23rd Biannual CDC/ATSDR Tribal Advisory Committee Meeting

February 2, 2022, 1:00–6:00 pm (EDT)
February 3, 2022, 1:00 –4:00 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 23rd Biannual Tribal Advisory Committee (TAC) Meeting during February 2-3, 2022.

Contents

CDC/ATSDR TAC Meeting Participants and Attendees

TAC Member Attendees

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

Council Woman Jennifer Webster
Oneida Nation
Bemidji Area Delegate

Debra Danforth, RN, BSN
Oneida Nation
Bemidji Area Authorized Representative

Council Member Teresa Sanchez
Morongo Band of Mission Indians
California Area Delegate

Jared Eagle
MHA Nation
Great Plains Area (Proxy Representative)

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

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

Lisa Pivec, MS
Cherokee Nation
Oklahoma Area Delegate

Councilman Nate Tyler
Makah Tribe
Portland Area Delegate

Council Woman Sandra Ortega
Tohono O'odham Nation
Tucson Area Delegate

Sharon Stanphill, MD
Cow Creek Band of Umpqua Tribe of Indians
Tribes At-Large

Legislator Connie Barker (TAC Co-Chair)
The Chickasaw Nation
Tribes At-Large

Trinidad Krystall
Torres Martinez Desert Cahuilla Indians
Tribes At-Large

Council Member Herminia Frias
Pascua Yaqui Tribe
Tribes At-Large

Absent TAC Members

***Affiliation*/Tribal Area**	**Name**	**Title**
Mescalero Apache Tribe/ Albuquerque Area	Bernalyn "Gina" Via	Council Member
Eastern Band of Cherokee Indians/ Nashville Area	Richard Sneed	Principal Chief
San Carlos Apache Tribe/Phoenix Area	David Reede	Executive Director

CDC Participants

Mark Anderson
Co-Lead, CDC COVID-19 Response, State, Local, & Territorial Support (STLTS) Task Force

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

Robin Bailey, MA
Chief Operating Officer, Office of the Chief Operating Officer (OCOO), OD

Patrick Breysse, PhD, CIH
Director, National Center for Environmental Health/Agency for Toxic Substances and Disease Registry (NCEH/ATSDR)

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

Teresa Durden, MPA
Acting Director for Office of Appropriations (OA), Office of Financial Resources (OFR), Office of the Chief Operating Officer (OCOO)

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

Debra Houry, MD, MPH
Principal Deputy Director, CDC

Stacy Mattison Jenkins
Director, Division of Program and Partnership Services (DPPS), CSTLTS

Stephanie Koh, MPH, MPA
Health Scientist, Office of Science, CSTLTS

Jose Montero, MD, MHCDS
Director, CSTLTS

Georgia Moore, MS
Acting Director, OTASA, CSTLTS

Mitchell Morris, BA
Acting Deputy Director, OTASA, CSTLTS

Celeste Philip, MD, MPH
Deputy Director, Non-Infectious Disease (DDNID)

Julianna Reece, MD, MPH
Director, Healthy Tribes, Division of Population Health, NCCDPHP

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

Rochelle Walensky, MD, MPH
Director, CDC

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

Wednesday, February 2, 2022

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

- Deputy Principal Chief Bryan Warner welcomed TAC members and representatives, CDC officials, and other guests to the 23rd Biannual CDC/ATSDR TAC Meeting.
- Legislator Connie Barker provided the opening blessing.
- Dr. Montero welcomed everyone to the meeting. He provided an overview of the agenda, updated TAC members on the position vacancy of Director of Office of Tribal Affairs and Strategic Alliances (OTASA) and encouraged tribal organizations to apply to be a host site for CDC's Public Health Associate Program (PHAP).
- Georgia Moore was honored to attend the meeting to learn and receive council from the TAC as Acting Director of OTASA. She highlighted the opportunity of continuing to build upon the relationship from lessons learned through our discussions and being prepared to act on opportunities to build and

improve tribal public health systems. She thanked TAC members for their dedication to serving tribal health on this committee and recognized the OTASA team for their hard work in planning the meeting.

1:15 pm—TAC Business and Housekeeping

Facilitators

- **Bryan Warner**, Deputy Principal Chief, *Cherokee Nation*, TAC
- **José Montero, MD, MHCDS,** Director, CSTLTS, CDC

Roll Call

- Mitchell Morris conducted the roll call. A quorum was present to conduct business.

TAC Roles and Responsibilities

- Deputy Principal Chief Bryan Warner discussed the TAC roles and responsibilities, including the Federal Advisory Committee Act (FACA) Unfunded Mandates Reform Act Section 204 exemption.

CDC/ATSDR Tribal Advisory Committee (TAC) Membership Update

- Deputy Principal Chief Bryan Warner provided a current status of the TAC membership. He stated that there is an active recruitment to fill the remaining vacant seat for Billings Area. He welcomed new and returning TAC members.

CDC/ATSDR TAC Charter Update

Comments from Deputy Principal Chief Bryan Warner:

- Deputy Principal Chief Bryan Warner shared that the full TAC reviewed and approved recommended revisions on December 9, 2021 and submitted to the CDC on December 13, 2021.

Response from Dr. Montero:

- The Charter is currently under review at CDC.
- Next steps include:
    1. Conducting a national listening session tentatively in the spring.
    2. Holding a formal tribal consultation tentatively scheduled for early to mid-summer of this year.
    3. Incorporating feedback into Charter from listening session and consultation.
    4. Returning the Charter to the TAC for final review.
- The tentative timeline is to have a new finalized Charter during the fall of this year.
- Thank you, TAC members for reviewing and submitting revisions. We really want to make sure revisions align with the Health and Human Services (HHS) Secretary Tribal Advisory Committee (STAC) charter's Rules of Order and FACA exempt status.
- Once the charter is final, we will draft Rules of Order for review and input from the TAC. `

Comment from Deputy Principal Chief Bryan Warner:

- Deputy Principal Chief Bryan Warner opened the floor for TAC members to ask questions or share comments.

CDC/ATSDR TAC Charter: Questions and Discussion

Comment from Deputy Principal Chief Bryan Warner:

- I want to thank everyone that worked so diligently, the subcommittee, National Indian Health Board (NIHB), the full TAC, and our CDC partners. The big help was the new members. You all have added to the TAC. We received good information from these members. It has taken us about 3 years to get to this

point. It was never a moment of frustration but making sure that we did things the right way in moving forward together.

- Are there any other comments from our TAC delegation?

Question from Dr. Sharon Stanphill:

- How will the CDC leadership interpret the role of our alternates? For example, will it be that the area gets an alternate or is it that we have an alternate from our own tribe?

Response from Dr. Jose Montero:

- That part is still under review, so I cannot give you a formal answer today. The Office of General Counsel and other entities of CDC are still reviewing. Ms. Moore, is there anything you would like to add?

Response from Georgia Moore:

- We are also looking to be as much in alignment with how the STAC functions.

Comment from Dr. Sharon Stanphill:

- Thank you. I know that in the Portland area with our 43 tribes, we don't necessarily have to have them be from the exact same tribe. We do that purposely. We want to have more tribal input. I just wanted to make sure you knew our preference in the northwest.

Question from Councilman Nate Tyler:

- I guess to expand off of what Dr. Stanphill discussed as far as the charter goes, I was curious if there's going to be an opportunity for the TAC to discuss the charter with the Office of General Counsel? I was concerned about all of the vacancies for alternate, and I think there's a reason for that. In order to be more efficient, it would be helpful for the alternate to be from another tribe within our area. Hopefully, this is going to be aligned with the STAC.

Response from Dr. Jose Montero:

- I'll get back to you with an answer.

Comment from Councilman Nate Tyler:

- I do not have an alternate. However, with proper changes to the charter, I would have an alternate this week. I just want to make sure we are more efficient as TAC members.

Response from Dr. Montero:

- The issue has always been representation and who you represent. Certainly, we will discuss with the Office of General Counsel to see if they would be able to attend one of our monthly calls. I will ask and follow up on that.

CDC/ATSDR Tribal Consultation Policy

Comments from Dr. Jose Montero:

- The CDC/ATSDR Tribal Consultation Policy is currently being reviewed based upon recommendations from the August Tribal Consultation. CDC is waiting to align the CDC/ATSDR Tribal Consultation Policy with the updated HHS Tribal Consultation policy. The August Tribal Consultation Summary report was sent to tribal leaders on November 10, 2021, along with a Dear Tribal Leader letter.

