATSDR. Deputy Principal Chief Warner seconded Mr. Larson's proposal. Dr. Montero agreed to the development of a subcommittee to provide input on the TAC charter.
- TAC members that volunteered to be included in the subcommittee included Representative Robert TwoBears, Byron Larson, Deputy Principal Chief Bryan Warner, Councilman Stephen Kutz.
- A motion passed to develop a subcommittee to review the draft TAC Charter and have results back to share at the next TAC meeting. There were nine affirmative votes and no votes against.

CDC/ATSDR TAC Charter: Discussion

Comment from Mr. Larson:

- We would like to give the revised TAC charter to our subcommittee for further review, so the subcommittee can have a thorough discussion and review the TAC's edits and recommendations with CDC.

Comment from Dr. Montero:

- There is no legal deadline for when the TAC Charter needs to be completed, but I would like for us to come to a consensus that we will complete the TAC charter discussion and finalize the TAC charter during the next meeting.

Comment from Mr. Larson:

- I agree with coming to a consensus regarding the TAC charter during our next meeting.

Comment from Commander Meyer:

- It might be helpful to have specific comments from TAC within the draft TAC Charter to allow CDC to easily identify comments from the TAC.

CDC/ATSDR October TAC Letter to CDC

- Dr. Montero provided a formal response to the TAC regarding the October letter verbally during the meeting. The TAC letter provided input on the remaining $14 million from the Coronavirus Aid, Relief, and Economic Security (CARES) Act funding set aside for Indian Country.
- Dr. Montero's response provided additional information on how CSTLTS will be moving forward on allocating the remaining funding.

CDC/ATSDR October TAC Letter to CDC: Discussion

Question from Ms. Bradley:

- The funding mechanism, OT20-2004, funds a portion of the tribes. How does this funding help those tribes who are not funded under this mechanism?

Comment from Dr. Montero:

- CDC is funding the same recipients that got awarded in the past. Several tribes decided to apply to other funding opportunities. Under the current mechanism, CDC is funding close to 500 tribes. CDC found this funding method to be more effective and efficient given that tribes can continue to work with various organizations under their current funding mechanism.

Comment from Ms. Bradley:

- Formal public health infrastructure is limited, and various tribes do not have the administrative capacity to apply for funding given the COVID-19 pandemic and allocation of resources and staff. I believe future considerations for tribes that have limited infrastructure need to be considered when structuring funding mechanisms.

Comment from Dr. Montero:

- I agree with your recommendations to consider tribes with limited infrastructure. For applicants that experience difficulties with the process, there are staff within CSTLTS who can assist. Please refer tribes that you know are having difficulty to CSTLTS so we can make sure that whoever is eligible and wants to apply can apply.

Comment from Ms. Bradley:

- I think it would be great if CDC had a list of those tribes that were not funded and maybe reached out to them to offer technical assistance

Comment from Dr. Montero:

- Thank you for that recommendation. I will take it to the team and figure out how we can do that.

2:10 pm—National Institute for Occupational Safety and Health (NIOSH) Worker and Safety Health Strategic Plan Update

Presenter

- **Elizabeth Dalsey,** NIOSH, Western States Division, CDC

Opening Remarks

- Elizabeth Dalsey presented on current plans for a strategic plan, which will outline the current needs of American Indian/Alaska Native (AI/AN) workers to ensure their safety and health and identify priority research and outreach activities related to AI/AN workers.
- There are four focus areas within the plan: research, practice, policy, and capacity building.
- NIOSH is currently conducting internal review and plan to engage relevant partners before moving on to developing the second draft of the plan, publication, and utilization. The strategic plan will be published in the Federal Register for 60–90 days.
- The strategic plan can be used to guide efforts at the tribal, local, state, federal, or organizational levels, as well as to steer partner development and collaboration.
- If TAC members are interested in reviewing the strategic plan to provide feedback on the content and approach described in the plan, please contact Elizabeth Dalsey.

2:30 pm—CDC/ATSDR Updates

Presenter

- **Rochelle P. Walensky, MD, MPH,** Director, CDC; Administrator, ATSDR
- **Nathaniel Smith, MD, MPH, MA,** Deputy Director for Public Health Service and Implementation Science, CDC
- **Alison Kelly, MPIA,** Director, Office of Appropriations, Office of Financial Resources, CDC

Opening Remarks

- CDC Director Dr. Rochelle Walensky and Dr. Nate Smith emphasized that the COVID-19 response and addressing health inequities are two critical priorities for CDC/ATSDR this year.
- CDC provided $208.7 million to tribal nations, consortia, and organizations for responding to COVID-19 across tribal communities. This included $140.2 million to 346 tribal recipients through a new noncompetitive grant for COVID-19 response.
- To address COVID-19 in tribal communities, CDC deployed 240 employees to the field in support of Indian Country to provide hands-on technical assistance, in addition to 12 remote deployments and 15 hybrid deployments in support of COVID-19 response in tribal communities.
- Within the budget updates portion of the meeting, Alison Kelly, director of CDC's Office of Appropriations, stated that the overall funding level for CDC is at an increase of $127 million or 2% above the fiscal year 2020 enacted level, when adjusted to exclude the one-time nonrecurring expenses transfer funding received in fiscal year 2020.
- Additional information on fiscal year 2022 information and formulation process is limited at this time, but additional details are to be provided to CDC in the next several weeks.

