

# CDC/ATSDR TRIBAL ADVISORY COMMITTEE MEETING

*The Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) hosted the Tribal Advisory Committee (TAC) Meeting and 17th Biannual Tribal Consultation Session on August 8–9, 2017, at the Artesian Hotel, in Sulphur, Oklahoma. During the two-day meeting, TAC members held discussions with CDC and ATSDR representatives.*

*Topics included CDC’s budget, tribal strategies for connecting cultural practices in competitive funding opportunities, Zika virus response, and tribal public health priorities.*

## **Tuesday, August 8, 2017**

### **Tribal Advisory Committee Business**

The session highlighted strategies to improve the structure of biannual TAC meetings. The Tribal Support Unit (TSU) shared ideas about identifying opportunities, enhancing engagement, and seeking other approaches and methods to disseminate information. TSU spoke about its new internal mechanism for tracking tribal inquiries and TAC meeting evaluations. The system will be piloted after the Summer 2017 TAC meeting has been completed.

### **CDC Office of the Director Updates**

Dr. José Montero, director, Office for State, Tribal, Local and Territorial Support (OSTLTS), deputy director, CDC, announced the appointment of Dr. Brenda Fitzgerald as the 17th CDC director and ATSDR administrator.

Dr. Montero discussed CDC’s opioid overdose prevention work in American Indian/Alaska Native (AI/AN) communities and addressed the Department of Health and Human Services’ (HHS’s) five-part strategy to combat the opioid epidemic. He highlighted that AI/AN populations continue to be affected disproportionately by various types of intentional and unintentional injuries, including opioid overdose. Dr. Montero also addressed how social determinants of health have created an environment in which injury prevention efforts have not been as successful as they have been in non-Native communities of similar socio-economic status. He shared that the strategic collaboration between tribal public health experts, tribal leaders, and the National Center for Injury Prevention and Control (NCIPC) to increase the cultural relevance of intervention strategies has been successful in lowering death rates attributed to motor vehicle injuries in the past decade.

Dr. Montero provided updates from CDC’s centers, institutes, and offices—

- NCIPC released the “Guideline for Prescribing Opioids for Chronic Pain” in March 2016 to help primary care doctors provide safer, more effective care for patients with chronic pain.
- The National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention is working with Indian Health Service (IHS) to analyze existing data sources that could inform IHS about regions and counties at potential risk for spread of HIV and hepatitis C virus.

- The National Center on Birth Defects and Developmental Disabilities (NCBDDD) is working to improve the availability and quality of data to help inform clinical management decisions for healthcare providers of women of all races/ethnicities who are pregnant or could become pregnant.
- The Division of Reproductive Health, in CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) has provided epidemiologic assistance—providing claims data and documenting substance use during pregnancy—related to the prevalence of maternal substance use (including opioids and neonatal abstinence syndrome) in the Sisseton Wahpeton Oyate and the Cheyenne River Sioux tribes.

Dr. Montero described tribal activities in the CDC Emergency Operations Center. The CDC Incident Management System's State Coordination Task Force (SCTF) includes a new tribal liaison officer position to facilitate working with tribes during emergency preparedness events. TAC members had the opportunity to ask questions about the opioid epidemic, public health infrastructure, and funding issues.

### Zika Virus Update

Ms. Stephanie Dulin, deputy director, NCBDDD, spoke about health consequences associated with Zika and the US Zika Pregnancy and Infant Registry. She described tribal engagement efforts by CDC's Emergency Response Team and collaborative activities with the National Indian Health Board (NIHB) and the American Mosquito Control Association.

Lt. Governor Jefferson Keel, Oklahoma Area delegate, participated in the session and asked about the reporting of AI/AN children infected with the Zika virus. Ms. Dulin stated there are no AI/AN data about the percentage of children with congenital Zika syndrome. He inquired about the tribal health systems' access to vaccines and availability in tribal formularies. Ms. Dulin replied that private companies are developing vaccines with public funds, and that implementation and dissemination plans are being discussed.

Chairwoman Cheryl Andrews-Maltais, Nashville Area delegate, asked about the tribal outreach efforts, vaccine effectiveness for AI/AN women, and best practices for prevention of Zika virus. Ms. Dulin stated the Biomedical Advanced Research and Development Authority is leading the vaccine development. She will make an inquiry with the Biomedical Advanced Research and Development Authority regarding the AI/AN inclusion in testing. She stated most cases in US states have been in US territories or travel-associated cases that did not originate in the states.

