CDC/ATSDR Tribal Advisory Committee Meeting and 19th Biannual Tribal Consultation Session

August 13, 2019, 8:00 am–4:00 pm and August 14, 2019, 8:00 am–5:00 pm

Harrah's Cherokee Casino Resort
777 Casino Drive
Cherokee, NC 28719

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 19th Biannual Tribal Consultation Session August 13–14, 2019. The meeting was open to the public. Thirty-one members of the public attended the first day, and 37 attended the second day.

Table of Contents

Tuesday, August 13, 2019

TAC Member Attendees

President Alicia Andrew
Native Village of Karluk
Alaska Area Delegate

Legislator Connie Barker
The Chickasaw Nation
Tribes At-Large Delegate

Rhonda Beaver
Muscogee (Creek) Nation
Oklahoma Area Authorized Representative

Councilman Stephen Kutz
Colwitz Indian Tribe
Portland Area Delegate

Byron Larson
Northern Cheyenne Nation
Billings Area Delegate

Chairwoman Cheryl Andrews-Maltais
Wampanoag Tribe of Gay Head Aquinnah
Nashville Area Delegate

Councilwoman Lana M. McCovey
Yurok Tribe
California Area Delegate

Lisa Pivec
Cherokee Nation
Tribes At-Large Authorized Representative

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

Council Delegate Alston Turtle
Ute Mountain Ute Tribe
Albuquerque Area Authorized Representative

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

Del Yazzie
Navajo Nation
Navajo Area Authorized Representative

Absent

***Affiliation*/Tribal Area**	**Name**	**Title**
*Yankton Sioux Tribe/*Great Plains Area	Robert Flying Hawk	Chairman
*Elko Band Council (Te-Moak Tribe of Western Shoshone)/*Phoenix Area	Jill Temoke	Council Member
Inupiat Community of the Arctic Slope/Tribes At-Large	Doreen Fogg-Leavitt	Secretary

CDC Attendees

LCDR Naomi Aspaas, BSN, RN
Lead Public Health Advisor, Office of Tribal Affairs and Strategic Alliances (OTASA), Center for State, Tribal, Local, and Territorial Support (CSTLTS)

Danae Bixler, MD MPH
Medical Officer, Epidemiology and Surveillance Branch, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)

CDR Renee Calanan, PhD, MS
Health Equity Coordinator, National Center for Emerging and Zoonotic Infectious Diseases (NCEZID)

CAPT Carmen Clelland, PharmD, MPA, MPH
Director, OTASA, CSTLTS

Audrey Dowling, MPA, MRE
Public Health Analyst, Budget Performance and Evaluation Team, National Center for Environmental Health

Krystal Gayle, MPH
Public Health Advisor, OTASA, CSTLTS

LCDR Kimberly Goodwin, MPH
Public Health Analyst, CSTLTS

Donata Green, PhD
Public Health Analyst, Partnership Policy Team, National Center for Environmental Health (NCEH)

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

LCDR Jason Hymer, REHS, MPH
Environmental Health Specialist, National Center for Injury Prevention and Control (NCIPC)

Kaitlyn Kelly-Reif
Associate Service Fellow, Field Research Branch, National Institute for Occupational Safety and Health

Janet Kennedy
Administrative Officer, CSTLTS

LCDR Jenna Meyer, MPH, BSN, RN
Deputy Director, OTASA, CSTLTS

Jessica Miller, MA
Public Health Advisor, OTASA, CSTLTS

José Montero, MD
Director, CSTLTS

Emily Nethercott
Public Health Advisor, OTASA, CSTLTS

Priyanka Oza
Public Health Advisor, OTASA, CSTLTS

Judith Qualters, PhD, MPH
Division Director, NCIPC

Delight Satter, MPH
Senior Health Scientist, OTASA, CSTLTS

Gregory Smith, MPA
Tribal Liaison Officer, Center for Preparedness and Response (CPR)

Craig Thomas, PhD, MS
Director, Division of Population Health, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

LT Jeffrey Walker, MPH
Public Health Advisor, CSTLTS

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

Nonfederal Attendees

Sherrie Aazami
Raquel Aviles
Dash Avito
Jessica Beach
Stacy Bohlen
Vickie Bradley
Veronica Bryant
Marcie Buickhart
Bridget Canniff
Valeria Carlson
Francis Crevier
Julie Deerinwater-Anderson
Kevin English
Shannon Fields
Sheryl Goodson
Ken Green
Melissa Green
Lynne Harlan
Jamie Ishcomer
Karrie Joseph
Julie Kimble
William Krepps
Sheena Lambert
Mike Lavoie
Daryl Beth Lovette
Debbie Matthews
Joseph Owle
Dwayne Reed
Martha Salyers
Thomas Simmons
Ashleigh Stephens
Illeen Sylvester
Shanna Tautolo
Katie Tiger
Leah Tsinajinnie
Jeff Tucker
Mark Tuttle

9:30AM–Opening Blessing, Welcome, and Introductions

- Presentation of Colors was done by Cherokee American Legion Honor Guard.

- Opening blessing was provided by New Kituwah Academy.
- Dr. Montero welcomed everyone to the summer 2019 CDC/ATSDR TAC Meeting and introduced the new TAC members, nonfederal partner guests, and CDC leadership attendees.
- Lieutenant Commander Meyer conducted the roll call. A quorum was present to conduct necessary business.

10:00 am–TAC Business

Facilitator

- **Robert TwoBears** (*Ho-Chunk Nation of Wisconsin*) Legislative District V Representative

TAC Business Opening

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

TAC Chair and Co-Chair Nominations

- Captain Clelland asked TAC members if they had any nominations for new TAC chair and co-chairs.
- Councilman Stephen Kutz made the motion to re-nominate the current TAC chair and co-chair. TAC members unanimously approved this motion.

Request for Subject Matter Experts on Violence Prevention

- Captain Clelland requested names for subject matter experts (SMEs) on violence prevention in Indian Country to provide input during the next summer TAC meeting in 2020. He asked TAC members to identify SMEs and send any names to him.

CDC/ATSDR: A Five-Year Snapshot of Tribal Activities Infographic

- Captain Clelland disseminated a draft infographic depicting a five-year summary of CDC/ATSDR tribal-related activities. This infographic divides activities by the TAC, engagement, funding, and accomplishments over the last five years. To improve the infographic, Captain Clelland requested that TAC members provide feedback or recommendations by email or in-person during this meeting. This is not yet an official document.

TAC Business Discussion

Comments from Councilwoman Lana McCovey:

- On the topic of consultation, Ms. McCovey stated she is not able to discuss her concerns on behalf of all California tribes. In other types of consultation, tribes have been able to bring in their wants and needs; however, she can represent only the Yurok Tribe.
- During last summer's TAC meeting, Ms. McCovey suggested that tribes should be able to bring their plans to CDC, and then should discuss funding. She is unclear how funding is conducted at CDC for activities relating to American Indian/Alaska Natives (AI/ANs).
- She also would like to hear more in this meeting about the Tribal Public Health Agenda project, updates on the TAC Charter, eligibility for Good Health and Wellness in Indian Country funding, and screening for hepatitis C.

