22nd Biannual CDC/ATSDR Tribal Advisory Committee Meeting

August 4, 2021 12:00–6:00 pm (EDT)
August 5, 2021 12:00 –3:00 pm (EDT)
Virtual Zoom Platform

The Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) hosted the 22nd Biannual Tribal Advisory Committee (TAC) Meeting during August 4–5, 2021.

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CDC/ATSDR TAC Meeting Participants and Attendees

TAC Member Attendees

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

Legislator Connie Barker
The Chickasaw Nation
Tribes At-Large Delegate

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

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

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

Lisa Pivec, MS
Cherokee Nation
Oklahoma Area Delegate

Councilmember Teresa Sanchez
Morongo Band of Mission Indians
California Area Delegate

Sharon Stanphill, MD
Cow Creek Band of Umpqua Tribe of Indians
Portland Area Delegate

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

Absent TAC Members

***Affiliation*/Tribal Area**	**Name**	**Title**
Ute Mountain Ute Tribe/Albuquerque Area	Selwyn Whiteskunk	Tribal Councilman
Mandan, Hidatsa, and Arikara Nation/Great Plains Area	Monica Mayer	Councilwoman
San Carlos Apache Tribe/Phoenix Area	David Reede	Executive Director
Inupiat Community of the Arctic Slope	Doreen Fogg-Leavitt	Secretary

CDC Participants

John Auerbach, MBA
Director, Intergovernmental and Strategic Affairs, Office of the Director (OD)

Patrick Breysse, PhD
Deputy Director for Non-Infectious Diseases (DDNID); Director, OD, National Center for Environmental Health (NCEH)/Agency for Toxic Substances and Disease Registry (ATSDR)

Sharunda Buchanan, PhD
Director, NCEH

Teresa Daub, MPH, CPH
Branch Chief, Health Department Program Branch,

Division of Program and Partnership Services, Center for State, Tribal, Local, and Territorial Support (CSTLTS)

Leslie Dauphin, PhD
Acting Director, Center for Surveillance, Epidemiology, and Laboratory Services (CSELS)

Melanie Duckworth, PhD
Associate Director for Policy, Office of Minority Health and Health Equity (OMHHE)

Karen Hacker, MD, MPH
Director, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

Jeffrey Hall, PhD, MA
Deputy Director, Minority Health and Health Equity Activity, OMHHE

CAPT Karen Hearod, MSW, LCSW
United States Public Health Service (USPHS), Director, Office of Tribal Affairs and Strategic Alliances (OTASA), CSTLTS

Robin Ikeda, MD, MPH
Director, Office of the Associate Director for Policy and Strategy (OADPS)

CAPT Christopher Jones, PharmD, MPH, DRPH
Acting Director, National Center for Injury Prevention and Control (NCIPC)

Donna McCree, PhD, MPH
Associate Director for Health Equity, National Center for HIV, Viral Hepatitis, STD, and TB Prevention

Jim Mercy, PhD
Director, Division of Violence Prevention, NCIPC

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

Jose Montero, MD, MHCDS
Director, CSTLTS

Georgia Moore, MS
Associate Director for Policy, CSTLTS

Kate Noelte, MPH
Deputy Division Director, Division of State and Local Readiness (DSLR), Center for Preparedness and Response (CPR)

Samuel Posner, PhD, MA
Acting Director, National Center for Immunization and Respiratory Diseases (NCIRD)

Steven Reynolds, MPH
Deputy Director, CSTLTS

Delight Satter, MPH
Senior Health Scientist, OTASA, CSTLTS

Elizabeth Skillen, PHD, MS
Health Scientist, Population Health and Healthcare Office, OADPS

Caroline Sulal, MBA
Branch Chief, National Partnership Branch, Division of Program and Partnership Services, CSTLTS

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

Rochelle Walensky, MD, MPH
Director, CDC

CAPT Craig Wilkins, MPH
USPHS (Ret.); Senior Advisor, OMHHE

Ian Williams, PhD, MS
Deputy Director, CPR

Wednesday, August 4, 2021

12:00 pm—Opening Blessing, Welcome, and Introductions

- Ms. Pivec welcomed TAC members and representatives, CDC officials, and other guests to the 22nd Biannual CDC/ATSDR TAC Meeting.

- Legislator Barker provided the opening blessing.
- Dr. Montero welcomed everyone to the meeting and provided an overview of the agenda.
- Captain Hearod introduced herself as the new OTASA director and welcomed the TAC members.

12:15 pm—TAC Business

Facilitators

- **Lisa Pivec**, **MS**, Senior Director of Public Health, *Cherokee Nation*, TAC
- **José Montero, MD, MHCDS,** Director, CSTLTS, CDC
- **CAPT Karen Hearod, MSW, LCSW,** USPHS, Director, OTASA, CSTLTS, CDC

Roll Call

- Commander Meyer conducted the roll call. A quorum was present to conduct business.

TAC Roles and Responsibilities

- Ms. Pivec discussed the TAC roles and responsibilities, including the Federal Advisory Committee Act (FACA) Unfunded Mandates Reform Act Section 204 exemption.

CDC/ATSDR TAC Charter

- Ms. Pivec proposed that the TAC Charter discussion be moved to the TAC Business portion of Thursday's agenda so that all TAC members would have the opportunity to look at comments made on the TAC Charter during Tribal Caucus.
- She provided a summary of suggested revisions to the TAC Charter during Tribal Caucus. She noted that the edits would be added to the draft charter and sent to the TAC members to review.
- Ms. Pivec also noted that during the second day of the 22nd Biannual TAC meeting, in the TAC Business portion of the agenda, the TAC will discuss whether the TAC Subcommittee should continue or be dismissed.

CDC/ATSDR TAC Charter: Questions and Discussion

Comments from Ms. Pivec:

- The TAC has made a few recommendations for the TAC charter, including:
    - Cite the January 26 Presidential "Memorandum on Tribal Consultation and Strengthening Nation-to Nation Relationships" and providing guidance on engaging with tribal nations for technical assistance.
    - Under "Purpose", strengthen the language and specify that the TAC does not replace formal consultation.
    - Under "Authority", note that engagement between CDC and tribal officials should be action based.
    - Under "Function", state the general function of the TAC and include eight specific functions.
    - Under "Selection Process", note the process of selecting new members is a shared responsibility led by the OTASA Director, the TAC Chair, and the TAC Co-Chair.
    - Under "Meetings", allow for virtual meeting participation, noting in-person meetings are preferred.
    - Under "Meetings", note that CDC and ATSDR senior leaders should participate in the TAC meetings.
    - Under "Meetings", specifying that OTASA Director is responsible for securing CDC senior leadership participation.

- Under "Reports", note that TAC minutes, reports, and other meeting materials will be distributed to all TAC members, as well as posted online.
- All requests by TAC members regarding TAC content will receive acknowledgment within two business days of receipt and responses within 14 business days.
- Specify that the TAC Chair, TAC Co-Chair, and OTASA Director will co-lead the development of each meeting agenda.

Response from Dr. Montero:

- Thank you for this report and for the work that has been accomplished by the TAC subcommittee. This is great progress.
- Next steps after CDC receives the charter edits from the TAC include an internal review by CDC, approval from TAC members of the updated charter, and formal consultation on the updated charter.

Comment from Ms. Pivec:

- Thank you to everyone involved.

1:00 pm—Tribal Public Health Infrastructure

Presenter

- **José Montero, MD, MHCDS,** Director, CSTLTS, CDC
- **Karen Hacker, MD, MPH,** Director, NCCDPHP, CDC
- **Craig Thomas, PhD,** Director, Division of Population Health (DPH), NCCDPHP, CDC

Opening Remarks: CSTLTS

- Dr. Montero presented on funding mechanisms within CSTLTS that are focused on tribal public health infrastructure and described the findings of the 2019 Public Health in Indian Country Capacity Scan report completed in partnership with the National Indian Health Board (NIHB). The report can be found on NIHB's website.
- Dr. Montero described two programs focused on supporting tribal nations in capacity building, infrastructure, and emergency preparedness and response related to the 2019 Novel Coronavirus Disease (COVID-19) pandemic:
  - CDC-RFA-OT20-2004 Grant: Supporting Tribal Public Health Capacity in Coronavirus Preparedness and Response
  - The COVID-19 supplement as part of the CDC-RFA-OT18-1803: Tribal Public Health Capacity Building and Quality Improvement
- For the CDC-RFA-OT20-2004 Grant, CSTLTS looked at a sample of 36 recipients. More than two-thirds of this sample (25 out of 36) allocated CDC-RFA-OT20-2004 funds towards three or more strategies. The top were countermeasures and mitigation, communications, and emergency operations and coordination. This sample informs CDC of capacity needs and reiterates the importance of flexible funding mechanisms for tribal nations.

Opening Remarks: NCCDPHP

- Dr. Thomas discussed three programs within NCCDPHP focused on building tribal public health infrastructure: Good Health and Wellness in Indian Country (GHWIC), Tribal Practices for Wellness in Indian Country (TPWIC), and the Tribal Epidemiology Centers for Public Health Infrastructure (TECPHI).
- NCCDPHP partners with American Indian/Alaska Native (AI/AN) communities through the Healthy Brain Initiative: Road Map for Indian Country to address aging, caregiving, dementia, and Alzheimer's disease.

Tribal Public Health Infrastructure: Questions and Discussion

Question from Dr. Montero:

- Dr. Montero posed questions to the TAC to guide the discussion. What is public health infrastructure? What does tribal public health infrastructure mean to the TAC?

Response from Ms. Pivec:

- Cherokee Nation is looking at crosscutting programs that go outside of our public health services of direct care. By partnering with education, road work, and housing, Cherokee Nation is starting to address social determinants of health and build community support.
- Cherokee Nation is working to provide the 10 Essential Public Health Services in a way that is culturally relevant to our community.
- Each tribal nation's definition of public health will be different.
- For Cherokee Nation, it is about building and being able to put together an infrastructure that is identified as relevant by the community and consistent with the essential public health services. Instead of being limited to just the ten essential public health services, we need to add in things that are culturally relevant to our community.
- This should be completed at the tribal level through direct funding.

Response from Dr. Stanphill:

- At the Cow Creek Band of Umpqua Tribe of Indians, and amongst many tribes in the Northwest, public health departments are just now being built.
- We are working on reaching the highest level of services and educating tribal leaders on what a tribal public health department should look like.
- It is important to know that some tribal nations will need a larger investment to begin to stand up a tribal public health department. Those who already have an infrastructure in place are completing more advanced work and becoming their own public health authority.
- Tribal nations need direct funding.