### CDC Budget Overview

Ms. Jenny Sewell, public health analyst, Office of Financial Resources, CDC, and Ms. Georgia Moore, associate director for policy, OSTLTS, CDC, provided an FY2017 budget summary. Dr. Ursula Bauer, director, NCCDPHP, CDC, provided an update about funding from that center. Ms. Sewell compared the FY2017 to the FY2016 distribution of funding. In 2016, CDC funding was decreased for immunization, sexually transmitted infections, tobacco, heart disease and diabetes, environment, workforce, and occupational safety. Funding was increased for the National Diabetes Prevention Program, birth defects, opioid prevention programs, and global health programs. Ms. Sewell addressed the president's budget request for FY2018, a decrease in CDC's budget from \$7.2 billion in FY2017 to \$5.976 billion in FY2018. She reported FY2018 House Appropriations Committee budget estimates for CDC program funding is \$7,001.5 million, a decrease of \$198.4 million compared to FY2017.

Ms. Moore presented updates about CDC/ATSDR funding to tribes and tribal organizations. Ms. Moore discussed analysis of funding streams and the difficulties with tracking funding. She stated that her team

commits to having an analysis that shows FY 2017 funding that supports tribes by the winter 2018 TAC meeting.

Dr. Bauer provided an update from NCCDPHP—

- NCCDPHP received \$34 million for the Racial and Ethnic Approaches to Community Health Program in the FY17 budget, a decrease of \$16 million from the continuing resolution.
- NCCDPHP received \$16 million for the Good Health and Wellness in Indian Country – a new budget line to support activities described in the FY17 President’s Budget Proposal.
- To cover the deficit between the \$50 million and the \$34 million, NCCDPHP reduced investments internally and to REACH grantees.

Dr. Bauer described NCCDPHP’s support for tribal epidemiology centers (TECs)—

- NCCDPHP deployed about \$8.5 million of the new FY17 funds to TECs to follow through with the program description contained in the Budget Initiative.
- In the fall, NCCDPHP will use \$5 million to support a notice of funding opportunity (NOFO) for tribes and urban Indian health centers.

Dr. Bauer stated that NCCDPHP will make progress to support cultural practices and learn what connects people to culture. She explained that the NOFO has been designed based on several years of input from tribal convenings, NIHB listening sessions, and meetings with Indian health boards and tribes. Dr. Bauer requested the TAC’s input on funding amounts so NCCDPHP can fund as many tribes as possible and support effective programs.

Melanie Fourkiller, policy analyst, Choctaw Nation Health Services, addressed the need for consistent and reliable funding (funding that does not have to be negotiated every year) for tribal public health infrastructure. She suggested an approach where tribes could compete among themselves for a percentage of CDC’s budget designated for Indian Country. Ms. Fourkiller addressed the NCCDPHP NOFO that was released on August 7 and asked if there was a directive to restrict that to TECs, or if CDC was required to restrict it in some way. Dr. Bauer responded that the \$42 million would fund activities over five years, which is equivalent to about \$8.5 million each year. She described the new funding opportunities as bringing to fruition the plans previously discussed at TAC meetings and through listening sessions and described in the President’s FY17 Budget Proposal.

Mr. Larson, Tribes At-Large Delegate, commented on the need for clarification of tribal needs so tribes have a basis for TAC members to work on crafting a budget initiative to fund tribal public health.

Ms. Moore announced an innovative emergency response NOFO that will identify tribal response opportunities and capacities so that when a tribe is in need of a response, CDC can identify needs and match funding to reach tribes.

In an effort to address the issue of tribes competing with states for funding, TSU is creating a tip sheet for project officers who write NOFOs. CDC will continue to rank the proposal separately for states, tribes, and large cities and fund each group accordingly. This focus will provide another opportunity to reach tribes. Dr. Bauer commented that NCCDPHP does fund tribes directly and meets the 2% threshold that the tribes are requesting. She asked for ideas about specific funding arrangements that will provide adequate, consistent, and reliable funding.

Lt. Governor Keel commented on the tribal-state relationship, saying that many states have good relationships with tribes, but there is no legislation that requires states to work with them. He addressed the need for tribal advocacy to Congress to use legislative language that directs funding to tribes. He commented on how he believes agencies use legislative language as a crutch to avoid or justify not funding tribes.

Tribal Councilor Bryan Warner, Cherokee Nation, inquired about congressional direction to CDC to make the new NOFO available only to TECs. Dr. Bauer explained that CDC followed the plan described in the FY17 President's Budget Proposal. The language in that Budget Initiative was crafted over the past two years with input from the TAC and others, and build on the Indian Health Care Improvement Act of 2010 and language directing CDC to provide support for the TECs. Dr. Montero added that TSU has a cooperative agreement with NIHB to conduct a scan of public health capacity in Indian Country.