TAC Questions and Discussion

Comment from TAC Members:

- TAC members thanked Dr. Walensky for her participation in the TAC meeting and for highlighting CDC's priorities. The TAC identified several of CDC's priorities that encompassed tribal nations' concerns and expressed interest in continuing meaningful tribal consultation with CDC in upcoming months.

Question from Representative TwoBears:

- When was the last time CDC received a nonrecurring expenses fund?

Response from Ms. Kelly:

- In 2018, CDC received it for construction of a high containment continuity laboratory for one of the CDC campuses.

3:00 pm—Technical Assistance Discussion

Presenter

- **Georgia Moore, MS,** Associate Director for Policy, CSTLTS, CDC

Opening Remarks

- Georgia Moore, Associate Director for Policy, presented on recent congressional language directing CDC to develop guidelines for CDC technical assistance and programmatic inclusion of tribes.
- Ms. Moore asked TAC members two questions to guide CDC in its work with Indian Country.
  - How and at what points does the TAC want to be engaged by CDC?
    - Draft ideas for key engagement points
      - Provide input to the approach and timeline for guideline development
      - Review and provide feedback on reported activity progress
      - Review and provide input on draft products
      - Provide input/feedback on guideline implementation
      - Provide input to a process for updating the guidelines over time
  - How should CDC get started?
    - Draft ideas
      - CSTLTS collects any immediate input the TAC has during and after this meeting
        - Deadline for TAC input after the meeting?
      - CSTLTS shares the consolidated input with the TAC and possible ideas for next steps
        - Deadline for CSTLTS to provide this information?

- Initial thoughts, preferences, and recommendations from TAC members were requested specifically for:
    - TAC engagement
    - Content of guidance
    - Stakeholders to engage
    - Sources of information to inform the effort (e.g., best or model practices)
    - Immediate next steps
- During the discussion portion of this presentation, the TAC members passed a motion to modify the subcommittee membership—originally developed to discuss just the draft TAC charter—to also discuss the technical assistance recommendations policy. Dr. Montero agreed to the change for the subcommittee and the motion passed unanimously. More context can be found below in the discussion.
- TAC members volunteering to join the subcommittee to discuss both the draft TAC charter and the technical assistance recommendations include Chair Representative Robert TwoBears, Mr. Byron Larson, Councilwoman Teresa Sanchez, Co-Chair Deputy Principal Chief Bryan Warner, Councilman Stephen Kutz, Legislator Connie Barker, and Ms. Trinidad Krystall.

TAC Questions and Discussion

Comment from Deputy Principal Chief Warner:

- Deputy Principal Chief Warner made a motion to develop a subcommittee to review the guidance questions asked by Georgia Moore during the technical assistance discussion.

Comments from Councilwoman Sanchez:

- Councilwoman Sanchez seconded the motion made by Deputy Principal Chief Warner. Councilwoman Sanchez inquired if this should be part of the already developed subcommittee from the earlier portion of this meeting.

Comments from Mr. Larson:

- Mr. Larson suggested that the two subcommittees be combined so that the subcommittee developed during this TAC meeting can review both the draft charter as well as the technical assistance discussion questions.
- He added that additional members could be added to this subcommittee to address the added task.

Response from Dr. Montero:

- Dr. Montero restated the motion suggested by TAC members to modify the subcommittee and opened the vote to TAC members. Dr. Montero reiterated that based on the Unfunded Mandates Reform Act (UMRA) exemption to the Federal Advisory Committee Act (FACA), urban Indian organization leaders and Indian health board members are not authorized to sit on an UMRA FACA-exempt group in their own right because they are not elected officials of tribal governments acting in their official capacities on behalf of their tribe. Also, technical advisors cannot participate in subcommittees except to advise members on the subcommittee.
- During the vote, ten TAC members were in favor and none against.

Comments from Mr. Larson:

- Mr. Larson suggested that performance measures be included in the technical assistance recommendations so the TAC can monitor and track progress.
- He added that in terms of budget, it would also be good to look back on previous requests from the TAC and bring them forward to see what has and has not been accomplished. Moreover, it would be good to look at those previous requests and see if they are still relevant. Specifically, Mr. Larson referenced older TAC requests regarding 5% of CDC's budget and using the US AI/AN population as a 51st state for directing funding. While CDC did state that those requests were not feasible, it would be good to have direct conversations with CDC's centers, institutes, and offices to discuss their individual budgets and work to make a portion of their budgets more relevant to Indian Country.

