CDC/ATSDR Tribal Advisory Committee Meeting and 18th Biannual Tribal Consultation Session

February 5, 8:00 am–5:30 pm and February 6, 8:00 am–4:45 pm

Global Communications Center
Building 19, Auditorium B3
CDC Headquarters, Atlanta, Georgia

The Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) hosted their Tribal Advisory Committee (TAC) Meeting and 18th Biannual Tribal Consultation Session February 5–6, 2019. The meeting was open to the public. Nine members of the public attended the first day, and twelve attended the second day.

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Tuesday February 5, 2019

TAC Member Attendees

Julie Deerinwater-Anderson
Cherokee Nation
Tribes-at-Large Authorized Representative

Councilman Chester Antone
Tohono O'odham Nation
Tucson Area Delegate

Rhonda Beaver
Muscogee (Creek) Nation
Oklahoma Area Authorized Representative

Vickie Bradley
Eastern Band of Cherokee Indians
Tribes-at-Large Authorized Representative

Chairman Robert Flying Hawk
Yankton Sioux Tribe
Great Plains Area Delegate

Councilwoman Lana M. McCovey
Yurok Tribe
California Area Delegate

Lisa Pivec
Cherokee Nation
Tribes-at-Large Authorized Representative

Principle Chief Richard Sneed (TAC Co-Chair)
Eastern Band of Cherokee Indians
Tribes-at-Large Delegate

Del Yazzie
Navajo Nation
Navajo Area Authorized Representative

Absent

Affiliation/Tribal Area	Name	Title
Alaska Area	Alicia L. Andrew	President
Billings Area	Byron Larson	
Nashville Area	Cheryl Andrews-Maltais	Chairwoman
Bemidji Area	Robert Two Bears (TAC Chair)	Representative

CDC Attendees

Romana Allison, MPH
Public Health Advisor/Analyst, Center for State, Tribal, Local, and Territorial Support (CSTLTS)

Robert "Bob" Anderson, PhD
Supervisor Statistician, National Center for Health Statistics (NCHS)

LCDR Naomi Aspaas, BSN, RN
Lead Public Health Advisor, Office of Tribal Affairs and Strategic Alliances (OTASA), CSTLS

Michael Bruce, MD, MPH
Medical Epidemiologist, National Center for Emerging and Zoonotic Infectious Diseases (NCEZID)

CAPT Deron Burton, MD, JD, MPH

CAPT Larry Alonso, MSN
Nurse Officer, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

Danielle Arellano, MPH
Public Health Advisor, National Center for Injury Prevention and Control (NCIPC)

Kelly L. Bishop, MA
Public Health Advisor, NCCDPHP

Sharunda Buchanan, PhD, MS
Director, National Center for Environmental Health (NCEH)

CAPT Carmen Clelland, PharmD, MPA, MPH

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

CDR Alex Crosby, MD, MPH
Medical Epidemiologist, NCIPC

Teresa Daub, MPH
Lead Public Health Advisor, CSTLTS

Naomi Drexler, MPH
Epidemiologist, NCEZID

Megan S. Early
Public Health Analyst, NCIPC

CDR Mary "Molly" Evans, MD, MPH
Medical Officer, NCIPC

Constance Franklin, MPA
Program Analyst, National Institute for Occupational Safety and Health (NIOSH)

Rebecca Gold, JD
Public Health Analyst, NCEZID

Corinne Graffunder, DrPH, MPH
Health Scientist, NCCDPHP

Wendy Heirendt, MPA
Lead Public Health Analyst, NCCDPHP

Wendy Holmes, MS
Senior Public Health Advisor, OTASA, CSTLTS

Schell Hufstetler, PhD, MS
ORISE Fellow, NCCDPHP

Robin Ikeda, MD, MPH
Deputy Director for Non-Infectious Diseases

Barbara Kitchens, MA
Public Health Analyst, Center for Preparedness and Response (CPR)

Director, OTASA, CSTLTS

Valerie Daniel, MPH
Health Communications Specialist, NCIPC

Jillian Doss-Walker, MPH
Public Health Advisor, National Center for Immunization and Respiratory Diseases (NCIRD)

Stephanie Dulin, MBA
Senior Advisor, National Center on Birth Defects and Developmental Disabilities (NCBDDD)

CAPT David Espey, MD
Medical Officer, NCCDPHP

CAPT Ryan Fagan, MD, MPH
Medical Officer, NCEZID

Krystal Gayle, MPH
Public Health Advisor, OTASA, CSTLTS

LT Kimberly Goodwin, MPH
Public Health Analyst, CSTLTS

Arlene Greenspan, DrPH, MPH, MS
Associate Director for Science, NCIPC

CAPT Thomas Hennessy, MD, MPH
Director of the Arctic Investigations Program, NCEZID

Heidi Holt, MPA
Public Health Advisor, NCCDPHP

LCDR Jason Hymer, REHS, MPH
Environmental Health Specialist, NCIPC

Gilbert Kersh, PhD
Branch Chief for the Rickettsial Zoonoses Branch, NCEZID

Laura Kollar, PhD, MA
Behavioral Scientist, NCIPC

Rachel Kossover-Smith, MPH, RD
Public Health Analyst, NCIPC

Karina Lifschitz, MPH, MAIA
Public Health Analyst, CSTLTS

Stacey Mattison-Jenkins, MPH
Deputy Director for Division of Program and Partnership Services, CSTLTS

Turcina McNeilly, MPH
Public Health Advisor, NCEH

Beth Michel, MPH
Project Evaluator, NCCDPHP

Mitchell "Mitch" Morris
Acting Deputy Director for OTASA, CSTLTS

Dagny Olivares, MPA
Associate Director for Communication, CSTLTS

Priyanka Oza
Public Health Advisor, OTASA, CSTLTS

Katherine "Katie" Pugh, MS
Environmental Health Scientist, Division of Community Health Investigations, ATSDR

Jean Randolph, MPA
Nurse, CPR

Delight Satter, MPH
Senior Health Scientist, OTASA, CSTLTS

Gregory Smith, MPA
Tribal Liaison Officer, CPR

CAPT Gail M. Stennies, MD, MPH
Senior Advisor, CPR

Craig Thomas, PhD, MS
Director for the Division of Population Health, NCCDPHP

Celia Toles
Health Communication Specialist, CPR

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

Connie Lo
Public Health Fellow, Office of the Associate Director for Policy and Strategy (OADPS)

Heather McCann, MPH
ORISE Fellow, NCBDDD

Pamela Meyer, PhD, MSPH
Health Scientist, OTASA/CSTLTS

Jessica Miller, MA
Public Health Advisor, OTASA, CSTLTS

Emily Nethercott
Public Health Advisor, OTASA, CSTLTS

Matthew Olivares
Health Communication Specialist, NCIPC

Kathryn "Katie" Ports, PhD
Behavioral Scientist, Division of Violence Prevention (DVP), NCIPC

Judith Qualters, PhD, MPH
Division Director, NCIPC

Shannon Robinson Ahmed
Health Education Specialist, NCCDPHP

Anne Schuchat, MD (RADM, USPHS, RET)
Principal Deputy Director

Daniel Sosin, MD, MPH
Deputy Director/Medical Officer, CPR

Chris Stockmyer, MPH
Public Health Advisor, NCCDPHP

Morgan Thomas, MFA
Health Communication Specialist, NCIPC

CAPT Amy Valderrama, PhD
Epidemiologist, NCEZID

LT Jeffrey Walker, MPH
Public Health Advisor, CSTLTS

Alleen Weathers, Med, MPH
Public Health Advisor, OTASA, CSTLTS

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

Kelly Wilkinson
Health Marketing/Communication Specialist, CSTLTS

Stacey Willocks, MS
Behavioral Scientist, NCIPC

Andrea Young, PhD, MS
Associate Director for Science, CSTLTS

Non-Federal Attendees

Robert (Bobby) Ahern
Teresa Y. Brown
Francys Crevier
Marisa Ervin
Sherry Everett Jones
Vivian García-López
Katie Grismala
Carolyn Angus-Hornbuckle
Jamie Ishcomer
Amy Lansley
Rebecca Ledsky
Caitlyn Lufty
Pam Myers
CoCo Villaluz

9:00AM–Opening Blessing, Welcome, and Introductions

- Councilman Chester Antone announced that he is filling in for Chairman Two Bears until Principal Chief Sneed is able to arrive later this afternoon. He led the opening blessing.
- Captain Clelland welcomed everyone to the winter 2019 CDC/ATSDR TAC Meeting and announced that he will be acting on behalf of Dr. Montero, who was unable to attend.
- Lieutenant Commander Aspaas conducted the roll call. A quorum was present to conduct necessary business.

