

Winter 2021

21st Biannual CDC/ATSDR Tribal Advisory Committee Meeting



CDC/ATSDR Tribal
Advisory Committee
Briefing Packet

February 3, 2021

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Overview

21st BIENNIAL CDC/ATSDR TRIBAL ADVISORY COMMITTEE MEETING



Federal Moderator: José Montero, MD, MHCDS, Director, Center for State, Tribal, Local, and Territorial Support (CSTLTS)

Tribal Moderator: Robert TwoBears, Legislative Representative, Ho Chunk Nation of Wisconsin, Tribal Advisory Committee (TAC) Chair

FEBRUARY - 2021

3 WEDNESDAY

- | | |
|----------------|---|
| 1:00 PM | Opening Blessing, Welcome, and Introductions |
| 1:20 PM | TAC Business |
| 2:10 PM | National Institute for Occupational Safety and Health Strategic Plan Update |
| 2:30 PM | CDC/ATSDR Updates |
| 3:00 PM | Technical Assistance Discussion |
| 3:30 PM | COVID-19 Response Update and Discussion |
| 5:00 PM | <i>Break</i> |
| 5:20 PM | Tribal Testimony |
| 6:30 PM | Summary, Closing Prayer, and Adjournment |

Agenda subject to change

TAC Business

CENTERS FOR DISEASE CONTROL AND PREVENTION AND AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

TRIBAL ADVISORY COMMITTEE CHARTER

Revised November 21, 2013

PURPOSE

The purpose of the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR)¹ Tribal Advisory Committee (TAC) is to provide a forum wherein Tribal representatives and CDC/ATSDR staff exchange information about public health issues in Indian country, identify urgent public health needs, and discuss collaborative approaches to address these issues and needs. The CDC/ATSDR TAC will support, and not supplant, any other government-to-government consultation activities that CDC/ATSDR undertakes. In addition to assisting CDC/ATSDR in the planning and coordination of tribal consultation sessions, the TAC will advise CDC/ATSDR regarding the government-to-government consultation process and will help ensure that CDC/ATSDR activities or policies that impact Indian country are brought to the attention of all Tribal leaders.

AUTHORITY

In recognition of the unique political and legal relationship that Indian Tribes have with the Federal Government, and pursuant to Presidential Executive Order No. 13175 (November 6, 2000) and the Presidential Memorandum of November 5, 2009, CDC/ATSDR has established a Tribal Consultation Policy for working with Federally-recognized Tribes on a government-to-government basis. The US Department of Health and Human Services (HHS) has adopted a Tribal Consultation Policy that applies to all HHS Operating Divisions, including CDC/ATSDR. The HHS Tribal Consultation Policy directs Operating Divisions to establish a process to ensure meaningful consultation and timely input from Indian Tribes before actions are taken that will significantly affect Indian Tribe(s).

The TAC Charter complies with the “Unfunded Mandates Reform Act Exemption” to the Federal Advisory Committee Act (FACA) found in Section 204 of the Unfunded Mandates Reform Act, P.L. 104-4², and is therefore exempt from FACA, 5 U.S.C. App. 2.

¹ Note: References to CDC also apply to the Agency for Toxic Substances and Disease Registry (ATSDR). The CDC Director also serves as the ATSDR Administrator.

² 2 U.S.C. § 1534 (b) provides:

The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to actions in support of intergovernmental communications where—

- (1) meetings are held exclusively between Federal official and elected officers of State, local and Tribal governments (or their designated employees with authority to act on their behalf) acting in their official capacities; and
- (2) such meetings are solely for the purposes of exchanging views, information, or advice relating to the management or implementation of Federal programs established pursuant to public law that explicitly or inherently share intergovernmental responsibilities or administration.

FUNCTION

The purpose of the TAC is to identify priorities and exchange views, information, or advice regarding the management or implementation of CDC/ATSDR programs and initiatives that affect Tribe(s) and American Indian and Alaska Native (AI/AN) communities, including those that arise explicitly or implicitly under statute, regulation, or Executive Order. This purpose will be accomplished through forums, meetings, and conversations among Federal officials and elected Tribal leaders in their official capacity (or their authorized representative).

The purview of the TAC covers, but is not limited to, the following core functions:

- Identify evolving issues and barriers to access, coverage, and delivery of services to AI/AN related to CDC/ATSDR programs;
- Propose clarifications, recommendations, and solutions to address issues raised at Tribal, regional, and national levels;
- Serve as a forum for Tribes and CDC/ATSDR to discuss these issues and proposals for changes to CDC/ATSDR regulations, policies, and procedures;
- Identify priorities and provide advice on appropriate strategies for Tribal consultation on issues at the Tribal, regional, and/or national levels; and
- Communicate with Indian Tribes in the respective area and gather feedback on pertinent issues.

The CDC/ATSDR TAC will support, and not supplant, any other government-to-government consultation activities that CDC/ATSDR undertakes.

COMMITTEE COMPOSITION

In accordance with the “Unfunded Mandates Reform Act Exemption” to FACA found in Section 204 of the Unfunded Mandates Reform Act, P.L. 104-4, CDC/ATSDR has incorporated the Indian Health Services (IHS) Area and the Federally-recognized Tribes At-Large positions as members of the TAC to provide specific representation for the regional and national concerns of Tribal governments. The TAC will be comprised of 16 members to be filled by voluntary representatives: one delegate (and one authorized representative) from a Federally-recognized Tribe geographically located in each of the 12 Indian Health Service Areas, and one delegate (and one authorized representative) from four Federally-recognized Tribes At-Large.

Delegates

The delegates must be elected Tribal officials, acting in their official capacity as elected officials of their Tribe, with authority to act on behalf of the Tribe, and qualified to represent the views of the Indian Tribes in the respective area from which they are nominated.

In the event that the delegate will not be attending a TAC meeting, the authorized representative will be notified to participate on behalf of the delegate prior to the meeting. If the authorized representative is not available, the delegate shall designate a second authorized representative, in writing, prior to the meeting.

Authorized Representatives

An authorized representative may be an elected Tribal official or designated Tribal official that is qualified to represent the views of, speak for, and bind the Tribe he or she is representing in the same manner as the delegate/Tribal official, and represent the views of Indian Tribes.

Authorized representatives might include, but are not limited to, tribal health officers, tribal

health system executive directors, and leadership of regional and national non-profit corporations (501(c)(3)) such as the National Congress of American Indians, the National Indian Health Board, and the National Indian Child Welfare Association. Authorized representatives act on behalf of the delegate, and therefore on behalf of the delegate's tribe, and may only represent one Tribe. A tribal leader may not serve as a representative of any entity other than his or her Tribe.