TAC Chairman, Councilman Chester Antone concluded the session.

### Overview of Public Health Programs

Mr. Bobby Saunkeah, manager, Research and Population Health Division, Chickasaw Nation Department of Health (CNDH), started the panel discussion by explaining the background and diversity of Native presence in Oklahoma. He concluded by stating that Oklahoma's diversity presents unique challenges when tribes apply for grants because the community is often pre-defined for them. Panel members suggested that the definition of "community" be less restrictive in NOFOs. In addition, Mr. Saunkeah mentioned that the lack of quality public health data (in terms of demographics) creates a challenge with tribal data. The panel members explained that tribes are using clinical data because tribal public health data is difficult to collect. This issue emphasizes the need for direct funding for tribes to build the public health workforce and infrastructure at CNDH.

Panel members provided a brief overview of project implementations in the Chickasaw Nation—

- Dr. Valarie Jernigan, associate professor, College of Public Health, University of Oklahoma Health Sciences Center described "A Mobile Food Basket Study and Initiatives on Farmers Markets"
- Miranda Willis, strategic prevention data analyst, Chickasaw Nation explained "Define Your Direction," a social media campaign that reaches more than 3,000 people per message; social media staff promote services and tools in Chickasaw Nation

Next, the award-winning "Define Your Direction" video was played and received a positive response from audience members.

### Cultural Practices and Mental Health Prevention Programs

Panelists presented about Chickasaw Nation's clinical research and the impact of cultural connectedness on health outcomes. Presenters shared the Chickasaw Nation's work to integrate behavioral health services to create a system-wide approach to domestic violence programs, opioid abuse, and their Zero Suicide Initiative.

Panel participants were—

- Shannon Dial, PhD, LMFT, executive officer, Integrated Services Division, Department of Family Services, CNDH
- Kelly M Roberts, PhD, LMFT, family initiatives advisor, Department of Family Services, CNDH

Dr. Dial provided a brief history of how Chickasaw Nation implemented strategies in its emergency rooms, such as standardizing their depression screening process. She emphasized that other tribal health systems can easily replicate their screening system for depression and opioid abuse. She described the model and the impact of embedding behavioral health providers into general clinics and emergency rooms. Chickasaw Nation was able to increase the reach and impact of behavioral health services. The approach resulted in a 152% increase in access to behavioral health care in three years. Before integration, the system had about 400 behavioral health patient encounters per month; now it averages closer to 1,100.

Dr. Roberts shared that the extent of integration is so successful that it is difficult to distinguish the silos that existed previously. Now, all partners are engaged and share the responsibility. Dr. Roberts provided details of their violence prevention activities and shared the following notes from Chickasaw Nation leaders:

- Chickasaw Nation has a 24-hour on-call service and is ready to respond.
- Chickasaw Nation collaborates closely with its medical team; coordination is strong and solid.
- A new facility that will quadruple the space for shelter services is under construction.
- Regarding violence prevention, domestic violence nurse examiner and sexual assault examiner are distinct roles; the certification and the follow-up process with patients are different. Chickasaw Nation is also exploring the distinction from an elder abuse role.
- In all Chickasaw Nation clinics, domestic violence nurse examiners address all intimate partner assaults, including strangulation, which has increased. Examiners encourage patients to have a medical screening and hospital monitoring after such an event.
- Chickasaw Nation reviews each case to identify possible improvements to the process to comprehensively address and implement trauma-informed care.

Dr. Roberts shared that the interdisciplinary group working on violence includes police, chaplains, nurses, and social services. All of these professionals train continuously to increase their knowledge and skills around trauma-informed care.

Dr. Roberts expressed the critical importance of reflecting the Chickasaw Nation culture in the care environment. She described a process they began two years ago to explore how culture can be incorporated in therapy protocols throughout the system of care. She first defined “historical trauma” as trauma passed on through generations. Chickasaw Nation considered how to include elements of culture in treatment plans to enhance identity, cohesiveness, and awareness. They explored an American Indian Enculturation Scale.