Response from Captain Clelland:

- Some of these topics will be discussed throughout the next two days. For example, we will hear more about hepatitis C screening through a presentation from the Eastern Band of Cherokee Indians (EBCI) later today.

- Revising the TAC charter is a lengthy process. CDC received the charter edits from the TAC, and it is currently being reviewed internally at CDC. The Office of General Council also will review it to ensure that the FACA exemption will still be accepted. CDC may have an updated charter by the next TAC meeting.
- Some leaders from CDC's centers, institutes, and offices also are here today to answer any questions we do not address during the meeting.

Comment from Chairwoman Andrews-Maltais:
Chairwoman Andrews-Maltais shared some concerns about the travel reimbursement process. She does not understand why tribal information cannot be used as an alternative to personal information. The current process is not feasible for all federally recognized tribes. The current policies as they exist do not allow for that government-to-government relationship.
Response from Janet Kennedy:
CDC will explore options to address this issue for the next TAC.

Comment from Councilman Kutz:
Tribes in the Northwest United States are focusing on strengthening public health infrastructure in Indian Country. It would be good to get additional information on the OT18-1803: Tribal Public Health Capacity Building and Quality Improvement Umbrella Cooperative Agreement (CoAg).
Response from Captain Clelland:
OTASA will make sure to get you the information on that CoAg.

10:45 am–CDC Updates

Presenters

- **José Montero, MD, MHCSDS,** Director, CSTLTS, CDC
- **Captain Carmen Clelland, PharmD, MPA, MPH,** United States Public Health Service (USPHS); Director, OTASA, CSTLTS, CDC
- **Patrick Breysse, PhD, CIH,** Director, NCEH, CDC; Director, ATSDR
- **Craig Thomas, PhD, MS,** NCCDPHP, CDC
- **Judith R. Qualters, PhD, MPH,** Director, Division of Analysis, Research and Practice Integration, NCIPC, CDC

CSTLTS

- Dr. Montero discussed CSTLTS's major accomplishments throughout fiscal year (FY) 2019.
- CDC, and CSTLTS specifically, visited several tribal nations throughout 2019.
    - In March 2019, CDC Director Robert Redfield, Dr. Montero, and Captain Clelland visited Chickasaw Nation, and Cherokee Nation to discuss the Ending the HIV Epidemic initiative, opioids, and other priority tribal-specific public health issues and tribal public health system needs.
    - On July 17, 2019, CDC Director Robert Redfield visited Arizona where he met with the Inter-Tribal Council of Arizona, Inc., and Navajo Nation, and participated in a roundtable discussion with Arizona tribal leaders. Discussion topics included the Ending the HIV Epidemic initiative, opioids, and Rocky Mountain Spotted Fever (RMSF). As a result of this discussion, CDC was able to gain a better understanding of the various daily challenges and pressing public health concerns tribes in Arizona face.
    - On July 18, 2019, Dr. Montero and Captain Clelland visited the Confederated Salish and Kootenai Tribes in Northwest Montana. Topics of discussion included the Ending the HIV Epidemic initiative, diabetes, data misclassification, data collection, access to care/infrastructure, obesity, commercial tobacco use, prescription drug abuse, and public health literacy. The meeting was

attended by multiple tribal health department staff, tribal leaders, and other partners from the community. CDC had the opportunity to see some of the work being accomplished through multiple programs administered by the Confederated Salish and Kootenai Tribes. Because of this meeting, CDC was able to hear about different challenges surrounding some of their health issues and some of their unique strategies to support a healthier community.

- From April 8–10, 2019, CSTLTS held the first grantee meeting for the OT18-1803: Tribal Public Health Capacity Building and Quality Improvement Umbrella CoAg during which 22/25 recipients met with their CDC project officers to plan Year 2 and received training on CDC grants and performance management.
- CSTLTS started year two of the CoAg in September 2019. This is a five-year CoAg funding 25 tribes and tribal organizations. Fourteen of these 25 were new CDC recipients. The purpose of the CoAg is to provide funding directly to AI/AN tribal nations and regional AI/AN tribally designated organizations to optimize the quality and performance of tribal public health systems. The CoAg uses a two-part strategy—
    - Funding Strategy 1 provides base funding of $22,000 to each recipient and supports building capacities and capabilities.
    - Funding Strategy 2 is subject to agency priorities and the availability of funds. In FY18, funding strategy 2 provided approximately $15,431,446 in direct funding to tribes and tribal organizations. For year 2 of this CoAg, CDC has added additional project plans under the umbrella co-ag, estimating a total of 15 project plans (3 continuing from FY18) from six centers, institutes, and offices under the initial CoAg.

OTASA

- Captain Clelland provided an overview of each of OTASA's projects.
    - Public Health Indian Country Capacity Scan (PHICCS):
        - CDC is working with the National Indian Health Board to collect information on tribal public health systems to understand how they may improve the health status and combat health disparities among tribal populations. PHICCS survey was launched in November 2018 and closed July 31, 2019. More than 100 tribal nations completed the survey. This information is in the analysis stage, and CDC hopes to have some data to share at the next winter TAC meeting in 2020.
    - AI/AN Racial Misclassification:
        - CDC is working with the National Council of Urban Indian Health (NCUIH) to improve data quality through interventions at the local level where death certificates originate. NCUIH has conducted listening sessions to identify root causes and potential solutions to the issue of AI/AN racial misclassification with medical examiners and will begin additional listening session with funeral directors in August 2019. The goal is to get accurate information on the death certificates.
    - Indigenous Determinants of Health (IDOH):
        - CDC has funded the National Network of Public Health Institutes (NNPHI), which is partnering with its member, Seven Directions. During this 5-year project, NNPHI and Seven Directions will publish a commentary describing the rationale and need for an IDOH framework, as well as gather input from tribal leaders, tribal public health professionals, and others to document lessons learned and best practices for addressing IDOH in tribal communities.
    - Tribal Public Health Framework (TPHF):
        - OTASA and the National Indian Health Board (NIHB) (in collaboration with key partners) are working on developing a public health agenda. The goal of this project is to develop a strategy for federal agencies to provide more support (funding, technical assistance, programmatic work) across the department, as well as potentially affecting other departments that have their realm within public health.

NCEH/ATSDR

- Dr. Breysse provided an overview of some of NCEH/ATSDR's FY19 projects and major accomplishments.
- Cherokee Nation's Snake Creek and Iron Post Indian Communities requested technical assistance to measure chemical and microbial contamination in wells at risk for long-term surface water intrusion. NCEH completed sampling private wells by September 2018. Participants received their well water test results and recommendations and information on the next step to addressing their water quality.
- NCEH partnered with the Indian Health Service (IHS) Division of Sanitation Facilities Construction (DSFC) to develop and pilot test a model that quantifies the benefits of water sanitation infrastructure improvement in Indian Country. The model estimates the number of avoided cases of acute respiratory infection, skin infection, and infectious diarrhea over the expected lifespan of the infrastructure. The model also projects the avoided healthcare costs for inpatient and outpatient services. This model will help show why investment in proper water sanitation infrastructure is a good investment and will help save costs in the long term. DSFC senior leaders and IHS agency leaders have endorsed the model, and materials are currently being packaged for third party review.
- CDC designed and implemented the Climate-Ready Tribes Initiative to address climate and health issues faced by indigenous peoples. This initiative provides funding and technical assistance to tribes to plan for the potential health effects of climate change. In partnership with NIHB, the initiative has provided assistance to the Blackfeet Nation, the Swinomish Indian Tribal Community, and the Village of Wainwright.