Subcommittees

The Executive Secretary has the authority to create FACA-exempt subcommittees, composed of TAC delegates (or their authorized representatives), as needed to accomplish the functions of the full TAC. Subcommittees must report back to the TAC, and must not provide advice or work products directly to the CDC/ATSDR.

SELECTION PROCESS

The process for selecting Tribal members of the TAC is designed to acknowledge the role of Tribal Governments and their elected or appointed officials with regard to consultation on policy issues. The CDC/ATSDR Associate Director for the Tribal Support Unit will serve as the Designated Federal Official/Executive Secretary for the TAC. As such, the Designated Federal Official/Executive Secretary will facilitate the solicitation and selection of Tribal representatives to the TAC. The names of each TAC delegate and authorized representative are to be submitted to the Designated Federal Official/Executive Secretary in an official letter from the Tribe. The Designated Federal Official/Executive Secretary is responsible for identifying and finalizing the body of members from those candidates nominated by Federally-recognized Tribes and ensuring that the delegates (and authorized representatives) meet the FACA exemption requirements. The seated TAC membership will be fully engaged in the recruitment process.

Nominations will be considered in the priority order listed below.

1. Tribal President/Chairperson/Governor
2. Tribal Vice-President/Vice-Chairperson/Lt. Governor
3. Elected or Appointed Tribal Official
4. Designated Tribal Official

In the event that there is more than one nomination for a delegate or authorized representative seat, submitted by more than one Federally-recognized Tribe, letters of support for individuals from regional Tribal organizations will be taken into consideration.

CDC/ATSDR SUPPORT

The CDC Office of the Director, through the Deputy Director for State, Tribal, Local and Territorial Support, will designate the Tribal Support Unit with the responsibility for implementation, coordination, and agency-wide adherence to CDC/ATSDR and HHS Tribal Consultation Policies. Unless otherwise designated by the Director, the Designated Federal Official/Executive Secretary will be the Associate Director for the Tribal Support Unit. The Designated Federal Official/Executive Secretary will support TAC functions and serve as a scientific and programmatic resource for the TAC.

In addition, key CDC/ATSDR managers and staff, as determined by the Designated Federal Official/Executive Secretary, shall serve as resources to the TAC by providing leadership, technical assistance, and subject matter expertise to the TAC in carrying out its duties and responsibilities. As part of these responsibilities, the Designated Federal Official/Executive Secretary will ensure that Tribal access to CDC/ATSDR programs that affect Tribe(s) and AI/AN communities is monitored by tracking the total resources allocated annually to serve AI/ANs and prepare an inventory of new programs and policies affecting AI/AN communities. Because the TAC is a high-level agency advisory committee, the CDC Director/ATSDR Administrator and agency senior leadership will make attendance at TAC meetings a high priority whenever possible.

LEADERSHIP

Chair

A Chair will be elected by and from the TAC members for a one calendar-year term of service. The Chair will be an elected Tribal leader. The number of terms is not limited.

Co-Chair

The Co-Chair will be elected by and from the TAC members for a one calendar-year term of service. The Co-Chair will be an elected Tribal leader. The number of terms is not limited.

Executive Secretary

The Designated Federal Official/Executive Secretary will serve as the lead point of contact for the TAC. In addition, he or she will provide programmatic guidance, technical assistance, and administrative support. Unless otherwise designated by the CDC Director/ATSDR Administrator or Deputy Director for State, Tribal, Local and Territorial Support, the Designated Federal Official/Executive Secretary will be the Associate Director for the Tribal Support Unit.

Re-election

The Chair and Co-Chair may be re-elected by the TAC for a one calendar-year term. Elections will be held annually, at which time the seated membership of the TAC may reconfirm the Chair/Co-Chair or vote on a new Chair/Co-Chair.

PERIOD OF SERVICE

TAC service periods are limited to two years. A delegate may serve successive, consecutive terms if nominated again when their term expires.

Vacancy

When a vacancy occurs, Federally-recognized Indian Tribes; Tribal, regional, or national organizations; Native-serving organizations; and CDC/ATSDR's HHS partners (including the Secretary's Tribal Advisory Committee and relevant HHS Operating Divisions and Staff Divisions) will be notified of the vacancy and solicited for nominations by the Designated Federal Official/Executive Secretary. In the event of a vacancy, the authorized representative will attend meetings until such a time as the vacancy is officially filled.

Removal

Committee delegates must make a good faith effort to attend all meetings either in person or via teleconference. If a delegate (or authorized representative) does not participate in a meeting or

teleconference on three successive occasions, the Chair or Designated Federal Official/Executive Secretary will notify the Indian Tribe(s) in the respective area and ask them to nominate a replacement.

MEETINGS³

Depending on availability of funds, the TAC will convene two face-to-face meetings per fiscal year. These meetings may be held in conjunction with formal CDC/ATSDR tribal consultation sessions. These meetings may be funded in whole or in part by CDC/ATSDR. TAC conference calls will be held as needed and additional meetings may be scheduled depending on need and availability of funds. The Designated Federal Official/Executive Secretary will collaborate with the TAC Co-Chairs and TAC membership to develop TAC meeting agendas. The TAC Co-Chairs and the Designated Federal Official/Executive Secretary will confer, establish consensus, and finalize the agenda for each meeting. CDC/ATSDR will host one meeting in Atlanta and the other will be hosted by a Tribe, in accordance with HHS and CDC/ATSDR meeting policies. TAC meetings will complement, and not supplant, the Tribal consultation process between CDC/ATSDR and Federally-recognized Tribes.

QUORUM

A quorum is established with a simple majority of voting members seated. In the event that the TAC is not able to establish a quorum for its meeting, then the co-chairs, at their discretion, can arrange for polling of members via conference call or any other manner.

VOTING

The TAC will operate by consensus. Where a consensus cannot be reached, the TAC will vote to resolve any differences. Each TAC member (delegate or authorized representative) will be allowed one vote. If both the delegate and his or her authorized representative participate in the same meeting or call, only the delegate will be counted for a quorum and voting purposes.

BUDGET

The TAC budget, including travel, per diem, communication, and other related expenses will be proposed to CDC/ATSDR annually for each subsequent fiscal year.

REPORTS

The Designated Federal Official/Executive Secretary will ensure that all TAC meeting proceedings and recommendations are formally recorded and provided to the TAC through written minutes within 60 days following the TAC meeting. Once approved, the minutes will be posted online on the CDC Tribal Support Unit's website to ensure that the information is accessible to the public. Recommended follow-up requiring federal actions and/or attention will be implemented and tracked within CDC/ATSDR and reported to the TAC at least 30 days before the next in-person TAC meeting.