Dr. Roberts explained that “enculturation” is reintroducing people to their first culture. After a pilot study, Chickasaw Nation determined that the AI Enculturation Scale was too pan-Indian and generic to resonate with Chickasaw people. Chickasaw Nation elders met with the Chickasaw Nation cultural department and identified 38 items that should appear in a Chickasaw Nation Enculturation Scale. The Chickasaw Nation Internal Review Board (IRB) Office further refined and strengthened the tool. Eventually the Chickasaw Nation health clinics tested it and determined that it is valid and reliable. The tool includes three primary measures: Satisfied Subscale, Identity Subscale, and Enculturation Subscale. In the pilot test, all subscales were above 0.8 with a variance of 0.61. Two-hundred-and-fifty Chickasaw participated in the preliminary test phase. Chickasaw Nation will now use the instrument to measure the impact of its efforts to incorporate a sense of identity and cohesion into wellness plans.

At the conclusion of Dr. Roberts’s statements, Councilman Antone opened the floor to the TAC delegates, invited CDC senior leaders, and other Tribal Nation leaders to sit at the table for questions and answers.

Chairwoman Cheryl Andrews-Maltais commented on the “extraordinary achievement” of this effort. She was excited to see the pilot outcomes and recounted that she often sees that the lack of a “cultural rudder” limits the recovery of AI/ANs from incarceration and drug addiction.

Dr. Montero congratulated the doctors on their “amazing work.” He stated that before working at CDC, he was not able to get his organization to a 100% depression screening at all points of entry. He asked the panelists about the organizational capacity to manage demand generated from the screenings.

Dr. Dial confirmed that their success always drives a demand for more behavioral health workers to meet the identified need. The integrated visits reflect a low effort, touch base-style interaction. All of the behavioral health providers now see 10–16 patients a day, as opposed to seeing only 6 previously. Chickasaw Nation has great communication between providers and patients.

Dr. Roberts stated that learning clinical patterns has been key to maximizing their capacity. Learning the best communication channels is crucial to make the team more efficient. Dr. Dial also asserted that integrated care depends on the quality of staff hired. Certain personality traits and high confidence in the behavioral health clinician are critical.

Councilman Antone thanked all panel members and noted that culture is a protective component of mental health and wellbeing. He stated that cultural practice is not pan-Indian and that the strength of Native people is in their unique historical and cultural identities. He applauded Chickasaw Nation for presenting a model and for finding the power to make their people stronger and more resilient.

### Health Policy and Law

This session explored the legal framework of tribal sovereignty and tribal engagement with other health law partners while maintaining tribal sovereignty.

Debra Gee, general counsel, Chickasaw Nation Legal Division, introduced the session by defining “sovereignty” as the inherent right to govern. She spoke about how the organizational structure of tribes in Oklahoma makes jurisdictional determinations challenging.

Kim Cravatt, assistant general counsel, Chickasaw Nation, presented examples of tribal health law and policy interventions that have affected tribes, including Chickasaw Nation. These included tribal food safety interventions; 53 tribes have adopted food safety codes. The use of policy and law to address the opioid epidemic is of special interest in the current state of health. Ms. Cravatt reported that Oklahoma ranks nationally in the top five states for opioid prescribing rates and the top ten for high-dose opioid prescriptions.

Carolyn Romberg, director, Chickasaw Nation Legal Division, presented about mental health and law. She stated that recognizing the close connection between illicit drug use and mental health issues, the Oklahoma court system created a unique set of specialty courts termed “drug courts.” The model, developed by the State Department of Justice, allows local jurisdictions, like Chickasaw Nation and other community partners, to collaborate with the court to provide services to Chickasaw people who face

drug charges. The Chickasaw Nation’s ultimate goal is to have its own mental health court. Securing hospital admissions for Chickasaw people caught in the court system has been far easier to accomplish with the integration of Chickasaw Nation health services. This work is carried out under executive directives from Chickasaw Nation’s governor. Ms. Romberg concluded by stating that the policies and procedures have been adopted to support this direction because legal codes can be far more difficult and time consuming to change.

The panelists shared that the Cherokee Nation Legal Division reviews grant opportunities and has seen that it is a challenge for tribes be successful applicants when they have to compete with states. The nation advises that this be kept in mind as CDC develops future NOFOs.

Councilwoman Delia Carlyle, TAC delegate, Phoenix Area, stated that the severity of the opioid abuse continues to grow due to lack of professional care and expertise for patients who are prescribed narcotic medications for pain management.

Ms. Romberg responded that Oklahoma does have a prescription drug monitoring system and that both providers and pharmacists can review prescribing records in this system. In addition, Chickasaw Nation employs a pain management contract within its clinics to support the pain management policy. This allows doctors who prescribe narcotics to hold patients accountable for compliance. If a patient violates the policy, then the physician will no longer prescribe narcotics to that patient.