NCCDPHP

- Dr. Thomas discussed the Healthy Tribes portfolio, as well as NCCDPHP's major accomplishments for FY19.
- In recognizing demographic trends with aging, and age being the greatest risk factor for Alzheimer's, CDC and the Alzheimer's Association helped develop the Healthy Brain Initiative. The Healthy Brain Initiative's *Road Map for Indian Country* is the first-ever public health guide focused on dementia in AI/AN communities. It is intended as a tool for leaders of the 573 federally recognized Indian tribes, as well as state-recognized tribes, to engage their communities in addressing this important issue.
    - The Healthy Brain Initiative's *Road Map for Indian Country* was published in FY19. This document is a guide for AI/AN leaders to learn about dementia and start discussions throughout their communities. The guide suggests eight strategies that embrace community strengths, including traditional practices, resilience, and existing services. AI/AN leaders can also use the Road Map to learn about Alzheimer's, find out what some AI/AN communities are doing, plan their responses, and start taking action throughout their own community.
- The Good Health and Wellness in Indian Country (GHWIC) CoAg: GHWIC provided tribes funding to develop and implement policy, systems, and environmental changes in their communities that help tribal residents make healthier choices. These changes include smoke-free building and other spaces, safe walking trails that connect different parts of the community, workplace policies that allow employees to attend diabetes prevention classes, and community gardens benefitting all tribal residents. Total funding to tribes/tribal organizations for this CoAg in FY18 was $13,194,966.
- Tribal Practices for Wellness in Indian Country (TPWIC) CoAg: TPWIC allows Tribal and Urban Indian Organization grantees to implement culturally relevant programs, often expanding on existing programs. Examples include native language health education classes, incorporating traditional sports into summer camps for youth, adding traditional healthy food items into community events and meals for gatherings, and creating opportunities for youth and elders to interact in community activities and decision-making. This $15.5 million, three-year program supports tribal practices that promote wellness in AI/AN communities and focuses on adapting evidence-based public health interventions. As a result, CDC expects that public health investment, infrastructure, and workforce will have increased sustainability

and growth due to the tailoring of interventions to individual tribal needs, culture, and history. Total funding to tribes/tribal organizations for this CoAg in FY18 was $5,186,089.

- Building Public Health Infrastructure in Tribal Communities (Tribal Epidemiology Center Public Health Infrastructure (TECPHI)) CoAg: TECPHI addresses crucial public health capacity and infrastructure gaps within their organizations and the tribes they serve. Examples include hiring additional staff to improve the collection and analysis of AI/AN health data, expanding or establishing new partnerships and data sharing agreements with states and other partners, and providing trainings and technical assistance to tribes. In FY18, total funding to tribes/tribal organizations for this CoAg was $12,808,742.

NCIPC

- Dr. Qualters provided an overview of NCIPC's major accomplishments for FY19.
- In May 2019, NCIPC launched a website that describes how jurisdictions can request assistance from a CDC Opioid Rapid Response Team.
    - These are specialized teams that can provide rapid, short-term (28 days) support to jurisdictions experiencing spikes in opioid-related overdoses or the closure of a clinic where patients are prescribed opioid therapy.
    - Teams join the community's public health staff and support public health partners while also working to build a jurisdiction's long-term response capacity.
    - They offer technical expertise in epidemiology and surveillance, clinical provider outreach, communications, policy and partnerships, community outreach, and capacity building from CDC and the Commissioned Corps.
    - The size and makeup of teams can be tailored to the needs of the situation.
    - The requesting public health authority provides overall leadership for the response, while the CDC team provides technical assistance.
    - CDC will pay for its team's lodging, rental cars, flights, meals, and equipment for federal responders.
    - Elected tribal leaders of federally recognized tribes can request a CDC team by calling CDC's Emergency Operations Center at 770-488-7100 and asking for the Opioid Rapid Response Team point of contact.
    - The website for more information is www.cdc.gov/opioids/opioid-rapid-response-teams.html.
- In July 2019, NCIPC and IHS co-sponsored the National Conference on AI/AN Injury and Violence Prevention: Bridging Science, Practice, and Culture. This conference was the first-ever convening of tribal injury prevention practitioners, bringing together more than 300 tribal, federal, and state injury prevention practitioners in Indian Country, injury researchers, subject matter experts, and other stakeholders.
- NCIPC will also reorganize its structure. It will retain a three-division structure, but one division will focus solely on the opioid epidemic in order to prioritize this issue. This reorganization will only affect points of contact and certain technical monitors. Once NCIPC knows more about the final changes, we will start notifying everyone as early as possible.

TAC Questions and Discussion

Question from Councilman Kutz:
Are tribes eligible to request an Opioid Rapid Response Team? Most tribes do not have a jurisdiction.
Answer from Dr. Montero:
Any elected tribal leader is eligible to request an Opioid Rapid Response Team.

Question from Councilman Kutz:
How much input does CSTLTS have in funding and how much input do TAC members have on CDC's budget for tribes? Have priorities been identified?

Answer from Dr. Montero:
Currently, CDC does not have a separate consultation process for budget, unlike IHS. However, TAC members do have an opportunity during these TAC meetings to provide input on budget.

Question from Ms. Pivec:
Has CSTLTS proposed a systems funding for tribes?
Answer from Dr. Montero:
A systems funding for tribes has not been proposed. CSTLTS would like to do a webinar with interested TAC members on the details of the budget in order to answer these questions more clearly.

Question from Councilwoman McCovey:
Has anything been developed for the Tribal Public Health Framework (TPHF) yet?
Answer from Captain Clelland:
No, currently the project is in its formative stages, looking at gaps and reaching out to tribal communities and nations for input. For the initial part of this, we have had more than 10 interactions with tribal leaders and input from AI/AN students, as well as from internal groups. OTASA is looking at the available literature to see what agendas have already been developed. We have also been working with NIHB on this project to conduct some coding of the initial agendas to determine what is already available.
Comment from Councilwoman McCovey:
I have not been contacted to provide feedback on this project. I am concerned about the preliminary outreach and consultation received already.
Comment from Chairwoman Andrews-Maltais:
I think it would be better for listening sessions to be at the beginning of these projects in order to provide feedback before the project is completed.

Question from Ms. Beaver:
Can Dr. Breysse clarify what model was used for water and sanitation infrastructure? I was in a meeting last month with IHS and did not hear this mentioned.
Answer from Dr. Breysse:
The purpose of this project is to quantify the benefits of water and sanitation infrastructure in Indian Country. This model will project the avoided healthcare costs for inpatient and outpatient services among other things. This project is currently under review and not operational.
Comment from Chairwoman Andrews-Maltais:
As there are three agencies working on this project (CDC, IHS, and Environmental Protection Agency), information should be provided to tribal leaders during a collective roundtable so we can share successes and challenges to promote collaboration.

Comment from Chairwoman Andrews-Maltais:
In reference to the Climate-Ready Tribes Initiatives, funding should be represented across all Health and Human Services regions.
Response from Dr. Breysse:
Thank you for this information, I will take this input back to the program.