Response from Secretary Bradley:

- The Eastern Band of Cherokee Indians subscribes to the 10 Essential Public Health Services outlined in a way that is culturally appropriate for our tribal nation. But what is culturally relevant for us may not be relevant to other tribal nations.
- Infrastructure and accreditation will look different for each tribal nation. There will be different needs depending on the scale and size of the tribal nation.
- The Eastern Band of Cherokee Indians' health department is not recognized in North Carolina. Our route for accreditation is very different than other county health departments. We are fortunate that we have good partnerships, but we are still excluded from having a voice in many areas.
- We rely on county partnerships for assurances of public health services in many areas.
- Some tribal nations do not provide all ten essential public health functions themselves. It is a costly and time-consuming process to seek public health accreditation. But without accreditation, it is hard to achieve credibility and trust in the states.
- Public health historically has not always been recognized as an essential health service in tribal communities. When tribal nations are trying to appropriate funding towards preventative services, funding is instead focused on acute healthcare such as diabetes or heart disease. It is hard to provide justification for tribal nations to put money in preventative services, but it is necessary to change the trajectory of population health in our communities.
- Tribal nations need federal support and appropriations towards public health. There needs to be funding to sustain full time employees (FTEs).

Comments from Dr. Jim in the chat box:

- There needs to be allocation of funding for different levels of public health infrastructure development across tribal nations.

- Tribal nations should be recognized as state/local health departments and included at the national level as so. Currently, we are excluded from the Association of State and Territorial Health Officials (ASTHO).

Response from Ms. Pivec:

- Tribal nations need funding for building infrastructure at a community level.
- Tribal nations need to collect and analyze their own data to address issues facing AI/AN communities. Historically, tribal nations must rely on samples of AI/AN data and surveys that are not representative of their specific communities. Survey work is expensive, and often there is no funding to complete it. Tribal nations need to know what issues their community is facing to make changes.

Comments from Secretary Bradley:

- Eastern Band of Cherokee Indians completed its first health assessment, which was expensive.
- When looking at data at the state level in North Carolina, AI/AN is self-identified from respondents. It is not relevant to our community. To have effective data relevant to the community, Eastern Band of Cherokee Indians needs to complete its own tribal health assessment and tribal health improvement plan, but it is costly and staff intensive.
- Eastern Band of Cherokee Indians has codified a public health code and are developing an internet platform with results-based accountability as benchmarks. This will show progress and outcomes within the community. It has to be built internally since there are no established tribal products available.

Comments from Dr. Montero:

- Data and surveillance are key components of infrastructure.
- From this session, I have heard that infrastructure is different for all tribal nations.
- Knowing that difference, how should CDC look at the improvement, development, and creation of health departments within AI/AN communities?

Response from Secretary Bradley:

- As a start, CDC can provide resources for tribal nations with varying levels of population. CDC can provide resources and show best practices for different-sized health departments.
- CDC can provide examples of what tribal nations can do with different sizes of health departments, along with forecasting how many potential FTEs will be needed and the primary duties of these FTEs. CDC can provide an organizational structure and basic resource kits. In addition to that, CDC can provide templates for public health codes.
- When the Eastern Band of Cherokee Indians wrote its public health code and had it codified, there were a number of other tribal nations reaching out and asking to use the same code. There is no need to recreate something that already exists.
- As a starting point, CDC can offer itself as a resource and inform tribal nations of the resources it can provide. CDC can assist with basic resources to help develop health departments. This will help tribal nations see what these best practices look like for different-sized health departments. CDC can also produce educational packets around the 10 essential public health services.

Comments from Ms. Pivec:

- CDC can help by defining or acknowledging the importance of a tribal public health department and what it should or could be doing. Every tribal health department struggles to justify and understand what its roles are.
- If CDC acknowledges or talks about tribal public health and gives examples of what it could look like, then tribal nations can build public health infrastructure in a way that best fits their community. CDC can offer examples of what tribal public health infrastructure looks like.

Response from Dr. Montero:

- CDC has had discussions on this before, and it can become complicated. If CDC provides a template, it can quickly become the normal method for doing something. Also, if a tribal nation develops

something that is outside of the CDC template, it can be seen as not following the standards. Sometimes, in trying to provide templates, CDC alters good approaches. GHWIC has done great work on engaging cultural practices. Developing one standard is a risk.

- In workforce development, some tribal nations may need to form an association of tribal nations. When describing workforce development, it may not be valuable to say how many FTEs are needed, but instead to describe functions and job descriptions. The accreditation board has completed some of this work when it created the standards for working for tribal nations.

Comments from Legislator Barker:

- As a tribal leader, I think something that would help leadership is for CDC to acknowledge that it is a good idea for tribal nations to engage in public health infrastructure.

Comments from Dr. Stanphill:

- Most tribal nations use CDC's recommendations.
- Funding is pushed from CDC to the Indian Health Service (IHS). When IHS administers funding for tribal public health infrastructure, technical assistance is vital. This technical assistance includes codifying, templates, and information on what public health infrastructure should look like.
- Tribal nations share information and mimic one another. We take one another's work and mold it to fit different regions.
- I think tribal nations want to do it their own way and have specific needs to do that.
- CDC needs to continue to fund and expand the base and supplemental funds of CDC-RFA-OT18-1803. Both Tribal Epidemiology Centers (TECs) and tribal nations need to be funded.
- Tribal nations need enough funding to begin to build public health infrastructure with CDC as a technical assistance partner.

Question from Dr. Montero:

- I have heard that some tribes do not want CDC to give funds directly to TECs. How should the CDC fund TECs, and for what purposes?

Response from Ms. Pivec:

- I support funding TECs, but it cannot be substituted for funding tribes. Both TECs and tribal nations need to be directly funded.
- I noticed in the presentation from CDC, the examples of work completed through TECs were great, but none were direct government public health infrastructure development.
- The CDC presentation mentioned that TECs were able to obtain over 100 staff members, and Indian Country needs that.

Comments from Secretary Bradley:

- I agree. The reason that tribal nations need direct funding in public health infrastructure capacity building is because current public health infrastructure standards are created by agencies who are used to nontribal agencies.
- There are very few accredited tribal agencies, and because tribal nations are all different, it is hard to apply those standards in a lot of cases, especially for smaller tribal infrastructure. The size of the tribal nation affects the standards. Some tribal nations are not serving hundreds of thousands of people like the standards are designed to address.
- I think there are synergies in tribal public health departments across the country in terms of the essential public health services, but we are not tribal health department look a-likes. There needs to be a separate carve out and support for tribal public health departments.

Question from Dr. Montero:

- What does funding for public health infrastructure look like? Is it funding to build, hire people, build data, or stand up a health department?

Response from Secretary Bradley:

- All of the above. There needs to be direct funding to help establish health departments in tribal communities.
- Startup funding for infrastructure can include operational costs and full-time employees or provide funding to contract expertise for assistance.

Question from Dr. Montero:

- How should CDC talk to tribal leaders about tribal public health infrastructure? What other vehicle or space should CDC work in to bring visibility of the need to develop public health infrastructure to tribal leaders?

Response from Ms. Pivec:

- CDC should post a policy or position statement. Something that can be referred to for best practices.
- The statement needs to talk about the importance of tribal public health infrastructure and that CDC supports that development.

Response from Dr. Stanphill:

- Another method that CDC could approach is posting a video that can be used to provide information for tribal leaders and other important decision makers.
- This video can also be shown with partner presentations, such as NIHB.
- The video can state that CDC supports public health infrastructure and will provide technical assistance.

Comments from Ms. Pivec:

- CDC can highlight that tribes are in a unique position. Tribal nations have boots on the ground and can be an effective public health force for all citizens in the area whether they are part of the tribe or not.

Comments Secretary Bradley:

- In Oklahoma, tribal nations were ahead of states and counties administering COVID-19 vaccines. Chickasaw Nation helped vaccinate the public.
- The conversation on public health infrastructure needs to be public. CDC should make a statement on tribal public health infrastructure.

Comments from Dr. Thomas:

- I wanted to point out a program with the Division of Global Health Protection called the National Network of Public Health Institutes (NNPHI), which is focused specifically on developing health departments for other countries. It could be a model to apply for this. It is very effective and has some great tools and models.

Comments from Secretary Bradley:

- To truly understand tribal sovereignty, states should not pass funding to tribal nations. Tribes are sovereign nations and separate from states. Ms. Pivec championed a paper on tribal health governance transformation, using public health authority as a resource to strengthen tribal sovereignty.
- That is another perspective—if tribal nations are recognized as exercising sovereignty through public health authority, then that elevates the importance to tribal leaders.
- Additionally, something that CDC can do is publish a position paper on the importance of exercising public health authority as a tribal nation. Tribal leaders look to CDC as subject matter experts for public health support. Anything CDC can do to lend support for this would be beneficial.

Questions from Dr. Montero:

- In the past, CDC has provided support for tribal nations to develop and assess the public health code. CDC also worked with tribal nations during the pandemic to look at authorities and powers. Part of the lessons that we are learning as a nation is how to better codify and where to go in the future with those particular authorities.

- Thank you for the suggestions provided during this session. CDC will discuss internally how to best follow through on requests. We will do that directly through the different calls we have through the next several months before the next TAC meeting.
- How do we codify the functions of tribal health departments? How do we make the 10 essential public health services implementable and scalable to different levels?
- How does public health accreditation apply to smaller tribal nations?
- How can CDC use workforce development to build public health infrastructure?
- What suggestions does the TAC have for CDC in regard to building a public health workforce down the road? Not solely on funding, but also building workforce capacity.
- We would appreciate hearing any comments and suggestions.

Response from Dr. Stanphill:

- When CDC is creating grants and funding opportunities for tribal nations, there are many public health experts in Indian Country that can be consulted and help CDC design the grants. That would be really helpful. These public health experts can help CDC focus on some of the public health infrastructure topics we have discussed.

Question from Dr. Montero:

- NCCDPHP at CDC has done something similar to that. Is that the model you are looking for? Or is it different from what they have historically done while consulting with tribal nations in developing grants?

Response from Dr. Stanphill:

- Consulting with tribal nations does mean consulting with tribal leaders, but I am referring to tribal public health experts as well.
- Tribal nations can provide answers into how funding should be utilized.

Response from Secretary Bradley:

- One of the domains in accreditation is committed to workforce development and maintaining a competent public health workforce by increasing public health competencies and professional development by individual training. All of this takes money.
- Developing a workforce development plan for a tribal public health department is significant. When talking about cooperative agreements, instead of passing funds from the state or other national agencies to tribal nations, direct appropriation for workforce development would be helpful.
- This has been done with some of the GHWIC funding. Tribal nations do not often have funding to host training for groups of people. It is easier to identify a service and bring someone in to train a workforce of 10 or 20 then to send one person out.
- It oftentimes comes down to funding because when you are competing for appropriations at the tribal level, there are so many other acute needs that oftentimes training is not on the priority list, especially for new competencies or new agencies.
- Workforce development is significant, particularly in tribal public health departments as we begin to build capacity. We need to look at long-term goals—what will we look like five years down the road? Tribal nations must have a workforce development plan.
- Tribal nations also have to have continuity in our authorities to build competencies to sustain a workforce in tribal systems and in tribal communities.

Response from Ms. Pivec:

- A lot of Cherokee Nation's Infrastructure development came from the NNPHI grant several years ago, and that set us up for accreditation because we were able to use that money to fund core staff and develop infrastructure.
- We are still working on infrastructure. This process will take a lot of time. We have not been funded at the same level as state and local health departments.