³ Pursuant to Section 204(b) of the Unfunded Mandates Reform Act (2 U.S.C. § 1534(b)), members of the public may be present at committee meetings, i.e., in the audience as observers, but, since members of the public are not allowed on the committee, they may not participate in any committee discussions, or any other committee business during the meeting.

MEETING LOGISTICS

The TAC membership, in collaboration with CDC/ATSDR, will determine the place and time of TAC meetings. Dates will be checked with HHS's Office of Intergovernmental and External Affairs to avoid conflicts whenever possible. The CDC/ATSDR Tribal Support Unit will provide onsite meeting coordination for the annual TAC meeting and consultation meetings.

TERMINATION DATE

This TAC Charter shall be effective as long as the CDC Tribal Consultation Policy is in effect. The TAC Charter may be revised or amended upon approval by the TAC and final approval by the Designated Federal Official/Executive Secretary.

ACRONYMS

CDC	Center for Disease Control and Prevention
ATSDR	Agency for Toxic Substance and Disease Registry
TAC	Tribal Advisory Committee
FACA	Federal Advisory Committee Act
AI/AN	American Indian/Alaska Native

**CENTERS FOR DISEASE CONTROL AND PREVENTION AND
AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY**

**TRIBAL ADVISORY COMMITTEE
CHARTER**

January 2020

BACKGROUND

The United States has a unique legal and political relationship with Indian Tribal governments, established through and confirmed by the Constitution of the United States, treaties, statutes, executive orders, and judicial decisions. In recognition of that special relationship, pursuant to Executive Order 13175 of November 6, 2000, executive departments and agencies are charged with engaging in regular and meaningful consultation and collaboration with Tribal officials in the development of federal policies that have Tribal implications and are responsible for strengthening the government-to-government relationship between the United States and Indian Tribal Nations.

PURPOSE

The purpose of the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR)¹ Tribal Advisory Committee (TAC) is to provide a forum wherein elected Tribal leaders acting in their official capacity (or their designated employees with authority to act on their behalf) and CDC/ATSDR staff exchange views, information, or advice about emerging public health issues in Indian Country, the identification of urgent public health needs, and collaborative approaches to address these public health issues and needs of American Indian/Alaska Native (AI/AN) populations. The content of the meetings consists of exchanges of views, information, or advice on CDC/ATSDR program, policies, and priorities that affect AI/AN populations, as well as the implementation of intergovernmental responsibilities or administration, including those that arise from statute, regulation, or executive order. The CDC/ATSDR TAC will support, and not supplant, any other government-to-government consultation activities that CDC/ATSDR undertakes. In addition to assisting CDC/ATSDR in the planning and coordination of Tribal consultation sessions, the TAC will advise CDC/ATSDR regarding the Tribal consultation process and will help ensure that CDC/ATSDR activities or policies that impact Indian Country are brought to the attention of all Tribal leaders.

AUTHORITY

Pursuant to Presidential Executive Order No. 13175, November 6, 2000, and the Presidential memoranda of September 23, 2004, and November 5, 2009, the United States Department of Health and Human Services (HHS) adopted a Tribal Consultation Policy that applies to all HHS operating and staff divisions, including CDC and ATSDR. The HHS Tribal Consultation Policy directs operating divisions to establish a process to ensure accountable, meaningful, and timely input by Tribal officials in the development of policies that have Tribal implications.

¹ Note: References to CDC also apply to the Agency for Toxic Substances and Disease Registry (ATSDR). The CDC director also serves as the ATSDR administrator.

Consistent with the HHS Tribal Consultation Policy, CDC and ATSDR established the CDC/ATSDR TAC as one method of enhancing communications with Tribal Nations. The TAC Charter complies with an exemption within the “Unfunded Mandates Reform Act” or UMRA (P.L. 104-4) to the Federal Advisory Committee Act (FACA) that promotes the free communication between the Federal government and Tribal governments. In accordance with this exemption, the CDC/ATSDR TAC facilitates the exchange of views, information, or advice between Federal officials and elected officers of Tribal governments (or their designated employees with authority to act on their behalf) acting in their official capacities.

FUNCTION

Per UMRA exemption policy and in recognition of Tribal sovereignty and the government-to-government relationship between Federally recognized Tribal Nations and the Federal government, TAC responsibilities are to exchange information or advice relating to the management or implementation of intergovernmental responsibilities or administration, including those arising from federal statute, regulation, or Executive Order.

COMMITTEE COMPOSITION

The TAC will include only elected officers of Tribal governments (or their designated employees with authority to act on their behalf) acting in their official capacities from each of the twelve geographic areas served by the Indian Health Service (IHS) and the five Federally-recognized Tribes At-Large Members (TALM). These areas currently are the following: Alaska, Albuquerque, Bemidji, Billings, California, Great Plains, Nashville, Navajo, Oklahoma, Phoenix, Portland, and Tucson. In addition, to achieve the broadest coverage of Tribal perspectives and views on CDC/ATSDR issues and programs, the TAC includes one representative (and designated alternate) for each of the five TALMs positions. These TAC members will provide specific representation for the regional and national concerns of Tribal governments. The TAC will consist of 17 members and will be structured to include the following representatives: one member and one alternate delegate from each of the 12 IHS areas, and one member and one alternate for each of the five TALM positions. A designated alternate may participate in TAC meetings on behalf of the primary member when that member cannot attend.

TAC Member

The Area/TALM member should be an elected officer of a Tribal government (or their designated employee with authority to act on their behalf), acting in his or her official capacity. The Area/TALM member must be qualified to represent the views of the Indian Tribal Nations in the respective area from which he or she was nominated.

Employees of an elected officer of a Tribal government who have authority to act on that officer's behalf and who are designated to do so in writing may participate on the TAC in lieu of the elected officer. A designated employee should have authority to speak for and bind the Tribal Nation he or she is representing in the same manner that the Tribal official would.

If a member cannot attend a TAC meeting, the member will notify, by email, the Director of the Office of Tribal Affairs and Strategic Alliances (OTASA) within CDC's Office of State, Tribal, Local, and Territorial Support (CSTLTS). OTASA will then notify the alternate, prior to the meeting, to participate on the TAC member's behalf.

TAC Alternate

The alternate should be an elected officer of a Tribal government (or their designated employee with authority to act on their behalf), acting in his or her official capacity. An area alternate must be qualified to represent the views of the Indian Tribal Nations in the respective area from which he or she was nominated. In the event the alternate will be participating on behalf of the member, the alternate will be given full voting rights. The alternate may attend all TAC meetings and activities but cannot participate actively unless the seat is ceded by the primary member.