Councilwoman Carlyle described that other factors contributing to the increase in opioid abuse include the lack of continuity of care in the Ak-Chin Indian community, few pain management doctors, and the lack of shared access to health record information for prescribing providers. Councilwoman Carlyle asked the panel if they had any experience with “medical marijuana cards.” Panelists responded that they have a zero tolerance policy regarding marijuana. Ms. Romberg shared that Oklahoma has not adopted a medical marijuana or recreational use statute.

TAC Chairman, Councilman Antone concluded the session.

## ***Wednesday, August 9, 2017***

### **Tribal Public Health Accreditation Panel**

Ms. Lisa Pivec, senior director of public health, Cherokee Nation, presented a brief overview of the Cherokee Nation accreditation process. She reviewed the standards, extrapolated what was important, and explained how Cherokee Nation compared to other types of public health departments, such as large municipalities and states, going through the accreditation process.

Ms. Pivec then presented a brief overview of Cherokee Nation—

- Multi-jurisdictional, with 14 counties and a tribal jurisdictional service area spanning 9200 square miles
- Home to more than 315,000 citizens
- 210,000 members live in Oklahoma
- 140,000 reside in a tribal jurisdictional service area
- Has a great relationship with the Tribal Public Health Advisory Committee to the State Department of Health

Ms. Pivec commented that tribes will never have enough direct care dollars, and the focus should be on healthier communities. Ms. Pivec presented the following timeline describing their accreditation process:

- 2007—Began exploring accreditation
- 2009 to 2010—Participated in a Public Health Accreditation Board (PHAB) beta test, which helped them to be successful in the application process
- 2011—Received National Public Health Improvement Initiative (NPHII) funding of \$800,000 for four years; it didn't completely fund their work but did help
- 2012—Completed the National Public Health Performance Standards Program
- 2013—Applied for accreditation; NPHII funding covered the \$25,000 cost to apply for accreditation
- 2014—Uploaded all documents to the e-PHAB system
- 2015—Hosted a site visit with the PHAB team
- 2017—Received accreditation; Cherokee Nation is the first tribe to receive accreditation

For next steps, Ms. Pivec and her staff are developing a conceptual map for organizational design and are still struggling to implement what they have documented. They will put the conceptual map into an organizational design they can implement practically into their health system. Ms. Pivec concluded that tribal public health infrastructure needs to be a priority. Tribes need people to do the work, through both workforce capacity and technical assistance. Tribes also need to have consistent funding mechanisms and to be eligible for NOFOs, as well as have access to successful state models.

Councilman Antone asked Ms. Pivec to elaborate on the complexities of public health accreditation process across multiple counties in Cherokee Nation. Ms. Pivec said that fewer counties means fewer cross-jurisdictional issues. She suggested looking at the conceptual map to identify what his tribe already does, which partnerships could create access to public health programs and services, and then what public health infrastructure they need to build. She emphasized that passing a public health code would be the best place to start. Ms. Pivec stated that PHAB can help with guiding the process and establishing performance measures. Dr. Montero and Lt. Governor Keel thanked Ms. Pivec and congratulated Cherokee Nation on its accreditation.

Lt. Governor Keel discussed the need for creative financing to go through the accreditation process. There are tribes that are interested; some are already doing many of the accreditation activities mentioned, but without sufficient funding, some do not see why they should pursue it. He encouraged her to reach out to other tribes.

TAC Chairman, Councilman Antone concluded the session.

### [Chickasaw Nation Youth Wellness Clinic Panel](#)

This session described how Chickasaw Nation addresses pediatric obesity treatment through its multi-disciplinary behavioral modification clinic. It highlighted the collaboration with Chickasaw Nation's public health teams, including a research component and an external collaboration with Oklahoma University Children's Hospital.

Mr. Saunkeah provided the background for the presentation, explaining that the clinic concept formed out of the relationship between clinical and public health work addressing obesity. The clinic focuses on



wellness behaviors, including behavioral modification with goal setting, rather than just weight control and monitoring. All factors that contribute to obesity in children, such as sleep patterns, physical activity, and relationship building, are considered.

Dr. Neilsson Rais, pediatric medicine specialist and general practitioner, Chickasaw Nation Medical Center, stated that he was seeing a vast array of comorbidities in children directly linked to their weight, so knew there was a need for intervention that adequately addressed pediatric obesity. Dr. Rais said that to achieve the greatest success in addressing pediatric obesity, it is incumbent on healthcare providers to engage the parents. He concluded by stating that at the Empowered Living Clinic, the goal is to show families how small changes can make a big difference in these complicated diagnostic measures that they might not understand.