Comment from Councilman Kutz:
In reference to water cleanup and contaminated fish, the state's response is to lower fish consumption, and not necessarily clean the water. This is not a solution for tribes.
Response from Dr. Breysse:
Unfortunately, the Environmental Protection Agency is mandated to work on clean-up projects, whereas CDC can only address health issues resulting from contaminated fish.

1:15 pm–Harm Reduction: Eastern Band of Cherokee Indians (EBCI) Syringe Service Program

Presenters

- **Richard Sneed** *(Eastern Band of Cherokee Indians)*, Principal Chief, EBCI; Co-Chair, TAC
- **Vickie L. Bradley, MPH, BSN, RN,** *(Eastern Band of Cherokee Indians)*, Secretary, Public Health and Human Services, EBCI
- **Danae Bixler, MD**, NCHHSTP, CDC
- **Lieutenant Commander Jason Hymer, REHS, MPH,** USPHS; Environmental Health Specialist, NCIPC, CDC

Opening Remarks

- Vicki Bradley, Secretary of EBCI Public Health and Human Services discussed EBCI's Syringe Service Program.
- While it took several years for the syringe service program to develop into the program it is today, the Eastern Band of Cherokee Indians was able to build a program to address EBCI community members with more than 2,488 naloxone kits distributed and about 406 reversals, which equate to 406 lives saved.
- Syringe services are a best-practice, and EBCI provides free access to sterile supplies, referral services, and other safe ways to discard needles.
- Some challenges or barriers discussed for developing a syringe service program are the distances spanning some of the tribal nations, lack of access to some of those communities, and the amount of direct funding to tribes to address these specific issues.

TAC Questions and Discussion

Question from Councilman Kutz:
Overall, how much would a program like this cost?
Answer from Ms. Bradley:
EBCI has five staff members, and we initially appropriated about $800,000 but used approximately $400,000. We serve the entire community, even nontribal members. EBCI also purchased two mobile units with grant funding.

Comment from Chairwoman Andrews-Maltais:
It has been a challenge for the Wampanoag Tribe of Gay Head Aquinnah to acquire naloxone, because our paramedics are allowed to carry only one dose at a time. Sometimes they have to make a choice on whom to save.
Response from Ms. Bradley:
EBCI has been fortunate in that two counties in North Carolina were provided naloxone at no cost. The Substance Abuse and Mental Health Services Administration also allows the purchase of naloxone.

Question from Legislator TwoBears:
In the Midwest we have clinics, not hospitals. Is it possible for a community health clinic to gather the type of data EBCI has gathered on this program?
Answer from Ms. Bradley:
Yes, and we can follow up with you on what resources we used for gathering data.

Question from Ms. Beaver:
What system does EBCI use to gather data?
Answer from Principal Chief Sneed:
EBCI uses Microsoft® Access® for data collection.

Question from Dr. Bixler:

What do syringe service programs look like in other tribes, and what are the needs and barriers to get those working like the EBCI program?

Answers (input from multiple people):

- (Portland Area) If you have a small population, it is hard to establish a program like this. We also have a large urban Indian population, so it is important for tribal epidemiology centers and urban health areas to have funding for these issues.
- (California Area) We are situated over two counties and in rural areas. My community is hard to access. We would need a lot of services spread across a large area; the cost of administering something like the EBCI Syringe Service Program is a hard sell. We depend a lot on the states to establish a program like this.

Question from Dr. Bixler:

How are syringe service programs funded in other areas?

Answers (input from multiple people):

- (Nashville Area) It is difficult to get funding from certain sources like the block grant, where the states are the main recipients. Rarely do we see money funnel down to tribes from this source. Another drawback with funding is the lack of stability, if there is no continuation. Funding needs to be provided directly to tribes.
- (California Area) It would be beneficial to addressing hepatitis C virus if there were a protocol established similar to the one for vaccines (which targets everyone). Right now, people are screened only if they are high risk or for other similar reasons. The cost of the screening is high as well. If we set up a protocol that utilizes cheaper screenings, we might be able to start screening younger generations before they become addicted.

Question from Dr. Bixler:

Medicated-assisted treatment (MAT) programs and syringe service programs are a great combination for some communities. How are MAT programs working in Indian Country?

Answers (input from multiple people):

- (Portland Area) We offer MAT in my tribe. The key to this type of treatment, however, is to administer the treatment right away.
- (California Area) Doctors must be certified to administer treatment for the MAT program. It becomes difficult because it requires our tribe to call in IHS doctors, and there is so much turnover among the doctors we have. The services that we have in our area are maxed out.

Wednesday, August 14, 2019

11:00 am–Economic Development and Diversification's Role in Health and Well-being of Tribal Members

Presenters

- **Richard Sneed** (*Eastern Band of Cherokee Indians*), Principal Chief, EBCI; Co-Chair, TAC

Opening Remarks

- Tribal nations need responsible economic development to improve the health outcomes and wellness of tribal communities. With improved economic development, there are also challenges to address. Challenges include—
    - Increased resources like casinos can increase programs and opportunities but can also multiply underlying problems that may exist in tribes

    - As money increases in tribal communities, the tendency is to create programs to address social and healthcare problems. You cannot create a social or healthcare program for every individual within tribes. This creates an unsustainable government.
- Principal Chief Sneed provided an example of how a tribal elder needed help with lawn mowing. As a result, the tribe arranged support to mow the elder's lawn. This then became a lawn-mowing program that cost about $400,000 last year. Principal Chief Sneed discussed that tribes cannot create a program for every perceived need.
- Gaming provides a great return on investment; however, it does warp the perception of a good return on investment. This can create difficulty when trying to gain commitment for health programs that may not have a similar return on investment.
- Often, the more we make, the more we spend, which just makes us broke at a higher income level. This is a pitfall we need to be mindful of.

TAC Questions and Discussion

Comment from Chairwoman Andrews-Maltais:
As leaders, we do not want to shy away from helping people and fulfilling a need; however, we do not want to create a false sense of wealth.

Question from Council Delegate Turtle:
I see everything that is going on with our tribe, the dependency, money, drugs, and alcohol problems. Why are we still being a contributing factor to those elements? What can we do to ensure success for our future? We are reliant on gaming, and our per capita, but how do we get them to be more independent?
Response from Principal Chief Sneed:
The situation is a paradox for elected leaders. The people we are trying to inspire and encourage to become more independent are the very people who decide if we have a job. The great challenge is risking a seat as a leader for doing what is right, which I am willing to do.

Question from Chairwoman Andrews-Maltais:
How do we help sustain these best-practices and health facilities, like what EBCI is doing, with the funding that is available from the federal government?
Response from Dr. Montero:
Within CDC, we are looking into how certain programs we fund can become sustainable. There were components for innovation and upstreaming in the opioid supplement for the OT18-1803 Tribal Public Health Capacity Building and Quality Improvement Umbrella CoAg. When we look at the Ending the HIV Epidemic initiative, we tell our partners to engage your community and write your plan in a way that will address their needs in a way that is feasible to their capacity. This is a good model that allows the CoAg to adapt to the recipient's needs. I know this does not fully answer your question, but this is an evolutionary process rather than revolutionary.