One-Time Appointment of an Interim Representative

If both the member and alternate are not available for a meeting, the member may designate an alternate, known as a "interim representative," who is an elected officer of a Tribal government (or their designated employee with authority to act on the Tribal Nations behalf), acting in his or her official capacity, to serve in his or her place. The interim representative will have the same voting rights as the member. The member must designate the interim representative in writing, via signed letter on official letterhead, to the OTASA Director prior to the TAC meeting.

When there is a vacancy in a member's position (due to removal or for other reasons) for which a designated alternate is currently serving, the Designated Federal Official (DFO) will notify the designated alternate and request that the alternate perform the duties of the TAC member to the extent the designated alternate would be eligible to serve as a member on the TAC. The criteria and process for selecting a replacement following a vacancy or removal will follow the selection process described above. The designated alternate will serve the remainder of the unexpired term of the original member and if nominated again may serve successive, consecutive terms.

SELECTION PROCESS

The Director of OTASA will serve as the executive secretary for the TAC (designated federal official). The executive secretary will announce TAC vacancies and solicit nominations from federally-recognized Tribes. Only federally-recognized Tribes may nominate TAC members and their alternates. Submissions must include signed nomination letters on official Tribal Nation letterhead with the following information and be sent to the executive secretary by the requested deadline:

1. Name of the nominee
2. Nominee's official title
3. Name of the Tribal Nations
4. Date of nominee's election to official Tribal position and term length
5. Nominee's contact information (mailing address, phone, fax, and email)
6. Name of elected officer submitting nomination
7. Official title of elected officer submitting nomination
8. Contact information for elected officer submitting nomination and/or administrative office for Tribal government
9. Confirmation that the nominee:
 - a. has the authority to act on behalf of the Tribal Nations
 - b. is qualified to represent the views of the Indian Tribal Nations in the area from which he or she is nominated

The executive secretary is also responsible for selecting the TAC members based on the submitted letter(s). The seated TAC membership will be notified of the results of the recruitment process via email. Nominations are considered for selection in the priority order listed below:

1. Tribal President/Chairperson/Governor
2. Tribal Vice-President/Vice-Chairperson/Lt. Governor
3. Elected or Appointed Tribal Official
4. Designated Tribal Official

In the event there is more than one nomination for a member or alternate seat, letters of support from regional and national Tribal organizations will be taken into consideration.

MEETINGS

CDC/ATSDR seeks to convene up to two face-to-face TAC meetings on a fiscal year basis, depending on the availability of funds. CDC/ATSDR expects to host one in-person meeting in Atlanta, Georgia, and a Tribal Nation will host the other meeting, in accordance with HHS and CDC/ATSDR meeting policies.

These meetings may be held in conjunction with formal CDC/ATSDR Tribal consultation sessions and may be funded in whole or in part by CDC/ATSDR. CDC/ATSDR may convene TAC conference calls as needed. Additional meetings may be scheduled depending on need and availability of funds.

Pursuant to Section 204 (b) of the Unfunded Mandates Reform Act (2 U.S.C. §1534 (b)), members of the public may be present at committee meetings (i.e., in the audience as observers), but since members of the public do not serve as or necessarily qualify as eligible to be TAC members, they may not participate in any committee discussions or any other committee business during meetings.

To ensure that members and alternates are afforded every opportunity to meaningfully engage in the TAC and fulfill their roles as members, members and alternates must be consulted on the date, time and location of the TAC meetings. Once date, time, and location have been finalized, members and alternates must be provided timely notice of the scheduled TAC meetings. Additionally, the purpose, preliminary charge, time frame, and other specific tasks of the meeting shall be clearly identified in the notice.

The CDC Director/ATSDR Administrator and CDC/ATSDR senior leadership will be invited and may participate in dialogue during TAC meetings.

TAC LEADERSHIP

Chair

A Chair is selected by and from the TAC members for a one calendar-year term of service. The Chair will be an elected or appointed Tribal officer. The Chair may serve additional terms provided he or she remains a TAC member.

Co-Chair

The Co-Chair is selected by and from the TAC members for a one calendar-year term of service. The Co-Chair will be an elected or appointed Tribal officer. The Vice-Chair may serve additional terms provided he or she remains a TAC member.

Designated Federal Official (DFO)

The DFO serves as the lead point of contact for the TAC. The DFO may delegate responsibilities for the administration and operational functions for the TAC to the executive secretary. In addition, this individual:

1. Provides programmatic guidance, technical assistance, and administrative support
2. Selects key CDC/ATSDR leaders and staff to serve as resources to the TAC by providing leadership, technical assistance, and subject matter expertise
3. Monitors and tracks the total resources allocated annually to serve AI/AN populations through CDC/ATSDR programs and initiatives
4. Actively engages the TAC in the creation of the agenda for all in-person and virtual TAC meetings and conference calls

Unless otherwise designated by the CDC Director/ATSDR Administrator, the DFO will be the Director for CDC's Center for State, Tribal, Local, and Territorial Support (CSTLTS).

Re-election

The TAC will hold elections annually, at which time the seated members of the TAC will call for nominations for an election. TAC members may reconfirm the Chair/Vice-Chair or vote on a new Chair/Vice-Chair.

TAC MEMBER PERIOD OF SERVICE

TAC members serve 2-year terms.

Vacancy

When a vacancy occurs on the TAC, the DFO will notify the following of the vacant seat to solicit nominations: federally-recognized Indian Tribes; Tribal, regional, or national organizations; AI/AN- serving organizations; and CDC/ATSDR's HHS partners (including HHS Secretary's Tribal Advisory Committee and relevant HHS Operating Divisions and Staff Divisions).

When a vacancy occurs, the DFO notifies the Tribal Nations in the respective area (all Tribal Nations will be notified if a TALM position is vacant) and ask them to nominate a replacement. Elected Tribal officers must submit a signed nomination letter of a nominee, in writing and by the deadline provided by the DFO. In the event no nominations are received, the DFO shall seek a new appointee. The designated alternate may attend meetings until the vacancy is officially filled.

Removal

TAC members must make a good faith effort to attend all official meetings either in person or via teleconference. If a member or alternate does not participate in a meeting or teleconference on three consecutive occasions, the DFO will send a letter to the Indian Tribal Nation(s) in the respective area, thanking them for their service. The executive secretary will then announce the position as vacant and will start the selection process for a new member. CDC/ATSDR may also request removal if a delegate fails to meet the requirements for TAC members (e.g., loss of election or change in elected Tribal position).