- Funding for infrastructure development is necessary, and something along the lines of the previous NNPHI grant for tribal nations specifically would be helpful.

Comments from Dr. Stanphill:

- I would like to provide an example of workforce development from Southern Oregon. There has been a high turnover rate of healthcare workers due to burnout. Tribal nations cannot keep up with the salary requirements that the hospitals are able to provide for nursing staff.
- When the pandemic hit, we were just starting up our public health department, and we had to train clinical nurses on public health nursing.
- We do not have the curriculum for public health nursing or public health policy.

Comments from Dr. Montero:

- I agree. The issues with public health nurse training and many other trainings have always been complex.
- We at CDC have been developing and supporting networks of training. People can join CDC Train, which has access to public health training.
- CDC will provide a summary of trainings and options that are available in our biweekly updates. There are also several initiatives across CDC to build public health workforce and training that we can share information on.

Comments from Dr. Thomas:

- There is such variability at the state and local levels when it comes to public health infrastructure that it may not be appropriate to use as a scale, but tribal nations need to know where to go for services and functions that are needed. That is an important piece to the conversation.
- Really understanding what the major gaps and barriers are moving forward would be helpful.
- CDC is focused on positive ways forward to address infrastructure needs.

Summary from Dr. Montero:

- Thank you for this conversation. This style of discussion is helpful.
- In summary, I heard that funding is a core aspect of tribal public health infrastructure. There needs to be funding for both tribal nations and TECs so we can build a systematic infrastructure that can respond to different levels of needs. Tribal public health infrastructure will be different for everyone.
- We need to look at all the different components, understanding that data is paramount to know what is happening and how to develop actions.
- Tribal nations need to know what the best practices are and adapt those to different sizes and needs.
- CDC needs to highlight the importance of public health infrastructure in Indian Country, so leadership knows the level of importance.
- CDC will share resources on workforce development on CDC Train as well as information on initiatives that are geared towards workforce development through the biweekly updates.

Comment from Ms. Pivec:

- Thank you, public health infrastructure is an important topic.
- The National Congress of American Indians might be a good forum to talk about public health infrastructure development.

Comments from Dr. Jim in the chat box:

- Offering scholarships for AI/AN students to go into the public health field would be helpful. How can CDC collaborate with AI/AN students to increase public health capacity? So, working with NIHB is a good thing.
- There should be separate epidemiology and public health infrastructure funding to tribes.
- IHS does support certain public health programs, but CDC should assess and support public health infrastructure capacity building.

2:30 pm—Tribal Public Health Data

Facilitator

- **Amy Branum, MSPH, PhD,** Health Statistician, National Center for Health Statistics (NCHS), CDC
- **Leslie Dauphin, PhD,** Deputy Director, CSELS, CDC

Opening Remarks: CSELS

Dr. Leslie Dauphin:

- Dr. Dauphin provided an overview of CSELS, outlining the mission and examples of work in core areas.
- CSELS has been accelerating work on electronic case reporting (eCR) which has automated the case reporting process. CSELS is supporting eCR for tribal entities with two projects in this area:
    - Expanding Electronic Case Reporting to Benefit Urban Tribal Populations
    - Improving Electronic Data Access for Reportable Conditions for Tribal Governments
- Throughout the COVID-19 response, CDC has worked with TECs to ensure access to the COVID-19 case data.
- CDC's Data Modernization Initiative is at the heart of a national effort to create modern, integrative, real time, trusted public health data and surveillance that can protect communities from health threats.
- Dr. Dauphin explained that one of the core functions of CSELS is to build the public health workforce through training and opportunity. CSELS manages CDC Train and the Training & Continuing Education Online.

Opening Remarks: NCHS

Dr. Amy Branum:

- Dr. Branum described the mission of NCHS and data access tools that NCHS provides, and she discussed current NCHS work on the misclassification of AI/AN data in data systems.
- NCHS is working on the misclassification of AI/AN people, specifically in mortality files.
    - As part of the CDC CORE Health Equity Initiative, NCHS will link the 2010 Census to the National Vital Statistics System Mortality data to better measure mortality of the AI/AN population.
- Under the Data Modernization Initiative, NCHS currently has projects focused on improving data access, including revising the website and using data science tools to improve data visualization and other access tools.

Tribal Public Health Data: TAC Questions and Discussion

Question from Ms. Pivec:

- Dr. Dauphin, in regard to the specific funding for building infrastructure, is there legislative language that prohibits directly funding tribes?

Response from Dr. Dauphin:

- CDC recognizes TECs as public health authorities, so we have been working to ensure that data are available to TECs.
- In terms of the funding mechanisms, there are two different funding authorities. There is the CDC-RFA-OT18-1803 cooperative agreement, which is available for TECs to apply to. CDC is using the cooperative agreement as a primary mechanism to provide funding and support.

Question from Ms. Pivec:

- Is there legislative language that restricts tribal nations from being able to apply for the data infrastructure funding?
- Are states given money through this funding to work with tribal organizations or tribes?

Response from Dr. Dauphin:

- For your first question, I believe there are no restrictions in legislative language.
- The states are not given money through this funding to work with tribal nations.

Question from Dr. Montero:

- How can we help build workforce capacity around data analytics, collection, and dissemination in Indian Country?

Response from Dr. Dauphin:

- The first step is understanding what the needs of the community are. How do we at CDC provide resources, tools, and trainings to address the needs?
- A formal needs assessment is one area in which CDC may be able to become involved. Finding out what the specific needs are and identifying what skills are currently available is going to require engagement. The next step is developing creative ways to deploy resources.
- Training is another way to develop a public health workforce.
- Listening to tribal nations and AI/AN communities is the best start.

Comments from Ms. Pivec:

- The NNPHI grant was how Cherokee Nation was able to hire staff to start cultivating the idea of projects involving data. We have a fairly robust staff.
- Having funding to hire staff and train them to understand our systems and listen to AI/AN community needs is important.

Questions from Dr. Montero:

- How do we facilitate data access to tribal nations?
- How should CDC provide access to TECs and tribal nations?
- How can the process be improved?

Response from Secretary Bradley:

- There are no data systems that track public health qualitive data around population health measures in AI/AN communities.
- Tribal nations have to develop their own software platform to be able to collect and develop data.
- Eastern Band of Cherokee Indians has codified population health measures, but it is hard to find benchmarks in populations similar to ours because most data are state data.
- We have to build a data set from the ground up to be able to develop our own outcome measures.

Comment from Dr. Dauphin:

- This might be the area where the technical assistance group within CSELS might be helpful.

Comments from Legislator Barker:

- We are trying to think of ways to collaborate in a more effective way.
- There cannot be a one size fits all approach. A collective individualized needs assessment for tribal nations would be beneficial, with CDC as a partner to develop the plan. Every tribal nation will have different needs.

Comment from Ms. Pivec:

- Each tribal nation will have different capacity. It is important to note that larger tribes can also provide technical assistance to smaller tribes in their areas as support.

Question from Dr. Stanphill:

- S. 1397—117th Congress (2021–2022): The Tribal Health Data Improvement Act of 2021 recently introduced and reaffirmed tribal public health authority and tribal nations' ability to access public health data.
- The act requires CDC to take certain actions to address, collect, and make available AI/AN data.
- Is that happening through the TECs?
- Is tribal data being made available to tribal nations?

Response from Dr. Dauphin:

- Yes. Right now, the COVID-19 case data is available, and that is happening through the TECs.

Question from Dr. Stanphill:

- Is the data being passed on to tribal nations?

Response from Dr. Dauphin:

- The US Department of Health and Human Services (HHS) Protect Public Data Hub is one example of a program that offers data to TECs.

Question from Ms. Pivec:

- The data goes to TECs as public health authorities, but it cannot go to tribal nations as public health authorities?

Response from Dr. Dauphin:

- The mechanism that CSELS is currently using is through the TECs. I'm not sure if it can go to tribal nations directly.
- CDC does not have ownership of all the data that is collected. Each data system is unique in terms of data ownership and sharing agreements and content. CDC is not the data holder, so we have to work with state departments to share data with TECs for COVID-19 data.

Question from Dr. Stanphill:

- Does CDC make sure that the TECs have access to national datasets with tribal data in it?

Response from Dr. Dauphin:

- Yes, I will follow up and let you know exactly what national datasets are available to TECs. I will create a line list of available datasets.

Comments from Secretary Bradley:

- The information that goes to the TECs does not always go out to the tribal nations and it is not always accurate.
- For instance, the Eastern Band of Cherokee Indians' vaccination rates were not entered into the COVID-19 Vaccine Management System at the state level because we were not recognized as a public health authority. Since the COVID-19 vaccine came from IHS, it went into Eastern Band of Cherokee Indians' own electronic health record, which manually sends the data to the state. We do not have direct access.
- The data transfer to the state is completed by the epidemiologist on staff. The state would not receive that data and it would not feed into the national database if the epidemiologist was not staffed.

Comments from Ms. Pivec:

- This circles back to the leadership discussion in the public health infrastructure session. When TECs are recognized by the state but tribal nations are not, it further cements the idea that tribal nations are not recognized as a public health authority. This permits the idea that TECs are all that is needed, and tribal public health departments are not needed.
- As sovereign nations, tribal nations should be afforded data access as public health authorities.

Question from Dr. Stanphill:

- Is there training on national datasets for tribal nations to take on exchanging data with state and local jurisdictions?

Comments from Ms. Pivec:

- During the height of COVID-19 in Oklahoma, tribal health departments were sharing information with the TECs, but only one TEC would share data with the tribal nations. That's concerning, because TECs need to have that information, and in areas where the tribal nation has the infrastructure, they should be afforded the information as well.

Comments from Secretary Bradley:

- The information that the TECs have is limited, and communities are looking for full transparency, so Eastern Band of Cherokee Indians has developed our own dashboards internally that show positivity rates and deaths, broken out into gender, ages, and by tribal community within our tribal lands.
- Many tribal nations have created data dashboard systems internally.

Comment from Ms. Pivec:

- In Oklahoma, currently, the state is not sharing information with Cherokee Nation in real time.

Question from Dr. Montero:

- Ms. Pivec, before COVID-19, was Oklahoma sharing data with you in real time? Or has that changed now?

Response from Ms. Pivec:

- Yes, there is a tribal liaison at the Oklahoma Department of Health who helps champion the state to work on data sharing with tribal nations. It was working well until COVID-19.
- Tribal public health data is an incredibly important topic. These issues are critical to us. Tribal nations must have that information and have the ability to develop it specifically for their areas.
- Not all tribal nations rely on TECs for information; they would prefer to be able to complete data work themselves. In other areas, some tribal nations rely completely on the TECs. It should not be one or the other, both tribal nations and TECs should have access to data.

Question from Dr. Montero:

- Dr. Branum, is NCHS linking the 2010 census data to mortality data by 2023?

Response from Dr. Branum:

- That is correct. The purpose of the data linkage is to evaluate race/ethnicity data.
- The data linkage will be used as part of the methodical evaluation to compare mortality data against census data for 2010 and see how they are comparing on race/ethnicity. This is something that CDC can do with other linked data, but the mortality data of all deaths that occurred in a given year will provide the best picture of how CDC mortality data is comparing against the census data.