Comment from Councilman Kutz:
One difficulty some of the tribes have in my region is that we must follow the law restricting the hiring of people with police records. A lot of addicts have records, and some tribes have stricter laws with those types of records. To address this, we can only work to ensure that younger generations do not go down that same path. But many of our members still have difficulties working within their own tribe.
Response from Principal Chief Sneed:
One of the great things about being a tribe is that we are sovereign nations; we can create our own laws and ordinances. We invest a lot in treatment programs and in building soft skills for young people to help prevent some of these issues later in life. We have to be okay with giving second chances to those who have made mistakes in the past. We can create our own ordinances, our own ways. We do not have to follow the federal system.

Comment from Mr. Larson:
How do we balance self-governance as a tribe and ensure that we have a good government-to-government relationship? For workforce development, I know the Public Health Associate Program (PHAP) is great, but I am not sure how that is being duplicated in our tribal communities. I think the PHAP group is exclusively non-Native individuals. When this happens, not many stay to work in Indian Country. It would be good to increase Native members in these PHAP positions so they can stay in that community long-term.
Response from Dr. Montero:
Yes, we do not have any AI/AN public health associates in PHAP. We do engage tribal communities and tribal colleges to encourage them to apply; however, AI/ANs are not applying to PHAP. PHAP does have 18 associates working on tribal-related issues and it would be good to have AI/AN apply for those positions.
Response from Mr. Larson:
I am wondering how these PHAP positions are created in the first place. If you are not getting applicants, we need to look into this. The requirements might be too expansive; maybe there is an approach where we can have an AI/AN-specific program.
Response from Dr. Montero:
Let's follow up on this discussion.

1:30PM–Environmental Health in Indian Country

Presenters

- **Joseph Owle** (*Eastern Band of Cherokee Indians*), Secretary, Department of Agriculture & National Resources, EBCI
- **Ken Green,** Lead Engineer, Project Management, Division of Operations
- **Mike LaVoie,** Natural Resources Manager, Department of Agriculture & National Resources, EBCI
- **Katie Tiger** (*Choctaw Nation of Oklahoma),* Air Quality Section Supervisor, Department of Agriculture & National Resources, EBCI

Opening Remarks

- Ms. Tiger discussed the air quality program at EBCI as well as past and future projects. EBCI is the only tribe in HHS region 4 with a continuous air monitoring program.
- Mr. LaVoie provided a historic overview of the evolution of EBCI's natural resource program, climate change, and how animals are linked to human health (rabies, prions, etc.).
- In looking at climate change, increased temperatures as predicted over the next few years will likely bring more frequent droughts and wildfire as a result. A warmer climate also holds more water, which increases the risk of flooding. All these environmental challenges have severe health impacts on individuals in the surrounding community.

TAC Questions and Discussion

Question from Mr. Yazzie:
We have a significant health disparity related to childhood asthma in Navajo Nation. Do you monitor asthma? I also saw that animal control was on one of your slides. Navajo Nation has a lot of reservation dogs. Do you have a code that dictates the number of dogs a household should own?
Response from Mr. LaVoie:
Asthma is more of an issue for the EBCI's health department to monitor. Animal control is housed under the police for EBCI. The code is currently being revised, but it does outline those requirements. I can get you more information on that.

Question from Councilman Kutz:

How do you ensure close coordination of programs due to separation of divisions? Can you share some of those codes with the TAC?

Response from Mr. Owle:

Communication has been vital to EBCI's successes, and I believe the revamping of our codes is the most recent and important feature that will look at where authorities lie.

Response from Principal Chief Sneed:

For the past few years, EBCI has been focused on ensuring that with change in government comes a continuity of authority plan.

Response from Mr. Owle:

Our codes can be found at https://library.municode.com/tribes_and_tribal_nations/eastern_band_of_cherokee_indians/codes/code_of_ordinances?nodeId=13359.

Question from Chairwoman Andrews-Maltais:

Are your treatment plants supplemented by EBCI or IHS/CDC money?

Response from Mr. Green:

EBCI funded construction of the plants. The EPA and IHS contributed significantly to the water and wastewater plant. The wastewater plant expansion cost $25 million.

Follow-up Question from Chairwoman Andrews-Maltais:

Does EBCI charge the community for some of those costs?

Response from Mr. Green:

Yes, and EBCI will shut off water systems. It is an uphill battle to go from not charging a community to charging them.

3:15 pm–Tribal Emergency Preparedness Partnerships

Presenters

- **Gregory Smith, MPA,** Public Health Advisor, Division of State and Local Readiness, CPR, CDC
- **Thomas J. Simmons,** Swift Water Rescue Team, EBCI

Opening Remarks

- Greg Smith discussed public health preparedness and response initiatives and collaboration opportunities with states and tribal nations.
- The Public Health Emergency Preparedness CoAg allows states to fund tribal nations directly or indirectly. CDC expects states to work with tribal nations to develop plans that will meet the needs of tribal populations in the event of an emergency.
- CDC encourages a comprehensive approach to assessing and addressing tribal preparedness capabilities, and approximately $3 million is sub-awarded to nearly 120 unique tribal nations from states.
- In the TP18-802: Public Health Crisis Response CoAg, there is limited eligibility to governmental public health departments, including AI/AN federally recognized tribal governments. To apply, the public health emergency preparedness programs must be able to provide the 15 public health preparedness capabilities and serve jurisdictions with at least 50,000 people. Applicants must also be able to demonstrate that their program has the existing capacity, capability, and infrastructure to provide the ten essential public health services.
- Thomas Simmons discussed the swift water rescue team and the partnership between Cherokee Nation and EBCI. Tribes do not always get help from states and the process to get federal assistance can be lengthy, so a partnership like this works well for EBCI. Cherokee Nation and EBCI have a memorandum of understanding (MOU) that helps us know that we can call on each other for help.

TAC Questions and Discussion

Comment from Chairwoman Andrews-Maltais:
I did not see any opportunities for funding for a tribe with a smaller population.
Response from Mr. Smith:
Please reach out to me, and I will connect you with the proper individuals that can assist you with this issue.

Comment from Councilman Kutz:
Tribal nations do not always have relationships with states and working with them to get money funneled down to tribes can be a challenge. With avian flu, vaccines went to tribes last. Some tribes in the United States do not recognize the states as having jurisdiction over them and will communicate only with the federal government, which causes communication issues.

Question from Mr. Larson:
Who developed the emergency preparedness working with states guide? Is there any kind of process for tribes listed within the guide, like a consultation policy, and has any previous work been done to establish these relationships because of the sovereignty issue?
Response from Dr. Montero:
CPR worked on the state guide. For engagement, internally at CSTLTS, we have used mechanisms in the past involving letters of intent, but they are not effective. We need a better tool to engage tribal nations.

Question from Councilwoman McCovey:
Can I get some clarification on the need for 50,000 to apply for the Public Health Crisis Response CoAg? Does a tribe need to have 50,000 members to be eligible to apply?
Response from Mr. Smith:
For a tribe to participate, they have to be able to administer services to 50,000 within their jurisdiction.
Follow-up Response from Ms. Pivec:
This funding is also just in case there is an emergency. The funding is not for preparedness activities.
Comment from Councilwoman McCovey:
The concern with this is that we have had to create relationships with state and local governments for these emergencies; however, when fires break out, tribes in very rural areas are often forgotten.
Response from Mr. Smith:
I did hear that the California governor has apologized for a recent incident of this. CPR will make sure that states are trained on engaging tribal nations. We are aware of issues like these now, and I would like to stay in touch with you, Councilwoman McCovey, to make sure this does not happen again.