Technical Advisor

Each TAC member is allowed to bring at least one technical advisor to the meeting to assist in the performance of the member's duties and responsibilities as a TAC member. The advisor's role is limited to giving advice to the member, and in a non-disruptive manner in the form of private counsel to the member, either communicated discreetly and directly to the

member, or away from the group meeting. Technical advisors are not members of the TAC and are not allowed to sit at the table or take part in the official dialogue during the meeting. Ideally, advisors have expertise in public health and/or experience and knowledge of CDC/ATSDR to fulfill their responsibility of advising TAC members with respect to CDC/ATSDR policies, programs, priorities, and other activities.

QUORUM

A quorum, which is a simple majority of TAC members (9 of 17), present in-person or by telephone, will be necessary for formal decisions and actions to be made by the TAC.. If both the member or alternate cannot attend, the designated interim representative may represent the area or TALM position and be counted toward a quorum. In the event the TAC is unable to establish a quorum for its meeting, then the TAC Chair or Co-Chair, at his or her discretion, can arrange for polling of members via conference call or any other manner. Informational sessions may occur in the absence of a quorum.

EXPENSES

Each primary TAC member (or the designated alternate, if the primary member is unable to attend) who is not a Federal employee will have travel expenses paid/ reimbursed by CDC for up to two face-to-face TAC meetings per year in accordance with standard government travel regulations and CDC travel policy, and dependent upon availability of federal funds.

VOTING

The TAC will operate by consensus. When a consensus cannot be reached, the TAC will vote to resolve any differences. Each TAC member (or designated alternate) will be allowed only one vote. If both the member and his or her designated alternate participate in the same meeting or call, only the member will be counted for a quorum and voting purposes.

REPORTS

The DFO will ensure that all TAC meeting proceedings and recommendations are made available to CDC/ATSDR leadership and provided to the TAC through written minutes within 90 days following the TAC meeting. Once approved, the minutes will be posted online on CDC's Tribal Health website within 90 days to ensure that the information is accessible to the public.

SUBCOMMITTEES

The TAC Chair and Vice-Chair, in consultation with the DFO, may form subcommittees, composed of TAC members (or their alternates), as needed, to accomplish the functions of the TAC. To satisfy the UMRA exemption, the members of the subcommittee must be:

1. Elected Tribal leaders acting in their official capacities; or
2. Designated employees of an elected Tribal leaders with authority to act on their behalf; or
3. The representative of a Washington association designated by elected Tribal leaders to act on their behalf.

Subcommittees must report directly to the full TAC and must not provide any advice or work products to a Federal officer or the CDC/ATSDR. The TAC can adopt and present such advice or work to a Federal officer or CDC/ATSDR.

TERMINATION DATE

This TAC Charter is in effect as long as the CDC/ATSDR Tribal Consultation Policy is in effect. The TAC Charter may be amended, as needed, upon approval by the TAC, and final approval by the DFO.

ACRONYMS

AI/AN	American Indian and/or Alaska Native
ATSDR	Agency for Toxic Substance and Disease Registry
CSTLTS	Center for State, Tribal, Local, and Territorial Support
CDC	Centers for Disease Control and Prevention
DFO	Designated Federal Official/Executive Secretary
FACA	Federal Advisory Committee Act
OTASA	Office of Tribal Affairs and Strategic Alliances (CDC)
STAC	Secretary's Tribal Advisory Committee
TAC	Tribal Advisory Committee
TALM	Tribes At-Large Member
UMRA	Unfunded Mandates Reform Act" (P.L. 104-4)

Submitted via e-mail

October 23, 2020

Robert R. Redfield, M.D.,
Director, Centers for Disease Control and Prevention
1600 Clifton Road,
Atlanta, Georgia, 30329

RE: TRIBAL TESTIMONY FOLLOWING OCTOBER 2020 CDC/ATSDR TAC MEETING

Dear Dr. Redfield,

On behalf of the Centers for Disease Control and Prevention (CDC) and Agency for Toxic Substances and Disease Registry (ATSDR) Tribal Advisory Committee (TAC), we write in follow-up to the October 15-16, 2020, TAC virtual convening. This letter lays out the TAC's responses to the two questions on which CDC requested the TAC comment. The questions posed by CDC to the TAC were:

1. How should CDC allocate funds for the \$14 million (remaining of their total \$208 million dedicated for Tribes) to support Tribal COVID-19 epidemiology, surveillance, laboratory capacity, or other infrastructure?
2. What comments does the TAC have on the current Tribal Practices for Wellness in Indian Country (TPWIC) cooperative agreement? These comments will inform the next TPWIC cooperative agreement, since the current one expires soon.

We thank the CDC for soliciting feedback from the TAC on these important funding items. It is essential that CDC engage in more frequent and timely communication with the TAC to ensure that Tribal recommendations and priorities are directly informing CDC decision-making on Tribally-specific funds and programs. The TAC has produced recommendations in response to the two CDC questions outlined above; however, we would like to note that the CDC must afford the TAC additional time in the future to submit such recommendations. We appreciate that CDC reached out to the TAC for guidance on how to allocate the \$14 million in unobligated COVID-19 funds, but feedback from the TAC should not be a substitute for CDC conducting direct government to government consultation with federally-recognized Tribal Nations.

The TAC also notes that given the amount of vacancies currently on the TAC, this Committee does not fully represent the diverse voices of all 574 federally-recognized sovereign Tribal governments. In the interest of urgency and need for distribution of these COVID-19 funds to Indian Country, we have provided the comments below. However, we strongly encourage CDC to engage in government to government consultation with Tribes prior to making final decisions on distribution of the \$14 million in unobligated COVID-19 funds, and for all future Tribally-specific programs.

Response to Question 1

We again thank the CDC for soliciting feedback from the TAC on the \$14 million in unobligated COVID-19 funds. The TAC was concerned to discover that \$14 million – or roughly 7 percent - of the \$208 million in total Tribally-specific, COVID-19 response funds appropriated to CDC remains unobligated. Not even in CDC’s September 2020 letter to the TAC did CDC inform the TAC that roughly \$14 million remains unobligated and available for allocation and expenditure. Congress appropriated these funds *seven months ago*, at the onset of the pandemic, to provide immediate assistance to the Tribes for a crisis that has disproportionately impacted American Indian and Alaska Native (AI/AN) people. The TAC asserts that CDC did not have to wait until the formal quarterly convening in October to solicit TAC input on how these COVID-19 funds should be distributed; instead, CDC could have easily connected with the TAC during any of the monthly calls held since April to garner feedback and recommendations.