Question from Dr. Montero:

- Will it be an ongoing process showcasing accurate mortality rates in AI/AN communities over time?

Response from Dr. Branum

- These evaluations have been done periodically. This next one will be the start of a larger process to evaluate where CDC currently is. At this point in time, I am not sure if the plan moving forward will be to evaluate data routinely or if this is going to be used as a measure to see where CDC is and where it needs to go to improve data classification.

Comment from Ms. Pivec:

- This is a highly technical issue, and TAC members need experts in data. We would like to bring technical advisors to the TAC meetings to answer and ask these questions on behalf of the area.

Comment from Dr. Stanphill:

- I want to re-emphasize the importance for both TECs and tribal nations to have access to national data.

Comments from Ms. Pivec:

- Many tribal leaders and authorized representatives that are on today are really in the midst of a critical situation with COVID-19.
- There are so many things happening at once, but we appreciate the opportunity to be able to discuss these important issues.

Question from Dr. Montero:

- How should CDC determine what data is critical to look at first? How should the priority for the data be determined?
- The goal is to use data in decision making. Sometimes, communities are not aware of problems because there has not been data available.
- How can CDC help or support assessments?
- There was discussion on a needs assessment. Can you elaborate a little bit more on how we at CDC can help or support you through those assessments and how to pick and choose data that are useful for you at a tribal level to address a public health issue?

Comment from Dr. Dauphin:

- I suggested needs assessments because each tribal nation will have different needs. That is a great place to start.

Comments from Ms. Pivec:

- Tribal nations need data information to prioritize needs.
- Tribal nations can use the information from tribal health assessments to improve tribal health improvement plans.

Comments from Secretary Bradley:

- When talking about tribal health assessments, Eastern Band of Cherokee Indians relies on internal partners because the data that we extract from the state is an inaccurate representation of our community. For the state data, people self-identity as AI/AN. We need health data that are specific to our tribe, which is the only federally recognized tribe in North Carolina. The data we receive are erroneous.
- It is difficult to use state data to develop priorities for health improvement. Eastern Band of Cherokee Indians completes health assessment surveys and collects qualitative and quantitative data locally.

Question from Dr. Montero:

- Thank you for explaining what support you would need from CDC.
- Some tribal nations already have needs assessments—are those comprehensive enough?

Comments from Ms. Pivec:

- Communities want access to accurate county-level information. That can be difficult to provide, so Cherokee Nation is exploring ways to tailor it to a community census track.
- Tribal nations need to be able to produce reports that have local data.

Comments from Dr. Stanphill:

- Data linkages are important. The TECs in the Northwest and Idaho were able to identify more COVID-19 cases due to data linkages.
- We currently do not know what national datasets are available for TECs. A list of available datasets would be useful to compare data.
- Many tribal nations in the Northwest have done assessments and know what data we want to get; it is just hard getting it.

Comments from Ms. Pivec:

- There are complex issues in each area, and needs may look different for each tribal nation.
- Thank you—we appreciate this discussion and will likely be revisiting the topic again at another TAC meeting.

Comment from Dr. Stanphill in the Zoom Chat Box:

- We could use a database of different public health codes already adopted by other jurisdictions as a resource.

4:00 pm—Social Determinants of Health

Facilitator

- **Karen Hacker, MD, MPH,** Director, NCCDPHP, CDC

Opening Remarks

- Dr. Hacker presented on the framework and mission of NCCDPHP.
- She discussed moving toward an upstream approach when working on social determinants of health (SDOH) and looking at them from a population level perspective. Health impact assessments help people understand the health effects of the built environment.
- NCCDPHP has been involved in programs with AI/AN communities, including:

    - TPWIC, which is focused on preserving culture and the relevance of the way an individual tribal nation sees health and wellness
    - Racial and Ethnic Approaches to Community Health, which focuses on built environment, tobacco policies, food availability, and availabilities to clinical care
- NCCDPHP is supporting communities to develop and implement solutions to advance health equity. Those things include identifying and implementing the evidence for community driven practices and measures and building workforce capacity. NCCDPHP has an SDOH notice of funding opportunity (NOFO) that is focused on planning.
- Dr. Hacker explained that NCCDPHP continues work in the Healthy Tribes program. NCCDPHP has expanded NOFOs that previously were not a part of the Healthy Tribes program so AI/AN communities may apply.

Social Determinants of Health: TAC Questions and Discussion

Questions from Ms. Pivec:

- What, as TAC members, do you feel are the most critical SDOH needs?
- In discussions with Dr. Hacker before the TAC meeting, we discussed the fact that SDOH are unique for tribal nations. Historical trauma contributes to today's SDOH.
- When looking at SDOH on an individual tribal level, what is the best way to determine SDOH for a specific tribal nation? That's an ongoing question with a unique answer for each tribal nation. This is an important issue—many of the things that the TAC has been asking CDC for over the years falls under the SDOH realm and receiving resources to address this is important.

Response from Legislator Barker:

- In Chickasaw Nation, we are equipped to build tribal housing and provide elder care, but speaking from a Tribes At-Large perspective, lack of clean water and housing is a large issue. Elders need homes to live in. Some Elders do not have adequate resources to live independently. Housing and water are basic needs.

Comments from Dr. Stanphill:

- GWHIC has been incredibly helpful and a good source of funding for tribal nations. It has been very open and culturally adaptable. Tribal nations have been able to leverage and work within our own culture and communities in ways that are best for us.
- Regarding food, medical care, and water, each tribal nation will address the topics differently. I'm grateful for those opportunities and funding sources which can be used by the tribal nation in a way that works best for the community.
- Adverse childhood experiences (ACEs) and childhood trauma prevention is important. In the Northwest, we have been focusing in on ACEs as an SDOH, which can later lead to chronic diseases.

Comments from Ms. Pivec:

- Being able to have flexible ways to spend funding to address SDOH, such as ACEs, is important. There is a lot of science around trauma-informed care. As a whole, that looks different for tribal nations.
- One of the things that we say at Cherokee Nation is that answers lie with our Elders and culture.

Comments from Dr. Jones:

- Thank you for raising the issue of ACEs. It underscores the opportunity of how we can work collaboratively across CDC. At the NCIPC, we have a specific but small funded program to do comprehensive ACES prevention work, but there is a long history of looking at the specific ACEs in our violence prevention work as well as the effects of living in a household with challenges like substance use and mental health.
- How communities engage with healthcare systems is important because there are trauma-focused cognitive behavioral therapies and trauma-informed care. There are also health systems policies.

- Those are typically to mitigate the risk of people who have already experience ACEs. In some cases, there may be multi-generational opportunities within the health system to try to break the cycle of ACEs. This underscores the importance of the public health lens as we think about bigger contextual factors that contribute to stress and contribute to why child abuse and neglect might occur.
- NCIPC provides technical assistance and funding to tribal nations, as well as for ACEs prevention resources. I would be happy to have further conversations on that.
- This is critical given decades of science showing the connection between the exposure to ACEs and later development of chronic disease and poor health outcomes.

Question from Dr. Hacker:

- What are ways tribal nations are trying to address these social determinants? Are there multisector activities?

Response from Legislator Barker:

- At Chickasaw Nation, we are encompassing a holistic approach to health in our clinics and hospitals.
- It is a public health approach to holistic medicine. Although the patient may be there for a clinical problem, we ask them questions about mental health. Try to make it a holistic exam that is both mental and physical.

Response from Dr. Stanphill:

- The Northwest Portland Area Indian Health Board (NPAIHB) works closely with the state.
- There is a population management team that is similar to a care coordination team. This team will join a patient and ensure that they receive all resources they could potentially need.
- As tribal members, the population management team can provide services such as housing. Homelessness is huge part of SDOH.
- There is an assessment that we do with all patients. The assessment is extensive and not just simply about following up but also about starting to uncover needs such as transportation and education, which impacts the entire family and can lead to chronic disease.
- Tribal nations are good about hearing the whole situation impacting not only the individual, but also the family. These appointments are long to ensure all needs are addressed and there is engagement and relationship building with the patient.
- The population management team is helpful, but it comes down to funding and resources. More funding is necessary.

Comments from Legislator Barker:

- In the Chickasaw Nation, case management in completed in the clinical setting instead of a hospital setting. One conversation may bring up other issues, such as housing or immunization access.
- Funding is the main resource needed. Each patient needs to be treated from a case management perspective.

Comments from Ms. Pivec:

- At Cherokee Nation, we are working on SDOH in close partnership with the cultural and language department for a grass roots approach with community members to discuss how to help and what help is welcome. Some community members do not want help, and that must be respected. That is some of the feedback that we have heard.
- It is important to have boots on the ground and engage with language and culture. Opportunities we are embarking on—we want to make sure that they are helping us and are a forward voice in the community.
- Another thing we are doing is a cross-collaborative experiment across several departments in the Cherokee Nation. We are bringing together all departments to engage collaboratively. How do we address the needs of our citizens and communities in concert with one another?

Question from Dr. Hacker:

- How might a smaller tribal nation try to approach SDOH?

Response from Dr. Stanphill:

- Do you mean different departments creating a multi-disciplinary team instead of completing it all on the clinical side?

Question from Dr. Hacker:

- That would be very helpful to know as well
- If there is a smaller tribal nation who is dependent on county resources or city resources, how is that working?
- How do tribal nations currently address SDOH if they do not have additional resources?

Response from Dr. Stanphill:

- The Cow Creek Band of Umpqua Tribe of Indians would be considered fairly small. For example, we are incorporated into the community, so we do not have our own school system. Cow Creek Band of Umpqua Tribe of Indians is on the hospital's board. We become involved in the community in whatever ways possible.
- We work closely with the state, and we do not have large amounts of infrastructure. Instead, we work with the community around us. Lots of time is built in expanding relationships and collaborations with police, fire, and referrals to make our funding go further.
- We give a lot back to the community, and they are aware of that, so the community is always eager to engage with us.

Question from Ms. Pivec:

- What challenges and opportunities do we face as tribal nations in addressing SDOH?

Response from Secretary Bradley:

- Challenges include working in silos without an integrated data system. It would be helpful to have an integrated package with real-time data to see services and resources that a tribal member is currently receiving and to see if we can wrap them around support systems that improve areas of social determinants.
- The challenge is to unify a system so that communities can receive a full comprehensive array of supportive services to help improve measures of population health that are connected to social determinants.
- The size of the tribal nation can be a challenge but also an opportunity. Tribal nations can work quickly to find resources.
- We need to be able use data to determine if outcomes are improving because of the services we provide. How do know if outcomes are improving and how do we measure outcomes?
- The challenge is integrating data systems to gather information about our communities to develop programs and services to help them.

Comments from Legislator Barker:

- Some of the challenges for the Chickasaw Nation are that our citizens live intermingled with the general population. What impacts the nonnative population may also impact Chickasaw Nation.
- It is important that funding mechanisms allow tribal nations to define the community, which might include nonnative people, along with AI/AN people.