- For distribution of budget, we also want to see the resources allocated for AI/AN populations within the OT18-1802: Strengthening Public Health Systems and Services through National Partnerships to Improve and Protect the Nation's Health and make sure that those resources are allocated appropriately.

3:30 pm—COVID-19 Response Update and Discussion

Presenters

- **Margaret Honein, PhD, MPH,** STLT Task Force Lead, COVID-19 Response, CDC
- **Amanda Cohn, MD,** NCIRD, CDC

Opening Remarks

- Dr. Honein discussed the COVID-19 response and reviewed four different themes: increasing emergency response capacity, building COVID-19 surveillance capacity, increasing testing capacity in remote areas, and health communications support.
- Dr. Honein emphasized the need to continue an open line of communication between CDC and tribal nations for allocation of resources and understanding unique challenges/concerns tribal nations face in addressing COVID-19.
- Dr. Cohn provided updates to the COVID-19 vaccination program, information on vaccine safety, and available resources for communicating vaccine confidence.
- Information on the latest COVID-19 vaccination data in the United States is available through the COVID-19 Data Tracker.
- CDC is focused on equitable access, reducing barriers, and increasing engagement to build trust in communities.
- The safety profile of COVID-19 vaccines in the recipients is consistent with that observed during clinical trials.
- COVID-19 Vaccination Toolkits are available to help build confidence in the COVID-19 vaccine and provide healthcare professionals with the tools they need to answer questions.

TAC Questions and Discussion

Question from Representative TwoBears:

- How have tribal nations been managing the COVID-19 response during religious events? Especially when there is a contrast between state and tribal restrictions.

Response from Dr. Honein:

- This is something we encounter a lot, trying to find a balance of following mitigation measures while trying to prevent transmission and still honoring important traditions. I would like to turn this question over to my colleague who has experience with this in the COVID-19 response.

Response from Commander Evans:

- In the case of the Hopi Tribe as it was discussed in the presentation, the Hopi villages, as other tribal nations, are autonomous and have sovereignty to determine restrictions. My colleague was on this deployment, and CDC worked closely with the tribal council on the recommendations, which was crucial in gaining the respect of the surrounding community concerning these recommendations.

Question from Representative TwoBears:

- Do you have any stories of challenges where one member of a household was positive and there were multiple people in that household?

Response from Dr. Honein:

- In a variety of settings, this is often a challenge when one household member is positive. We try to ensure that we provide options that would support the different variations that families might experience in a household (ability to self-isolate or not). CDC works with tribal nations that have requested assistance for support for isolating individuals who are unable to self-isolate at home.

Response from Commander Evans:

- Isolation facilities or alternate care sites are an option for family members not able to self-isolate in the home. Some tribal nations also use tents which can and have in some instances been provided through the Federal Emergency Management Agency.

Question from Representative TwoBears:

- What are your recommendations for communities that might have conflicting isolation and quarantine periods (from tribal land versus county) for positive and exposed people?

Response from Dr. Honein:

- Our primary recommendation is still 14 days of quarantine, and isolation requirements have not changed. CDC guidance from time of positive test for asymptomatic individuals is 10 days of isolation.

Question from Legislator Barker:

- Can you speak to the new variants we are seeing for COVID-19 and how that might be affecting tribal nations?

Response from Dr. Honein:

- CDC is monitoring the three variants of concern identified and the cases announced by Maryland, South Carolina, and Minnesota in a couple of ways. CDC is monitoring all of the variants through national strain surveillance, where health departments are submitting to CDC a small number of positive samples, adding up to around 750 samples a week. CDC has also entered into contracts with three large commercial labs, where thousands of samples are being sequenced, to look for variants of concern.

Question from Councilman Kutz:

- We are starting to see that more people are flying more frequently, and I was wondering if you had any recommendations or guidance for us to implement before they come back into our communities and workplaces. We have different workplace guidance here that will not let people come back to work until they have a negative test. Is there a criteria maybe that we can follow?

Response from Dr. Honein:

- CDC does have guidance and recommendations available on our website. The first recommendation is asking people not to travel right now. However, if people do travel, we recommend that they be tested before travel and after travel. For international travel, testing is required, but it is only recommended for domestic travel.

Question from Councilwoman Sanchez:

- Is there any way to know how many of the vaccines are going to AI/AN populations per state?

Response from Dr. Cohn:

- We are working to provide you that, however, there is an issue with the system in calculating it. But we just have to work through the data. We anticipate being able to make that information available as soon as we have analyzed the data.