9:15AM–TAC Business

Facilitator

- **Chester Antone** (*Tohono O'odham Nation*) Councilman

TAC Business Opening

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

Changes to the Agenda

- Dr. Houry is unavailable for the NCIPC updates during the Centers, Institutes, and Offices (CIOs) Leadership Discussion. Dr. Arlene Greenspan, NCIPC associate director for science, and Dr. Judy Qualters, division director for NCIPC's Division of Analysis, Research and Practice Integration and the executive sponsor for the Injury Center Tribal Work Group, is filling in on Dr. Houry's behalf.
- The NCCDPHP is replacing the Elimination of Viral Hepatitis in Tribal Nations discussion originally scheduled for Wednesday, February 6. NCCDPHP will discuss the work they are currently doing in Indian Country.
- Dr. Anne Schuchat, principal deputy director for CDC, will provide the CDC director and ATSDR administrator updates.
- TAC members seconded and unanimously approved the motion to approve the changes to the agenda.

TAC Charter Review

- Current charter is more than three years old.
- CDC received a revised charter draft about a week ago and is currently reviewing it to ensure it meets consultation requirements.

Tribal Public Health Workgroup Discussion

- Captain Clelland opened a discussion on what the new Tribal Public Health Workgroup (TPHWG) should address under CDC's new cooperative agreement (CoAg) with the National Indian Health Board (NIHB), and what types of subject matter experts should be included. One area of work suggested is to help support the TAC.
    - Councilman Antone stated the TPHWG should be able to convene more often but that requires additional funding. To help inform and identify gaps, the TAC often requests research on specific areas.
    - Vickie Bradley asked about opportunities for funding to develop a charter for the TPHWG.
        - CDC will reach out to partners to look into this opportunity.
    - Vickie Bradley proposed that CDC continue the TPHWG and for TAC input to help decide membership. This should be a priority agenda item for the TAC.

Location Recommendations for Summer TAC 2019

- Captain Clelland asked for location recommendations for the 2019 Summer TAC meeting.
    - Principle Chief Sneed made the invitation for the Eastern Band of Cherokee Indians to host the 2019 Summer TAC in Cherokee, North Carolina.

10:00AM–Data Discussion on Racial Misclassification

Presenters

- **Jamie Ishcomer MPH, MSW, (Choctaw Nation of Oklahoma),** Deputy Director, National Council of Urban Indian Health (NCUIH)
- **Robert "Bob" Anderson, PhD,** Branch Chief, NCHS, CDC
- **Pamela Meyer, PhD, MSPH,** Senior Epidemiologist, CSTLTS, CDC

Opening Remarks

- Some areas report that up to 60% of American Indian/Alaska Natives (AI/ANs) are misclassified.
- Working to use linkage data to find a systems level approach to improve misclassification. This is not necessarily specific to death certificates but burden of disease overall.
- Currently NCUIH is working to identify best practices in states to identify potential gaps, including licensing, training, and continuing education requirements to determine potential policy recommendations.
- There is a standard death certificate model; however, there are variations across each state.
- The funeral director in each state is often providing the demographic information. The funeral directors are supposed to get this information from an informant, such as a family member or acquaintance.
    - In total, there are 52 death certificate variations; this includes each state, the District of Columbia, and New York City.
    - This project includes a review of each of these variations to determine their consistency with the standard. This review will also look at the number of variations that have a space for tribal affiliation.

TAC Questions and Discussion

Question from Jamie Ishcomer: Do TAC members understand the death certificate process? Do TAC members have a role in the process?

Answers (input from multiple people):

- (California Area) Identifying tribal members was easier in the past. We had a funeral director who had been there for years and knew everyone in the community. With a recent change in director, completing the forms correctly is now a problem. We provide funding for tribal members for burial. To receive this funding, a death certificate from the funeral home is required.
- (Tribes-at-Large) In North Carolina, the county instead of the state records death certificates. It becomes challenging to gather information across multiple county lines. We require tribes submit death certificates to us for our public health program.
- (Navajo Area) We have a data sharing agreement with states that border our nation. When tribes request mortality data, they receive AI/AN race, but there is no mention of tribal affiliation. States are not aware of the importance for specific tribal affiliation information. It is important to gather tribal affiliation in order to know tribal-specific disease rates.

Question from Jamie Ishcomer: How do we address barriers for AI/AN who live off reservations? Have tribal communities explored these barriers? The Indian Health Service (IHS) does not always capture the whole AI/AN population. What are your communities doing to move past only relying on IHS data?

Answers (input from multiple people):

- (Tribes-at-Large) Oklahoma's tribal public health workgroup has been discussing this issue with the state health department. Conducting linkages between IHS data and state data is not timely. What is CDC's role and the state's role in assisting the racial misclassification issue?
    - (Bob Anderson) CDC is working on training funeral directors to address the importance of accurately capturing race on death certificates.
    - (Pamela Meyer) OTASA is working to learn everyone's processes to figure out who all the partners are and how states can play a larger role in addressing this issue.
- (Tribes-at-Large) For our region, the National Association of Public Health Statistics is working with the United South and Eastern Tribes Tribal Epidemiology Center (TEC) on this.
- (Tucson Area) Tribes have a hesitancy to share data. In the Tucson area, the tribes do not work much with the state. They have their own tribal funeral home. For this specific region, there is an issue with classifying cause of death accurately.
- (Oklahoma Area) Working with states to learn their best practices is not going to be effective. CDC needs to help fund and provide guidance to develop a sustainable system to allow tribes to build the infrastructure to obtain data themselves. Lack of data on affiliation is our issue.

Question from Jamie Ishcomer: In Montana, Northern Cheyenne shares paternity acknowledgement information with their state. What challenges have you encountered in sharing information with your states and would sharing enrollment data be a viable option?

Answers (input from multiple people):

- (Tribes-at-Large) No, sharing would not be a viable option. Enrollment data is very privileged.
- (Tucson Area) The challenge is determining affiliation as opposed to getting data directly. I propose that we look into this issue more. Can funeral director trainings with continuing education credits include the importance of marking tribal affiliation? If so, can tribes submit confirmation of this training to CDC?
    - (Bob Anderson) Focusing on education works very well, but it would be difficult for a funeral director to determine affiliation without a database somewhere.

12:30PM–Children's Eagle Book Discussion and Consultation (*Working Lunch*)

Presenters

- **Laura Kollar, PhD,** Behavioral Scientist, DVP, NCIPC, CDC
- **Katie Ports, PhD,** Behavioral Scientist, DVP, NCIPC, CDC
- **Morgan Thomas, MFA,** Health Communication Specialist, DVP, NCIPC, CDC
- **Marisa Ervin, BA,** (Coquille Indian Tribe), Native Author and Illustrator
- **Vivian García López, PhD LEd,** (Pascua Yaqui Tribe)
- **Rebecca Ledsky, MBA, BA,** (Research Lead, FHI 360)

Opening Remarks

- The focus of this discussion will be to hear TAC member's thoughts about these storylines and some book two story ideas, as well as on other issues concerning these books.
- CDC's NCIPC is developing two books for AI/AN children in kindergarten through third grade, their parents, caregivers, and educators.
- The books aim to promote cultural protective factors and modeling bystander behavior to help achieve the overall goal to prevent injury and violence in Native communities.
- Neither of the books will depict violence.
- Book 1 will focus on AI/AN cultural protective factors or tribal characteristics that buffer against risks for injury and violence.
- Protective factors include positive social norms, and cultural protective factors include shared tribal language, ceremonies, traditional activities, and relationships with other tribal members, such as elders.
- Book 2 will be a supportive bystander intervention story.
- These books are tentatively scheduled to publish in late 2020.

TAC Questions and Discussion

Question from Moderator Vivian García López: What images do you associate with your own tribes or regions that may relate to or have meaning for the books' topics?
Answers (Chairman Flying Hawk):

- The Missouri River comes to mind and the importance of that river.

Question from Moderator Vivian García López: What might help strengthen the message of first book's storyline?
Answers (input from multiple people):

- Does the feather have to go back to the Earth in the first book? The feather should go instead with the wind.
- Sometimes families themselves might change to protect the ones they love. That is, the change could be in the form of moving or staying away from certain family members.

Question from Moderator Vivian García López: In what ways does this story reflect the supportive community cultural characteristics that exist in your own tribal community or region or other tribal communities?
Answers (input from multiple people):

- Some tribes look at the earth in a different way.
- Tribes have commonalities, but individually we all look at things differently. The commonalities should then be the focus. Commonalities include Indian Reorganization Act, constitutions, resilience, and historical trauma.
- There should be more use of general terminology recognizable to all children. Some children do not know what an ocean looks like, but they do know the term water. Fishing and salmon may not be relatable.