Comment from Ms. Pivec:

- It is important to look at SDOH not just on the individual level. Although SDOH can be incorporated into the medical system and delivery of care systems, it cannot just be solved on the individual level.
- The healthcare delivery is important, but it must be balanced by looking at community as a whole.
- Another challenge is determining what is leading to the SDOH. It will look different for each tribal nation.
- How do we heal historic trauma in our areas? Each tribal nation has its own context to historical trauma.
- There are many opportunities to bring different divisions together to work in concert to address SDOH.

Question from Dr. Hacker:

- Are TAC members involved in policy at the tribal level or at the community level?

Response from Ms. Pivec:

- Yes, we have an in-depth government relations department that helps with developing and analyzing policy. As a public health department, we support and facilitate local policies and municipalities. We help give them the tools to go before the city, county, and school board and work with them to promote policy change.

Comments from Dr. Stanphill:

- NPAIHB leads many efforts in regard to policy and works with tribal nations at the state and federal level, as does NIHB.
- Many tribal nations have staff to complete policy work. Even in the local community, we help set policy at the state level.

Question from Dr. Hacker:

- The last question is focused on funding received by NCCDPHP. If we receive resources focused on SDOH, what should CDC do with it? What would make the difference for tribal nations working within SDOH?

Comments from Dr. Stanphill:

- Nonrestrictive funding that allows for creative solutions and extensions of what is already being completed by the tribal nation would be helpful.
- For example, in the state of Oregon, we received an impact grant that had few parameters and allowed for creative thinking. Tribal nations provided innovative solutions for responding to mental health crises. Instead of having law enforcement respond to situations, mental health workers responded. Both small and large tribes were able to participate. The program is being piloted, and the state is learning from us.
- Tribal nations know what is going to work and what resources are needed.

Comment from Legislator Barker:

- CDC needs to ask the tribal nation what will work best for their community. Let tribal nations come up with their own plan and tell CDC what they need.

Question from Dr. Montero:

- Dr. Stanphill, do you mind sharing that experience with CDC?

Comment from Dr. Stanphill:

- I will share that information.

Comment from Dr. Montero:

- Thank you. It will be interesting to analyze that information and use it as an example here.

Comments from Ms. Pivec:

- Cherokee Nation received funding from the Robert Wood Johnson Foundation that had few parameters.
- Using the funding, Cherokee Nation was able to engage with its community, which developed a sense of community and belonging.
- There has been limited funding to sponsor cultural activities. GHWIC is a great model.

Comments from Secretary Bradley:

- Funding for basic needs is important as there are very few funding opportunities that will fund basic needs.
- Housing is a part of SDOH.
- Tribal nations can complete needs assessments and gap analyses but that does not fix the issue until there is the ability to put services and boots on the ground.
- Health navigators could help communities understand systems and resources in place.
- Let tribal nations determine what to use the funding for and define the scope of work.

Comment from Dr. Hacker:

- Currently, the funding is for planning and not implementation. It sounds like it might be worthwhile to continue with planning resources even if you receive implementation resources.

Comments from Secretary Bradley:

- Yes, planning is essential in the initial phase. That would be very useful.
- As the phases progress, we have to get to a point where we can put boots on the ground and get funding for implementation.

Comments from Ms. Pivec:

- When piloting new programs, there may be a bit of natural chaos to the process, which is normal for most communities to experience.
- Investment in building supplies to build community resources that address social determinants of health is important.

Questions from Dr. Montero:

- How do tribal nations leverage their funding across sectors?
- How are tribal nations connecting across their social programs and using that in an integrated social determinants of health approach?

Comment from Secretary Bradley:

- Eastern Band of Cherokee Indians uses an integrated model. For example, public health and human services is integrated. When creating treatment plans, full continuum of care is addressed.

Comment from Ms. Pivec:

- From a public health perspective, Cherokee Nation is doing this work on an individual level and community level. We work with other departments to fill those needs.

Question from Dr. Skillen:

- I am here from the policy office. Are there specific tools or messages that would be helpful in terms of crafting or supporting tribal engagement in local policy? The policy office creates guides and provides translation tools.

Response from Ms. Pivec:

- That would be helpful for engaging on government relations and with our internal partners.

Comments from Secretary Bradley:

- We try to address those social determinants through the lifespan or through the continuum when someone's on the path to recovery by creating temporary homes.
- Eastern Band of Cherokee Indians has innovative programs. For example, there is the Mother Town Project where we provide temporary employment with stipends, and people can build life skills training with continued support to connect to permanent jobs and housing in the community. That is an example of how we tie multiple services together.

Comment from Ms. Pivec:

- I have been to Eastern band of Cherokee Indians, and they have a great system that seamlessly provides public health and clinical delivery. They work in concert caring for their people in a way that is consistent and a good model for SDOH approach.

Comment from Dr. Montero:

- Thank you for reminding us of those successes.

Comments from Dr. Hacker:

- Tribal nations have been completing work in SDOH for a long time, and there is much we can learn from one another.
- From what I have heard today, if NCCDPHP receives additional funding, then the goal is to help build on what is already being completed rather than starting something completely separate.
- Thank you for a rich discussion.

5:00 pm—Missing and Murdered Indigenous Persons

Presenters

- **Marcia Good,** Executive Director, Office of Tribal Justice, Department of Justice
- **Michelle Suave, MPP,** Acting Commissioner, Administration for Native Americans, Acting Deputy Assistant Secretary for Native American Affairs, Administration for Children and Families, HHS, *St. Regis Mohawk Tribe*
- **James Mercy, PhD,** Director, Division of Violence Prevention, NCIPC, CDC
- **Delight Satter, MPH,** Senior Advisor, Tribal Research, OTASA, CSTLTS, CDC
- **Laura Kollar, PhD, MA,** Behavioral Scientist, Division of Violence Prevention, NCIPC, CDC

Opening Remarks

- Ms. Good provided an overview and background of the Presidential Task Force on Missing and Murdered AI/AN people, known as Operation Lady Justice (OLJ), as well as a breakdown of the task force membership and tasks assigned under the Executive Order 13898.
- More than 95% of AI/AN people who go missing return home and do not become long-term missing persons. OLJ is focused on finding the underlying cause of the issue rather than what is portrayed by the field and media. This involves focused listening to tribal nations through consultation and panels.
- Dr. Mercy provided a high-level look at data on homicides among tribal populations in the United States.
- Ms. Satter gave an overview of work completed to address the issue of missing and murdered indigenous persons, including listening sessions and panels such as the "Changing Directions: Protecting Communities and Prevention Violence" panel discussion.
- Dr. Mercy covered the public health approach for violence prevention and the National Diabetes Prevention Program's vision for making progress, which is focused on SDOH and primary prevention methods. He noted that through all of this work, an underlying theme is the need for close partnerships.
- CDC worked in collaboration with NIHB to create an ACEs resource basket and collaborated with the Association of American Indian Physicians to create an ACEs toolkit.
- Dr. Mercy concluded by stating a public health approach based on science and grounded in close partnership and traditional native wisdom offers a promising way forward.

5:30 pm—Opioid Overdose Prevention

Presenter

- **Chris Jones, PharmD, MPH, DRPH,** Deputy Director, NCIPC, CDC

Opening Remarks

- Dr. Jones provided an update on CDC's opioid overdose prevention work and noted that AI/AN populations have been heavily impacted by overdose-related deaths.
- Overdose Data to Action (OD2A) funds 47 states and a number of large cities and local health departments to advance overdose prevention and to scale up prevention activities that reduce overdose and related harms. Program recipients are required to direct a minimum of 20% of their prevention funding to local communities. Currently, six states have made connections with local tribal nations and tribal organizations as a part of the OD2A program.
- Dr. Jones also discussed the Overdose Detection Mapping Application Program, which provides near real-time suspected overdose surveillance data across jurisdictions to support on-the-ground efforts to mobilize an immediate response to a sudden increase or spike in overdose events.

Opioid Overdose Prevention: TAC Questions and Discussion

Comments from Dr. Stanphill:

- In the Portland area, we are experiencing high rates of fentanyl overdoses and shortages of naloxone, also known as Narcan.
- With the fentanyl overdoses and the lack of supply of naloxone, we are wondering what CDC can do to support us and help us locally in the Northwest.

Response from Dr. Jones:

- Fentanyl is moving westward, and we are seeing some of the largest increases in the states in the western part of the United States.
- CDC recommends people carry an adequate supply of naloxone, but the data is somewhat mixed if multiple doses are needed. The United States Food and Drug Administration (FDA) did recently approve a higher dose naloxone product that will be on the market.
- It is important to understand what the local trends are and the naloxone supply that is needed. There are cases where someone receives a large dose of fentanyl or a more potent fentanyl drug where multiple doses of naloxone might be needed.
- CDC is supporting fentanyl overdose prevention efforts by providing awareness that fentanyl is now in communities in the western part of the United States, and public health entities should prepare for that.
- CDC has had conversations with other community organizations, such as syringe service programs, and has heard they were not able to get their supply of naloxone or were close to running out.
- CDC heard from the naloxone manufacturer that the naloxone shortage should have been addressed in July so supply shortages should end soon.
- Another option is to look at other manufacturers and different formulations of naloxone. Some are not as convenient to use but are available. I will see if I can get more information about the supply shortages and share it through Dr. Montero.

Comment from Dr. Stanphill:

- I was just given this information, so I am not sure if this has been resolved in the Northwest yet. Please provide the information to the NPAIHB board, who will distribute the information to the tribal nations.

Comments from Ms. Pivec:

- The last two presentations have highlighted the need to focus on SDOH and to look at tribal solutions and cultural solutions within tribal nations to address issues.
- With this critical time of COVID-19, this is going to be a continued problem.

Comments from Dr. Stanphill:

- Tribal nations need to be able to support issues from different types of approaches.
- Most tribal nations would like to have flexibility for different approaches described within the funding agreement.
- The Special Diabetes Program for Indians has done amazing work because it is a flexible funding opportunity, and I hope that can also be applied to behavioral health funding sources.

Comment from Ms. Pivec:

- Thank you Dr. Stanphill, I agree with your statement that tribal nations need to be able to try different things at the individual tribal level to see what works for our communities.

6:00 pm—Summary, Closing Prayer, and Adjournment

Presenters

- **Lisa Pivec**, Senior Director of Public Health, *Cherokee Nation*, TAC
- **Dr. Montero, MD, MHCDS,** Director, CSTLTS, CDC

Closing Remarks

- Legislator Barker thanked Ms. Pivec for leading the TAC meeting.
- Dr. Montero provided summary highlights of the meeting and thanked everyone for attending and participating throughout the meeting.
- Ms. Pivec expressed thanks to the TAC, CDC, presenters, and partners for participating and providing input during the meeting and reminded everyone about the second day of the 22nd Biannual TAC, Tribal Caucus and Tribal Consultation.
- Legislator Barked closed the meeting with a prayer.