Comment from Deputy Principal Chief Warner:

- The level of trust, especially in Indian Country, is paramount to everything. Cherokee Nation has an accredited public health department with public health authority. We had some issues early in the pandemic, and that is why we went through the Indian Health Service (IHS) to get our vaccines. Last week we administered our 10,000th vaccination, so we are trying to ramp up more of those movements and build infrastructure. In the future, we need to look at funding that is awarded and how we can get it directly to the tribal nations. Each of us is unique in our culture and traditions, but that level of trust, and seeing our faces on some of the messaging, is very important.

Comment from Councilman Kutz:

- IHS never focused on building public health infrastructure, and so in the northwest we have been working on getting up to speed. Most of the CDC funding for public health infrastructure goes to states, which under most circumstances does not reach the tribal nations. I will be advocating for CDC to really work on building a more robust public health system in Indian Country.

Comment from Mr. Larson:

- I want to reiterate the points that my colleagues made. One of the concerns that I have is that the distribution of resources as it relates to tribes, tribal organizations, and urban Indian programs is skewed more heavily towards the latter two. I am looking at the total amount of resources that have been expended under the OT18-1802: Strengthening Public Health Systems and Services through National partnerships to Improve and Protect the Nation's Health and OT18-1803: Tribal Public Health Capacity Building and Quality Improvement Umbrella cooperative agreements, as well as other direct funding to tribes. It is not consistent with what tribal nations should be advocating for.

Question from Councilwoman Sanchez:

- When will more vaccines be rolling out?

Response from Dr. Cohn:

- This is something we are carefully monitoring. We have our distribution numbers right now and anticipate we will be steady for the next three weeks overall in the country (between 10 to 11 million doses). But we really need a new vaccine product, and so when the Johnson and Johnson vaccine is approved, we will be able to increase the number of doses pretty rapidly.

Question from Councilman Kutz:

- The President has signed the Defense Production Act. Is that going to authorize vaccine producers aside from Moderna and Pfizer to bring more production capacity available to us, or are we stuck with the production capacity that they have internally to their systems?

Response from Dr. Cohn:

- I do not have enough visibility to see where this will go, but I do know that changing production capacity is an option that is being explored.

5:20 pm—Tribal Testimony

Testimony from Deputy Principal Chief Warner:

- I want to thank everyone for the opportunity to offer comments on behalf of Cherokee Nation. Chief Hoskin and I took oaths to protect and preserve culture, traditions, and language. We feel that once we lose our language, we lose what it is to be Cherokee. For the first vaccine distribution, Cherokee Nation has distributed the vaccine to elders and those who are fluent in Cherokee. More than 1,000 of those people are vaccinated today, so I would like to say thank you to IHS, as well as those who helped distribute the vaccine.
- CDC and ASTDR are essential for advancing public health in Indian Country. As a main part of US trust responsibility, I want to continue to urge the CDC to strengthen funding and resources supplied directly to the tribes. We feel that direct federal funding is essential to expanding public health. CDC and ASTDR funding to tribes is well below what is needed to address the public health needs of AI/AN. Although our public health systems in Indian Country are continually being built up, there are still gaps, thus we are looking towards the future.
- I offer some solutions, one of which is to urge the CDC to allocate 2–4% of the budget of all the centers, institutes, and offices as direct funding to the tribe's public health infrastructure. New funding streams should go directly to tribes by formulas that are vetted through strong tribal consultation. Tribes should be given an equal opportunity to receive competitive funding through funding opportunities currently open only to the tribal epidemiology centers. Tribal epidemiology centers play an important role, but they are not tribal governments. Tribal governments should decide how to best build public health infrastructure. All funding opportunity announcements should state that the federally recognized tribal governments are eligible for direct funding except where specifically prohibited by statute. When direct funding to tribal governments is restricted, an explanation as to why it should be provided. States that receive funds should also be required to interface with tribes as part of the funded activities.
- The pandemic has created more regular and open communication than in the past, and it is important to continue that communication though annual updates from the CDC director and senior CDC employees.

It is paramount that there is government-to-government tribal-based consultation moving forward to discuss public health infrastructure across Indian Country.

- I want to also urge TAC committee members to take full advantage of the opportunity to be a venue for discussion, collaboration, and meaningful participation in CDC decisions. Although, we have all been overworked, it is important to have effective, positive change in Indian Country. The global COVID-19 pandemic has magnified the need for strong public health infrastructure, but even before the pandemic, this has been one of the greatest needs for improving wellbeing in Indian Country. Public health is what protects all of us, and today we see that more than ever with the pandemic.