- Families may not be accessible for all children. Be cautious in using terms like grandma and grandpa, but say, "Someone that loves and supports me" instead.
- Some commonalities can include health disparities. One such health disparity that some tribes have in common is diseases from ticks. For example, the story could include taking care of a dog and keeping your home clean and orderly so as not to attract bad things, that could include diseases such as Rocky Mountain Spotted Fever (RMSF).
- The title Starry Lights is okay but "The Stars That Connect Us" may be a better title.
- Need to change the title of Spirit Flight. The current title makes it seem like the children are going into the spirit world.
- Will these books come with directions on how to use them? For example, "This is an example of how to deal with this situation."

Question from Moderator Vivian García López: When it comes to the visuals of the two books, what else is important to keep in mind to make sure they are culturally appropriate and as relevant as possible across AI/AN tribal communities?

Answers (input from multiple people):

- Mountains are good to show.
- In general, daily living with people who look like us is important.
- One thing I did not see here is that we have a sense of community. We are always together helping each other—dinners, church, community meetings, and traditional gatherings with traditional foods.
- In certain tribes, people cannot touch certain types of feathers.
- It is important to watch out for "pan-Indianism," which is something that could happen by propagating stereotyped images or by relying too much on commonalities. It might be a good idea to have notes on the sides that say, "This is a Cherokee tradition."
- Another alternative to relying on commonalities is to add a discussion guide so tribes can tailor the book to their culture as it is used.
- Not all animals are common between tribes. For example, many tribal areas do not have bears, and not many have seen a bear before. The rabbit and owl are more common.

Comments on the five bystander intervention story ideas:

- (California Area) I like the first and fifth story idea. The fifth one is particularly relevant because a lot of kids experience trauma.
- (Navajo Area) I like the second and fifth story idea. They seemed the most relevant to Navajo and White Mountain Apache. Suicide prevention efforts are a priority in the southwest.
- (Great Plains Area) I like the fifth story idea. Reaching out to help each other in every stage of our lives is very important.
- (Tucson Area) I did not understand the message of the third one, but I like the second story idea. It is hard to seek help, and it can come across as demeaning to ask for help, but it is important to ask.

2:00PM–Opioids, Adverse Childhood Experiences, and Suicide Prevention Updates and Listening Session

Presenters

- **Arlene Greenspan, DrPH, MPH, MS,** Associate Director for Science, NCIPC, CDC
- **Judith Qualters, PhD, MPH,** Division Director, NCIPC, CDC

Opening Remarks

- The top three priorities at NCIPC are adverse childhood experiences (ACEs), suicide prevention, and opioids.

- NCIPC projects in Indian Country (aside from the top three priorities) include motor vehicle crash prevention, intimate partner violence prevention, and falls prevention.

TAC Questions and Discussion

Question from Councilwoman McCovey: How can we prevent post-traumatic stress disorder (PTSD) and drug abuse if they are co-occurring?
Answer (Dr. Qualters) For PTSD, there are potentially many causes. CDC understands that there is a relationship between ACEs, opioids, and suicide. ACEs for example can lead to longer-term mental health issues. So one of the areas we are looking at for primary prevention is to address children to reduce the risk of these issues later in life.
Answer (Dr. Greenspan): There is a link between PTSD, suicide, opioids, and ACEs so it is important to provide resilience for kids and adults for primary prevention. CDC is working to focus efforts on children so the problems do not persist in adulthood. NCIPC works to develop funding announcements that are broad enough to allow for culturally appropriate approaches that can address a variety of challenges. We are also looking at these linkages to try to understand them in more detail to improve prevention strategies.

Question from Dr. Greenspan: Are there particular injury prevention messages that resonate with your community to prevent ACEs?
Answer (Ms. Bradley): We are starting a new campaign on ACEs. We want to devise a system to conduct more tests on ACEs, but are unsure what to do with the data once they are collected. We need to educate the community more about ACEs and then identify potential protective mechanisms. For this campaign, we need assistance or effective community-based strategies on community-wide education campaigns.

Question (Dr. Greenspan): We have begun to compile evidence-based strategies, and we do have a child-abuse technical package to provide more guidance on implementation of the evidence-based strategies. What are some of those evidence-based strategies that resonate in Indian Country, and what can we improve to make these messages more culturally sensitive?
Answer (Councilman Antone): Not all programs have tribal-specific projects. When we apply to them, we have to change our strategies to become competitive. Would there be assistance available for the tribes?
Response (Dr. Crosby): NCIPC developed technical packages to help communities learn more about implementing evidence-based strategies. These packages include a number of strategies to help communities learn more about the problem and the best program to address it.
Response (Dr. Qualters): NCIPC recently developed an implementation guide for communities. Other projects include suicide data and misclassification in the National Violent Death Reporting System.
Comment from Ms. Pivec: The different types of funding going to tribes for specific things hinders the bigger picture of creating public health infrastructure. We are doing a lot in the clinic setting, but we need to increase public health efforts.
Response (Dr. Qualters): We do have some funding opportunities directed toward strategic planning. We are encouraging partners to use strategic planning efforts to help manage and direct the other funding streams coming through.

Question from NCIPC: Who are the key partners in Indian Country?
Answers (input from multiple people):

- Elders.
- We developed the Opioid Tribal Action Plan Coalition and brought in people from different sectors; however, it was hard to manage multiple groups/projects.
- It is difficult to recruit staff in tribal communities.

Statements from NCIPC:

- There is a funding opportunity with a population size requirement going out to states, cities, and territories to address overdose data.
- NCIPC is encouraging tribes to reach out to their state representatives and partners to ensure there are efforts going to tribes because of this funding.
- There is a need for better data to use better interventions.

Wednesday, February 6, 2019

9:00AM–Healthy Tribes, NCCDPHP Updates

Presenters

- **Craig Thomas, PhD,** Director, Division of Population Health
- **David Espey, MD,** Director, Healthy Tribes

Overview of the Healthy Tribes Program

- In 2014, NCCDPHP took steps to work more cohesively and increase CDC's investment in Indian Country.
- By fiscal year 2019, NCCDPHP will provide approximately $34.5 million to more than 100 tribes, tribal organizations, and TECs through three CoAgs: Good Health and Wellness in Indian Country (GHWIC), Tribal Epidemiology Center Public Health Infrastructure (TECPHI), and Tribal Practices for Wellness in Indian Country (TPWIC).
- GHWIC is a $76.5 million, five-year CoAg.
    - Our GHWIC partners include 12 individual tribes and 11 tribal organizations.
    - This CoAg will help tribal organizations support tribes in their arena in the form of sub-awards, evaluation support, training and leadership.
    - GHWIC is the largest investment to Indian Country from CDC to date.
    - The cornerstone strategy of GHWIC is promoting partnerships between all 23 grantees and partners.
    - This CoAg takes a more integrated approach to reduce obesity and tobacco use and to prevent and manage diabetes and cardiovascular disease.
    - Within GHWIC, NCCDPHP emphasized policy, systems, and environmental approaches because they reach deeper into the community and last longer compared to behavioral change efforts.
    - GHWIC also promotes community-clinical linkages between the services available in the community and those provided in the clinical setting to assure those at high risk for chronic disease are receiving the clinical preventive services they need.
- TECPHI is a $42.5 million, five-year CoAg to strengthen the infrastructure of TECs and to increase their capacity to address regional public health priorities, including chronic disease prevention, to the tribes they serve.
- TPWIC is a $15.5 million, three-year CoAg.
    - Input from CDC's TAC suggest that AI/AN cultural and traditional teachings and practices are not widely understood or supported through financial and technical resources by federal agencies.
    - After convening three meetings with tribal leaders and cultural advisors, NCCDPHP identified seven strategies that strengthen connections to community, family, and culture to reduce risks for chronic disease in their communities.
    - This CoAg provides funding to 21 individual tribes and 16 urban Indian organizations.

The PowerPoint presented by NCCDPHP is available upon request. Email tribalsupport@cdc.gov to request a copy of the presentation.

TAC Questions and Discussion

Question from Ms. Beaver: Can you explain the decision to fund the epidemiology centers instead of individual tribes? What about those tribes that do not have a relationship with their epidemiology center? Will you be conducting an evaluation on this CoAg to determine how effective it is to fund epidemiology centers?
Answer (Dr. Espey): The goal of this particular funding is to target a network of tribal organizations that serve a number of tribes. There will be an opportunity to apply for direct funding for tribes through our next round of funding for GHWIC.
Answer (Dr. Thomas): When TECPHI is in its third or fourth year, it will be a good time to evaluate whether this was a good model for NCCDPHP and what we might like to do differently. We are currently in the second year of the grant.