Moreover, we are disappointed that CDC has not held a national listening session to solicit recommendations from elected Tribal leaders or their designated officials on how Tribally-directed COVID-19 funds should be expended. It is inappropriate for CDC to claim it has done its due diligence in soliciting direct Tribal input, as the agency stated in its September 2020 letter to the TAC, by virtue of agency officials attending “...*all IHS, White House, National Indian Health Board and National Council of Urban Indian Health*” calls. While we are pleased that CDC officials attended these calls, attendance is not the same as active facilitation and participation. CDC is its own separate federal agency, and it retains a separate and distinct responsibility to fulfill treaty obligations to the Tribes for public health. Moreover, CDC has its own distinct obligation to directly engage with Tribal leaders and the TAC for guidance, recommendations and input. We urge the CDC to heed this requirement for direct engagement with the Tribes through CDC-led listening and consultation sessions, in addition to attending Tribal calls held by other federal entities and Tribal-serving organizations.

Again - we patiently remind CDC that engagement with the TAC is not a replacement for direct government to government consultation with elected Tribal leaders and/or their designees. Any engagement with the TAC is meant to supplement – not supplant – true and meaningful Tribal consultation.

The TAC also requests further engagement with the CDC to develop methodologies for any future funding distributions to the Tribes, in direct consultation with federally-recognized Tribal governments and engagement with the TAC. This will ensure that the broad and diverse voices of all 574 federally-recognized sovereign Tribal governments are guiding and informing CDC decision-making.

TAC Recommendations on \$14 million in Unspent Tribal COVID-19 Funds

As specified under Title VIII of the CARES Act, under “CDC-Wide Activities and Program Support”, Congress appropriated relief dollars to the CDC “...*to carry out surveillance, epidemiology, laboratory capacity, infection control, mitigation, communications, and other preparedness and response activities.*” As the TAC has discussed at length with the CDC, there is no one-size-fits-all approach to Tribal public health. Each Tribal Nation has its own degree of public health capacity and infrastructure. Within this context, the TAC submits the following recommendations to CDC on how the remaining \$14 million in Tribally-directed, COVID-19 response funds should be disseminated:

- 1. Tribal Nations should be afforded maximum flexibility in how these COVID-19 funds are expended, in accordance with the law, so that Tribes may design programs and response efforts that are best tailored to the local needs of their Tribal community. Additionally, we urge CDC to ensure these funds are distributed expeditiously.**
 - All of the permitted activities outlined in Title VIII of the CARES Act for “CDC-Wide Activities and Program Support” help to build Tribal public health capacity to respond to COVID-19.
 - Thus, Tribes should be permitted to submit applications to use these Tribally-directed CARES Act funds for *any* or *all* of the activities permitted under law.
 - Tribal awardees should be able to utilize these funds to ensure their infrastructure is set up for COVID-19 vaccine distribution. Similar to state and local governments, Tribal governments will need to develop plans, make adjustments to their infrastructure capabilities, and develop communication plans for the vaccine – among other priorities.
 - Maximum flexibility honors inherent Tribal sovereignty, and ensures that each Tribe can design programs that best meet their community needs.
- 2. The CDC should prioritize allocation of the \$14 million directly to federally-recognized Tribal governments using a non-competitive and formula-based allocation methodology that is developed in direct consultation with federally-recognized Tribal governments.**
 - We remind CDC that Tribal organizations – including Tribal Epidemiology Centers – are not Tribal governments. While many Tribes work very closely and collaboratively with Tribal organizations, they are not a substitute for Tribal governments.
 - CDC must also ensure that funding applications are non-competitive so that no Tribal Nation is left behind if they submit an application.
 - The TAC strongly encourages CDC to add these remaining funds to existing Tribal COVID-19 awardees so that Tribes do not have to submit new applications for funding.
- 3. CDC should minimize all application and reporting requirements to ensure expeditious delivery of funds, and to reduce burdensome administrative requirements that take personnel time and energy away from program operations and delivery of public health services**
 - Many Tribes have had to furlough non-essential staff, or lack dedicated grant writers altogether. Due to capacity constraints, many Tribal healthcare providers are forced to perform multiple roles within the health system, including writing grant applications. This has detracted from patient care, and created other challenges.
 - As such, we urge the CDC to streamline and minimize application and reporting requirements

Response to Question 2

The TAC appreciates the efforts of programs such as TPWIC and Good Health and Wellness in Indian Country (GHWIC) to support practice-based knowledge and Indigenous wisdom. The TPWIC program has assisted many Tribes in revitalizing Tribal practices, teachings and

knowledge to inform and improve Tribal public health practice. Tribal practices promote resilience and community connection, which have become especially important during COVID-19. The TAC offers the following recommendations to ensure dedicated support for such strategies, including continuing funding and robust technical assistance.

TAC Recommendations to Question 2

- 1. Recommend that CDC create a sustainability plan to continue to fund this important program beyond the 3-year funding cycle. This includes working with Congress to ensure long-term sustainability and funding, expanding to a 5-year cycle, and including more Tribal Nation recipients. *The CDC should distribute funds through non-competitive awards to ensure that all Tribes that submit an application can receive funding.***
- 2. Recommend that CDC allow funds to be spent toward sustaining and growing the program at the local level.**
 - a. Recommend that CDC provide technical assistance (TA) toward this end. Possible TA activities and topics could include partnership development, grant writing, presenting program impact, evaluation, program integration, program self-efficacy, capacity building.
- 3. Recommend that any evaluations are relevant and realistic to funded programs' activities and objectives. Where possible, the burden of evaluation should be minimized to allow for maximum focus on program activities.**
- 4. CDC should enhance its efforts to highlight the value of funding traditional and cultural practices for wellness and their impact on program outcomes. Other than funding amounts and recipient names, the CDC webpages for this program contain no additional information. The same recommendation also applies to the GHWIC program.**
- 5. Recommend that CDC conduct outreach with CDC Centers, Institutes, and Offices as well as outside federal agencies within HHS to increase awareness of traditional and cultural practices for wellness, practice-based evidence, wise practices, etc. We recommend that CDC provide technical assistance, support and platforms for telling the stories of recipients to raise awareness of traditional and cultural practices' impact on wellness.**
- 6. Recommend that CDC maintain the potential to expand strategies beyond the seven identified. This could be solicited through meetings of the TAC and the regular data presentations from existing TPWIC programs to the TAC (see earlier recommendation).**
- 7. Encourage diversity in programs to encompass both long-standing programs and those that are new or pilot programs.**
- 8. Recommend that any evaluation of the TPWIC program also include assessment of impact on behavioral/mental health and well-being. TPWIC strategies may impact not only physical health and clinical outcomes, but have strong ties to identity, community cohesion, and belonging.**

Conclusion

Thank you for considering the TAC's recommendations on the remaining \$14 million in Tribal COVID-19 response funds, and on the next cooperative agreements for the Tribal Practices for

Wellness in Indian Country program. We look forward to closely working with you to achieve the goals outlined in this letter, and the broader goals of advancing Tribal public health. Please contact the full TAC if you have any questions or comments regarding the requests outlined in this letter. We look forward to hearing a response from the CDC as soon as possible, but no later than during the next scheduled monthly TAC phone meeting.