Question from Pascua Yaqui in Audience:
What is the reason that CDC does not fund tribes directly for emergency preparedness activities?
Response from Mr. Smith:
Congress did not mandate that we fund tribes directly, and we have to abide by Congress.
Follow-up Question from Chairwoman Andrews-Maltais:
You said that Congress did not mandate that CPR funds tribes, but did they prohibit this?
Response from Mr. Smith:
I will take this question back to senior leaders to ensure that your questions are answered and followed-up on.

Request from Councilman Kutz:
I would be interested in seeing the MOU between Cherokee Nation and EBCI for this emergency preparedness partnership.
Response from Mr. Simmons:
If we get permission to share the MOU from Principal Chief Sneed, OTASA can circulate the document to you.

4:30 pm–Tribal Testimony

Presenters

- **Cheryl Andrews-Maltais** *Wampanoag Tribe of Gay Head Aquinnah*, Nashville Area
- **Del Yazzie** *Navajo Nation*, Navajo Area
- **Lana McCovey** *Yurok Tribe*, California Area
- **Lisa Pivec** *Cherokee Nation*, Tribes At-Large
- **Alston Turtle** *Ute Mountain Ute Tribe*, Albuquerque Area
- **Connie Barker** *The Chickasaw Nation*, Tribes At-Large
- **Byron Larson** *Northern Cheyenne Nation*, Billings Area
- **Stephen Kutz** *Colwitz Indian Tribe*, Portland Area
- **Robert TwoBears** *Ho-Chunk Nation of Wisconsin*, Bemidji Area

Testimony

- Chairwoman Andrews-Maltais, *Wampanoag Tribe of Gay Head Aquinnah*, Nashville Area–
    - Thank you to EBCI and CDC for this meeting.
    - The tribes in the Northeast are having a significant problem with tickborne diseases. There is a need to educate the medical community, particularly in southeastern Massachusetts, because we are trying to tell the medical community that we are suffering from Lyme disease on an exponentially large scale.
    - We have had recent diagnoses of RMSF, tularemia, babesiosis, and Eastern Equine Encephalitis. We are trying to get a better test to diagnose these diseases because we are getting too many false negatives, and this prevents us from treating the disease until the effects are irreversible.
    - Is there a way to issue a memo or a directive from CDC to say that in instances where there are areas of high incidence of tick-borne diseases, doctors need to prescribe the antibiotic regimen in cases of a possible false negative?
- Del Yazzie, *Navajo Nation*, Navajo Area–
    - Thank you to EBCI for hosting the meeting and to CDC for the continued partnerships and funds.
    - I want to acknowledge the viral special pathogens branch, as well as the funding for GHWIC, TECPHI and the OT18-1803: Tribal Public Health Capacity Building and Quality Improvement Umbrella CoAg.
    - I also want to thank CDC as well for the potential partnership with Epidemic Intelligence Service (EIS) for opioid work in Navajo Nation and the new PHAP associate we will receive in the fall.
- Councilwoman McCovey, *Yurok Tribe*, California Area–
    - I would like to thank EBCI and CDC for having us at this meeting. I would like to recap on the items I discussed earlier.
    - It is important to have hepatitis C screening available to clinics and to screen people earlier before they are in crisis.
    - I believe something as large or as important as the AI/AN Tribal Public Health Framework is to tribes should be brought to us through a true consultation. This will allow tribes across the nation to bring their concerns to the CDC on what is truly important to them.
    - I also hope that TAC members will be able to see the new TAC charter at the next TAC meeting.
- Lisa Pivec, *Cherokee Nation*, Tribes At-Large–
    - I do not have any formal tribal testimony, but I wanted to say thank you to EBCI and CDC for this meeting.
    - This was a lively meeting and I want us to know that our strength is in our struggle. We are learning what our responsibilities are and how to hold each accountable.
- Council Delegate Turtle, *Ute Mountain Ute Tribe*, Albuquerque Area–
    - It is good to have the Albuquerque area seat filled after it has been empty for a while.

    - I hope we can build our networking and share information with our tribes and voice our concerns to CDC.
    - I would also like to thank EBCI for hosting the meeting.
- Legislator Barker, *The Chickasaw Nation*, Tribes At-Large–
    - I want to thank CDC for appointing me to this TAC, and I appreciate the help from other committee members on getting me up to speed. I look forward to working with everyone at the next TAC meeting.
- Byron Larson, *Northern Cheyenne Nation*, Billings Area–
    - I want to start by saying thank you to EBCI as well for hosting this meeting, it is really wonderful to see tribes that are extremely successful both in economic development but also in healthcare delivery.
    - I also want to say thank you to CDC for the development of the OT18-1803 CoAg.
    - I have concerns about transitioning the racial misclassification project to the National Center of Urban Indian Health, as their constituents are not tribal sovereign nations.
    - In terms of CDC grants and contracts, it would be good to see consequences for states that do not engage tribes.
    - Other concerns include ensuring that PHAP has Native participants, re-engage the working effectively with tribal governments program, and include more EIS officers within Indian Country.
- Councilman Kutz, *Colwitz Indian Tribe*, Portland Area–
    - Thank you to EBCI and CDC for this meeting.
    - Since we are only meeting twice a year, I would like to see if we can work together to make the TAC conference calls more product oriented. It would be good to do work in between the face-to-face meetings.

—Byron Larson ceded his seat to NIHB so they could testify to the TAC.

- Stacy Bohlen, *Sault Sainte Marie Tribe of Chippewa Indians,* NIHB Executive Director–
    - NIHB is empowered by all the federally recognized tribes in the country, to be their technical advisors and their advocates. NIHB has worked with other committees to build a national cadre of experts in the areas that are priorities to the tribes so they can build their own public health agenda for Indian Country.
    - When we were awarded the CoAg by CDC, all of that was articulated within our proposal and it was funded and since that time, there have been very significant shifts in the work. "I want to give this to the committee for the record. This is what we submitted, and I want to commit to both the CDC and to this committee that we will do this work whether we're funded or not. Because that is what the tribes expect from us. And we're servants of the tribes. So as sovereign nations it is our obligation to honor that. And that's what the National Indian Health Board will do. And I'd like this if it could be included in the record, for that to be the case."
    - NIHB is held accountable by its 573 bosses who will not hesitate to speak to NIHB about what it is that we should be doing and what the priorities of the tribes are. NIHB is ever mindful of that because the organization belongs to the tribes.
    - One of the areas that I am really proud of on behalf of our excellent staff and leadership is that when you engage with NIHB you can count on receiving the tribal perspective and having high quality work that will inform, engage, and advance, hopefully a partnership relationship.

Question from Legislator Connie Barker:
Who directed NIHB to shift the work and why, when the contract[1] has been signed?
Response from NIHB Executive Director Stacy Bohlen:

[1] The contract referred to in this section is a CoAg not a contract.