Day 2

Thursday, August 5, 2021

12:00 pm—Opening Blessing, Welcome, and Introductions

Facilitators

- **Bryan Warner**, Deputy Principal Chief, *Cherokee Nation*, Co-Chair, TAC
- **José Montero, MD, MHCDS,** Director, CSTLTS, CDC
- **CAPT Karen Hearod, MSW, LCSW,** USPHS; Director, OTASA, CSTLTS, CDC

Opening Remarks

- Deputy Principal Chief Bryan Warner welcomed everyone to the meeting and provided an opening blessing.
- Captain Hearod welcomed everyone to the last day of the TAC meeting and briefly discussed the agenda for the day.
- Commander Meyer conducted the roll call. A quorum was present to conduct necessary business.
- Deputy Principal Chief Warner discussed TAC roles and responsibilities as well as the FACA exemption.
- Deputy Principal Chief Warner provided a TAC membership update and introduced the new TAC members.

12:15 pm—CDC Director/ATSDR Administrator Updates

Presenter

- **Rochelle Walensky, MD, MPH,** Director, CDC; Administrator, ATSDR

Opening Remarks

- CDC Director Dr. Walensky provided brief CDC updates as well as an update on the COVID-19 pandemic and acknowledged the leadership of tribal nations in the COVID-19 response. Dr. Walensky thanked tribal leaders for providing support to the United States and public health system.
- CDC is committed to standing in partnership with tribal nations against COVID-19 by expanding funding, providing remote technical assistance at the request of tribes, sending in CDC experts and staff on field deployments, and providing support for vaccine implementation.
- The CDC Emergency Operation Center's Tribal Support Section has provided technical assistance to 29 tribal nations and five tribal service units, with 58 cumulative CDC staff deployments through the response thus far.
- CDC also supports public health capacity in Indian Country by assigning 14 Public Health Associate Program (PHAP) associates to tribal host sites or to assignments that were tribally focused.

CDC Director/ATSDR Administrator Updates: TAC Questions and Discussion

Question from Deputy Principal Chief Warner:

- Currently, Cherokee Nation is at a 76% vaccination rate. Cherokee Nation used an initiative which was effective, but now there are increasing numbers of hospitalizations.
- What kind of efforts are there currently from a public relations standpoint on breakthrough case information? There is a lot misinformation on the internet. Are there concerns about the breakthrough infections? How can tribal nations help to reduce breakthrough infections?

Response from Dr. Walensky:

- Congratulations on that vaccination rate; that is much higher than in the United States. I want to applaud your efforts. I know you are working towards the final vaccinations and have made extraordinary strides.
- As we have the conversations, we need to understand that every shot is a win. We need to understand and acknowledge that not everyone will have the same questions.
- If your community members are looking for information on specific topics or are looking for resources, CDC can provide those.
- There was a Morbidity and Mortality Weekly Report about the experience in Massachusetts. There were initially over 300 cases of COVID-19, and now over 900 cases of COVID-19, in July in a community that was densely packed with over 240,000 visitors that month.
- This could have been a devastating event, but instead led to only 900 cases of mild COVID-19 and only 9 hospitalizations. When you think about this community, which was over 75% vaccinated, that is a win for what COVID-19 vaccination can do.
- We need to convey the information about breakthrough infections in context of what was averted and not necessarily the number of mild infections that occurred.

Comments from Councilmember Sanchez:

- In terms of the vaccination rate, we have a high number of people who came for the first vaccine but did not come back for their second shot. Are those numbers including those people or only those who are fully vaccinated?
- They are included in the vaccination rate, but it is not a true number because they did not come for the second shot.

Response from Dr. Walensky:

- Thank you for that question; that is vitally important right now with the Delta variant. We know now and have seen data from other countries that have demonstrated that the vaccines do not work as well with just one dose with the Delta variant.
- I would urge those in your community who have only gotten one vaccination to come back for a second shot and to presume they are not protected until they do.

Question from Legislator Barker:

- Do you have a timeframe for when the FDA will approve the vaccine? Will that make a difference to some of the people who are afraid of the vaccine?

Response from Dr. Walensky:

- Hopefully, that will make a difference. The timeline for FDA approval is projected for early September.
- We need to understand that sometimes vaccines take a year to approve.
- As CDC looks at the survey data, many people have said once it's approved, they will be willing to get vaccinated.
- We are watching the safety data closely.

Question from Dr. Stanphill:

- Can you speak to the vaccination going forward with our children?

Response from Dr. Walensky:

- The FDA is anticipating mid-fall to the end of the year for approval for vaccinations for children.
- The best way to protect children is to reduce exposure to the virus. I am encouraging all parents, teachers, and anyone who is around children to be vaccinated.

- In areas seeing high rates of hospitalization in children, the children have not been masked, and they engaged in activities in communities where there is a lot of disease.
- This is unlike what we saw last summer and last winter when there were mitigation strategies.

Comment from Deputy Principal Chief Warner:

- I will yield my time to Ms. Pivec.

Comment from Ms. Pivec:

- Thank you for your time. COVID-19 has highlighted public health infrastructure issues across the nation. We see the importance of it, especially in tribal nations. We are behind in funding for public health. We are requesting that CDC prioritize tribal nations to develop public health departments and infrastructure. Tribal nations are a great partner for everyone.

Response from Dr. Walensky:

- Thank you, Ms. Pivec. I have emphasized the importance of disease diagnostic public health infrastructure, public health workforce, data modernization, laboratory capacity, and health equity to Congress. I agree with you, it is important to build public health infrastructure.

Comment from Ms. Pivec:

- It is important to develop infrastructure at the sovereign tribal level and not let that impact funding for TECs. Public health infrastructure should be provided to both TECs and tribal nations directly.

Comment from Secretary Bradley:

- At Eastern Band of Cherokee Indians, we have had a PHAP for about six years in a row, and they are tremendous help in building public health capacity and increasing the competencies of other staff members. I would encourage CDC to increase the PHAP program specifically for tribal communities. I think that would move public health capacity forward in AI/AN communities.

Comment from Dr. Walensky:

- I would like to encourage other tribal nations to engage with PHAP.

Comment from Secretary Bradley:

- Yes, PHAP has been extremely helpful, and our epidemiologist now is a prior PHAP that worked for our tribe.
- I also want to echo Ms. Pivec's comments about public health infrastructure and building capacity in tribal communities and the importance of recognizing tribal public health authority as sovereign nations.
- We encourage support through cooperative agreements to help build capacity.

Comment from Dr. Montero:

- PHAP has many positions throughout tribal lands but has not been successful at recruiting AI/AN people into the program.
- Please help us to recruit AI/AN people into PHAP to build the workforce of the future.

Comment from Secretary Bradley:

- That might be a great partnership and initiative.
- We would love to have further conversations on this topic.

Comment from Deputy Principal Chief Warner:

- Thank you, Dr. Walensky, and everyone for the comments.

12:45 pm—Technical Assistance Guidelines and Recommendations

Presenter

- **Bryan Warner**, Deputy Principal Chief, *Cherokee Nation*, Co-Chair, TAC
- **Georgia Moore, MS,** Associate Director for Policy, CSTLTS, CDC

TAC Subcommittee Updates

- Deputy Principal Chief Warner provided an update on the work that has been completed in the TAC Subcommittee regarding the Technical Assistance Guidance and Guidelines. He opened the floor for other TAC members to share their thoughts and opinions on the TAC Technical Assistance Guidance and Guidelines.
- Deputy Principal Chief Warner discussed the CDC Centers, Institute, and Offices (CIO) Resource Guide that will be given to new TAC members to provide detailed information about CDC.
- Deputy Principal Chief Warner encouraged TAC members to join the TAC Subcommittee and noted that this will be a continuing project to build the Technical Assistance Guidelines and Recommendations.

TAC Charter

- Deputy Principal Chief Warner provided updates on the TAC Charter.
- During the August 5, 2021, Tribal Caucus, the TAC clarified wording around letters of support for membership selection, revising the language to reflect open conversation and maintain consistency with other federal TAC charters as well as clarifying the content of quarterly reports to include results of tribal consultations.
- During Tribal Caucus, the TAC determined that it is important that the full TAC has time to review and comment on these items. Deputy Principal Chief Warner will send out these changes for review to the full TAC with a deadline for comments by close of business on August 20, 2021.

TAC Charter: TAC Questions and Discussion

Comments from Dr. Stanphill:

- I want to clarify and explain what we mean by communication at the meetings in the comments on the TAC Charter.
- The TAC is asking for a comfortable relationship. TAC delegates would like to call upon their authorized representative or technical advisor for clarification with less formality to not disrupt the meeting.
- The TAC understands the rules of the FACA exemption but would like a more comfortable environment by which we all can participate, and technical advisors can add comments quickly.

Response from Dr. Montero:

- There are limitations within the rules of the FACA exemption that cannot be altered, but I believe what you are asking for is a more efficient way of providing comments from technical teams.
- We can figure out ways of doing this efficiently without losing the essence of the meeting.

Question from Deputy Principal Chief Warner:

- Dr. Montero, what is the next step after the TAC presents the Charter to CDC?

Response from Dr. Montero:

- CDC will perform an internal review and determine if the new suggestions will need to be reviewed by the legal team to ensure that the TAC will not lose FACA exemption.
- Afterwards, the TAC will vote on the Charter and it will move forward for tribal consultation.

Comment from Captain Hearod:

- I would like to remind the TAC of the guidelines that we are under for the Tribal Consultation and how that might impact the time frame. CDC will need about a 60-day lead time for tribal consultation.

1:30 pm—TAC Business

Facilitators

- **Bryan Warner**, Deputy Principal Chief, *Cherokee Nation*, Co-Chair, TAC
- **José Montero, MD, MHCDS,** Director, CSTLTS, CDC
- **CAPT Karen Hearod, MSW, LCSW,** USPHS; Director, OTASA, CSTLTS, CDC

TAC Subcommittee Membership

- Deputy Principal Chief Warner asked the TAC if it would like to continue the TAC Subcommittee to discuss Technical Assistance Guidelines and Recommendations and other intensive work needing to be completed for the TAC.
- Deputy Principal Chief Warner also asked if any other TAC members would like to join the TAC Subcommittee.
- The TAC decided to keep the Subcommittee standing and open for additional TAC members to join.

TAC Chair/Co-Chair Vote

- Dr. Montero thanked Representative TwoBears for his time and dedication as the TAC Chair and provided information on the TAC Chair and Co-Chair position and terms.
- Deputy Principal Chief Warner opened the floor to TAC members for nominations for a new TAC Chair.
- Councilmember Sanchez nominated Deputy Principal Chief Warner for TAC Chair. Ms. Trinidad Krystal seconded the motion. Deputy Principal Chief Warner accepted this nomination and TAC members unanimously approved this motion.
- Deputy Principal Chief Warner opened the floor for Co-Chair nominations. Secretary Bradley nominated Legislator Connie Barker. Legislator Barker accepted the nomination. Councilmember Sanchez seconded the nomination. TAC members unanimously approved this motion.