Sincerely,

Robert TwoBears,
Representative, Legislative District V, *Ho-Chunk
Nation of Wisconsin*
Chairman
Bemidji Area Delegate

Alicia L. Andrew,
President, Karluk IRA Tribal Council, *Native Village
of Karluk*
Alaska Area Delegate

Selwyn Whiteskunk
Tribal Councilman, *Ute Mountain Ute Tribe*
Albuquerque Area Delegate

Byron Larson
Rocky Mountain Tribal Leaders Council, *Northern
Cheyenne Nation*
Billings Area Delegate

Myron Lizer
Vice President, *Navajo Nation*
Navajo Area Delegate

Richard Sneed,
Principal Chief, *Eastern Band of Cherokee Indians*
Vice-Chair
Tribes At-Large Delegate

Bryan Warner
Deputy Principal Chief, *Cherokee Nation*
Oklahoma Area Delegate

Stephen Kutz
Tribal Council Member, *Cowlitz Indian Tribe*
Portland Area Delegate

Doreen Fogg-Leavitt
Secretary, Inupiat Community of the Arctic Slope
Council, *Inupiat Community of the Arctic Slope*
Tribes At-Large Delegate

Connie Barker
Tribal Legislator, *Chickasaw Nation*
Tribes At-Large Delegate

Trinidad Krystall
Tribal Representative, *Torres Martinez Desert
Cahuilla Indians*
Tribes At-Large Delegate

NIOSH Strategic Plan Update



National American Indian and Alaska Native Worker Safety and Health Strategic Plan

Elizabeth Dalsey, MA

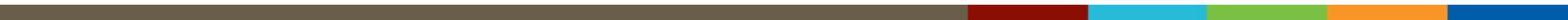
Health Communication Specialist

Tribal Advisory Committee Meeting

February 3rd, 2021

Disclaimer

The findings and conclusions in this presentation are those of the author and do not necessarily represent the views of the National Institute for Occupational Safety and Health.



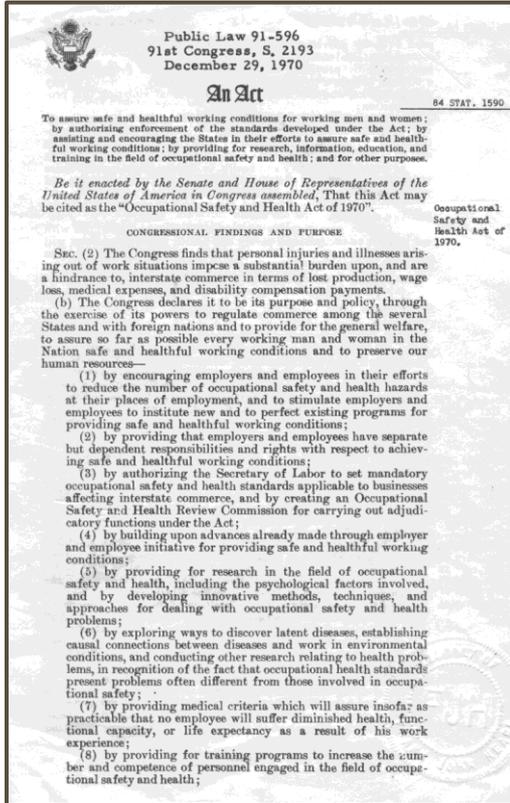
Overview

- National Institute for Occupational Safety and Health (NIOSH)
- NIOSH American Indian and Alaska Native (AI/AN) Initiative
- National AI/AN Worker Safety and Health Strategic Plan



**National Institute for Occupational Safety
and Health (NIOSH)**

Origin of NIOSH



- Occupational Safety and Health Act of 1970 created NIOSH and OSHA
- U.S. federal agency that conducts occupational safety and health (OSH) research and makes recommendations to prevent worker injury and illness.

Mission: To develop new knowledge in the field of occupational safety and health and to transfer that knowledge into practice.

Research & Recommendations

Department of
Health and Human Services
(HHS)



Centers for Disease
Control and Prevention



National Institute for
Occupational Safety
and Health (NIOSH)

Regulation & Enforcement

Department of Labor
(DOL)



Mine Safety
and Health
Administration
(MSHA)

Occupational
Safety and Health
Administration
(OSHA)

NIOSH American Indian and Alaska Native (AI/AN) Initiative

NIOSH AI/AN Initiative

Partner with AI/AN communities, tribal serving organizations, and partners to provide occupational safety and health support.

- Over **2.7 million AI/AN workers** in the US
- AI/AN workers **42%** more likely to be employed in a high-risk occupation
- **Limited research on occupational safety and health initiatives** in tribal communities

The National Institute for Occupational Safety and Health (NIOSH)

Workplace Safety and Health Topics

Workplace Safety and Health Topics

American Indian and Alaska Native Initiative

AI/AN Workers

Outreach

Resources

Contact Us
AI/AN Program Manager:
Elizabeth Dalsey
Health Communication Specialist
NIOSH Western States Division
edalsey@cdc.gov
303-236-5955

Promoting productive workplaces through safety and health research

American Indian and Alaska Native Initiative

In 2013, NIOSH launched an initiative to partner with American Indians and Alaska Natives (AI/AN) communities, organizations, and other stakeholders to identify priority issues, conduct outreach, and determine how NIOSH could best provide occupational safety and health support to tribal communities. The main goal of the initiative is to build and strengthen tribal occupational safety and health capacity to ensure workers make it home safely and healthily to their families and communities every day. All activities are coordinated with the U.S. Centers for Disease Control and Prevention's [Center for State, Tribal, Local, and Territorial Support \(CSTLTS\)](#).