Question from Mr. Yazzie: How can tribes find more resources—specifically to do Tribal Behavioral Risk Factor Surveillance System (BRFSS)—and not just community health assessments or community health improvement plans? The cost burden currently is about $300,000 across five agencies or about $1.5 million to conduct a tribal BRFSS.
Answer (Dr. Thomas): Now is a good time to start modernizing the BRFSS instrument. This would allow more opportunities for funding for tribes and tribal communities. Dr. Thomas made a request to discuss some lessons learned from tribal BRFSS at Navajo with Mr. Yazzie.
Answer (Dr. Espey): TECPHI is another opportunity for epidemiology centers to apply for funding for tribal BRFSS projects.

Question from Mr. Yazzie: State health departments do not always share data with tribes or epidemiology centers. Is it possible to include language in the notice of funding opportunity (NOFO) requiring states to share data with tribes and epidemiology centers?
Answer (Dr. Thomas): The NOFO for BRFSS will expire in 2020, so now is a good time to start incorporating new language.

Question from Councilman Antone: Which regions in Indian Country experienced higher increases in homicide and is there a specific reason for this increase? It would be good to invest funding into the root causes of unintentional injuries and homicide so that we are responding proactively rather than reactively. We need guidance for setting up benchmarks so that we know we are moving towards the goals that we have defined.
Answer (Dr. Espey): Alaska and Southwest Areas. The reason for the increase could be a result of multiple factors, but factors like this increase in homicide are a part of our goal of TPWIC is addressing health through culture. We want to work to address these social determinants of health to improve some of these health conditions.

10:00AM–CIO Senior Leadership Updates and Listening Session

Presenters

- **Captain Carmen Clelland, PharmD, MPA, MPH,** Director, OTASA, CSTLTS, CDC (*on behalf of Dr. José Montero, CSTLTS Director*)
- **Captain Deron Burton, MD, JD, MPH,** Associate Director for Health Equity, NCHHSTP, CDC
- **Sharunda Buchanan, PhD, MS,** Director, Division of Emergency and Environmental Health Services, NCEH/ATSDR
- **Stephanie Dulin, MBA,** Deputy Director, NCBDDD, CDC
- **Captain Thomas Hennessey, MD, MPH,** Director, Arctic Investigations Program, NCEZID, CDC
- **Craig Thomas, PhD,** Director, Division of Population Health, NCCDPHP, CDC
- **Captain David Espey, MD,** Director, Healthy Tribes, NCCDPHP, CDC
- **Constance Franklin, MPA,** Program Analyst, NIOSH, CDC

- **Gregory Smith, MPA,** Tribal Liaison Officer, Program Services Branch, Division of State and Local Readiness, CPR, CDC

CSTLTS

- CSTLTS has been working on a strategic plan to guide communication and decision making for the next 3–5 years. The updated mission is "to improve community health outcomes by strengthening state, tribal, local, and territorial public health agencies."
    - The three goals of the strategic plan are to—
        - Enhance public health system coordination and collaboration to advance public health priorities
        - Fortify public health infrastructure and core capabilities of state, tribal, local, and territorial health departments
        - Put public health systems science into action to achieve public health impact
    - Some examples of strategic objectives that support tribes include the following:
        - Increase CDC engagement and collaboration with tribal elected leaders and tribal health officials
        - Increase workforce capacity and competencies for improving AI/AN health
        - Develop tools and guidance for responding to the social determinants of health
        - Improve tribal resource strategies, systems, and performance
        - Provide opportunities, resources, and tools to support and improve public health system response to emerging and emergency issues
- CSTLTS has recently started a new five-year CoAg to build capacity in Indian Country by providing direct funding to tribes and tribal-serving organizations. This is the Tribal Public Health Capacity Building and Quality Improvement Umbrella CoAg and will use a two-part strategy:
    - Funding strategy 1 supports building capacities and capabilities and provided $550,000 to tribes and tribal-serving organizations in fiscal year 2018.
    - Funding strategy 2 enables CIOs to make awards to funding strategy 1 recipients. This strategy provided $15,431,446 to tribes and tribal-serving organizations in fiscal year 2018.
- Starting in fiscal year 2018, CSTLTS began funding national partnerships through a five-year CoAg. This CoAg provided $1,890,000 in funding to help strengthen the nation's public health infrastructure by implementing activities to strengthen governmental and nongovernmental components of the public health system to ensure a competent, current, and connected public health system and to improve the delivery of essential public health services through capacity-building assistance.
- The Public Health Associate Program (PHAP) is a two-year training program managed by CSTLTS. In fiscal year 2018, PHAP had 23 associates working in tribal host sites or in tribally focused assignments. This represents a total financial investment of $1.5 million to support tribes and tribal-related capacity building.

NCHHSTP

- Division of Sexually Transmitted Diseases: The Community Approaches to STD Disparities project, currently in its second year, focuses on community engagement to promote wellness and sexual health in tribal communities. It works to establish partnerships, conduct needs assessments and local testing events, and apply primary interventions for teen sexual health.
- Division of Adolescent and School Health (DASH): Youth Risk Behavior Survey (YRBS) monitors youth risk behaviors. CDC administers the YRBS nationally and directly funds states, tribes, and territories to conduct their own assessments independent of the national YRBS. CDC provides technical assistance to do this and allows awardees to keep their own data and modify the survey as needed. The Division of Adolescent and School Health can also provide technical assistance to tribal communities for conducting surveys and assessments so long as the population size is representative and substantial.

- Division of HIV/AIDs Prevention: Provides comprehensive HIV prevention for community organizations, including the Indigenous Peoples Task Force in Minnesota and the Native American Health Center in California.
- Division of Viral Hepatitis: From 2013 and 2018, a CoAg with the Alaska Native TEC, addressed Hepatitis A and Hepatitis B prevention via vaccination and interventions. The outcomes of this project helped develop publications and vaccine strategies.

NCEH/ATSDR

- NCEH/ATSDR's mission is to protect people's health from environmental hazards that can be present in the air we breathe, the water we drink, and the world that sustains us by investigating the relationship between environmental factors and health, developing guidance, and building partnerships to support healthy decision making.
- Phase One of our Tribal Drinking Water Program included training 24 professionals from 13 tribes and developing program improvement plans.
- Phase Two of our Tribal Drinking Water Program included assistance in implementing the program improvement plans developed during first phase, creating an inventory of environmental health data sources, and designing an electronic platform for better management of data to prioritize program improvement needs.
- NCEH helped provide onsite consultation and technical assistance to the Cherokee Nation, Northern Cheyenne Tribe, and the Tuscarora Nation.
- Per-and-Poly-fluoroalkyl Substances (PFAS) are contaminants that can pollute water systems. In 2018, NCEH/ATSDR conducted outreach and health assessments in Alaska to help address the PFAS problem.
- In collaboration with NIHB, NCEH/ATSDR is in the initial stages of planning a Tribal Environmental Health Summit for 2020.

NCBDDD

- This program works to advance CDC's mission of preventing the leading causes of disease, disability, and death, while promoting the health of people of all ages.
- In fiscal year 2019, Congress appropriated an additional $10 million to NCBDDD to protect mothers and babies from emerging threats.
- To implement surveillance for this project, CDC will support public health partners to prepare for and respond to emerging threats to mothers and babies.
- CDC will provide a more accurate picture of infants and children affected by the Zika virus infection during pregnancy (up to age 2) included in CDC's Zika Pregnancy and Infant Surveillance System. These data will help inform the needs of and optimal care for children and families.
- CDC will also pilot the innovative Zika surveillance system to monitor and respond to additional or emerging threats, including prenatal opioid exposure and related infections and their impact on mothers and babies.
- In fiscal year 2020, CDC will continue using Surveillance for Emerging Threats to Mothers and Babies as a key component of preparedness and rapid response activities for these populations. CDC will also focus on monitoring the impact of Zika, the opioid crisis, infectious diseases, and natural disasters affecting mothers and babies.

NCEZID

- Division of Vector-Borne Diseases: Currently working on RMSF control in Arizona. Funding recently announced targeting early diagnosis and better RMSF control.
- Division of High-Consequence Pathogens and Pathology: Dr. Hennessey discussed the capacity of their division to analyze data from the IHS Data Mart, which started with Hantavirus data in Arizona. This IHS

data analysis capacity has since led to the publishing of about 60 papers. This service is available to tribal members and other centers.

- Division of Foodborne, Waterborne, and Environmental Diseases: Currently working on activities related to the early diagnosis and management of Valley Fever, as well as certain waterborne infectious diseases. An example of this would be the Great Lakes Restoration Initiative, which seeks to build capacity to better analyze these water systems.