6:30 pm—Summary, Closing Prayer, and Adjournment

Presenters

- **Dr. Montero, MD, MHCDS**, Director, CSTLTS, CDC
- **Representative TwoBears** (Ho-Chunk Nation of Wisconsin), Legislative Representative District V, Ho-Chunk Nation of Wisconsin; Chair, TAC
- **Deputy Principal Chief Bryan Warner** (Cherokee Nation), Deputy Principal Chief, Cherokee Nation; Co-Chair, TAC

Closing Remarks

- Dr. Montero provided summary highlights of the meeting and thanked everyone for their participation.
- Representative TwoBears expressed thanks to the TAC for participating and providing input during the meeting.
- Deputy Principal Chief Bryan Warner closed the meeting with a prayer.
- Representative TwoBears called the meeting adjourned.

Appendices

Appendix A: Tribal Testimony

Testimony from Governor J. Michael Chavarria, Santa Clara Pueblo:

Virtual Roundtable Written Testimony Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR), 21st Biannual CDC/ATSDR Tribal Advisory Committee (TAC) Meeting, February 3, 2021

Written Comments Submitted by:
J. Michael Chavarria, Governor
Ph: at 505-929-2120
Email: governor@santaclarapueblo.org

Submitted: January 21, 2020

On behalf of Santa Clara Pueblo located in northern New Mexico, I submit the following written comments related to the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR), 21st Biannual CDC/ATSDR Tribal Advisory Committee (TAC) Meeting scheduled for February 3, 2021.

Trust and Treaty Responsibility:

The United States Federal Government has a trust and treaty responsibility to protect the health, safety, welfare, housing and interests of the Pueblos, Tribes and Nations. As that responsibility extends to every federal agency and Department, it is the job of Congress to help fulfill this obligation by ensuring that American Indian and Alaska Natives (AI/ANs) have access to critical programs and services based on our political status as sovereign Tribal Nations/governments engaged in a government-to-government relationship with the United States. Members of Congress, federal agencies and federal officials each serve as trustees of that federal trust responsibility. It is their solemn duty to ensure that tribal interests are protected as part of any action, legislation, programming, or policy undertaken by the Federal Government, including in the federal budgeting process and national emergency relief efforts. As the urgency, infection rate, and death toll of the COVID-19 pandemic intensifies, it has become increasingly clear that more funding resources are needed to protect and preserve our tribal communities pursuant to these federal trust and treaty responsibilities.

With the onset of a new Administration, we hope that this will be the beginning of a new era for the federal government's relationship with Tribal Nations, and indeed, we are encouraged by many positive developments so far. At the CDC, there are numerous opportunities to improve the interaction and public health system in tribal communities. In the following testimony we discuss key opportunities for enhancement and future collaboration.

COVID-19 Challenges:

Among the many things we have learned from the COVID-19 pandemic is that basic public health functions are critical to preserving life and the overall health of Americans. However, this crisis is especially acute in Indian

Country and for our community in particular. According to CDC's own data, COVID-19 death rates among AI/ANs are 2.6 times the rate for non-Hispanic Whites.[1]

As you are aware, AI/ANs also face serious health disparities for diseases such as type 2 diabetes and respiratory illness, which leads to an increased risk of severe COVID-19 illness and death.

During this pandemic, the CDC has disappointed tribal communities because it has failed to hold national virtual listening sessions to solicit feedback, guidance and recommendations from tribal leaders. Decisions that CDC makes every day are critical to the health and well-being of AI/AN people. CDC should engage regularly with tribal leaders to ensure that the needs of Indian Country are met in response to the pandemic. The latest round of supplemental funding made available through the (P.L. 116-260) (Act) for testing, vaccine distribution and related activities was transferred to the Indian Health Service (IHS), who then distributed it to the Indian health system. We hope that CDC works closely with IHS to ensure a seamless approach to data and activities that would be complementary—not duplicative of efforts in other areas.

The same Act provides CDC with $300 million "for high-risk and underserved populations, including racial and ethnic minority populations and rural communities." The agency should work closely with tribes to ensure that their communities are addressed as part of this targeted funding. AI/AN communities, especially those in remote areas like ours, are especially vulnerable to COVID-19 and experience some of the greatest logistical challenges when it comes to vaccine distribution. Further, the law requires that CDC provide "an updated and comprehensive coronavirus vaccine distribution strategy…" to Congress and requires the plan to include the Indian health system. We request that in the development of this plan you engage in robust, meaningful consultation with Tribal Nations, and also work collaboratively with the IHS so that Indian Country's unique challenges are appropriately incorporated into this document.

As in many areas of the United States, vaccine hesitancy is a serious concern in Indian Country. CDC should also work closely with IHS to develop culturally appropriate messaging that will help AI/ANs feel comfortable taking the COVID-19 vaccine.