Comments from Deputy Chief Bryan Warner:

- Deputy Chief Bryan Warner opened the floor for TAC members to ask questions and share comments.

CDC/ATSDR Tribal Consultation Policy: Questions and Discussion

Comment/Question from Councilman Nate Tyler:

- I was on the Indian Health Services (IHS) consultation workgroup. We spent quite a few months reviewing that document. There are a couple problems there. You mentioned HHS is updating their consultation policy. We are all not on the same page. I'm hoping that CDC will engage TAC members in the process.

- How do you all plan to engage with us through this process?

Response from Dr. Jose Montero:

- Thank you for that question, Councilman Tyler. We actually have been engaged. Ms. Georgia Moore, prior to becoming OTASA director, was leading that process. We had many meetings to discuss and review this approach.
- All of HHS needs to be on the same page. We are balancing the work we are doing with you, as well as, waiting on the final HHS document to have the same framework.
- Georgia, would you like to add?

Response from Georgia Moore:

- After we complete the next draft using the input from Tribal Consultation and the updated HHS tribal consultation policy, there will be further engagement.

Question from Councilman Nate Tyler:

- Will we have access to the report that outlines all written comments?

Response from Georgia Moore:

- Yes. It is on our website and has been shared in the chat. It was also included in your packets.
- We will make sure that you have it.

2:00 pm—CDC Budget Update

Presenter

- **Teresa Durden, MPA,** Acting Director, Office of Appropriations (OA), Office of Financial Resources (OFR), Office of the Chief Operating Officer (OCOO), CDC

Opening Remarks: OA

- Ms. Durden presented on the CDC's annual budget, budget highlights, COVID-19 supplemental funding for tribes and tribal organizations, and the Build Back Better bill.
- She shared that the CDC is currently using a continuing resolution (CR) which expires February 18th.

Comments from Deputy Principal Chief Bryan Warner:

- Deputy Principal Chief Bryan Warner thanked Teresa Durden for her presentation and opened the floor for to TAC member to ask questions.

CDC Budget Update: Questions and Discussion

Question from Councilman Nate Tyler:

- You mentioned the CR. I've never been a fan of the CR for quite a few different reasons. Pending additional Congressional action, what is the CDC doing in the event of a shutdown?

Response from Teresa Durden:

- We are not fans of CRs either. Although, they are a lot better than a shutdown.
- If we do not get a full year of appropriation by February 18th, they anticipate another short-term CR. Those are difficult for us to continue to administer, run grant programs, ask for grant funding, and solicit applications in that environment, but it is better than shutting down.
- We do have a plan in place for a shutdown. We're not anticipating that at this point in time. I do want to assure folks our response for COVID-19 is an emergency response and those activities are necessary for health and safety. They will continue during a shutdown.

Question from Nate Tyle:

- Thank you. I have a second question.

- The president came down with his executive order on consultation. We all kicked it into gear and took part in consultation with the Treasury Department, Office of Management and Business (OMB), and IHS, and one of the biggest asks from tribes was equitable access to funding.
- This brings up my question on pass through funding. I've never agreed that any money should be sent to states and distributed to the tribes. We're sovereign and the federal government is sovereign. We have a treaty with the United States government, not with the state government, and money should never be passed to the states for tribes to fight over. I really think the CDC should partner with IHS through interagency agreements (IAA) for this funding which would allow tribes to compact and contract the funding if they choose. We know what our needs are. We serve our needs to a tee and responsibly. My hope is that we can operate in more of a fair process that gives us access to funding we deserve. I was curious on CDC's position on that.

Comments from Teresa Durden:

- Thank you, Councilman, for that.
- We did provide IHS funding for COVID, and we collaborated closely with them.
- Our budget structure and what we have in authorization is established. It is something that we will continue to work on.

Comments from Dr. Jose Montero:

- Thank you for that question, Councilman Tyler. Thank you for the answer provided, Ms. Durden. CDC's budget structure is incredibly complex and different from most agencies. When we engage in the process of our consultation, we do it under the umbrella of HHS. Our budget is not separate from the overarching HHS agency, but many components of the funds are tied to actions directed specifically to IHS.
- Also, we do not pass funding through states to tribes. We fund states to cover actions that cover all populations in that state. As we are learning and improving the way we fund tribes at CDC, we have new funding vehicles that provide direct funding. We have more money coming through our umbrella cooperative agreement which will be discussed later today. It allows other centers from CDC to directly fund tribes. Different centers at CDC have well established programs that actually fund tribes directly, for example, the Good Health and Wellness in Indian Country (GHWIC) in NCCDPHP. We are addressing those points that you bring up Councilman Tyler. Thank you for raising those.

Question from Deputy Principal Chief Bryan Warner:

- Adding to Councilman Tyler's comment about equitable access to all funding, we feel that tribes are public health authorities. We should have that equitable access to all available funding. However, some tribes are denied due to overly restrictive categories that may favor larger entities. What is the CDC doing to ensure that the eligibility criteria do not block tribes from this essential funding?

Comment from Dr. Jose Montero:

- Thank you, Deputy Principal Chief Warner.
- When we talk about public health infrastructure, there are services that require a certain level of expertise and capacity. The issue isn't sovereignty but how are services provided in an effective and efficient manner? We've been trying to address questions: How do we improve data? Do we need an epidemiologist in every tribe? The answer is no, you don't need a full-time epidemiologist, but we need capacity to be able to look at data. What is the capacity that each group needs to have and who needs to fund that? These are complex answers because many funding streams are specific to HHS and not CDC. Even though, we support each other being under the umbrella of HHS. I agree with you that we need to be incredibly careful in how we fund, so we build that capacity together with all of the other agencies that are part of this process.

Comment/Question from Deputy Principal Chief Bryan Warner:

- We talk a lot about a minimum 5% set aside across all CIOs for tribes and tribal organizations. You hear that a lot from tribes and representation from the TAC. I'll just give you an example, when you look at the president's FY22 budget request at 160 million for preventative health and health services block grant. It is the same funding as 2021. Of the 61 FY21 grantees, only two tribes were awarded funds totaling about 92,000. Of the $145 million awarded, that is roughly .64% of those total funds. We want to achieve equitable funding, given that AI/AN makeup is roughly 2.9% of total US population, we request a minimum of 5% set a side across CIOs to support public health infrastructure.
- I'll pose another question. What is the CDC doing to limit those competitive block grants, and providing funding directly to tribes? I speak for Cherokee Nation. We know what we need in the world of epidemiology. We've been blessed to stand up a public health infrastructure with our nine clinics and new hospital. We are looking to limit that competitive block grant and provide more direct funding.

Comment from Dr. Jose Montero:

- About 40 years ago, block grants were created by Congress by an aggregation of already existing funding streams. It has not changed since then. We have had discussions on how we change block grants, but a solution was not identified. It is up to Congress.
- The answer to the 5% set aside has multiple components. One of the components is the CDC's Budget and Appropriations language that tells how funds will be distributed. The other component is that CDC's budget does not work in isolation. It is a part of the HHS budget. We look at some of the funding that came for COVID-19 as an example, CDC received funds for social determinants and there was a specific appropriation that went to IHS. There was a specific direction from the appropriators and from HHS that separated the funds and how they were portioned. That explains why we cannot say that is a 5% or 3% blank cut of all the different pieces of funding.
- Using the example of the NCCDPHP's GHWIC. This actually went to the tribes to discuss the terms, issues, language and topics to make it culturally appropriate. We have been learning from those examples across CDC. When we had the opportunity to distribute around $200 million that came in COVID-19 funds through two different streams, we removed most of the requirements to decrease the competitiveness. At the same time, we all recognize that we need to be able to get back to Congress to report how the money was used and what goals were achieved. We need to set up reporting systems to show the money given to the CDC is benefitting tribes. As much as we want to simplify and remove requirements, there are still fiduciary and legislative obligations that the agency needs to fulfill. Within that framework, we are doing everything possible to decrease the burden, the application, and the reporting process for tribes and actually we will be talking about that as we look at our next umbrella cooperative agreement later today. We continue to listen to your input and build on the learning experiences from the last couple of years.

Comments from Deputy Principal Chief Warner:

- Thank you, Dr. Montero. I see Dr. Jim's hand raised and she now has the floor.

Comments from Dr. Jill Jim:

- I concur with the comments made by Councilman Tyler about interagency collaboration. I think that's sort of the gap and shortfall we witness in the COVID-19 pandemic.
- The only way to kind of move forward in strengthening tribal capacity and funding access is to have federal understanding of what tribal leaders are asking for and have alignment of funding opportunities across the agency. Under the Department of Health and Human Services is that their result for some of the meetings with the Secretary and other tribal leaders is that IHS is primarily responsible for health in Indian Country. That's not the case.