Next, Jeff Wells, physical therapist, Empowered Living Clinic, emphasized that this approach is unique. The clinic has collaborated with Healthy Futures, a non-profit organization dedicated to supporting positive youth development. Mr. Wells stated that a physical therapist's role is to rule out musculoskeletal issues and identify any limitations that might keep a patient from obtaining physical activity goals.

Dr. Ashley Weedn, assistant professor, General and Community Pediatrics, University of Oklahoma Health Sciences Center and medical director, Healthy Futures, University of Oklahoma, stated that the model for the program came from the expert pediatric committee on obesity; the committee includes members from CDC, the Health Resources and Services Administration, and the American Medical Association. In 2012, Oklahoma University Health Science Center developed and implemented the model in Oklahoma and began to study its impacts. In 2014, the Empowered Living Registry was created for every academic center or community team to report data.

Dr. Weedn stated that, from a research perspective, the next steps are to begin evaluating the registry. Since the Empowered Living Clinic is a closed system, it is possible to explore the family impacts of the clinic rather than only effects on the pediatric patient. Chickasaw Nation has the only community-based multidisciplinary team—all other teams are academic institutions—making Chickasaw Nation's clinic design a unique evaluation opportunity. Dr. Weedn concluded by stating that when a child sets a goal, each family member supporting that child commits to that change as well (e.g., removal of sugary drinks from the home).

Mr. Saunkeah shared that Chickasaw Nation is developing a biorepository as part of the Empowered Living Clinic, with infrastructure currently in the planning phase. Lt. Governor Keel thanked the group for the presentation and shared his thoughts about how inclusion of the registered dietician in the team is valuable because there are native communities across the country who depend on the commodity distribution.

Dr. Montero asked the panel that when it comes to prevention, how they maintain consistency in messaging while also addressing cultural needs when health behaviors might be culturally specific.

Dr. Weedn responded that development of cultural messaging is tribe-specific and should occur at the tribal level rather than the state level. Mr. Saunkeah responded that the program just received IRB approval last month to begin the research piece within the program. Every component has the Chickasaw culture embedded in it. Consent forms for participants are being finalized and an application for an Empowered Communities grant is with the HHS Office on Minority Health. It is anticipated that next year Chickasaw Nation will have data to share.

With this final response, Councilman Antone concluded the session.

## Tribal Data Panel

This session highlighted issues such as disease surveillance, data protection, and research partnerships.

Mr. Michael Peercy, Epidemiologist/Biostatistician, IRB Administrator, Division of Research and Population Health, Chickasaw Nation Department of Health, shared that his staff members focus on the surveillance of chronic disease, infectious disease, emerging pathogens, community health assessments, outbreaks, and more for the Chickasaw Nation. The division uses many tools to explore community health, including geographic information system mapping. In an outbreak response, the division frequently encounters complex jurisdictional issues and must work to ensure that all appropriate response actions. Mr. Peercy stated that cancer (lack of screening contributes to high rates), motor vehicle accidents, and accidental opioid poisonings are leading causes of death. Mr. Saunkeah described the Chickasaw Nation IRB and explained the difference between academic IRBs and tribal IRBs. Tribal IRBs are charged not only with protecting the individual, but also the tribe as a whole.

Mr. Peercy then discussed “data sovereignty,” (i.e., data ownership), stating that data sovereignty, as it applies to tribes, is the right to govern the collection, use, and storage of its own data. As with most tribes, the Chickasaw Nation does not allow for research data transfer or secondary analysis without tribal approval. The state health department employs epidemiologists across all of their sections; however, tribes might not have an epidemiologist at all, or at best might have one who must take their skills and evolve into a “jack of all ‘epi’ trades.”

Councilman Antone asked about the essential compositions of an IRB.

Mr. Peercy replied that for federal recognition, an IRB must have community involvement, directorship, and a mix of scientists and nonscientific members. A tribe can form a research review board without a federally recognized IRB. This would route all research decisions to the council or other designated tribal group. Chickasaw Nation chose to have the federal registration, which gives tribes more influence when engaged with academic institutions should a difference of opinion occur.

President George Edwardson, Tribes At-Large delegate, shared his personal history regarding research abuses within his tribe.

Mr. Saunkeah responded that this example provides shows why tribes are forming IRBs and exerting their sovereign authority to review all potential research. The tribal IRBs can then prevent these abuses.

Representative Robert TwoBears, Billings Area delegate, asked the panel if Chickasaw Nation provides insurance coverage for tribal members, and if so, if it shares information with the insurer.