Future Funding:

We are encouraged by the Biden Administration's proposal to provide $20 billion to "support Tribal governments' response to the pandemic." This much-needed investment will save AI/AN lives, but we must also ensure that it is provided appropriately, with maximum flexibility for Tribal Nations so that they can respond effectively to the unique needs of their communities. We hope to engage with CDC as partners to advance this request in Congress and ensure that any legislative text developed fully honors Tribal Nations' sovereignty and addresses urgent needs.

Interdepartmental Coordination:

The pandemic has made indisputably clear the importance of inter- and intra-governmental cooperation in addressing unmet needs. Coordinating supply chain distributions and targeting response actions are essential to protecting community welfare. It is the mission of the U.S. Department of Health and Human Services (HHS) to

---

[1] Centers for Disease Control and Prevention. COVID-19 Hospitalization and Death by Race/Ethnicity. Retrieved from www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-raceethnicity.html#footnote03

enhance and protect the health and well-being of all Americans. We fulfill that mission by providing for effective health and human services and fostering advances in medicine, public health, and social services for Pueblo people – a mission that is based on the trust responsibilities flowing from the political government-to-government relationship between federal and tribal sovereigns.

Too often, agencies designated as the administering entities for tribal funds lack the institutional knowledge and funding distribution networks for working effectively with Indian Country. This has contributed, among other challenges, to significant delays in delivering funds to Tribal Nations. This is unacceptable at a time when every day counts in meeting the needs of our people. Whenever there are funding opportunities available, we encourage you to work closely with IHS to ensure that the funds reach the places they are needed most.

CDC Funding for Tribal Communities:

COVID-19 has underscored how persistent gaps in funding for the Indian health system have contributed to negative health outcomes for Native peoples and the under-resourcing of IHS, tribal, and urban Indian healthcare facilities. Planning for future fiscal years must address not only the immediate needs of the Indian health system, but also its long-term preparedness and financial sustainability. This is especially true of CDC's budget for Tribal Nations.

For too long, CDC has not provided significant resources to tribal communities, yet it continues to provide significant funding to states and localities. This leaves dangerous gaps in responding to key public health functions and will only continue to worsen if Tribal Nations are not empowered to develop the robust public health systems they deserve. Up until the COVID-19 pandemic, the only set-aside funds for Tribal Nations was the Good Health and Wellness in Indian Country (GHWIC) program, which is funded at only $22 million in FY 2021. Still, CDC proposed in consecutive budgets to eliminate this funding and replace it with America's Health Block grant and focus funds on Tribal Epidemiology Centers (TECs). While TECs provide a valuable service to Tribal Nations, they are not tribal governments—they are regional nonprofits. Instead, CDC should fund Tribal Nations directly, as it does for states. Where the law requires funding only to state governments, CDC should require states to demonstrate how they will work collaboratively with tribes within their borders for any funding that is provided.

As CDC finalizes its budget request for FY 2022, we request that CDC include increased direct funding to tribal communities across its Centers. In the longer term, we reiterate requests of the CDC/ATSDR TAC to develop an annual budget consultation with Tribal Nations.

Cultural and Traditional Practices:

The CDC should include language in their Funding Opportunity Announcements (FOAs) that recognizes the value and applicability of cultural and traditional practices as viable grantee activities. Unfortunately, Tribal Nations often experience barriers when seeking to implement or incorporate traditional and cultural practices and activities. We should not have to explain or defend the benefit of our cultural practices and the positive impact that it can have on behaviors and community identity. As we have seen with the Special Diabetes Program for Indians, and the GHWIC program, infusing cultural practices with public health interventions leads to greater success.

Data Sovereignty and Improvement:

CDC should ensure Tribal Nations are equipped with the necessary public health data to operate public health programs and improve health outcomes within their communities by clarifying the Secretary of HHS's role in collection and availability of health data with respect to Tribal Nations. In the 116th Congress, H.R.7948 – the Tribal Health Data Improvement Act – passed the House by voice vote but was not considered in the Senate. This bill would have ensured that Tribal Nations are equipped with the necessary public health data to operate public health programs and improve health outcomes within their communities by clarifying the Secretary of HHS's role in the collection and availability of health data with respect to Tribal Nations. As noted in in the Committee report, "[i]t also mandates ways of improving health statistics reporting with respect to Indian Tribes such as requiring the Secretary to release all applicable public health data to TECs … and requiring the CDC to expand and improve their assistance to States with respect to sharing data with Tribal entities" (H. Rept. 116-546). As we continue to battle the COVID-19 pandemic and enhance public health in our communities, we hope that CDC and HHS can continue to support this legislation should it be reintroduced in the 117th Congress.

Conclusion. Thank you for the opportunity to provide comments to the CDC/ATSDR TAC. We believe there are many wonderful opportunities for collaboration in the coming months and year.

We look forward to addressing the matters raised in this testimony with you and your staff. Kuunda; thank you.