- I would like to suggest that if there were any actions taken based on the recommendations made during the meeting that we receive feedback, and it is reiterated in the next meeting. We want to know that tribal leader's voices are being heard.

Comments from Dr. Jose Montero:

- We have been sending written responses and updates to the committee via email.
- You are telling us to bring those to the next meeting. Other than a verbal report, do you envision a different mechanism that will be more functional? I am always hesitant with verbal reports because the people who missed the meeting will not get access to it. We wrote those answers in letters before and we have been sending those to you to fulfill the request.

Comments from Dr. Jill Jim:

- I'm not sure if that would be the best method. There needs to be an opportunity for dialogue and feedback from the TAC. Just sending an email, we miss out on that opportunity.

Comments from Dr. Jose Montero:

- Years ago, we tried to do a matrix approach to keep track of the items and updates**.** It didn't go well, but I didn't know if it was our delivery or something else. Maybe we will have a discussion on that topic at some of our conference calls to make it more operational. Thank you for raising that point. Reporting back to you and receiving your feedback is really important.

Comments from Deputy Principal Chief Bryan Warner:

- I second suggestion on an ongoing project management matrix. If we can figure out that viewable format, we could tribal caucus ahead of time. I enjoy a good old PowerPoint.

Comments from Dr. Jose Montero:

- The package for today's meeting for the members of the committee included the report on recommendations from last meeting. If that's not the right format, let's discuss how to make it more efficient, effective, and functional.
- I do have some questions. What is the right way to fund tribes? What is the correct way to develop? Do we do it based on population, based on capacity, or burden of illness? When we're talking about tribes, do you envision a system that you have ideas about for those funds that we are going to be distributed? Any comments, suggestions, ideas from the group of advisors are welcomed.

Comments from Deputy Principal Chief Bryan Warner:

- Thank you for those questions, Dr. Montero. I will open the floor to the TAC members.

Comments from Dr. Jill Jim:

- I'm wondering if CDC has looked at other budget formulation models, like IHS. In their special diabetes group, they are looking at disparities as well. Another index is what Health Resources and Services Administration (HRSA) uses, but I'm not sure how representative it is.
- If you're going to change budget formulas for funding, I would encourage that to be a Dear Tribal Leader Letter and consultation for tribes to provide input. It allows us to provide government to government input. The TAC group should not be the only group that you ask.

Comments from Dr. Jose Montero:

- It is a question to build in your expertise. As stated, before and put in writing, this discussion today will not be used to replace a listening session or formal consultation. We want to start a discussion to get an idea. The advantage is that we can explore before we go into a listening session or formal consultation.
- We will be looking at what other agencies have done. Also, we do have a formula that we used for the COVID-19 funding where we were trying to be inclusive, setting baselines, and looking at need. This is complex.
- My intentions in asking the question were to gather initial input that will be tied to the appropriation language. They may tell us for this disease you have to distribute funds to tribes. I want to anticipate

that because the process of consultation can take months. We need to have processes that are expeditious. The intent is not to bypass tribal sovereignty.

Comments from Legislator Connie Barker:

- A good formula to review is the Special Diabetes Program for Indians (SDPI). There are three defining categories in that formula that you score distribution of the grant funds. It's a very successful program that has been around for 25 years.

Comments from Dr. Sharon Stanphill:

- The three defining categories are disease burden, tribal size adjustment, and user population. There is always pros and cons. We have had to use 2012's user population numbers because everybody's used to that amount, and you can't pull it back. It creates different issues, but we have a little bit more in the formula.

Comments from Dr. Jose Montero:

- Thank you. That is great input. We will certainly speak with our IHS colleagues.

Comments from Deputy Principal Chief Bryan Warner:

- I see Councilman Tyler's hand. I will now give him the floor.

Comments from Councilman Nate Tyler:

- I too was going to mention user population. It would be nice to have some type of rapid consultation in place for pressing issues. If you do have money coming through, you need tribes involved.

Comments from Dr. Jose Montero:

- Two years ago, we got funds for COVID-19. We called our partners at NIHB to help organize an immediate tribal listening session. It allowed us to get quick input from tribal leaders and communities.
- As we look at the consultation policy, we may need to look an emergency procedure.

Comment from Deputy Chief Bryan Warner:

- I do like what Dr. Jill Jim suggested to you. IHS has been distributing funds through formulas for years. I do think it would benefit CDC and tribes to discuss their various formulas.
- Thank you for that question, Dr. Montero.

Comment from Dr. Jose Montero:

- I really appreciate the feedback. I will come back with more question in the future.

3:00 pm— Tribal Panel on Tribal Public Health Infrastructure

TAC meeting was paused for a learning session with TAC members and CDC leadership.

4:50 pm—Tribal Public Health Infrastructure Discussions

Facilitator

- **José Montero, MD, MHCDS,** Director, CSTLTS, CDC

Presenters

- **Andrea Young, PhD, Associate** Director of Science, CSTLTS, CDC
- **Stephanie Koh, MPA, MPH,** Health Scientist, Office of The Director (OD), CSTLTS, CDC
- **Stacey M. Jenkins, MPH, CHES,** Director of Division of Program and Partnership Services (DPPS), CSTLTS, CDC

Opening Remarks: Supporting Tribal Public Health Capacity in Coronavirus Preparedness & Response (OT20-2004): Preliminary Summary Findings from End-of-Year One Assessment, CSTLTS

- Ms. Koh presented on the background and results from an end-of-year one assessment on the OT20-2004 Grant, Supporting Tribal Public Health Capacity in Coronavirus Preparedness and Response.
- Dr. Young presented on how the grant was supporting foundational public health capabilities and core public health programs in Indian country through the lens of the Foundational Public Health Services framework.
- She shared the goal of the discussion was to dive a little deeper into the results being achieved through this grant and inform our collective thinking about what is needed for a longer-term public health capacity building in Indian country.

Opening Remarks: Tribal Public Health Capacity Building and Quality Improvement Umbrella Cooperative Agreement (OT18-1803), CSTLTS

- Ms. Jenkins presented an overview on OT18-1803 cooperative agreement grant, highlighted current program and funding information, and discussed future program direction.

Tribal Public Health Infrastructure Discussions: TAC Questions and Discussion

Question from Dr. Jose Montero:

- We talked earlier on the complexity of budget and funding public health infrastructure. It includes a multitude of things such as personnel, equipment, technology, and programmatic activities, to name a few, for all the different risk factors and conditions that that we work with.
- You look at two different models of funding that we're using, I want to ask a couple of questions with one key disclaimer up front.
    - This does not replace the listening sessions or the consultation sessions that will come later on.
- How should CDC move forward in envisioning long term tribal public health infrastructure funding.

Response from Deputy Chief Bryan Warner:

- Perhaps the CDC should commission a study to determine the amount of funding needed to ensure the tribes can improve health and wellbeing in tribal communities.
- In talking about this as a whole, the amount of funding that will be needed to build tribal public health infrastructure will be greater than the funding required to maintain the existing infrastructure and will require engagement with agencies and offices all across HHS.
- Looking at funding should account for other essential resources such as training, technical assistance, and policies that prioritize development of sustainable local tribal workforce capacity.

Question from Councilwoman Teresa Sanchez:

- How is the funding granted? Is it competitive or non-competitive? In my opinion, it should be non-competitive.

Comment/ Question from Dr. Jose Montero:

- We are not talking about the funding specifically right now. The question is general and can apply to the next iteration.
- Of the two cooperative agreements mentioned, the one Dr. Young and Ms. Koh presented on was non-competitive. We used IHS's formula to get started and build upon that framework. The one Ms. Jenkins presented on was too small to be non-competitive.
- I am asking questions toward the future. How do we do this? What happens if we don't have money for everyone?

- Deputy Chief Warner suggested we do a study to figure out what is needed, how much does it cost to implement, and then to maintain. We started a similar process funding NIHB to do an assessment. The tricky piece is defining what is needed because we don't have a national agreement on what is public health infrastructure and how big it should be.
- What should we put in place for long-term public health capacity building in Indian Country?

Comments from Councilwoman Teresa Sanchez:

- There are larger facilities and there are smaller facilities. You have to look at doing for both, adequately because there's different needs.