That would be Dr. Montero.

Response from Dr. Montero:

We are not talking about a signed contract that was changed. I am not able to discuss specifics because I cannot discuss the contracting process. However, when CDC contracts with organization A to build a house, for example. They deliver the house; I don't need to contract organization A again to build the house, because the house was built. The next contract will address a different product, because the initial one was completed. Now, if the contract is for house maintenance, an ongoing contract for many years is required. When CDC does the bidding process, organizations can apply and state how much money they will do the work for. However, as an agency, we can only choose the work that we have funds for and cannot fund everything. This is not because I change my mind; it is because I don't have enough money and I have a body of organizations applying to conduct different activities. However, CDC budget is also reliant on funds allocated by Congress. If Congress decides this year that they will not fund a program, then everything that program does, will stop, because Congress didn't give us the money. So, there are many things that could influence a shift in work.

Response from Chairwoman Andrews-Maltais:

If the priorities either change or those items within the contract appear satisfied from CDC's perspective, but not NIHB's perspective, I would consider that to be something that should be discussed at a consultation. If not with full consultation, then maybe it should be discussed with the TAC, for tribes to be fully informed and engaged. I am trying to figure out how it went from being this to that, and we are just being made aware of the change.

Response from Dr. Montero:

The consultation process asked for CDC to increase direct funding to tribes. We do not get appropriation from Congress to do that. CSTLTS had to reshuffle the amount of money that we as an organization can provide. Our budget has not increased, and we have been on a quest to develop a better understanding of tribal health, so we are finishing an assessment of public health capacity through a contractual relationship of one organization. Then, CSTLTS will need to move into the development of the TPHF and research agenda based on those findings. It is an aggregate process that gets us through different stages, each requiring a different expertise. So that is why, later on, CSTLTS is going to bring those developments back to the TAC to get your input. You asked us in the various TAC meetings to start finding mechanisms to fund tribes directly, so we implemented the OT18-1803 CoAg. In an environment where CDC does not have increased financial capacity, CSTLTS needed to figure out how to meet the requests to increase direct funding to tribes.

Response from Chairwoman Andrews-Maltais:

The decision to divert funds to fund tribes directly falls underneath Executive Order 13175, because it is an administrative decision that would have impacts and implications to tribes and tribal interests. That was an opportunity to communicate with us as well as NIHB, so that the TAC understood why you were making the decision and what other options there were, so we could provide input in the decision.

Response from Councilman Kutz:

One of my other jobs is to act as chair of the American Indian Health Commission of Washington. This group represents 29 tribes and two urban programs, so we collaborate to take care of broader issues in the state. We aim to fund those areas that affect all of us in the best way and to where the funds will be spread out the best. Otherwise, if we all get a little bit of money to do one thing, nothing will be accomplished, because there is not enough money to do all of it. Sometimes work must be done on a bigger broader level. We want to make sure that if mutual work is going to be conducted between CDC and the tribes, that we know that CDC will be working with an organization that works with tribes and understands them and not some other entity.

Response from Councilwoman McCovey:

I ask that any time there are changes to services to members or staff, CDC comes back to us to explain why. Tribes talk to Congress, and if there is an issue that we need to bring to Congress, regarding funding or other things, then we need to know that. If there are needs here for funding services or particular staff, then we can take that back to Congress and let them know that tribes need this.

- Stacy Bohlen, *Sault Sainte Marie Tribe of Chippewa Indians,* NIHB Executive Director–
    - A committee like this TAC is representing the tribes and the country.

- "It was a good decision that CDC supported NIHB to do this project. But last year, CDC asked NCUIH to step in to do the work that NIHB was initially asked to do. This would have put NCUIH in a position that would be politically untenable for the next 40 years because that is not the lane they are in. This was a really difficult situation for us because we were "basically asked how will we fund them and we are not their funder."
- "The President in the CDC budget, zeroed out Good Health and Wellness in Indian Country, two years in a row. That's the program that you and everyone here has acknowledged is a fundamental groundbreaking game changer for Indian Country. It was the National Indian Health Board that fought for that money. And not only did we get the $16 million that was originally in the fund, over the last 2 years you got a $5 million budget increase because of the work that we did with all of the people in this room. That's who we are. So I know that your budget was increased because…all of the tribal leaders and our board worked together to get that budget increased. And we can do so in a variety of other venues as well at the will of the tribes. But I think that it would be fundamental for you, in the position you hold, to be more intimately engaged in budget consultation and formulation. The leaders of this table are very clear about what they wish and the National Indian Health Board is very clear, and we'll support you and give you what you need to be successful. But I will just say that we never want to see a President's budget again zero out Good Health and Wellness in Indian Country because I think everyone at this table can agree, it's a game changer for our people."

—NIHB Executive Director Stacy Bohlen relinquished her seat back to Byron Larson.

5:00 pm–Summary, Closing Prayer, and Adjournment

Presenters

- **Captain Carmen Clelland, PharmD, MPA, MPH,** (*Cheyenne and Arapaho Tribes),* USPHS; Director, OTASA, CSTLTS, CDC
- **Jose Montero, MD, MHCDS,** Director, CSTLTS, CDC
- **Robert TwoBears** (*Ho-Chunk Nation of Wisconsin)*, Legislative Representative District V, Ho-Chunk Nation of Wisconsin; Chair, TAC

Closing Remarks

- Dr. Montero provided summary highlights of the meeting and, on behalf of CDC, thanked everyone for attending and participating throughout the meeting.
- Legislator TwoBears closed the meeting with a prayer.

Appendices

Appendix A: Acronym List

AI/AN	American Indian/Alaska Native
ATSDR	Agency for Toxic Substances and Disease Registry
CDC	Centers for Disease Control and Prevention
CPR	Center for Preparedness and Response
CSTLTS	Center for State, Tribal, Local, and Territorial Support
DSFC	Division of Sanitation Facilities Construction
EBCI	Eastern Band of Cherokee Indians
EPA	Environmental Protection Agency
FACA	Federal Advisory Committee Act
FY	Fiscal Year
GHWIC	Good Health and Wellness in Indian Country
HHS	Health and Human Services
HIV	Human Immunodeficiency Virus
IDOH	Indigenous Determinants of Health
IHS	Indian Health Service
MAT	Medicated-Assisted Treatment
MOU	Memorandum of Understanding
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCEH	National Center for Environmental Health
NCEZID	National Center for Emerging and Zoonotic Infectious Diseases
NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
NCIPC	National Center for Injury Prevention and Control
NCUIH	National Council of Urban Indian Health
NIHB	National Indian Health Board
NNPHI	National Network of Public Health Institutes
OTASA	Office of Tribal Affairs and Strategic Alliances
PHAP	Public Health Associate Program
PHICCS	Public Health Indian Country Capacity Scan
RMSF	Rocky Mountain Spotted Fever
SME	Subject Matter Expert
TAC	Tribal Advisory Committee
TEC	Tribal Epidemiology Center
TECPHI	Tribal Epidemiology Center Public Health Infrastructure
TPHF	Tribal Public Health Framework
TPWIC	Tribal Practices for Wellness in Indian Country
USPHS	United States Public Health Service