Testimony from Deputy Principal Chief Bryan Warner, Cherokee Nation:

GWY.Ꮎ DᏰᏢ
CHEROKEE NATION®
P.O. Box 948 • Tahlequah, OK 74465-0948
918-453-5000 • www.cherokee.org

Office of the Chief

Chuck Hoskin Jr.
Principal Chief

Bryan Warner
Deputy Principal Chief

February 3, 2021

Rochelle P. Walensky, MD, MPH Director, Centers for Disease Control and Prevention Administrator, Agency for Toxic Substances and Disease Registry 1600 Clifton Rd Atlanta, GA 30329

Dear Dr. Walensky,

On behalf of Cherokee Nation and the Oklahoma City Indian Health Services area, thank you for this opportunity to offer comments to the Centers for Diseases Control and Prevention and Agency for Toxic Substances and Disease Registry (CDC/ATSDR).

The CDC/ATSDR is essential for advancing public health in Indian Country, as part of the United States' trust responsibility to provide health care to American Indians and to meet its obligations to tribal governments. In line with that responsibility, I submit the following comments.

First, I urge the CDC/ATSDR to strengthen funding and resources supplied directly to Tribes. As Tribes do not have a local tax base on par with states to support public health activities, direct federal funding is essential for high quality tribal disease prevention and public health promotion activities. Both historically and at present, CDC/ATSDR funding to Tribes has fallen well below what is needed for sustainable and effective public health programs and infrastructure.

To close this gap, I urge the CDC/ATSDR to adopt regular policy of allocating 2-4% of the budget of its Centers, Institutes, and Offices to direct funding of Tribes for public health infrastructure. In the case of any new funding opportunities, I urge that those funding streams go directly to Tribes by formulas that are vetted through strong tribal consultation. For any existing competitive funding opportunities that are currently open only to Tribal Epidemiology Centers (TECs), Tribes should be given equal opportunity to receive funding. While TECs may play an important role in some areas, they are not federally recognized tribal governments. Each area should be given the opportunity to decide at the tribal government level how best to build long term public health infrastructure.

Going forward, I urge CDC/ATSDR to make proactive efforts to ensure strong Tribal inclusion and consultation on all funding opportunities. In addition, all funding opportunity announcements should include language that clearly includes all federally recognized tribal governments as eligible for direct funding, except where specifically prohibited by statute. When direct funding to Tribal governments by CDC/ATSDR is restricted, an explanation as to why should be provided. States that receive CDC/ATSDR funds should be required to actively interface with federally recognized tribes within their state boundaries as part of funded activities.

Besides strengthening direct funding to Tribes, the CDC/ATSDR can benefit from full utilization of CDC/ATSDR Tribal Advisory Committee (TAC). While the CDC/ATSDR TAC does not replace the need for Tribal consultation, it is an effective means for gathering additional input from Tribal leaders and tribal public health experts. The CDC/ATSDR can encourage full engagement of TAC members by committing to regular, open communications with the TAC, including at least annual updates from the CDC Director and senior CDC/ATSDR employees. Likewise, I urge TAC members to take full advantage of the opportunity of the TAC to be a venue for discussion, collaboration, and meaningful participation in CDC/ATSDR decisions.

Cherokee Nation is a leader in developing progressive public health strategies and interventions for our citizens. We value the CDC/ATSDR as an effective partner in advancing public health for Cherokees and all American Indians and Alaska Natives. The global COVID-19 pandemic has magnified the need for strong public health programs and infrastructure, but even before the pandemic, this development has been one of the greatest needs for improving well-being in Indian Country. Thank you again for this opportunity to provide feedback, and we look forward to making these a reality alongside CDC/ATSDR leadership.

Sincerely,

Bryan Warner
Cherokee Nation Deputy Principal Chief
CDC/ATSDR Tribal Advisory Committee Oklahoma City Area Delegate