23rd Biannual TAC Meeting Date

- Deputy Principal Chief Warner asked if the dates of Wednesday, February 2, and Thursday, February 3, 2022, worked for the TAC for the 23rd Biannual TAC Meeting. He noted that although the meeting is planned to be conducted virtually, it could be changed to an in-person meeting.
- A consensus was reached to have February 9–10, 2021, as the preferred dates, with February 2–3, 2021, as the alternative dates.
- Captain Hearod noted that if the meeting is in person, it will be in Atlanta.

2:00 pm—Tribal Testimony

Testimony from Dr. Stanphill:

- Notice of tribal consultation should be not only through the Federal Register, but also through a Dear Tribal Leader Letter that is widely distributed among tribal nations.
- The Tribal Consultation Policy requires CDC to use all appropriate methods in order to give official notice of consultations, including mailings, broadcast emails, and the Federal Register.
- Portland Area recommends that official CDC consultations follow the proper timeline to ensure tribal leaders are aware of the consultation and have enough time to plan and prepare for consultations.

Testimony from Deputy Principal Chief Warner:

- It is valuable to have built relationships within CDC and the TAC to keep open dialogue and create meaningful, robust consultation.
- From the Cherokee Nation perspective, now more than ever, we are seeing disparities and gaps in public health.
- Public health infrastructure is not only providing boots on the ground but is also funding and infrastructure to move and enact policies that best represent our area and region.
- We need to continue to keep public health infrastructure dialogue moving forward to identify gaps in public health as well as identify health disparities.

- Public health is valuable in the continuation of our culture, history, language, and the overall preservation of our heritage moving forward. Both tribal nations and CDC need to think about the next seven generations of health.
- Today is the day to provide public health infrastructure to tribal nations through direct funding and other types of funding that best fits the needs of the communities.
- I look forward to working with CDC to tailor public health to fit the needs of each individual tribal nation and Indian Country as a whole.

3:00 pm—Summary, Closing Prayer, and Adjournment

Presenters

- **Bryan Warner**, Deputy Principal Chief, *Cherokee Nation*, Co-Chair, TAC
- **Dr. Montero, MD, MHCDS,** Director, CSTLTS, CDC

Closing Comments

- Deputy Principal Chief Warner reminded the TAC that written tribal testimony is due by 5:00 pm September 7, 2021.
- Dr. Montero provided summary highlights of the meeting and thanked everyone for attending and participating throughout the meeting. Dr. Montero also mentioned that the next TAC planning meeting will be virtual due to the COVID-19 pandemic.
- Deputy Principal Chief Warner thanked everyone for their participation and discussion during the meeting as well as Legislator Barker for stepping into the role of TAC Co-Chair.
- Captain Hearod expressed her thanks to the TAC.
- Deputy Principal Chief Warner closed the meeting with a prayer.

Appendices

Appendix A: Tribal Testimony

Testimony from Dr. Stanphill, Cow Creek Band of Umpqua Tribe of Indians

Dear Dr. Montero:

As the Portland Area CDC/ATSDR Tribal Advisory Committee (TAC) representative and a delegate of the NPAIHB, I submit this formal written testimony to be included in the 22nd Biannual Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry (CDC/ATSDR) TAC Meeting.

On August 4 and 5, 2021, the TAC convened for the 22nd Biannual CDC/ATSDR Meeting to discuss a plethora of topics and priorities that directly impact Tribal Nations and American Indian/Alaska Native (AI/AN) people. We had robust discussions on tribal public health infrastructure, tribal public health data, social determinants of health, Missing and Murdered Indigenous Persons, and opioid overdose prevention. On behalf of our Northwest Tribal Leaders, we extend our gratitude to you, Captain Hearod, CDC OTASA staff and others who supported this meeting.

RECOMMENDATIONS
Our Area makes the following requests of the CDC:

1. Tribal Public Health Capacity and Infrastructure

Tribes have historically been and currently are often unrecognized as public health entities in landmark documents steering the growth and direction of the US governmental public health system.[1] Although Tribes have worked hard to build capacity, many tribal systems are young, underfunded, and gaps remain in their public health infrastructure.

The COVID-19 pandemic has underscored the need for strong public health infrastructure in Indian Country. According to the latest data from the CDC, AI/AN people are 1.7 times (70%) more likely to be diagnosed with COVID-19, 3.4 times (340%) more likely to require hospitalization, and 2.4 times (240%) more likely to die from COVID-19-related infection when compared to non-Hispanic white people.[2] The last 18 months have highlighted Tribes' abilities to lead successful public health response efforts to protect their people from COVID-19, such as the imposition of widespread health and safety restrictions, implementation of alternate care sites, and the launch of successful vaccination campaigns. However, despite these public health response efforts, tribes are still underfunded and lack full capacity to adequately respond to public health emergencies.

In order to support tribal public health infrastructure and capacity, we request the following:

- ***$1 billion for a CDC Tribal Public Health Emergency Fund established through the Secretary of the Department of Health and Human Services (HHS) that Tribes can access directly for tribally-declared public health emergencies.***
- ***Continue to fund and expand both base and supplement funding for another round of the 1803 Tribal Public Health Capacity Building and QI Cooperative Agreement.*** The 1803 program should have two tracks, one specifically for tribes to allow them to develop their own public health capacity, including

[1] https://www.cdc.gov/pcd/issues/2017/17_0017.htm
[2] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html

tribal health departments; and another track for the TECs/Tribal Organizations to support tribal public health infrastructure. CDC should provide both tracks with on-going training on successful applications to apply for the cooperative agreement.

- ***Public health infrastructure grants should work together with Good Health and Wellness in Indian Country (GHWIC) and Tribal Epidemiology Centers' (TEC) PHI (Public Health Infrastructure) to streamline community reach across CDC agencies to successfully address the needs of longstanding weaknesses that have resulted from inadequate funding.*** The infrastructure grants should provide sustained support in the areas of chronic disease prevention, emergency response, community health assessment, and program evaluation. In addition, CDC should fund systems and workforce development initiatives that build capacity around the collection, analysis, and governance of data by tribal communities.

2. Tribal Public Health Data

Sturdy data systems are key elements of strong Tribal public health systems. This includes both during times of emergency, such as this ongoing pandemic, and routine operations of essential public health services. For example, according to the Public Health in Indian Country Capacity Scan, syndromic surveillance occurs in only 24% of Tribal health organization service areas. Conversely, according to the 2019 ASTHO profile, 88% of states (44/50) report performing syndromic surveillance activities. THOs also reported a lack of epidemiologists and statisticians and cited a need for technical assistance and training related to epidemiology, data analysis, and public health informatics.

Many tribes in the Portland Area do not have data analysts, data infrastructure, and data storage capacity. Because of these limitations, and as a result of advocacy of tribal leaders, Tribal Epidemiology Centers (TECs) were created in 1996 for the purposes of research and for preventing and controlling disease, injury, or disability.[3] TECs fill this crucial public health gap by providing data support for the tribes and urban programs.

Under Section 214 of the Indian Health Care Improvement Act (25 U.S.C. § 1621m et. seq.), the Northwest Tribal Epidemiology Center (NWTEC) is defined as a public health authority and authorized to access federal and state data to conduct health-related research and surveillance.
We make the following requests as to tribal public health data access:

- ***NWTEC should be able to access all national data sets. Specifically, NWTEC has been unable to access the National Death Index (and National Death Index linked to National Hospital Care Survey); National EMS Information System; and the Medicare/Medicaid claim data from CMS.*** The National Death Index has been a lengthy process to access this dataset and pretty substantive cost on the TEC.
- ***Provide training on use of national data sets at the tribal level for the exchange of tribal information to allow effective work with state and local health jurisdiction partners.***

3. Social Determinants of Health (SDOH)

The most advanced research on social and economic factors related to health by the Robert Wood Johnson Foundation (RWJ, 2018, 2019, 2020) clearly demonstrates the large, negative impact poverty, poor housing (and water and sanitation), food insecurity, and education have on the health of AI/ANs. An NIHB analysis of the prevalence of negative outcomes in counties with large AI/AN populations affirms the findings of the RWJF research. When combined with workforce shortages, these socio-economic factors result in shortened life spans for AI/ANs compared with the all-races US population morbidity rates.

[3] 25 U.SC. §1621m (e) (1), 25 U.S.C. §1621m (e) (3)

Additional SDOHs such as adverse childhood experiences (ACES), race-based stress and historical trauma for AI/ANs also contribute to health disparities.

One of the vital programs in Indian Country that helps address SDOH, and here in the Northwest, is the Good Health and Wellness in Indian Country (GWHIC) program. This initiative is important in cultural and traditional ways of sustenance in order to reduce and prevent chronic disease.

- We recommend that the GWHIC initiative is funded at $32 million in FY 2023.
- ***SDOH unique to AI/ANs must be acknowledged and better understood.*** CDC should work with Tribes to better understand SDOH in Indian Country and incorporate the Tribal perspective and needs in any efforts to address SDOH.
- ***Any efforts to invest in SDOH must also engage Tribes and Tribal public health experts.***

4. Missing and Murdered Indigenous Persons (MMIP)

The MMIP Crisis has long impacted Tribal communities. Grassroots activists have worked to raise national attention and work to respond to and prevent these tragedies. Related and connected to MMIP Nationally and in the Northwest, AI/AN people have the highest death rates from police violence compared to other race/ethnicity groups – we believe there is connection between these rates and how we access and use data from national datasets like those held by the CDC. On July 27, 2021, Operation Lady Justice hosted a discussion session on federal public health and safety data about MMIP.

- We request that there is Tribal representation on the Operation Lady Justice taskforce.

Additionally, we have the following questions:
- What is CDC doing to develop data collection for MMIP?
- How is the National Center for Health Statistics involved?

5. Opioid Overdose Prevention

There is a dire need to fund behavioral health programs for AI/ANs. Even before the COVID-19 pandemic, AI/AN communities experienced some of the largest disparities in mental and behavioral health outcomes. The COVID-19 pandemic has made this worse, especially for Native youth. A 2018 survey found that AI/AN youth in 8th, 10th, and 12th grades were more likely than non-Native youth to have used alcohol or illicit drugs in the past 30-days. Also, according to the CDC, suicide rates for AI/ANs across 18 states were reported to be 3.5 times higher than demographic groups with the lowest rates. These statistics reflect both the intergenerational trauma that many of our community's face and our need for additional support to address this trauma.

In the Northwest, our tribes are experiencing high rates of fentanyl overdoses. We are also experiencing a shortage of Narcan.
- ***We need community advocacy materials specific for our tribal communities and tribal providers to address the high rates of fentanyl use.***
- ***We request that CDC follows up with NPAIHB on the resolution around Narcan shortage in the Northwest.***

6. Tribal Set-Asides and Direct Funding to Tribes

Like State and territorial governments, Tribes have both the rights and responsibilities to provide vital public health services for their communities. To do this, they must also have the funding and the tools to carry out these functions.