Appendix B: CDC/ATSDR TAC Roster

Area Office	Delegate	Authorized Representative
Alaska Area Term Expires: February 28, 2021	**Alicia L. Andrew** President, Karluk IRA Tribal Council *Native Village of Karluk*	**VACANT**
Albuquerque Area Term Expires: August 31, 2021	**Selwyn Whiteskunk** Tribal Councilman *Ute Mountain Ute Tribe*	**Alston Turtle** Council Delegate *Ute Mountain Ute Tribe*
Bemidji Area Term Expires: July 31, 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: August 31, 2021	**Byron Larson** Rocky Mountain Tribal Leaders Council *Northern Cheyenne Nation*	**VACANT**
California Area Term Expires: March 30, 2020	**Lana M. McCovey** Council Member *Yurok Tribe*	**VACANT**
Great Plains Area Term Expires: August 31, 2019	**Robert Flying Hawk** Chairman *Yankton Sioux Tribe*	**VACANT**
Nashville Area Term Expires: August 31, 2019	**Cheryl Andrews-Maltais** Chairwoman *Wampanoag Tribe of Gay Head Aquinnah*	**VACANT**
Navajo Area Term Expires: August 31, 2021	**Myron Lizer** Vice President *The Navajo Nation*	**Jill Jim, PhD, MHA/MPH** Executive Director, Navajo Department of Health *The Navajo Nation*

Oklahoma Area Term Expires: February 28, 2021	**James R. Floyd** Principal Chief *Muscogee (Creek) Nation*	**Shawn Terry** Secretary of Health *Muscogee (Creek) Nation*
Phoenix Area Term Expires: February 28, 2022	**Jill Temoke** Council Member *Elko Band Council (Te-Moak Tribe of Western Shoshone)*	**VACANT**
Portland Area Term Expires: August 31, 2021	**Stephen Kutz, RN, BSN, MPH** Tribal Council Member *Colwitz Indian Tribe*	**Sharon Stanphill, MD** Chief Health Officer *Cow Creek Band of Umpqua Tribe of Indians*
Tucson Area	**VACANT**	**VACANT**
Tribes At-Large Term Expires: August 31, 2021	**Richard Sneed (TAC Co-Chair)** Principal Chief *Eastern Band of Cherokee Indians*	**VACANT**
Tribes At-Large Term Expires: August 31, 2019	**Bryan Warner** Tribal Councilor, District 6 *Cherokee Nation*	**Lisa Pivec, MS** Senior Director of Public Health, Cherokee Nation Health Services *Cherokee Nation*
Tribes At-Large Term Expires: August 31, 2021	**Doreen Fogg-Leavitt** Secretary, Inupiat Community of the Arctic Slope Council *Inupiat Community of the Arctic Slope*	**VACANT**
Tribes At-Large Term Expires: August 31, 2021	**Connie Barker** Tribal Legislator *The Chickasaw Nation*	**Darcy Morrow** Board of Directors Member *Sault Ste. Marie Tribe of Chippewa Indians*

Appendix C: Written Testimony

Testimony: Karluk IRA Tribal Council

There is a lot of misinformation about the effect of opioids and treatment options:

- People are not getting treatment because of wrong information and lack of information.
- Opioids change how the brain is structured and how it works. That doesn't always go back to normal even when people stop being on opioids. That message isn't getting across.
- People still think opioids are like cigarettes. They don't understand that brain changes from opioids are long lasting. Cravings are long lasting. Cravings don't go away like cigarettes. People can't just shake it off.
- Medication assisted treatment can help make the cravings go away so people can recover.
- But people who need treatment choose not to get it because they don't know
    - how medication assisted treatment works
    - how effective medication assisted treatment is
    - how their brain and nervous system may have changed as a result of opioids
- We underscore that opioids affect the brain and nervous system. That's really hard to explain. It's not like measles or infectious disease.
- Unless your organization has a neuroscientist on staff, it's hard to use CDC-provided information and PSAs to make key messages. For most organizations it's impossible.
- Even doctors have a hard time explaining how medication assisted treatment works.
- Even state government health offices can't explain this clearly.
- State governments are well funded for opioids, but epidemiology and public health offices often don't have people who can explain brain changes and the drugs to treat that.
- Unless people know how the brain is affected, how those treatment drugs work, it's hard for them to make good decisions about treatment.
- When there were emergencies for the Zika virus and Ebola, CDC made key messages.
- The key messages simplify things people need to know and what they can do.
- Key messages mean information is accurate and consistent from the state government, NGOs, and health organizations.
- Without key messages, we think the federal government could spend billions to increase access to opioid use disorder care – but people won't get that care because nobody's taken the time and care to explain how it works and why they need it.
- The same barrier to treatment – bad information, lack of information – has been highlighted at every opioid forum we've attended in every state.
- Consistent key messages will save lives and money.

Alicia Andrew
President

Testimony: Pasqua Yaqui Tribe of Arizona

Pascua Yaqui Tribe of Arizona
Center for Disease Control and Prevention/Agency for Toxic Substance and Disease Registry
Tribal Advisory Committee Meeting and 19th Biannual Tribal Consultation session
Cherokee, NC
August 12-13, 2019

On behalf of the Pascua Yaqui Tribe, I respectfully submit the following testimony as an official record for the CDC/ATSDR Biannual Tribal Consultation session. We are committed to the public health accreditation and enhancing the internal frameworks for public health in tribal settings.

1) The Pascua Yaqui Tribe has been a recipient of CDC's Tribal Infrastructure Grant. This provided the tribe's health services division with the funding to create a Hepatitis C Registry utilizing Indian Health Service's Resource and Patient Management System or RPMS. This registry enable our tribal nurses and Community Health Representatives to document case management services and track the care provided our tribal members diagnose with Hep C. This opportunity also provided funding to contract the expertise needed to gather and analyze our own data pertaining to Hepatitis C.

   Recommendation: For CDC to provide additional funding for tribal nations to build their internal infrastructure and enhance their data and electric health record capabilities. The Tribal Infrastructure grant provided tribal nation the flexibility to choose which areas they wanted to focus on as CDC provided technical assistance.

2) One of the tribe's greatest challenges is obtaining funding for Tribal public health. When compared to the state and local health departments there are inequalities. States receive funding for public health through various mechanisms, such as block grants from the federal government, and those opportunities do not exist for Tribes.
   Moreover, tribes are not aware how they are included in the CDC's funding to State. Most tribes do not receive notification from the State regarding the CDC funding that is award. Tribes are also not notified if this CDC funding is available to the tribe or how tribes will benefit from services funding by CDC funding.

   Recommendation: For CDC to provide the same funding opportunities to tribes as State and local public health departments. In addition, require States to provide a breakdown of CDC funding they received and how the State is passing on the funding and/or services to tribes.

3) Our Health Services Division was successful in obtaining a CDC Public Health Associate in 2016-2018 who helped us in our Public Health Accreditation process. Since 2018, we have not been successful in having CDC match another PHAP Associate. We will continue to apply to the PHAP application process. Also, we would like to encourage Tribe's participate in the PHAP program since this was a great help.

   Recommendation: For CDC to make every effort in finding a match for Tribal Communities.

In closing, we want to thank you for allowing us this opportunity to give feedback.

Respectfully,
Robert Valencia
Tribal Chairman