Comment/Question from Dr. Jose Montero:

- We have to look at CDC engagement with health care facilities versus IHS. What is public health that is not health care delivery?
- How do we separate those two things because it's not about the size of the facility? Maybe it's about the need of the population from a public health policy perspective.

Comment from Councilwoman Herminia Frias:

- If you're thinking long-term funding, there are a couple things to consider.
    - What is the readiness of the health department?
    - Are they looking at public health accreditation?
    - What level of public health accreditation?
    - Do they have codes that your Tribal Council has created and passed in law?
    - Is there consistency? For the purpose of information not changing when tribal election occurs.

Response from Dr. Jose Montero:

- There is the public health standard for accreditation that kind of tells you what a health department should do. However, as mentioned by Mr. Auerbach and Ms. Pivec, it is not enough. There is more work that needs to be done by the public health system in defining what are those specific needs in tribal content.

Comment from Dr. Leslie Dauphin:

- I really appreciate the idea from Deputy Principal Chief Bryan Warner mentioned about a study to look at what will be needed to support public health infrastructure.
- I pose a question for consideration. Which mechanisms have shown to be most effective at meeting the needs when thinking about investments in grants versus cooperative agreements or technical assistance provided by various contracts?

Comments from Dr. Jose Montero:

- I will add, under what circumstances? We tried the grant under COVID-19, and we learned a lot of things. When we look at NCCDPHP did on GHWIC is a wealth of information there for us to use as well.
- We will engage internally at CDC with follow up as we prepare for how to address these if new funding comes and how do we use these grants.

Response from Councilman Nate Tyler:

- I don't know where to start on the questions you posed.
- I think it's really important to engage with us early and often when it comes to public health plans and funding mechanisms.
- There are 574 tribes, and we all have unique needs. A lot of tribes share the same issues as well. We have been forced to do more with less that is the way we have been operating.
- I do not know what listening sessions means to CDC. I'm not sure what a listening session is myself.
- As a reminder, we're not just the primary provider for our people in the healthcare arena. We're spread across the board with everything health care, law enforcement, natural resources, education, and you name it. We're chronically underfunded. The pandemic highlighted the need for a strong public health

infrastructure in Indian Country. That's clearly evident. Going back to partnering with HIS, interagency agreement is very important.

- As far as us having access to funding, you know we're going through so many different agencies. Some tribes aren't in the same position that they may or may not have staffing or access to funding. It really depends on if its direct funding or grant funding. Some kind of mechanism equitable to all tribes would be a good idea.
- Just for the Portland area, for example, there's 43 tribes, and we have quarterly board meetings. Not all 43 tribes attend. I speak on the behalf of my area. I really think an equitable approach and the needs of the community needs to be considered.

Comments from Deputy Principal Chief Bryan Warner:

- I'd like to give my time to my alternate delegate Ms. Lisa Pivec.

Comment from Ms. Lisa Pivec:

- I keep hearing about the IHS mechanism, which I think for CDC would be great for CDC to keep the dollars focused on public health infrastructure.
- I have worked with IHS and CDC. The difference between clinical delivery services, funding those, and building that foundational public health infrastructure are different. Establishing funding around the idea of building those foundational capacities as a starting point, assessing where tribes are, and this would be up to you, Dr Montero, to say that in a health equity framework that tribal public health infrastructure is a priority. We are so far behind state and local health departments that the funding that goes to the CDC directly to fund health departments across the country should also consider tribes.

Comment from Dr. Jose Montero:

- I do agree. Tribes should be prioritized in a framework of health equity.

Comment from Legislator Connie Barker:

- I agree with Deputy Principal Chief Warner and Lisa Pivec.
- If you are going to do a study, you may start with some type of a tiered system based on readiness and capacity for the tribes. You might start off with those bigger tribes, who already have things in place. We're all in Indian Country. Sometimes those larger tribes can help pull up smaller tribes and teach them. Why try to recreate the wheel? Some tribes have already created it, you know as far as their infrastructure.

Comment from Dr Jose Montero:

- We tried to do with the COVID-19 funding with those tribes that already had an infrastructure and capacity. In an emergency, it's very hard to have that model for growth and further development.
- The intent of the presentations today was to highlight some of those things. Even though we reached almost all of the tribes, not all of the tribes applied individually. Many of them applied through the regional private organization and that was a better vehicle for them to receive funds.
- It is complex, for us to propose that, because then people will say that we are not respecting tribal sovereignty. The reality was that for those tribes that have independent public health infrastructure could do more quickly and help those in their surrounding areas not reached by local health departments.
- As we look at the next iteration of our own private umbrella, would a model like that work? It will be a decision made by the tribes. Again, it will not be decided today. Many of the suggestion provided overlap trying to work with groups.
- Any thought on that?

Comments from Deputy Principal Chief Bryan Warner:

- I think the larger tribes should have a responsibility to come in and help and bring everybody together. To gather information about our communities to develop programs and services to help them.

Comments from Councilwoman Teresa Sanchez:

- There are 105 tribes in California, and I'm not sure how many have public health infrastructure down like the rest of tribes in the country.
- I think it's a disadvantage for those that don't have it, if you decide to work with the larger tribes. In California, there are a lot of smaller tribes, and we really need help in the development.
- I do think the larger tribes have the model that we, the smaller tribes, need to develop a public health infrastructure.
- When you mentioned doing a survey, I think it would be a good way to see who does and does not want a public health infrastructure. Some tribes do not have that capacity.

Comment from Dr. Jose Montero:

- Earlier today, we saw 3 different tribal communities public health approaches and there were commonalities. Maybe we should conduct a study in understanding the different levels, but still supporting those most in need.

Comment from Councilwoman Herminia Frias:

- Part of the responsibility when you become public health accredited is the cost. It is very expensive which is also a challenge in maintaining accreditation. Having a consortium of other tribes come together there might be a possibility that another tribe might be able to even sponsor them. It might work better collaboratively.
- Public health accreditation it's not just one piece, it's really looking at the whole picture.

Comment from Dr. Jose Montero:

- Accreditation is a component. It does have a cost implication. We have partnered with NIHB to provide technical assistance to organizations to support them in that.
- For the last comment of the day, we have Dr. Julianna Reece.

Comments from Dr. Julianna Reece:

- I'm trying to put this all together because everyone is touching the topic at so many different places.
- I'm intrigued by the whole idea of a study because we have the Public Health Indian Country Capacity Scan (PHICCS), the PHICCS project assessing tribal capacity. The response rate is in the high 40% and I was wondering if there was something that we could do to improve the response rate. We could use that tool as a launching point.
- As you all have highlighted there it's a spectrum and there are some tribes that are further behind and further ahead than others. Once we understand that a little bit better, I think we're going to be able to make a lot more headway and be able to support tribes that really don't feel comfortable applying. Maybe we can look at it from an equity lens in assessing the needs. We could also have tiers of support.
- Also, the Tribal Epidemiology Centers (TECs) in TECPHI are established in 12 different areas across the nation. Those are essential vehicles for exactly what we're talking about.
- Expanding that might be areas that we can consider for even pilot projects or ways to address certain gaps that we're seeing in the scan or the study that we could come up with.

Comments from Dr. Montero:

- Thank you, Dr. Reece. I really appreciate those comments. Thank you for all of the input and feedback in today's discussion. We will bring it back up again in the next several meetings we have.

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

Presenters

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

Closing Remarks

- Dr. Jose Montero thanked everyone for their feedback in the Tribal Public Health Infrastructure discussion and turned the meeting back over to Deputy Principal Chief Bryan Warner.
- Deputy Principal Chief Bryan Warner 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 23rd Biannual TACand Tribal Consultation.
- Dr. Montero provided summary highlights of the meeting and thanked everyone for attending and participating throughout the meeting.
- Deputy Principal Chief Bryan Warner closed the meeting with a prayer.

Day 2

Thursday, February 3, 2022

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

Facilitators

- **Bryan Warner**, Deputy Principal Chief, *Cherokee Nation*, Co-Chair, TAC
- **José Montero, MD, MHCDS,** Director, CSTLTS, CDC
- **Georgia Moore, MA,** Acting Director, OTASA, CSTLTS, CDC

Opening Remarks

- Deputy Principal Chief Bryan Warner welcomed everyone to the meeting.
- Legislator Connie Barker provided an opening blessing.
- Georgia Moore welcomed everyone to the last day of the TAC meeting and briefly discussed the agenda for the day.
- Mitchell Morris conducted the roll call. A quorum was present to conduct necessary business.