Mr. Peercy replied that there is no close partnership with the insurance company, although there has been an effort to break down the barriers in the separate caches of tribally owned data. That would help to identify a greater economic impact of prevention activities through sharing.

Mr. Saunkeah shared that the division strives to improve its external communication through its newspaper and website and is exploring additional communication strategies, such as community focus groups and leadership presentations. Mr. Peercy stated that they share some of the more clinical projects within the Chickasaw Nation’s Grand Rounds so that providers have this as quickly as possible.

With no further questions, Councilman Antone concluded the session.

## FITWEL<sup>SM</sup> Built Environment Panel

Dr. Kimmons, health scientist, Division of Nutrition, Physical Activity and Obesity, NCCDPHP, CDC, described the connection between the built environment and health behaviors. He explained that a built environment can make a healthy lifestyle more accessible, affordable, and sustainable. The built environment encompasses social structures, cultural norms, and personal values to change behavior. To

improve health outcomes, it is necessary to consider how to better design communities' built environments to support for healthy behaviors. He explained that behavioral choices are reactive and driven by sensory exposure, availability, cultural norms, and mindset. Analyzing how design affects behavior will allow one to affect individual behavior.

Next, Ms. Giselle Sebag, Fitwel Ambassador, presented about Fitwel<sup>SM</sup>, a certification system that optimizes building design to promote healthy behavior. Ms. Sebag explained how atmosphere can affect the brain, using the example that subliminal triggers can affect the vagus nerve and make someone irritable. She stated that Fitwel is a high-impact building certification that supports healthier workplace environments and improves occupant health and productivity. Fitwel is an independent non-profit organization in New York and is currently in its beta phase of product development. CDC and the General Services Administration lead the Fitwel effort.

Next, Dr. Kimmons explained that CDC scientists have researched the link between built environments, physical activity, and building structures. Dr. Kimmons and his CDC colleagues spoke about health issues that are becoming an increasing priority for Fitwel. These priorities include chronic disease risk factors, mental health, social equality for vulnerable populations, occupational safety, and improvements in community health. Fitwel's unique value lies in the fact that all strategies suggested by the certification program are voluntary and require no prerequisite strategies that could be cost-prohibitive.

Dr. Kimmons explained the steps in the certification process.

Councilman Antone thanked the panel members for their time and concluded the session.

### [Association of American Indian Physicians Panel](#)

Mr. Gary Lankford, program director, Advances in Indian Health Care Students Programs, Association of American Indian Physicians (AAIP), shared details about the Data Into Action Project. He stated that the evaluation ratings for the Data Into Action Workshop and Grant Writing Workshop have been positive. In 2018, AAIP will offer three more workshops in the eastern United States, possibly focusing on tribes in North Carolina, New England, or the Great Lakes region.

Ms. Jamie McDaniel, program manager, Million Hearts: Hypertension Control Improvement in Indian Country, AAIP, presented more details about AAIP's Grant Writing Workshop. AAIP worked with June Strickland, University of Washington, to develop the Grant Writing Workshop curriculum and to implement the workshop in tribal communities. Dr. Strickland implemented in-person workshops in Oklahoma City, Oklahoma, and at the University of Washington. Post-workshop evaluations revealed that although people gained knowledge, the workshop was not long enough for the attendees to get an in-depth understanding that they could use to develop effective proposals.

Eight AI/AN communities have been funded to incorporate 10 strategies to increase fruit and vegetable consumption and 10 strategies to increase physical activity. For example, the Absentee Shawnee Tribe used AAIP funding to incorporate two 5- to 10-minute during the workday and add a social support component. The tribe had an existing physical activity policy that allowed tribal employees to use three hours of paid leave to use either the tribe's fitness facilities or a preapproved offsite facility, but interest eventually dwindled over time. As indicated in CDC's Winnable Battles initiative, programs with a participant support component are more effective. At Absentee Shawnee, the employees turn in walking logs and have monthly incentives and awards ceremonies. The tribe also modified the policy language from "exercising for fitness" to "exercising for health," which survey responses indicate is more favorable.

The presenters described a few more Urban Indian programs focused on policy systems and environmental changes—

- The Indian Child and Family Preservation Program’s work centers on the Indian Child Welfare Act compliance and supervised visits. The program is based in California.
- The Oklahoma Indian Clinic is providing a space for children to be more physically active.
- The Sacramento Native American Health Center is implementing community and home gardens. The center is specifically intended for use by young families and patients with diabetes and hypertension.

To conclude, the presenters stated that participants’ common theme is that partnerships were crucial to the success and sustainability of the projects. Councilman Antone then opened the floor for questions.