Appendix B: Acronym List

AI/AN	American Indian/Alaska Native
ATSDR	Agency for Toxic Substances and Disease Registry
CDC	Centers for Disease Control and Prevention
CGH	Center for Global Health
COVID-19	2019 Novel Coronavirus Disease
CPR	Center for Preparedness and Response
CSELS	Center for Surveillance, Epidemiology, and Laboratory Services
CSTLTS	Center for State, Tribal, Local, and Territorial Support
CTR	Contractor
DBDID	Division of Birth Defects and Infant Disorders
DDNID	Deputy Director for Non-Infectious Diseases
DHPIRS	Division of HIV/AIDS Prevention-Intervention Response and Support
DIP	Division of Injury Prevention
DPDM	Division of Parasitic Disease Malaria
DPEI	Division of Preparedness and Emerging Infections
DPH	Division of Population Health
DPIFS	Division of Performance Improvement and Field Services
DPPS	Division of Program and Partner Services
DRH	Division of Reproductive Health
DSLR	Division of State and Local Readiness
DVD	Division of Viral Diseases
FACA	Federal Advisory Committee Act
FSB	Field Support Branch
HDPB	Health Department Program Branch
HHS	Health and Human Services
IHS	Indian Health Service
IOMRPB	Infant Outcomes Monitoring, Research and Prevention Branch
NCBDDD	National Center on Birth Defects and Developmental Disabilities
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 Prevention
NCIPC	National Center for Injury Prevention and Control
NCIRD	National Center for Immunization and Respiratory Diseases
NIHB	National Indian Health Board
NIOSH	National Institute for Occupational Safety and Health
OA	Office of Appropriations
OCHHA	Office of Community Health Hazard Assessment
OCOO	Office of the Chief Operating Officer
OD	Office of the Director
OFR	Office of Financial Resources
OGS	Office of Grants Services
OPPP	Office of Policy, Partnerships, and Planning
ORISE	Oak Ridge Institute for Science and Education
OTASA	Office of Tribal Affairs and Strategic Alliances
PDETB	Performance Development, Evaluation and Training Branch
PIB	Program Implementation Branch
PIEB	Program Implementation and Evaluation Branch
SLTST	State, Local and Tribal Support Team

TAC	Tribal Advisory Committee
TEC	Tribal Epidemiology Center
UMRA	Unfunded Mandates Reform Act
USPHS	United States Public Health Service
WSD	Western State Division

Appendix C: Roster (As of February 3, 2021)

Area Office	Delegate	Authorized Representative
Alaska Area **Term Expires:** February 28, 2021	**Alicia L. Andrew** President, Karluk IRA Tribal Council *Native Village of Karluk*	**VACANT**
Albuquerque Area **Term Expires:** August 31, 2021	**Selwyn Whiteskunk** Tribal Councilman *Ute Mountain Ute Tribe*	**Alston Turtle** Council Delegate *Ute Mountain Ute Tribe*
Bemidji Area **Term Expires:** November 30, 2022	**Robert TwoBears (TAC Chair)** Legislative District V Representative *Ho-Chunk Nation of Wisconsin*	**Wally Apland** Director of Finance, Department of Health *Ho-Chunk Nation of Wisconsin*
Billings Area **Term Expires:** August 31, 2021	**Byron Larson, MHA** Rocky Mountain Tribal Leaders Council *Northern Cheyenne Nation*	**VACANT**
California Area **Term Expires:** November 30, 2022	**Teresa Sanchez** Tribal Council Member *Morongo Band of Mission Indians*	**VACANT**
Great Plains Area **Term Expires:** November 30, 2022	**Monica Mayer** Councilwoman, North Segment Representative *Mandan, Hidatsa, and Arikara Nation*	**VACANT**
Nashville Area	**VACANT**	**VACANT**
Navajo Area **Term Expires:** August 31, 2021	**Myron Lizer** Vice President *The Navajo Nation*	**Jill Jim, PhD, MHA/MPH** Executive Director, Department of Health *The Navajo Nation*
Oklahoma Area **Term Expires:** October 31, 2021	**Bryan Warner (TAC Co-Chair)** Deputy Principal Chief *Cherokee Nation*	**Lisa Pivec, MS** Senior Director of Public Health, Cherokee Nation Health Services *Cherokee Nation*
Phoenix Area	**VACANT**	**VACANT**
Portland Area **Term Expires:** August 31, 2021	**Stephen Kutz, RN, BSN, MPH** Tribal Council Member *Cowlitz Indian Tribe*	**Sharon Stanphill, MD** Chief Health Officer *Cow Creek Band of Umpqua Tribe of Indians*

Tucson Area	**VACANT**	**VACANT**
Tribes At-Large **Term Expires:** August 31, 2021	**Doreen Fogg-Leavitt** Secretary, Inupiat Community of the Arctic Slope Council *Inupiat Community of the Arctic Slope*	**VACANT**
Tribes At-Large **Term Expires:** August 31, 2021	**Connie Barker** Tribal Legislator *The Chickasaw Nation*	**Darcy Morrow** Tribal Council Member *Sault Ste. Marie Tribe of Chippewa Indians*
Tribes At-Large **Term Expires:** August 31, 2022	**Trinidad Krystall** Riverside San Bernardino County Indian Health Clinic Inc. *Torres Martinez Desert Cahuilla Indians*	**VACANT**
Tribes At-Large **Term Expires:** August 31, 2021	**Richard Sneed** Principal Chief *Eastern Band of Cherokee Indians*	**Vickie Bradley, MPH, BSN, RN** Secretary of Public Health and Human Services *Eastern Band of Cherokee Indians*