1:15 pm—TAC Business

Facilitators

- **Bryan Warner**, Deputy Principal Chief, *Cherokee Nation*, Co-Chair, TAC
- **Jose Montero, MD, MHCDS,** Director, CSTLTS, CDC
- **Georgia Moore, MA,** Director, OTASA, CSTLTS, CDC

TAC Subcommittee

- Deputy Principal Chief Bryan Warner asked the TAC if it would like to continue the TAC Subcommittee to continue work on the Technical Assistance Guidelines and/or any other topics? If so, how often?
- TAC members decided to continue with the Subcommittee with the members being, Deputy Chief Bryan Warner, Legislator Connie Barker, Councilwoman Trinidad Krystall, Council Woman Jennifer Webster, and Dr. Sharon Stanphill, meeting monthly on topics of funding and technical assistance.
- Georgia Moore provided an overview of the technical assistance presented to the Subcommittee in the past year by CIOs.
- Dr. Jose Montero suggested potential topics for the Subcommittee to discuss such as the needs to be funded, the structure of public health in Indian Country, and the cooperative agreement presented yesterday.

24th Bi-Annual TAC Meeting - August

- Deputy Principal Chief Bryan Warner reminded TAC members that the 24th Bi-Annual TAC meeting could be taking place in person August 3rd and 4th , 2022, hosted by Cherokee Nation in Oklahoma depending on the pandemic.
- Dr. Jose Montero thanked Deputy Principal Chief Bryan Warner and Cherokee Nation for hosting and assured them that CDC will be a part of planning and logistics.
- Dr. Jose Montero introduced senior leadership in the meeting and the CDC Director, Dr. Rochelle Walensky for CDC/ATSDR updates.

1:30 pm— CDC Director/ATSDR Administrator Updates

Presenter

- **Rochelle Walensky, MD, MPH,** Director, CDC; Administrator, ATSDR
- **Debra Houry, MD, MPH,** Acting Deputy Director, CDC

Opening Remarks

- CDC Director Dr. Walensky provided updates on CDC's work with tribal communities in the areas of health equity, the public health workforce, tribal public health data, and response to COVID-19.
- CDC's Division of Reproductive Health partnered with the HHS Office of Minority Health to develop a segment of the "Hear Her" campaign focused on reaching AI/AN women and their communities.
- CDC recently published two important data analyses on American Indian and Alaska Native homicides and overall mortality. In addition, representatives from our National Center for Injury Prevention and Control and the Office of Tribal Affairs and Strategic Alliances are participating in the "Not Invisible Act Commission."
- CDC also supports public health capacity in Indian Country by encouraging eligible tribal organizations to apply to be a host site for PHAP before midnight Eastern, Friday, February 18.
- ATSDR launched a community engagement playbook, along with a community engagement planning tool and a guide to active listening, to help ensure mutual understanding between ATSDR staff, funded partners, public health professionals, and state, tribal, local, and territorial partners. Also, ATSDR and N-I-H-B are also planning a series of regional tribal environmental health summits that are expected to take place over the next two years.
- Beginning in January, the Tribal Epidemiology Centers started receiving data in HHS Protects from the Vaccine Adverse Event Reporting System (VAERS) to support tribes and Native-serving organizations in obtaining and sharing health data, the Improving Data and Enhancing Access Northwest Project launched "NativeDATA."
- CDC is still 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.
- Dr. Rochelle Walensky thanked TAC members for their support and commitment to improving public health for all tribal nations.

CDC Director/ATSDR Administrator Updates: TAC Questions and Discussion

Question from Councilwoman Jennifer Webster:

- I wanted to talk a little bit about expanding and strengthening self-governance. The IHS is the only agency within HHS that has the authority to establish self-determination contracting for self-governance compatible agreements with tribes and tribal organizations. This restriction means the successful approaches not available for other HHS operating divisions.

- We asked for HHS's partnership in expanding and strengthening self-governance across HHS agencies and programs. Under self-governance programs throughout HHS will be better coordinated to produce better health outcomes for our tribal citizens, our families, and our communities. Self-governance would reduce program administrative costs and eliminate the duplicative reporting requirements which pulls valuable time away from servicing our clients.
- Tribes have drafted legislation and White Papers. We ask for CDC's commitment in partnership in moving these efforts forward to fulfill President Biden's commitment to working to empower tribal nations to govern their own communities and make their own decisions.
- We request that CDC Director/ ATSDR Administrator support legislation that would expand self-governance to programs beyond IHS and HHS including CDC.
- In the absence of revised legislation, we request that CDC partner with IHS, an IAA to pass funding to tribes through IHS, so that tribes can compact and contract funding. Also, noting providing funding directly to tribes does not relieve from its responsibility to provide training, technical assistance, and other support in the same manner that they would for grants from your own CIOs.

Response from Dr. Rochelle Walensky:

- Thank you, Councilwoman Webster.
- I do need to spend a little bit more time with the White Paper as you discussed but it's something I'd be happy to look into.

Comments from Councilwoman Herminia Frias:

- Thank you, Dr. Walensky for meeting with us.
- I really do appreciate you also looking at all of the PowerPoint presentations from yesterday's presentation. We're one of the 6 tribes nationwide that are public health accredited.
- When it comes to the emergency preparedness money that comes through CDC, we're not eligible to apply for that funding, because that funding goes directly through the states. It's really important that money is eligible to be available to tribes.
- When we experience the pandemic and called for a State of Emergency, we had the option of going through the state or going through the tribes. Tribal Council decided to go through the tribes because of tribal sovereignty. We understood that we needed to protect our community and we understood what we needed to do.
- The messaging that has come from CDC and the changes in the messaging about COVID-19 has been a little bit confusing. When there's information that is shared from the CDC that changes, and we have our own laws and regulations that may not be consistent with the CDC, it's important that there is communication.
- I do appreciate everything that the CDC has done, the funding, the response, and the work that you have done with tribal communities.

Response from Dr. Rochelle Walensky:

- Congratulations on the accreditation. It was truly a pleasure to review the slides you have provided for us and the extraordinary work that you've been doing.
- I do want to speak for a minute to some of our guidance, because that was raised. First, always our guidance at the policy level has to be local. There are very few exceptions and I have frequently been on the airwaves saying we provide guidance. Implementation has to be local. I'd be happy to re articulate that because I believe that to be true this disease is locally driven.
- Currently, our recommendation is that anywhere that there is a level of community transmission, that is in the moderate or high range, public indoor masking. That has not changed for the most part, sadly.
- I do want to speak to quarantine, and isolation guidance released during the holidays. We anticipated that we were about to get very high rates of disease. Our healthcare workforce could not staff beds,

pharmacies couldn’t open, dialysis centers that couldn't supply dialysis because they couldn't actually get the dialysis from FedEx workers. We wanted to make sure that the people who are at highest risk of disease continue to stay home and those that are feeling well could decrease transmission.

- I will just end with two questions, and that is as we roll these things out are there ways we could communicate better to you specifically and then are there, talking points or other pieces that might be helpful for you as we implement new guidance?

Comment from Councilwoman Herminia Frias:

- Improving communication is always good. I think that talking points are good. I think you're absolutely right it's always at the local level. We have always communicated with our community is that the CDC is guidance, and we take that.
- When you were talking about vaccine confidence, how is it that you really get to the point where people are actually understanding through various modes of communication? We had gotten to a point in our community where everything was white noise until Omicron came. It was like nobody paid attention, and so we had to go back in and re-educate everyone.
- I think it's the communication from CDC and with the tribes. There could be real time and culturally appropriate messaging. As tribes, we could say we're going to do this, but it's going to be more conservative.

Comment from Dr. Sharon Stanphill:

- My questions and comments have to do with public health modernization. We are a very new to this public health we're getting all of our funds directly through the state of Oregon, where we're located.
- If they had not come up legislatively with these funds, we're not sure how we would be able to do the work we're doing today. Thank you for the CDC funds and the resources.
- How were tribes included in data modernization efforts? Can you continue to help us assist with future planning? We acknowledge and respect our tribal sovereignty. Our tribe is hoping to become a public health authority.
- We have electronic health record issues for data. We want to continue to build our infrastructure. Maybe you could speak to that and just realize that we really do need their funding to come directly to our tribes, so we can continue to build our systems.