NCCDPHP

- Division of Diabetes Translation
    - The Division of Diabetes Translation currently has 38 tribes and tribal-affiliated organizations offering the National Diabetes Prevention Program (DPP) lifestyle change program and participating in the CDC recognition program.
    - A pre-conference workshop at the upcoming Diabetes in Indian Country Conference (August 2019) will focus on practical how-to's and highlight lessons learned from tribes that have been successful in offering the National DPP lifestyle change program in their communities.
    - In November 2018, the Division of Diabetes Translation released an announcement in the Federal Register for public comment related to the evaluation of their CoAg-funded programs that are working to support new program startups in underserved areas.
- Division of Nutrition, Physical Activity, and Obesity (DPNAO): On May 6–10, 2019, DPNAO will acknowledge the 20th Anniversary of Racial and Ethnic Approaches to Community Health (REACH) during the National Training meeting in Atlanta, Georgia.
- Division of Cancer Prevention and Control has about four CoAgs providing funding of approximately $10 million. One of these CoAgs for breast and cervical cancer currently has thirteen recipients. Another for colorectal cancer has one recipient.
- Division of Heart Disease and Stroke Prevention (DHDSP)
    - In fiscal year 2018, DHDSP funded two tribal organizations for Well Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN), which provides heart disease and stroke risk factor screenings and services that promote healthy behaviors.
    - DHDSP funded tribes and tribal orgs through the current GHWIC and will continue to do so with enhanced community clinical linkages to support heart disease and stroke prevention in the next funding cycle for GHWIC beginning in fiscal year 2019.
- The Office on Smoking and Health (OSH)
    - In fiscal year 2018, OSH funded the National Native Network through Inter-Tribal Council of Michigan, Inc., which serves as a public health resource to decrease commercial tobacco use and cancer health disparities among AI/AN. There are eight funded networks.
    - Every year as part of the Tips campaign, OSH invests funds for targeted media to enhance the reach of the campaign to AI/AN audiences. In 2018, examples of media channels containing Tips ads include on looped videos in health clinics serving this audience and on radio (Native Voice One), as well on digital and in print (Whispering Winds).
- Division of Oral Health
    - Through a supplemental award within TECPHI, the Division of Oral Health provided fiscal year 2018 funding to all 12 TECs to 1) assess infrastructure, capacity, gaps, and needs among selected tribes to conduct oral health surveillance and 2) develop capacity building and technical assistance resources for conducting oral health surveillance among selected tribes.
- Division of Population Health
    - Announced an initiative for a new road map for tribal leaders to engage communities on Alzheimer, which coincides with their Healthy Brain Initiative. Tentative release date is spring 2019.

- Collaborating with the Division of Heart Disease and Stroke Prevention to produce posters, flyers, videos, and newspaper articles on the management of blood pressure as a mechanism for preventing stroke.

NIOSH

- NIOSH is announcing the "Building Bridges to Enhance the Safety of American Indian Workers" conference for July 30–31. The goal of this conference is to meet and discuss tribal worker safety health and solutions.
- NIOSH also currently has two recently released NOFOs (totaling about $6 million) on commercial fishing safety research and training.

CPR

- The Cherokee Nation received CDC's FY 2019 CoAg for Emergency Response: Public Health Crisis Response because their application met the population size criteria. The next cycle for applications will begin at the end of 2019.
- CPR will post a NOFO for CDC's Public Health Emergency Preparedness in the next few weeks, which will cover a period of performance from July 2019 through June 2024. Congress has stipulated that funding go mainly to state-level public health departments, so CDC has taken additional steps to strengthen state relationships with tribal nations to help ensure greater coordination for public health emergency preparedness.
- CDC's tribal support pilot program "Pathways to Preparedness" is mid-way through its first year. The focus of this program is to gather resources and engage with partners to help tribes prepare for public health emergencies. The program hopes to provide a toolkit of resources for AI/AN audiences.
- Currently, CPR is preparing to present its "Working Effectively with Tribal Public Health Emergency Management Programs and Tribal Governments" presentation and training program at two upcoming events. The first presentation will take place at the 10th Annual Native American Healthcare Conference held in Temecula, California, June 11–12, 2019. In addition, CPR will be presenting at the 6th Annual National Tribal Emergency Management Conference in Green Bay, Wisconsin, August 22–23, 2019. This conference will include representatives from the Northwest Tribal Emergency Management Council, the Montana Indian Nation Working Group, the Inter Tribal Council of Arizona, the Inter Tribal Long Term Recovery Foundation, and the National Joint Powers Alliance, now known as Sourcewell, Inc.

11:00AM–CDC Director and ATSDR Administrator Updates and Listening Session

Presenter

- **Anne Schuchat, MD, (RADM, USPHS, RET)**, Principal Deputy Director, CDC

Opening Remarks

- CDC understands the need for direct funding for tribes and tribal organizations. As a result, CDC provided nearly $65 million of direct funding to tribes and tribal organizations in fiscal year 2018.
- The diversity of tribes and tribal organizations means that one size does not fit all and as such, there is not always a capacity to apply for funds.
- CDC also understands that short-term or one-time funding opportunities will not necessarily lead to long-term results. GHWIC is a good example of a successful and sustainable program providing direct funding to Indian Country. GHWIC was innovative at the time of its release, but CDC hopes that the GHWIC model will continue to expand across all CIOs.

Dr. Redfield's Priorities

1. Health security and preparedness. The 2009 influenza pandemic in particular hit AI/AN communities and children especially hard. We need to ensure support for vulnerable communities in particular.

2. The opioid epidemic, referred to as "the epidemic of our time." The social determinants of health underpin the epidemic itself.
3. Eliminating disease. President Trump hopes to eliminate AIDs and the spread of HIV by 2030. A related epidemic is the hepatitis epidemic, and CDC recognizes the exemplary work that Cherokee has done to eliminate hepatitis C.

Foundational Capabilities of Public Health

1. Data Analytics and Strengthening Data: AI/AN data needs to be more timely and actionable.
2. Workforce: PHAP is a model program for mobilizing the interests of younger generations and applying them in the areas of the greatest need.
3. Protecting Mothers and Babies: reducing the burden of maternal mortality has been a priority at CDC for years, as well as addressing emerging threats for babies like Zika. Too many women are still dying in childbirth.

TAC Questions and Discussion

Question from Councilman Antone: How is CDC coordinating to include tribal public health and traditional practices?
Answer (Dr. Schuchat): The GHWIC program was CDC's first formalized effort to support and improve health by building off cultural and traditional practices. This started when NCCDPHP was conducting listening sessions, developing funding, and sharing their experience with other CIOs. Most recently, NCIPC adopted that model to build their own opioid funding opportunities.

Question from Councilman Antone: I know that CDC is aware of the Tribal Behavioral Health Agenda from the Substance Abuse and Mental Health Services Administration (SAMHSA). How will CDC coordinate with SAMHSA and other federal agencies to implement it?
Answer (Dr. Schuchat): Working effectively across the federal government is important, especially in the government-to-government relationship. CDC is committed to coordinating with other agencies on the behavioral health effort. There is a behavioral health council that all of the federal agencies, including CDC participate in. CDC is looking for more opportunities to work more coordinated with other agencies. The way that CDC does funding sometimes makes it difficult to coordinate with other agencies. SAMHSA, for example, provides many block grants, whereas CDC funding can include more requirements. Accountability is important to CDC, and it helps us with our commitment to ensure that we are making an impact. This also helps us gain congressional support to sustain and grow the resources that we get, because CDC puts a priority on being able to show results. The critical issue of importance for grants that CDC provides to tribes and tribal organizations is the sustainability lens. We want to support activities that have incremental improvements built for the long run. CDC grants try to work in a way that is sensitive and responsive.

Question from Ms. Pivec: The Cherokee Nation came up a lot as an example during the CIO leadership listening session; however, Cherokee does not have funding for public health infrastructure. The clean drinking water initiative was $10,000, BRFSS was $12,000, and the hepatitis funding was minimal and cost quite a bit "in-kind." The emergency management CoAg takes time as well. It is important for everyone to know that Cherokee participates in these small funding opportunities because we have the infrastructure to take these dollars, and the people who work on these projects wear multiple hats. There needs to be consistent public health infrastructure funding so that if a new priority comes along, the old priority does not completely fade away. CDC also needs to focus beyond TECs. What works in Oklahoma does not always work elsewhere. How can the bigger tribes in Oklahoma develop public health capacity and ensure that smaller tribes benefit from capacity-building activities in Oklahoma?
Answer (Dr. Schuchat): Thank you for these comments. There is a common challenge to ensuring infrastructure to do this work. Many of these projects rely on the assumption that there is infrastructure already in place to execute them. Dr. Redfield has observed that CDC has neglected foundational infrastructure at the expense of

individual projects. Because of this observation, there may be interest by policy makers in supporting infrastructure.