Councilwoman Carlyle asked if the tribes in Arizona work with the Inter-Tribal Council of Arizona Tribal Epidemiology Center and if presenters know if anyone from that organization has attended the grant writing trainings.

Presenters responded that AAIP is planning to offer two or three more trainings before funding ends in 2018. Those interested can request to have a training in their area.

TAC Chairman, Councilman Antone concluded the session.

### [Enhanced Emergency Preparedness Panel](#)

Ms. Mendy Spohn, administrative director for health departments, Oklahoma State Department of Health, started the panel by stating that three years ago, the Oklahoma State Department of Health collaborated with the Chickasaw Research and Population Health program on a community-wide project to reduce the incidence of flu hospitalizations and deaths. The project helped identify roles and responsibilities, data storage, and definitions. Because the outbreak occurred on Trust Lands, it involved several health departments, school systems, and employee worksites.

In addition, the Oklahoma State Department of Health is working to increase risk communication capabilities by creating or designating liaisons between incident command systems and hospitals, city and county governments, and school systems. Ms. Spohn concluded emphasizing that building relationships and remaining active in daily activities is the core to providing effective preparedness and emergency response.

Dr. Montero commented that it was great to learn about a model where state, tribal, and local health departments are working together. He asked panel members to specify what makes their collaborative efforts successful.

Mr. Jeff Morris, institutional environmental health officer, Chickasaw Nation, responded that the Oklahoma State Health Department and CNDH have established personal relationships and intentionally trained together and shared information to break down social barriers.

Next, Dr. Montero asked the panel how CDC could institutionalize a similar program.

Ms. Spohn suggested the following activities:

- Establish policies
- Create a plan that is easy to follow regardless of who holds different roles
- Build a Memoranda of Understanding to help institutionalize programs
- Define the urgency of issues at hand and work to address them effectively

Dr. Montero then asked what CDC could do beyond provide funding to support efforts like this or to step aside.

Ms. Spohn suggested that CDC build flexibility into program guidelines or grant applications, and be less prescriptive with requirements (e.g., forms). She suggested that CDC focus on community readiness, distribution of the Strategic National Stockpile materials to the appropriate people within 72 hours, documentation and tracking of medication administration, and improving risk communication.

Del Yazzie, acting director, Navajo Nation Tribal Epidemiology Center, commented that Navajo Nation, with three state borders (i.e., New Mexico, Arizona, Utah), has made strides in building relationships with those states and their counties. Navajo Nation is working to coordinate on public health emergencies, communicable diseases, environmental health assessments, and outbreaks. At Navajo Nation, responding to emergencies in a coordinated way is a challenge and they need protocols for samples sent to the state health departments and/or CDC. Mr. Yazzie asked if CDC had any tools (e.g., flow chart) to help with messaging.

Ms. Spohn replied that mind-mapping software is a good tool and that it is helpful to think about the public health message. If the message gets too complicated, start scheduling meetings with partners to determine roles, responsibilities, and top issues that need to be addressed immediately. She has some logic models that she would be happy to share.

Councilman Antone responded to Dr. Montero's question regarding what CDC can do to help by stating that funding to tribes and allowing for flexibility is important. He emphasized the need to increase funding for tribes and changing policy.

TAC Chairman, Councilman Antone concluded the session.

### [Tribal Testimonies Were Accepted](#)

### [Closing Prayer/Adjournment](#)

Dr. Montero thanked Councilman Antone for facilitating the meeting and thanked everyone for his or her input, recommendations, and ideas. He stated that CDC has been continuously improving the way it manages TAC meetings and that it will continue to do that to make the most of TAC delegates' time.

Captain Clelland thanked Chickasaw Nation hosts for their gracious hospitality.

Councilman Antone thanked the state of Oklahoma and tribes.

## Acronyms Table

AI/AN	American Indian/Alaska Native
AAIP	Association of American Indian Physicians
ATSDR	Agency for Toxic Substances and Disease Registry
CDC	Centers for Disease Control and Prevention
CNDH	Chickasaw Nation Department of Health
IHS	Indian Health Service
IRB	Institutional Review Board
NCBDDD	National Center on Birth Defects and Developmental Disabilities
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCIPC	National Center for Injury Prevention and Control
NIHB	National Indian Health Board
NOFO	Notice of Funding Opportunity
OSTLTS	Office for State, Tribal, Local and Territorial Support
PHAB	Public Health Accreditation Board
STAC	Secretary Tribal Advisory Committee
TAC	Tribal Advisory Committee
TEC	Tribal Epidemiology Center
TSU	Tribal Support Unit