Response from Dr. Rochelle Walensky:

- I have been doing a lot of in terms of trying to advocate for resources throughout public health systems tribal state local territorial. I will call it connecting the pipes, so that your public health data are able to talk to your electronic health record data. That we're able to maintain personal identification information as personal. Also, we can all report it together, so that we can have a line of sight as to what is happening in tribes, what is happening in states, and what is happening in jurisdictions.
- I was personally surprised at how little the pipes were talking. The 3 areas of public health infrastructure are workforce, data infrastructure, and laboratory infrastructure. We need to make sure the workforce is developed locally. We talked a little bit about that with PHAP program. There has to be data sovereignty for tribes, but interconnected abilities to compare with tribes and the country.
- Now on our vaccine effectiveness page our vaccine data on COVID-19 are now available to look at 27 jurisdictions. I invite you to look at it. In those 27 jurisdictions, we can look at vaccines administered, positive tests, and deaths. It has taken months for us to have those data systems. A lot of work has jumpstarted because of the pandemic. We look forward to partnering with you and other tribes, to be able to modernize those data systems.

Comments from Dr. Jill Jim:

- I just wanted to follow up from our last meeting in August on the Tribal Consultation Policy. Will there be any report of the results that will be provided back to us including all written comments and the

process of revising the consultation policy? We ask for the CDC to engage with the TAC as the policy is being updated.

- I want to also echo the sentiments of other tribal leaders. I am representing the Navajo nation as an alternate on the TAC and an executive director for the Navajo Department of Health. I agree on communications. As we continue to respond to the pandemic, I'm curious to see how the CDC will change their relationship and working ability around public health infrastructure going forward, knowing that there are definitely areas of jurisdictions and relationships at the state level. Some have found a relationship, and some have not.
- CDC needs to make sure funding is equitable, representative of the disparities, population size, and the location, fairly. I know Navajo Nation has experienced some issues with funding. Those eligibility criteria for funding needs to be reviewed. There is a unique system that tribes have to deal with. Re-assessing that budget formula for allocating funding is going to be very important.
- As you mentioned, CDC provides recommendations to the general public and local health officials. It has been a whirlwind with all the recommendations. It is chaotic at times trying to defend our decisions and adjust, when we know some are not reasonable. Navajo Nation has had an indoor and outdoor mask mandate since March 2020. We never wavered from that, even though, the media presents misinformation. It really makes life complicated to enforce the mask mandate. Coexisting with COVID-19, we need a national platform for everyone. Omicron just blew us over and wiped us out. We are recovering and we feel burned out from the last few years. There has to be a plan. There are still a lot of individuals that are vaccinated but need a booster. Now, we have to target those individuals who don't think they need the booster because they are fully vaccinated. Catching up with the decision to mitigate need to be done quickly but clear. Since we're moving into coexisting with COVID-19, what does that look like? We cannot rely on medical people doing medical clearances at our facilities. They are just as confused. In Navajo Nation, we have a vaccine mandate. We ask for requirements. We now allow home test kits, but now some don't think they are accurate. We hear multiple complaints. Also, we have to isolate and quarantine people, but those requirements changed during Christmas. We have had issues regarding the type of mask to wear, when to use a respirator, and making visuals better for illiterate individuals. I could go on and on, but my point is that these recommendations are not timely. I know we're in a pandemic. What is the national plan in moving forward on responding to COVID-19? That is worrisome to me.
- Navajo Nation's numbers are now going down and we are looking at community empowerment to address the pandemic. However, our community is still in need of personal protective equipment to move forward. Our schools need masks and testing kits. When the announcements were sent out nationwide about the N95 masks and test kits, there wasn't any tribal allocations.

Response from Dr. Rochelle Walensky:

- Thank you so much. There was a lot there and I have taken some notes.
- First, I do want to say that we're grateful for the August 5th discussion and a review of the consultation session is on CDC Tribal Health site. I invite you to take a look at that. We are actively working to update our consultation policy along with HHS. More is to come on that.
- I want to comment briefly on the vaccines because I have personally started pivoting my language. CDC, about a month ago, updated our recommendations for vaccination to say up to date. The reason we've done so is because that is how we really describe every other vaccine. We want people to be up to date because we don't know exactly what will come in the future of COVID-19 vaccines. So, the way I've been saying it is, "you got your primary series, but you are not yet up to date on your vaccine." We saw some data just this week that I presented at a press conference yesterday that demonstrated if you're unvaccinated you're 14 times more likely to die, then, if you're received your primary series and 97

times more likely to die if you're not up to date. We want to encourage people there is protection from that primary series for sure, but we want to make sure that people really understand how important it is to be up to date with your vaccine series.

- I want to comment on moving from crisis to coexisting. We are still in crisis mode, I would say. While cases continue to come down 34% week over week, so we're now in the 450,000 range in terms of documented cases in the United States. I am optimistic. However, our hospitalizations are only down 10% and our deaths continue to rise up around 4%. If look at peak over peak over the last year, our hospitalizations are still higher than it was during the alpha wave and delta wave. While we still need to continue to look ahead to see what is coming next or pivot from crisis to coexisting, as you commented, we need everyone to recognize that we are still in crisis. While we are communicating what coexistence may look like, we also have to articulate that may we see other variants and we may see mini surges. We need to have people understand that we need to continue to be vigilant and to watch as public health authorities.
- I'm grateful for your comments and feedback.

Comment from Nate Tyler:

- Dr. Walensky, I really appreciated your opening comments because you covered so much. I'm really glad you covered Missing and Murdered Indian women. We've faced that on every tribal reservation throughout the nation. I'm from the Makah Tribe in Washington State. It was mentioned that tribes were being forced to opt in/opt out. We have 28 federally recognized tribes in Washington State. We are lucky to have a good relationship with the state of Washington and the governor in the state of Washington and not all tribes are in that position throughout the United States.
- Two issues I would like to address. The first is just encouraging CDC to work with IHS on funding. You mentioned that we are spread all across the board, as far as funding being easily accessible and equitable. We do not want pass through funding. Allow tribes to potentially compact some of these funding sources through the IHS.
- My second is on the TAC. I'm recently appointed to the TAC, and I received quite a bit of documentation on the charter. I read through it, and one of the things that stuck out to me is having technical assistance is against the TAC charter. And the way tribes operate, we have assistance at the table with us to help guide. So, if we can make some changes to the TAC on technical assistance wording that would be quite helpful for us.
- I too want to talk about CDC's messaging. I do not know the process and I do not know if you involve tribal leadership on CDC guidelines, but it is quite confusing to our communities. Some may not be coming from the CDC, but I do want to encourage CDC to work closer with tribal leadership on the messaging. We should be made aware prior to the messaging goes out. The closest hospital to the Makah tribe is in Port Angeles, one hour and a half away and it only has a 67-bed unit. Throughout the last two years, that place has served its purpose and not counting the COPD patients. Other than that, we're a five-hour trip to Seattle, which would be the next closest hospitals for our tribe. We do a lot of flights. COVID has taken a major toll on our community. We're still shut down today. At our clinic, we have 80 employees. 18 came out at our clinic, so we had to shut down our clinic as worst-case scenario.

Comment from Deputy Principal Chief Warner:

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

2:35 pm—COVID-19 Emergency Response Transition

Presenter

- **Mark Anderson, MD, MPH,** Co-Lead, CDC COVID-19 Response, STLTS Task Force

Opening Remarks: State, Tribal, Local, & Territorial Support Task Force for the CDC COVID-19 Response

- Mark Anderson shared how CDC provides technical assistance and that President Biden announced federal government's actions to expand COVID-19 testing across the country. He mentioned tribal communities that need assistance in understanding their options for increasing testing capacity may contact CDC at eocevent588@cdc.gov.
- He presented framing questions to the TAC to help CDC examine the transition from the COVID-19 pandemic to a constant presence in order to better support the needs of Indian Country.
    - What are your recommendations for measuring burden of COVID-19 in your communities?
    - What are your recommendations on case investigation and contact tracing?
    - What do you see as important data needs for COVID-19 going forward?
    - What are the most important considerations for COVID-19 testing?

COVID-19 Emergency Response Transition: Questions and Discussions

Comments from Dr. Jose Montero:

- Thank you very much, Mark. I hope you were here for Dr. Walensky's session because some of the issues came up. Now, that you have asked these 4 questions, I would love to hear from the TAC members. Of the four questions, you can answer however you want, but we want to know what you think CDC should be doing. We did share the questions with you before the meeting. Some of you asked if your technical support person could answer the questions, and we said that it was fine to do so.

Comment from Deputy Chief Bryan Warner:

- At this time, the floor is open for any comments from TAC members. Remember, you can give the floor to your technical advisor or alternate.