- ***We request tribal set-asides for AI/AN programs and services.***
- ***CDC must ensure direct funding to tribal governments for AI/AN communities.*** Tribes should not have to access funds through state block grants. For example, CDC HIV and Hepatitis C funds for prevention and education generally flows to states via block grants. This leaves many tribes with limited or no resources and forces tribes to complete with states for funding.
- ***We request that CDC enter into intergovernmental agreements with tribes directly or allocate funding through ISDEAA compacts and contracts.*** We just saw the latter done with COVID-19 funding so it can and must be done moving forward.

7. CIO Technical Assistance Guidelines

The Consolidated Appropriations Act of 2021 (CAA21) directed each CDC Center, Institute, and Office (CIO) within the CDC to create written guidelines to integrate Tribal public health priorities and needs across the entire agency. These written guidelines are to be developed in consultation with the CDC TAC and will establish best practices around the delivery of Tribal technical assistance, as well as the consideration of cultural and traditional Tribal public health practices. Because the CDC is required to work with the TAC to develop these guidelines, the Tribes will have a valuable opportunity to create a new, more inclusive path forward for working with CDC.

- ***We reiterate the requirement to ensure TAC inclusion, as well as tribal consultation, in developing guidelines or in integrating Tribal public health priorities across the agencies.*** For example, at the April 14th Subcommittee meeting we heard a presentation from the National Center for Environmental Health. They highlighted the Environmental Tribal Public Health Think Tank, which is funded by CDC via the American Public Health Association (APHA) to identify areas of interest and provide feedback on CDC environmental health initiatives impacting Tribes. The TAC expressed concerns that this body does not represent all Tribes and should not replace engagement with the TAC or formal consultation.
- ***When CDC creates the guidelines with the TAC, tribal consultation must still be conducted.*** Consultation with the CDC TAC does not supplant Tribal consultation. It is important that the agency seek input from all Tribal leaders, across Indian Country, on issues impacting Indian country. We hope the recent Tribal consultation addresses some of these challenges and that CDC leadership is accountable to the requests of Tribal Leaders shared in addition to any further testimony provided via e-mail communication in the coming weeks.

8. Tribal Consultation Policy

Recently, CDC announced formal tribal consultation on the Tribal Consultation Policy through the Federal Register. The current tribal consultation policy requires the agency to use all appropriate methods to provide official notification, including mailing, broadcast email, Federal Register, and other outlets. ***We recommend that CDC uses a Dear Tribal Leader Letter (DTLL) for any tribal consultation official notification and widely broadcasts the DTLL to the TAC listserv and any other tribal listserv CDC maintains.*** All copies of DTLL should be posted on the CDC tribal webpage, any CDC associated social media streams and Tribal partner agency coordination including the Indian Health Service, HHS divisions, National and regional Tribal organizations.

Conclusion

We kindly request formal response from the CDC on the requests identified above. We look forward to further collaboration with the CDC through the TAC in furtherance of our government-to-government relationship. We will be providing written testimony for the recent tribal consultation on the CDC/ATSDR Tribal Consultation Policy.

Sincerely,
Sharon Stanphill, DrPH
Chief Health Officer
Cow Creek Band of Umpqua Tribe of Indians
Portland Area Representative, CDC TAC
Northwest Portland Area Indian Health Board, Delegate

Appendix B: Acronym List

ACEs	Adverse Childhood Experiences
AI/AN	American Indian/Alaska Native
ASTHO	Association of State and Territorial Health Officials
ATSDR	Agency for Toxic Substances and Disease Registry
CDC	Centers for Disease Control and Prevention
CIOs	Centers, Institute, and Offices
COVID-19	2019 Novel Coronavirus Disease
CSELS	Center for Surveillance, Epidemiology, and Laboratory Services
CSTLTS	Center for State, Tribal, Local, and Territorial Support
DPH	Division of Population Health
eCR	Electronic Case Reporting
FACA	Federal Advisory Committee Act
FDA	Food and Drug Administration
FTE	Full Time Employee
GHWIC	Good Health and Wellness in Indian Country
HHS	United States Department of Health and Human Services
IHS	Indian Health Service
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCEH	National Center for Environmental Health
NCHS	National Center for Health Statistics
NCIPC	National Center for Injury Prevention and Control
NIHB	National Indian Health Board
NNPHI	National Network of Public Health Institutes
NOFO	Notice of Funding Opportunity
NPAIHB	Northwest Portland Area Indian Health Board
OD	Office of the Director
OD2A	Overdose Data to Action
OLJ	Operation Lady Justice
OTASA	Office of Tribal Affairs and Strategic Alliances
PHAP	Public Health Associate Program
SDOH	Social Determinants of Health
TAC	Tribal Advisory Committee
TEC	Tribal Epidemiology Center
TECPHI	Tribal Epidemiology Centers for Public Health Infrastructure
TPWIC	Tribal Practices for Wellness in Indian Country
USPHS	United States Public Health Service

Appendix C: TAC Roster

Area Office	Delegate	Authorized Representative
Alaska Area **Term Expires:** June 30, 2023	**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	**VACANT**	**VACANT**
Billings Area	**VACANT**	**VACANT**
California Area **Term Expires:** November 30, 2022	**Teresa Sanchez** Tribal Council Member *Morongo Band of Mission Indians*	**VACANT**
Great Plains Area **Term Expires:** November 30, 2022	**Monica Mayer** Councilwoman, North Segment Representative *Mandan, Hidatsa, and Arikara Nation*	**VACANT**
Nashville Area	**VACANT**	**VACANT**
Navajo Area **Term Expires:** August 31, 2021	**Myron Lizer** Vice President *The Navajo Nation*	**Jill Jim, PhD, MHA/MPH** Executive Director, Department of Health *The Navajo Nation*
Oklahoma Area **Term Expires:** October 31, 2021	**Bryan Warner (TAC Chair)** Deputy Principal Chief *Cherokee Nation*	**Lisa Pivec, MS** Senior Director of Public Health, Cherokee Nation Health Services *Cherokee Nation*
Phoenix Area **Term Expires:** June 30, 2023	**David Reede** Executive Director, Department of Health and Human Services *San Carlos Apache Tribe*	**VACANT**
Portland Area **Term Expires:** August 31, 2021	**Sharon Stanphill, MD** Chief Health Officer *Cow Creek Band of Umpqua Tribe of Indians*	
Tucson Area **Term Expires:** July 30, 2023	**Sandra Ortega** Councilwoman *Tohono O'odham Nation*	**Evelyn Juan-Manuel** Representative *Tohono O'odham 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** Tribal Council Member *Sault Ste. Marie Tribe of Chippewa Indians*
Tribes At-Large **Term Expires:** August 31, 2022	**Trinidad Krystall** Riverside San Bernardino County Indian Health Clinic, Inc. *Torres Martinez Desert Cahuilla Indians*	**VACANT**
Tribes At-Large **Term Expires:** August 31, 2021	**Richard Sneed** Principal Chief *Eastern Band of Cherokee Indians*	**Vickie Bradley, MPH, BSN, RN** Secretary of Public Health and Human Services *Eastern Band of Cherokee Indians*

Appendix D: CDC Attendees

Cleopatra Adedeji
Danielle Arellano
Maria Ayala-Perales
Heather Bashaw
Leann Bing
Kailyn Bostic
Tonia Burk
Kristine Camper
David Caruso
Bryan Christensen
Carri Cottengim
Amy DeGroff
Sonal Doshi
Evelyn Dunn
Hannah Fogarty
CheBreia Gibbs
Nathan Griffin
Karen Hacker
Lesliann Helmus
Kamelya Hinson
Sarah Huber-Krum
Monica Jamison
Marisa Kanemitsu
Kathy Keys
Stephanie Koh
Jim Kucik
Valerie Levy
Gerda Louizi
Cynthia Marshall
Timothy McLeod
Maria Mirabelli
Georgia Moore
Ekwutosi Okoroh
Nita Patel
Lauren Peretz
Vivian Porter
Lauren Ramsey
Steven Reynolds
Virginia Roberts
Delight Satter
Elizabeth Skillen
Jon Streater
Craig Thomas
Melissa Victor
Lisa Walker
Seh Welch
Ian Williams
Andrea Young

Rasha Al Rawi
Julie Armstrong
Coretta Bailey
Ann Bauman
Randella Bluehouse
Amy Branum
Catherine Cairns
David Capo
AnnMarie Chase
Christopher Jones
Teresa Daub
Heather Dennehy
Jillian Doss-Walker
Christopher Earl
TR Fuller
Dave Goodman
Amy Groom
Jeffrey Hall
Noelle Henderson
Kim Hoch
Jason Hymer
Harriet Jett
Karen Hearod
Kelly Kilburn
Laura Kollar
Danielle LaFleur
Kelsey Linzell
Sarah Mardovich
Donna McCree
Jessica Miller
Andrea Moore
Joanne Odenkirchen
Stacey Parker
Chandra Pendergraft
Lori Phillips
Gemille Purnell
Karen Remley
Tekerri Rivers
Aishwarya Sasidharen
Gia Simon
Katy Standish
JT Theofilos
Stephanie Tran
Nicole Wachter
Conne Ward-Cameron
Rachel West
Stephanie Williams
Andrea Zekis

Romana Allison
Ana Arroyo Ortiz
April Bankston
James Beck
Lacey Bokeloh
Patrick Breysse
Renee Calanan
Alicia Cardwell-Alston
Karla Checo
Karen Cobham Owens
Leslie Dauphin
Pasha Diallo
Audrey Dowling
Jessica Elm
Debra Gable
Brittany Grear
Diya Gundlapalli
Mary Hall
Roberto Henry
Tara Holiday
Robin Ikeda
Melissa Jim
Patrice Kemp
Tiffany Kim
Alfred Koroma
Tamara Lamia
Karina Lifschitz
Jon Macomber
Victoria McBee
Jenna Meyer
Jose Montero
Kate Noelte
Demetrius Parker
Charisse Pelaez Walcott
Florence Pham
Lindsay Prescod
Kelly Regan
Annie Rivera
Santos Sanchez
Alexandria Sedlak
Yuri Springer
Andrew Terranella
Stephanie U'Ren
Rochelle Walensky
Leisha Ware-Fennoy
Jessica Wiens
Maddie Woodruff

Noelle Anderson
John Auerbach
Nicole Barron
Herlynn Benoit
Anthony Boone
Sharunda Buchanan
Deanna Campbell
Yulia Carroll
Jason Chou
Catina Conner
Heidi Davidson
Brooke Doman
Melanie Duckworth
T'Ronda Flagg
Cynthia Garcia
Donata Green
Gabriela Guzman
Veda Harrell
Jan Hicks-Thomson
Joy Hsu
Ikovwa Irune
Sherry Jones
Samantha Kessler
Barbara Kitchens
Rachel Kossover-Smith
Jane Li
Katherine Luce
Cheryl Mayo
Jim Mercy
Miranda Mitchell
Mitch Morris
Matt O'Shea
Margaret Patterson
Kiyana Perrino
Samuel Posner
Marjorie Reaves
Nicole Richardson-Smith
Jeanne Ruff
Lenora Satterfield
Gregory Smith
Caroline Sulal
Rhea Lansang Tran
Angelita Vasser
Jeffrey Walker
Alleen Weathers
Craig Wilkins
Joann Wu Shortt