Statement from Ms. Beaver: We recognize and respect relationships and would really appreciate a direct relationship with CDC. If we truly want to work together, we have to be able to have mutual respect for each other to move forward in addressing health disparities. As tribal nations, we want the help from CDC, and we need the direct relationship to do that.
Response (Dr. Schuchat): Over the past few years, CDC has become more aware of the importance of a direct relationship with tribes. Ursula Bauer's example at NCCDPHP was transformational for other leaders at CDC. It showed us at CDC that funding travel to Indian Country is very important and says a lot. It was because of her work that CDC was able to understand why our approach to grants funding tribes and tribal organizations needed to change. CDC does have restrictions on how we can operate, particularly when it comes to resources. However, the beginning does need to start with that relationship, trust, and understanding.

Question from Mr. Yazzie: PHAP is a great program, but it does not provide us with workers who have a higher skillset. We have asked CDC during these consultations for Epidemic Intelligence Service (EIS) officers and we have the capacity to house an EIS officer because we have had two former officers here at Navajo Nation. We could also use career epidemiology field officers (CEFOs) at Navajo. Would it be possible to place staff in these programs in Indian Country?
Answer (Dr. Schuchat): I am happy to follow up and look into this request.

Question from Principle Chief Sneed: I want to echo Ms. Pivec's and Ms. Beaver's statements. The Eastern Band of Cherokee are in a similar situation as the Cherokee Nation of Oklahoma. We receive funding for specific projects, but we are able to apply only because we have some infrastructure in place. Is there a plan for building lasting infrastructure? Tribes cannot always step in to fund certain project expenses "in-kind."
Answer (Dr. Schuchat): We are working to develop a plan for the workforce issue. In 2019, CDC will focus more on understanding the present and future scope of the public health workforce. We need to focus on the career ladder as a whole and provide more training for mid-career public health professionals. The issue of resources to support infrastructure and workforce gaps is a continual battle. It is sometimes easier to want to eliminate a disease rather than to build infrastructure to be flexible for whatever disease might occur. However, CDC's focus on health security and preparedness and the public health data strategy both help address infrastructure needs and workforce gaps.

Statement from Councilman Antone: I would like to extend an invitation to Dr. Schuchat and Dr. Redfield to visit the Tohono O'odham Nation during the upcoming Secretary's Tribal Advisory Council meeting. It is good to visit these areas and see how rural and hard to access Indian Country can be.
Response (Dr. Schuchat): We will coordinate this with Captain Clelland's office to ensure that one of us can visit during that time.

Question from Mr. Yazzie: When will CDC release the new GHWIC NOFO?
Answer (Dr. Espey): April 2019.

Question from Ms. Beaver: Is the IHS data tribal-specific?
Answer (Dr. Hennessey): No, it is regional.

1:30PM–Commercial Smoking Cessation within Tribal Communities

Presenters

- **Corinne Graffunder, DrPH, MPH,** Director, OSH, NCCDPHP, CDC
- **CoCo Villaluz,** (Hidatsa [Three Affiliated Tribes], Assiniboine [Montana], and Chamorro [Guam]), Senior Community Development Manager, ClearWay Minnesota℠

Opening Remarks

- CDC recognizes the importance of distinguishing between traditional and commercial tobacco use.
- CDC's goal is to collaborate with tribal communities to promote cessation of commercial tobacco use.
- Tribal communities have a higher risk of experiencing tobacco-related illnesses, such as cancer, heart disease, diabetes, and stroke.
- The good news is that estimates show the majority (55.6%) of AI/AN adult smokers want to quit smoking.
- OSH launched the Reimagining Cessation initiative to gather, synthesize, and create recommendations for clear and contemporary vision for cessation support that takes advantage of research, practice, and lessons learned, and considers a range of contextual factors.
- OSH seeks to build on its commitment to understanding the unique complex issues of commercial tobacco use among AI/ANs and developing effective quit strategies.
- OSH's overarching priority areas include increasing the—
    - Quit attempts among people who use tobacco products
    - Use and reach of evidence-based cessation interventions

TAC Questions and Discussion

Question from Dr. Graffunder: Given the burden of commercial tobacco use on AI/ANs, what do you see as the change needed in your communities? What strategy could tribal communities use to address commercial tobacco use?
Answer (Councilwoman McCovey): Vaping is a big issue for some tribes, especially in college areas. Parents may by unaware of what vaping is and how harmful and addicting it can be. There needs to be a campaign to discuss this and help older generations become more aware.
Response from Dr. Graffunder: OSH would be happy to work with tribes to make resources available for education and training. There is no safe tobacco product for kids and any messaging or sharing conducted is helpful. OSH encourages tribes to make use and think about what policy levers are available for tribes to use to address tobacco control. One tribe started to incorporate no e-cigarette policies when they found out that people were starting to use other types of drugs in the JUUL cartridges.

Question from Principle Chief Sneed: What is the efficacy of raising the smoking age for youth as well as raising taxes on commercial tobacco?
Answer (Dr. Graffunder): There is scientific evidence that raising the smoking age for youth helps curb initiation, but not cessation as much. Increasing the purchasing age from 18 to 21 is a powerful example of taking a stance against youth tobacco use. Eighteen-year-olds are still in high school, and often their first exposure to tobacco is from friends at school. Taxes also help for both cessation and prevention of initiation because having fees for both buyers and sellers are excellent deterrents. Increasing prices is a greater motivator to quit. Marrying tax interventions with cessation techniques helps people who want to quit smoking feel more supported.

Question from Principle Chief Sneed: Are there any studies showing the long-term effects of e-cigarettes and vaping use?
Answer (Dr. Graffunder): Studies on e-cigarette and vaping use mostly document their impact on cardiovascular disease. Studies show that e-cigarettes and vaping release toxins that negatively affect cardiovascular health. This is still a relatively new issue and there is not currently too much long-term research for e-cigarettes/vaping. It is important to note that e-cigarettes are unregulated products, so no one really knows what is in them. The liquids are coming from places like India, China, etc. and do usually contain nicotine, which is most likely modified to increase its addictiveness.

Question from Ms. Pivec: How can we present information to stakeholders and tribal governments that accurately describe the scope of the problem? We are able to present the facts, but since it is a sensitive issue,

we would like to present it in a respectful and impactful way. In addition, has anyone tapped into tribal citizen groups or community coalitions to address this issue effectively?
Answer (Ms. Villaluz): Surveys really helped a lot in Minnesota. Election season was also a great time to bring these issues up. We need to send out the message of protecting our future generations. In Minnesota, we have engaged casino and facility management coalitions and we provided trainings for tribal governments. Often smokers and chewers are some of our strongest advocates for changing policies.
Answer (Dr. Graffunder): If you need assistance or studies showing the effectiveness of coalitions, resources to help quitters, etc., we are happy to help. Many know how harmful it is, and smokers always wish they never started. The majority of people, including smokers, are receptive to policy interventions and the support for solutions.

Question from Ms. Pivec: Will there be more funding offered to tribes for commercial tobacco cessation?
Answer (Dr. Graffunder): OSH has contributed to the GHWIC program as our flagship investment to tribes. We have also made independent investments, but are always looking for ways to improve. This includes technical assistance with data analysis, providing resources, funding tribes to do their own data collection.

Question from Mr. Yazzie: Is the tobacco survey available to the public?
Answer (Dr. Graffunder): Yes, the link is in our briefing document (www.cdc.gov/tobacco/data_statistics/surveys/american_indian/index.htm).

Question from Councilman Antone: When Arizona taxed cigarettes, there was a 24% reduction in use. Do you have any data on tobacco use in Arizona's native communities?
Answer (Dr. Graffunder): We will have to follow up on this. I know we have a program in Arizona that studies population-level data on tobacco cessation. The increase in price for cigarettes had reduced the number of people smoking in public spaces.

Question from Ms. Beaver: What are the current partnerships with behavioral health programs? Muscogee Creek is trying to coordinate care for our citizens, and we do not want programs to have to do this work alone.
Answer (Dr. Graffunder): The National Native Network and the National Behavioral Health Association are some of the major partnerships we have. We can share with you the other partners in our network after the meeting. Treating the whole person, including their nicotine addiction, is important.

2:30PM–Supporting Indian Health Services' Improvements in Healthcare Infection Prevention and Control

Presenters

- **Captain Amy L. Valderrama, PhD,** USPHS; Epidemiologist, NCEZID, CDC
- **Captain Ryan Fagan, MD, MPH,** USPHS; Medical Officer, NCEZID, CDC

Opening Remarks

- The Division of Healthcare Quality Promotion's (DHQPs) mission is to protect patients, healthcare personnel, and to promote safety, quality, and value in healthcare delivery systems.
- This division is multidisciplinary and crosscutting and provides a coordinated response with other offices and divisions.
- This presentation will help inform the TAC on the work that this division has been doing with IHS for the past year and a half and would like to learn about healthcare administration in Indian Country.
- Collaboration with IHS began in 2016, when some hospitals were at risk for losing their Centers for Medicare and Medicaid Services certification.
- In 2017, DHQP assisted IHS in developing a new general infection, prevention, and control training curriculum for IHS healthcare facility staff and support IHS Area-based training.