Comment from Dr. Jill Jim:

- I think we might need more time. If we can provide written feedback, we can do that later. If I could circle back to my team that would be helpful.
- For measuring burden, I do think about the prevalence data for COVID-19. What is the incidence and mortality rates? I think there are also implication due to the pandemic that we have not focused on such as behavioral health and menta health across all age groups.
- The pandemic is not over. We are not living in a normalcy to understand what the new normal will look like. This is very difficult to talk about. We're not done with the crisis, but we still have to live with COVID-19, and we have not been able to address our existing health issues. There are many areas that we should look at in regard to all ages, nationalities, and location.
- Recommendations on case investigation and contact tracing, we have a discussion internally in the Navajo Nation with the National Association of County and City Health Officials (NACCHO) recommendations on eliminating universal content tracing. I don't think CDC has adopted those recommendations, but local jurisdictions and associations have provided a statement on not looking at every single person for contact tracing. The difficult thing about contact tracing, in Navajo nation, we had developed our own curriculum and process. We don't know if that was the best tool to provide but there isn't really a toolkit on this. Since we are just responding to the pandemic, we do not have time to evaluate the tools we are using and have additional training.
- Even when talking about public health infrastructure, I feel like it's difficult to hire people in our existing system. I'm just speaking for Navajo nation. We're saying that we will increase the workforce, but how many people are actually qualified? But, the same time, how do we cross train those individuals to take on different responsibilities. The pandemic of this magnitude has highlighted that we need to have consistent training.

- As far as data needs moving forward, there has been a lot of conversations on data modernization meaning health care records systems. Ideally, what I would like to see is for tribes to own health information exchange systems to connect to different health facilities and systems within their areas to receive data. The Resource and Patient Management System (RPMS) is outdated and cannot compete with the newer electronic health records system. There is a difference between health data and public health data. I was talking to my team today about community readiness and how do we know what their capacity is to keep on responding to the pandemic. I think our team would continue to try to figure out what the data would be to share, and I think there would need to be conversations, not only through us but other States may have similar questions
- The considerations for COVID testing need to be reliable and rapid. We have some availability, but not a large supply chain. We cannot control every single person. We encouraged those that took off the shelf COVID-19 test to report back to us because we are required to report to the state. We are trying to let go of some of that control and be more flexible. Testing has been very interesting. I think I will stop there. There's a lot of work that still needs to be done around these four areas.

Question from Councilwoman Herminia Frias:

- I have a question on the question of measuring burden of COVID-19 in your communities. What is it specific to?

Comment from Mark Anderson:

- We're looking more at what do you think would be the appropriate indicators to look at in a public health surveillance system? Should it be deaths, mortality number of cases, there have been some questions in the past on the value of percent positivity so indicators like that are they still worth collecting, or is there still value from collecting that information or is it becoming too much of a burden to collect those details?

Comment from Councilwoman Herminia Frias:

- If we're thinking that it's going to be an endemic, I think we should track that.
- We should also consider, what type of data should we be collecting. Important data that needs to be collected moving forward should be about the long-term health effects of those that have tested positive. We need to look at those indicators now and start having some baseline data. I'm really concerned about our children. We have not had that socialization in our communities. We have not been able to participate in our ceremonies. How has that affected them? How does that affect us in the long term?

Comment from Deputy Principal Chief Bryan Warner:

- I want to give my time to Ms. Lisa Pivec, my authorized representative.

Comment from Ms. Lisa Pivec:

- I'll try to be brief and succinct on behalf of Cherokee Nation and Cherokee Nation Health Services.
- When we look at the recommendations for measuring burden of COVID-19 in our communities, I agree with Councilwoman Frias that question one and three are kind of similar in an answer. In her answer, she alluded to measuring the burden from other perspectives, other than positivity rate and testing.
- One of the things that we do in a model that I think could be geared towards helping us in our tribal communities is the use of the Social Vulnerability Index Scores. And one of the things I think about when looking at those scores is, how can those be tailored to tribal communities. We are covering all a part of 14 counties in eastern Oklahoma with a total population of close to half a million people. Being able to prioritize efforts is important for us, from a tribal perspective, where we provide all kinds of services across all programs and departments. We look at burden more collectively. It's not just health outcomes, but how do we look at the burden from another angle, provide data, and prioritize where we put those resources.

- For us, an issue on important data needs is that we have tribal citizens within the reservation who seek services elsewhere outside of the tribal Cherokee nation. We have a very difficult time getting American Indian Alaska native specific information and data throughout through the state of Oklahoma and CDC. We really need that information to see how we are doing in our efforts and to see what really do need to prioritize. It's very important in measuring burden, in the present to try to predict what we're going to need to do for a potential next disaster or for potential next variant that comes out and what can we do to strengthen our efforts in those communities to reduce that burden.
- With case investigation and contact tracing much like the other tribes we stood up contact tracing case investigation very early in the process, using examples from the World Health Organization (WHO) and I'm happy to see that CDC has come out with some very helpful tools. I serve on the NATO board of directors, representing tribes, last week, we had a conversation about the updated scaling down of case investigation contact tracing during high transmission communities. What I will comment on is that while case investigation and contact tracing is very consistent in its outcomes with other states, it also has an additional component. We really do community service needs with this component. We actually answer questions and prioritize elders. We look at those vulnerable communities. In the language of the update guidelines for contact tracing and case investigation, it's really important to acknowledge how tribes have those individual need. I have seen it in statements, but it is not emphasized that this is a really individual endeavor and if we were to completely stop what we're doing or reduce our efforts, specifically to just nothing, then we would be missing a lot of those opportunities to measure burden.
- I think the CDC can help tribes with very strong language for tribal health system to understand the difference between Contact tracing and case investigation as a public health and governmental responsibility that protects the public and healthcare delivery services. Often, we've seen that those lines become blurred throughout the pandemic of what exactly case investigation and contact tracings use for tribes is. We as tribes, we look to CDC for guidance. We look at you as the experts.
- Those of us at Cherokee Nation look closely to the CDC for guidance as the rule and the more that you can specify and help tribes specify in the lens of health equity is super helpful. It helps us to navigate our way through COVID-19 testing. It is very important for CDC to talk about what tribal communities look like and COVID-19 testing looking at the social vulnerability scales.

Comments from Councilman Nate Tyler:

- Measuring the burden, there's quite a bit out there that has measured burden. As tribal leaders the burden has been funding, mental health, and substance abuse. One of the biggest that we see with our community is the hesitancy. We've had so many people that tested positive, I don't know what the rate is, but they've shown absolutely no symptoms. Then people start to think that it is not serious, and it is very serious. I don't know the answer for those that tested positive and showed no symptoms. I'd like more information on that.
- On to data needs. The University of Washington was asking for volunteers to do trial studies, so I emailed them. There isn't enough information on Native Americans, so I emailed as a tribal leader. I didn't hear back from them, so I haven't heard about any studies on Native Americans. That research is a missing part. There isn't enough information on our youth. When COVID-19 first hit, a specific population was expected to be largely hit, the elderly and those with underlying health conditions. Today, that is not really the case. We're starting to see a lot of a younger generation test positive. Children under five cannot get the vaccine yet, so I'm worried about the youth. Nationally, PPE has been hard to come by. Tribal communities are vaccinated at 87% rate of vaccinated with the first two shots but only 42% with the booster. Access to tests is a must.
- There was no playbook for us with contact tracing. It came to a point where we could not keep up. We're a small community with 3,000 tribal members and 1,500 live in the community. We're talking

multi-generational homes. We really got hit hard by COVID-19. We were seeing houses with 10 people testing positive. It became too much for us to contact trace.

Comment from Mark Anderson:

- Thank you to everyone for listening and for contributing. If anyone has any other comments, please email eocevent424@cddc.gov.

3:15 pm—Tribal Testimony

- Deputy Principal Chief Bryan Warner reminded TAC members that written testimony is due February 10th and should be sent to tribalsupport@cdc.gov.

Tribal Testimony

Testimony from Deputy Principal Chief Bryan Warner:

- Throughout time and during this TAC meeting, there were several questions posed. One of those that took an overall tone is what tribal public health infrastructure needs should be addressed. I know that is very broad subject, but when we look at funding and recognition of tribal public health authority that falls underneath infrastructure.
- The 2019 Public Health in Indian Country Capacity Scan identified the two most fundamental priorities. Number one is consistent and equitable funding. Number two is recognition and respect of tribal public health authority while tribal health organizations maximize their available resources to administer various public health activities and services. With the existing public health workforce, tribal public health remains inadequately resourced. Increase stable funding, technical assistance, and public health education are needed to ensure that tribes can improve the health and wellbeing of tribal communities.
- Furthermore, the sovereign political status of tribal nations presents opportunities for advancing public health capacity but requires that federal agencies honor the federal trust responsibility in respect of tribal sovereignty.
- Therefore, we request that the CDC work to ensure consistent and appropriate funding to address those needs identified through a tribal public health infrastructure assessment.
- The CDC should use allocation and distribution mechanisms to allow federally recognized tribes to receive funding directly, not through states or through competitive grants.
- The CDC should ease funding restrictions that may limit how tribes apply for and use the funding.
- And this last one is for us, there's been many times that the Cherokee Nation throughout this within our own state, within our own tribal nation, and government to government relationship, there has been strain. When we look at public health authority, its paramount that the CDC help provide official guidance to federal state, local, and territorial public health systems that affirms tribal nations role as a legally established government public health authority. Doing this will clear misinformation that hinders how we need to move throughout the pandemic. Tribes are always trying to figure out how they can do things better, not just for the government's sake, but for the communities. It is all for tribal household all the way to tribal individual.
- The heartbeat of our nation is within our individuals that make up our family units and communities. That is the reason why we have established governments and we have business arms to make sure that we can maintain the safety and the integrity of the resources that we have.

3:50 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

- Dr. Montero provided summary highlights of the meeting and thanked everyone for attending and participating throughout the meeting. Dr. Montero also mentioned that the 24th Bi-Annual TAC meeting will be hosted in person in Oklahoma by Cherokee nation August 3rd and 4th .
- Deputy Principal Chief Warner thanked everyone for their participation and discussion during the meeting.
- Deputy Principal Chief Warner closed the meeting with a prayer.

Appendices

Appendix A: Acronym List

AI/AN	American Indian/Alaska Native
ATSDR	Agency for Toxic Substances and Disease Registry
CDC	Centers for Disease Control and Prevention
CIOs	Centers, Institute, and Offices
COVID-19	2019 Novel Coronavirus Disease
CR	Continuing Resolution
CSELS	Center for Surveillance, Epidemiology, and Laboratory Services
CSTLTS	Center for State, Tribal, Local, and Territorial Support
DPH	Division of Population Health
DPPS	Division of Program and Partnership Services
FACA	Federal Advisory Committee Act
GHWIC	Good Health and Wellness in Indian Country
HHS	United States Department of Health and Human Services
HRSA	Health Resources and Services Administration
IAA	Interagency Agreement
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
OA	Office of Appropriations
OD	Office of The Director
OCOO	Office of The Chief Operating Officer
OFR	Office of Financial Resources
OMB	Office of Management and Business
OTASA	Office of Tribal Affairs and Strategic Alliances
PHAP	Public Health Associate Program
PHICCS	Public Health in Indian Country Capacity Scan
RPMS	Resource and Patient Management System
SDOH	Social Determinants of Health
SDPI	Special Diabetes Program for Indians
STAC	Secretary Tribal Advisory Committee
TAC	Tribal Advisory Committee
TEC	Tribal Epidemiology Center
TECPHI	Tribal Epidemiology Centers for Public Health Infrastructure
TPWIC	Tribal Practices for Wellness in Indian Country
WHO	World Health Organization

Appendix B: 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, 2023	**Bernalyn "Gina" Via** Council Member *Mescalero Apache Tribe*	**VACANT**
Bemidji Area **Term Expires:** August 31, 2023	**Jennifer Webster** Councilwoman *Oneida Nation*	**Debra Danforth** Division Director *Oneida Nation*
Billings Area **Term Expires:**	**VACANT**	**VACANT**
California Area **Term Expires:** October 31, 2023	**Teresa Sanchez** 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*	**Fred Fox** Executive Secretary *Mandan, Hidatsa, and Arikara Nation*
Nashville Area **Term Expires:** August 31, 2023	**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*
Navajo Area **Term Expires:** August 31, 2023	**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, 2023	**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	**VACANT**

	San Carlos Apache Tribe	
Portland Area **Term Expires:** August 31, 2023	**Nate Tyler** Councilman *Makah Tribe*	**VACANT**
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:** October 31, 2023	**Sharon Stanphill, MD** Chief Health Officer *Cow Creek Band of Umpqua Tribe of Indians*	**VACANT**
Tribes At-Large **Term Expires:** August 31, 2023	**Connie Barker (TAC Co-Chair)** Tribal Legislator *The Chickasaw Nation*	**VACANT**
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, 2023	**Herminia Frias** Councilwoman *Pascua Yaqui Tribe*	**VACANT**

Appendix C: CDC Attendees

Karon Abe
Melanie Amacker
Fata Baako
Coley Bean
Leann Bing
Kailyn Bostic
Ashley Busacker
Renee Calanan
Justin Casto
Karen Cobham- Owens
James Crockett
Pasha Diallo
Naomi Drexler
Nyame Nti Nsibienakou Fawohodie
Anika Garner
Dave Goodman
Nathan Griffin
Veda Harrell
Noelle Henderson
Kim Hoch
Tracy Ingraham
Ryan Jackson
Irving Julien
Jacob Kerns
Sophia Kiselova
Danielle LaFleur
Monica Leonard
Judy Lipshutz
Victoria McBee
Donna McCree
Jenna Meyer
Karen Mumford
Matt O'Shea
Kiyana Perrino
Talia Pindyck
Vivian Porter
Judith Robinson
Delight Satter
Sadie Shervheim
Katy Standish
Stephanie Tran
Anjel Vahratian
Nicole Wachter
Angela Webb
Cori Wigington
Maddie Woodruff

Cleopatra Adedeji
Mark Anderson
Kimberly Badger
James Beck
April Blowe
Breanna Branche
Treasure Byrge
David Capo
AnnMarie Chase
Elizabeth Conrey
Christina Dahlstrom
Kelly Dickinson
Shelby Duessel
Jennifer Frazier
CheBreia Gibbs
Carissa Grant
Keira Hall
Diane Harris
Roberto Henry
Jessie Hood
Katherine Irani
Yolanda Jacobs
Rhonda Kaetzel
Michael Kerzner
Laura Kollar
Tamara Lamia
Jane Li
Katherine Luce
Erin McCanlies
Michelle McKinney
Jessica Miller
Stephanie Neitzel
Sara Patterson
Emily Pham
Melissa Podolsky
Homma Rafi
Ren Salerno
Lenora Satterfield
Gia Simon
Catherine Sugg
Elizabeth Triece
Lia Van Steeter
Charisse Walcott
Seh Welch
Rebecca Willis
Tom Young

Rasha Al Rawi
Nancy Andrade
Nicole Barron
Christina Becker
Randella Bluehouse
Joi Brownlee
Amanda Cadore
Hallie Carde
Karla Checo
Amy Cordero
Elizabeth Dalsey
Sonal Doshi
Jessica Enhelder
TR Fuller
Adrienne Gill
Brittany Grear
Hannah Hanson
Samantha Harrykissoon
Jan Hicks Thomson
Emily Hops
Ikovwa Irune
Calla Jamison
Dolly Katz
Kathy Keys
Alfred Koroma
Rhea-Lanee Lansang Tran
Karina Lifschitz
Karin Mack
LaNesha McCann
Timothy McLeod
Holly Miranda
Joanne Odenkirchen
Chelsea Payne
Victoria Phifer
Beth Pollak
Bridget Richards
Shannon Saltclah
Andrea Schmidt
Gregory Smith
Summer Terry
Jared Tucker
Brandy Vaughn
Conne Ward-Cameron
Rolieria West
Nancy Wong

Annabelle Allison
Danielle Arellano
Joanna Barton
Kevin Begay
Lacey Bokeloh
Sharunda Buchanan
Catherine Cairns
Rosalind Carter
Jason Chou
Liza Corso
Ariana Desmore
Audrey Dowling
Siobhan Eze
Victoria Gaines
Micaiah Gilliam
Donata Green
Megan Harbour
Annie Hatley
Cynthia Hill
Jason Hymer
Asha Ivey-Stephenson
Melissa Jim
Molly Kellum
Thyra Kimbell
Rachel Kossover-Smith
Janet Lee
Kelsey Linzell
Helen Malcolm
Tia McClelland
Jonathan Mermin
Staci Morris
Kenny A Ortiz
Chandra Pendergraft
Lori Phillips
Kristin Pope
Laura Richardson-Smith
Aishwarya Sasidharen
Alexys Scott
Yuri Springer
Annie Tran
Madilynn Turner
Melissa Victor
Alleen Weathers
Jessica Wiens
Andrea Wooddall