TAC Questions and Discussion

Question from Principle Chief Sneed: Are the trainings for IHS facilities and CDC TRAIN courses available for 638 tribes?
Answer (Dr. Fagan): Yes, and we could think about creating trainings for 638 facilities in general.

Question from Councilman Antone: Healthcare-acquired infections were a priority in the previous administration. Has there been a decrease in those infections at IHS clinics? There are also many complaints about re-admittance to emergency rooms at IHS hospitals, before referral to a high-acuity hospital.
Answer (Dr. Fagan): We are aware that IHS hospitals conduct many referrals for high-acuity patients to other hospitals, and we do have evidence that surveillance of these infections works. Thank you for your suggestion, emergency department readmission rate is definitely a metric for us to consider.

The PowerPoint presented by DHQP is available upon request. Email tribalsupport@cdc.gov to request a copy of the presentation.

3:45PM–Tribal Testimony

Presenters

- **Councilman Chester Antone,** *Tohono O'odham Nation,* Tucson Area
- **Del Yazzie,** *Navajo Nation*, Navajo Area
- **Principle Chief Sneed,** *Eastern Band of Cherokee Indians*, Tribes-at-Large
- **Councilwoman Lana McCovey,** *Yurok Tribe,* California Area

Testimony

- Councilman Chester Antone, *Tohono O'odham Nation,* Tucson Area—
    - Reaffirmed the importance of the Tribal Public Health Framework. It is an important project because it is defining CDC's roles and responsibilities of how it can contribute to behavioral health in its mission. It is an effort that is about three years old now. That is my first consideration for CDC to consider as a priority and move forward.
    - Stated that one other priority is the Tribal Public Health Workgroup. The thought may be for NIHB to establish a policy that would guide this work and of course, the TAC would have to review this, but we need to look into the legal ramifications of this.
- Del Yazzie, *Navajo Nation*, Navajo Area—
    - Thanked CDC for support.
    - Acknowledged the work provided by the GHWIC and TECPHI.
    - Requested EIS officers and higher skilled labor for Navajo Nation and Indian Country.
- Principle Chief Sneed, *Eastern Band of Cherokee Indians*, Tribes-at-Large
    - Thanked CDC and presenters for sharing information.
    - Thanked NIHB for their tireless efforts.
- Councilwoman Lana McCovey, *Yurok Tribe,* California Area
    - Stated there is a need to look at how to get both SAMHSA and CDC working together.
    - There needs to be more follow-up from the 2018 Summer TAC meeting in DC.

Closing Remarks

- Captain Clelland, on behalf of the CDC, thanked everyone for participating.

4:45PM–Adjournment of CDC/ATSDR TAC Meeting

Appendices

Appendix A: Acronym List

ACEs	Adverse Childhood Experiences
AI/AN	American Indian/Alaska Native
ATSDR	Agency for Toxic Substances and Disease Registry
BRFSS	Behavioral Risk Factor Surveillance System
CDC	Centers for Disease Control and Prevention
CEFO	Career Epidemiology Field Officers
CIO	Centers, Institutes, and Offices
CoAg	Cooperative Agreement
CPR	Center for Preparedness and Response
CSTLTS	Center for State, Tribal, Local, and Territorial Support
DHDSP	Division of Heart Disease and Stroke Prevention
DHQP	Division of Healthcare Quality Promotion
DPNAO	Division of Nutrition, Physical Activity, and Obesity
DPP	Diabetes Prevention Program
DVP	Division of Violence Prevention
EIS	Epidemic Intelligence Service
FACA	Federal Advisory Committee Act
GHWIC	Good Health and Wellness in Indian Country
IHS	Indian Health Service
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
NCHS	National Center for Health Statistics
NCIPC	National Center for Injury Prevention and Control
NCIRD	National Center for Immunization and Respiratory Diseases
NCUIH	National Council of Urban Indian Health
NIHB	National Indian Health Board
NIOSH	National Institute for Occupational Safety and Health
NOFO	Notice of Funding Opportunity
OADPS	Office of the Associate Director for Policy and Strategy
OSH	Office on Smoking and Health
OTASA	Office of Tribal Affairs and Strategic Alliances
PFAS	Per-and-Poly-fluoroalkyl Substances
PHAP	Public Health Associate Program
PTSD	Post-Traumatic Stress Disorder
REACH	Racial and Ethnic Approaches to Community Health
RMSF	Rocky Mountain Spotted Fever
SAMHSA	Substance Abuse and Mental Health Services Administration
TAC	Tribal Advisory Committee
TEC	Tribal Epidemiology Center
TECPHI	Tribal Epidemiology Center Public Health Infrastructure
TPHWG	Tribal Public Health Workgroup
TPWIC	Tribal Practices for Wellness in Indian Country
WISEWOMAN	Well Integrated Screening and Evaluation for Women Across the Nation
YRBS	Youth Risk Behavior Survey

Appendix B: CDC/ATSDR TAC Roster

Area Office	Delegate	Authorized Representative (Designated by Delegate)
Alaska Area Term Expires: February 2021	**Alicia L. Andrew** President, Karluk IRA Tribal Council Native Village of Karluk	**VACANT**
Albuquerque Area	**VACANT**	**VACANT**
Bemidji Area Term Expires: August 2020	**Robert TwoBears (TAC Chair)** Representative, Legislative District V *Ho-Chunk Nation of Wisconsin*	**Wally Apland** Director of Finance, Department of Health *Ho-Chunk Nation of Wisconsin*
Billings Area Term Expires: February 2019	**Byron Larson** Rocky Mountain Tribal Leaders Council *Northern Cheyenne Nation*	**VACANT**
California Area Term Expires: February 2020	**Lana M. McCovey** Council Member *Yurok Tribe*	**VACANT**
Great Plains Area Term Expires: August 2019	**Robert Flying Hawk** Chairman *Yankton Sioux Tribe*	**VACANT**
Nashville Area Term Expires: August 2019	**Cheryl Andrews-Maltais** Chairwoman *Wampanoag Tribe of Gay Head Aquinnah*	**VACANT**
Navajo Area Term Expires: August 2019	**Jonathan Nez** President *Navajo Nation*	**Del Yazzie** Senior Epidemiologist, Navajo Epidemiology Center *Navajo Nation*

Oklahoma Area Term Expires: February 2021	**James R. Floyd** Principal Chief *Muscogee (Creek) Nation*	**Shawn Terry** Secretary of Health *Muscogee (Creek) Nation*
Phoenix Area	**VACANT**	**VACANT**
Portland Area	**VACANT**	**VACANT**
Tucson Area Term Expires: August 2019	**Chester Antone** Councilman *Tohono O'odham Nation*	**Sandra Ortega** Councilwoman *Tohono O'odham Nation*
Tribes-at-Large Term Expires: February 2019	**Richard Sneed (TAC Co-Chair)** Principal Chief *Eastern Band of Cherokee Indians*	**VACANT**
Tribes-at-Large Term Expires: August 2019	**Bryan Warner** Tribal Councilor, District 6 *Cherokee Nation*	**Lisa Pivec** Senior Director of Public Health, Cherokee Nation Health Serivces *Cherokee Nation*
Tribes-at-Large	**VACANT**	**VACANT**
Tribes-at-Large	**VACANT**	**VACANT**

Appendix C: Oral and Written Statements

To: CDC/ATSDR

From: Rhonda K Beaver, Muscogee (Creek) Nation, Oklahoma Representative

Date: February 6, 2019

Re: Tribal Testimony

On behalf of Oklahoma Area Tribes, the great Muscogee (Creek) Nation, and Principal Chief James R. Floyd, I bring greetings and appreciate the opportunity to share our recommendations. We serve over 370,000 American Indians/Alaskan Natives in the Oklahoma Area. Oklahoma Area supports investments in Public Health, Health Promotion, and Tribal Sovereignty to care for our citizens and patients.

- *Preliminary grants to funding*: We are thankful the CDC provides funding opportunities that help raise the health status of our citizens and patients. It is disheartening when funding announcements do not accurately relay the intent for full consideration. Most recently, the Tribal Public Health Capacity Building and Quality Improvement Umbrella Cooperative Agreement was advertised as a $50,000 a year grant, then, later explained that award of this opportunity was required to be connected to future funding opportunities. This presents several issues. First, many tribal nations review grant applications to determine whether they can feasible implement a program given the budget—for many health systems $50,000 would not cover appropriate salary, fringe, and indirect costs to implement a new program with qualified staff. So many tribal nations likely reviewed this opportunity and made a choice not to apply because the initial funding was not sufficient to institute a program. Second, the practice of making grants competitive is not one that tribes support nationwide. The federal government has a trust responsibility to provide adequate access and quality care. Additionally, creating additional administrative burdens, like secondary applications, makes it very difficult for smaller, less resourced tribes to take on a grant project without guarantee of additional federal support. All in all it is frustrating that the grant announcement was misleading and leaves the question, how can communication be improved to notify tribes that future funding is connected to future grants and is it possible to open the future funding for public health infrastructure to tribes who did not apply? Many tribes lack infrastructure and stable funding. Without access to this funding, it will not be possible to increase the infrastructure.

- *Tribal Epidemiology Centers*: Many funding opportunities from the CDC are available to Tribal Epidemiology Centers and it is at the determination of the TEC to distribute funding to tribes. Although, many tribes across the nation have a direct relationship with TECs, this is not always the case. This process does not reflect the government-to-government relationship we expect from all federal agencies. Each tribal nation should have to right to exercise tribal sovereignty over their patient and citizen data. In Oklahoma, the single TEC cannot be expected to act on behalf of or provide the services to meet each of the 39 American Indian Tribes' needs. Opening funding streams to tribes empowers tribes to develop public health infrastructure for their own Tribes while respecting their sovereign status. Tribal Epidemiology Centers are viewed as a provider of services to Tribes as the customer; however, this is not the reality in every area. A core set of services, demonstration of capacity to deliver those services, and an evaluation of the services provided directly to Tribes should be a function of CDC. Tribal Epidemiology Centers vary greatly across the US and we do not suggest interruption of those areas in which they function appropriately but request greater accountability for TEC's to ensure they

are meeting the intent of the funding. Funding short term low funded projects to Tribes does not increase the capacity for Tribes to build public health infrastructure. Basic services such as direct technical assistance for surveillance are not available in the Oklahoma Area, instead Tribes in Oklahoma Area have to directly contact CDC or use their own dollars to contract with other providers. A potentially more effective funding strategy would be to directly fund the Tribes in Oklahoma Area and per Tribal Sovereignty allow Tribes to choose the technical assistance provider that is able to do the best job. If the Oklahoma Area TEC is the best provider then naturally Tribes will utilize them to conduct the services. Tribes building their own public health infrastructure should be trusted to make our own decisions regarding services to our People.

    - In the same manner, Emergency Preparedness funding is distributed to the States. The Muscogee (Creek) Nation has a full functioning Emergency Response Program which has assisted County and State efforts in water and flood rescues, person searches, and cleanup after ice, snow, and wind storms in and around our jurisdiction. Funding directly to this Tribal program allows our Tribes to strengthen their ability to act in a timely manner directly for our people while meeting their needs.

- *Racial Misclassification:* Data drives funding and without data, many funding sources are not able to accurately define the need. Racial misclassification is one example that deters funding to Tribes; without proper racial classification and cause of deaths addressing the need through partnerships are a challenge. However, it is important to note Tribes are a sovereign nation and should be given the opportunity with funding to develop data linkages within our Nation from burial programs, social services, health systems, etc. Funding Tribes directly will allow Tribal Nations to develop culturally appropriate and respectful mechanisms to educate and accurately report mortality rates. States that work directly with Tribal Epidemiology Centers are not fully capturing data. It is up to the Tribes to develop and distinguish processes to develop data linkages within the Nations. Funding Tribal Vital Records programs is necessary to correct this issue.

In conclusion, the Oklahoma Area respectfully appreciates the opportunity to share these recommendations with CDC. The needs in Indian Country are great and we thank you for respecting the Sovereign status of our Tribal Nations. Mvto (Thank you).

THE NAVAJO NATION

JONATHAN NEZ | PRESIDENT MYRON LIZER | VICE PRESIDENT

February 6, 2019

CDC Tribal Advisory Committee Meeting – Navajo Nation Tribal Testimony

Thank you for CDC's partnership and support in addressing our public health concerns and needs on the Navajo Nation. We appreciate the support for the following:

1. **WORKFORCE: Public Health Associate Program (PHAP)** – The Navajo Epidemiology Center (NEC) appreciates the PHAP Associate (Brittany Quy) assignment (2017-2019 class) to assist with infectious disease surveillance and prevention activities. NEC will be applying for more PHAP Associates for 2019-2021 class.
2. **TECHNICAL ASSISTANCE: Viral Special Pathogens Branch –** The NEC appreciates the technical assistance provided addressing infectious diseases including Hantavirus and Rock Mountain Spotted Fever (RMSF). The NEC also appreciates the funding support (Rickett Benckiser donation via CDC Foundation) to implement a home-based rodent exclusion project (home patch-up and prevention education) focusing on reducing risk of Hantavirus exposure.
3. **FUNDING: Good Health & Wellness in Indian Country –** The NEC is using the funding support to focus on reducing rates of chronic diseases on the Navajo Nation (NN). The funding support has allowed NEC to conduct community health assessments on the NN (Tribal Behavioral Risk Factor Surveillance Survey) and develop community wellness plan toolkit.
4. **FUNDING: Tribal Epidemiology Center Public Health Infrastructure –** The NEC is using the funding support to develop an Indicator-Based Information System for Public Health (IBIS).
5. **FUNDING: Injury Prevention** – The NEC has established the Navajo Injury Prevention Coalition and is using the funding support to develop an injury atlas for NN looking at unintentional and intentional injury morbidity and mortality that describes magnitude, trends, and patterns of motor vehicle injuries, elderly falls, suicide, violence, substance abuse (including opioid) and traumatic brain injuries.
6. **FUNDING: Tribal Public Health Capacity Building and Quality Improvement** – The NEC appreciates the funding support to build public infrastructure and conduct infectious disease surveillance, prevention, and investigation activities.
7. **FUNDING: Breast and Cervical Cancer Prevention** – The Navajo Breast and Cervical Prevention Program appreciates the funding support to provide screening services for breast and cervical cancers. The program helps low-income, uninsured, and underinsured Navajo women gain access to breast and cervical cancer screening and diagnostic services.

8. **FUNDING: Public Health Emergency Preparedness and Response** – The Navajo Public Health Emergency Preparedness and Response Program is using the funding support to address public health emergency such as a natural disaster, act of terrorism, or disease outbreak in partnership with local, state and federal agencies.

9. **NAVAJO NATION REQUESTS:**

    a. Explore ways for placement of Epidemic Intelligent Service (EIS) officers and Career Epidemiology Field Officer (CEFO) to be housed at NDOH/NEC to provide technical assistance and increase capacity for disease surveillance, disease outbreak, informatics, emergency preparedness, etc.

    b. We urge CDC to continue and expand the groundbreaking work initiated by Dr. Ursula Bauer at the Director of the National Center for Chronic Disease Prevention and Health Promotion to advance the health and wellness of American Indian and Alaska Native populations nationwide. Specifically, these critical programs include:

        i. Good Health & Wellness in Indian Country Program

        ii. Tribal Epidemiology Center Public Health Infrastructure Program

        iii. Tribal Practices for Wellness in Indian Country

    These multiyear initiatives have led to the dissemination of sorely needed dollars directly to Indian Country to address critical tribal public health infrastructure needs and health priority areas such as diabetes, heart and kidney disease, stroke, and affiliated risk factors. Throughout her tenure at CDC, Dr. Bauer dedicated herself to visiting tribal communities, building relationships, and most important, listening to the needs and wishes of tribal leaders. She was committed to translating words into action, and kept her word by mobilizing funding throughout Indian Country to build a robust foundation of resources that will undoubtedly strengthen tribal public health infrastructure locally, regionally, and nationally. It is imperative that the CDC not only protect and ensure the continuity of these initiatives, but also look to them as models to guide resource dissemination from other CIOs to advance the health and wellness of Indian Country.

    c. Funding for Injury Prevention **–** motor vehicle injury is the #1 cause of mortality on NN.

    d. Funding for Colorectal Cancer Prevention and Screening for Early Detection – colorectal cancer is the #1 cause of cancer mortality on NN.

    e. Funding for Navajo Department of Health Public Health Accreditation.

    f. Funding for Maternal and Child Health projects.

        i. Tribal Pregnancy Risk Assessment Monitoring System (PRAMS) – to collect Navajo-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy.

        ii. Birth Defects Surveillance – to examine whether known risk factors for birth defects explain the higher prevalence of selected birth defects among Navajo newborns.

g. Funding for Healthy Dine Nation Act (Unhealthy Food Tax) Evaluation Project **–** Conducting a review of the collection, distribution and implementation (including health impact) of HDNA is essential to make informed decisions about the future of the tax.

h. Funding for Navajo Behavioral Risk Factor Surveillance System Survey (Tribal BRFSS) **–** The survey was conducted on the NN for the first time and the need to continue the survey activities is imperative so that health trends over time can be established.

i. Direct funding for Public Health Emergency Preparedness.

j. Explore funding a NN tribal recycling project – reduce, reuse and recycle on NN.