As sovereign nations, AI/AN tribes maintain a government-to-government relationship with the United States. There are currently 567 federally recognized tribes across the U.S.^[1] Over 5.4 million AI/AN live across the United States, comprising about 2 percent of the population.^[2] Twenty-two percent of AI/AN live on reservations.^[3]



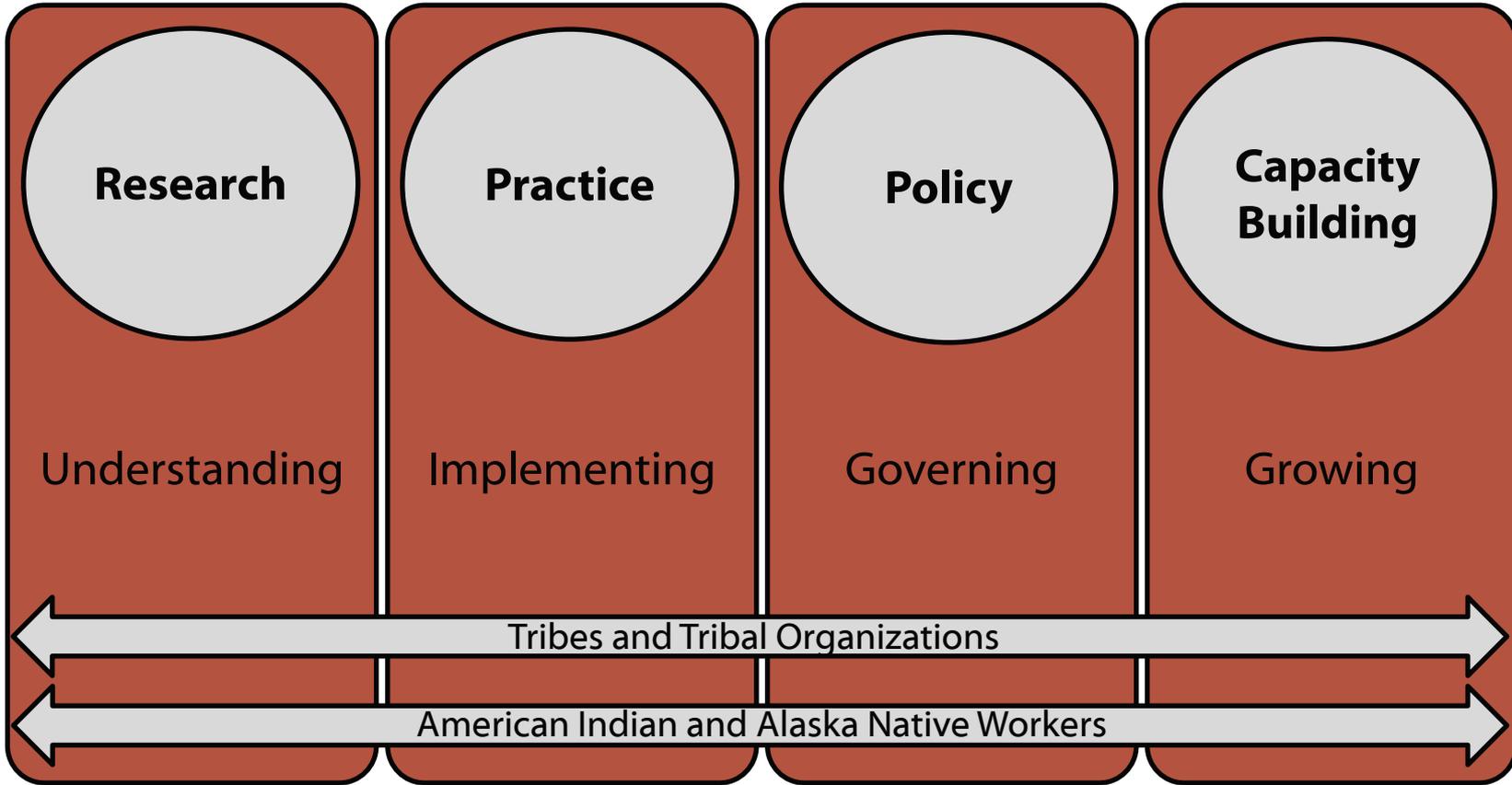
Construction workers on the Fort Hall Indian Reservation. Photo by NIOSH

National American Indian and Alaska Native Worker Safety and Health Strategic Plan

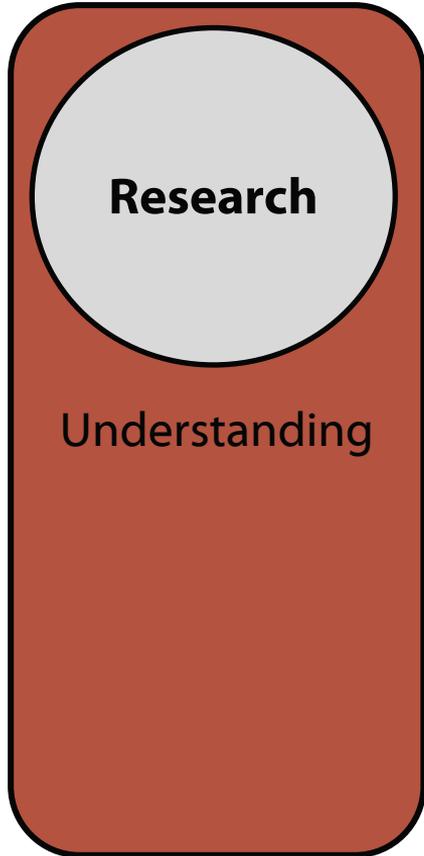
Overview of Strategic Plan

- Outlines the current needs of AI/AN workers to ensure their safety and health.
- Identifies priority research and outreach activities related to AI/AN workers.
- 10-year plan

Focus Areas



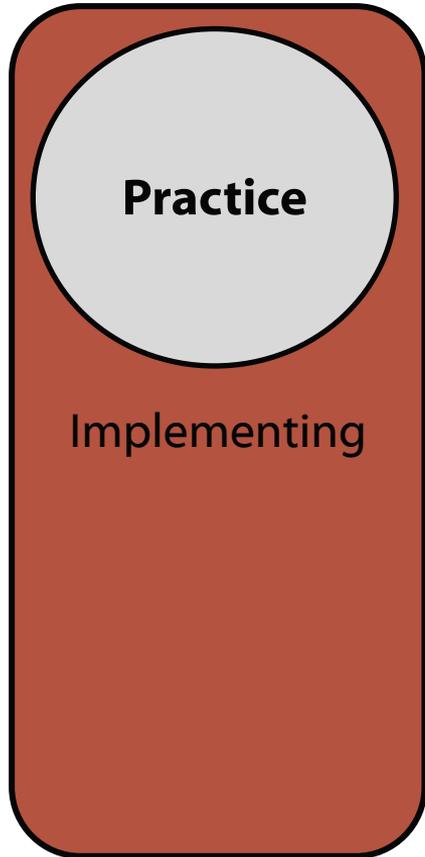
Focus Areas – Research



Example Objective

Identify and evaluate data sources that can be used to describe occupational safety and health risk factors among AI/AN workers.

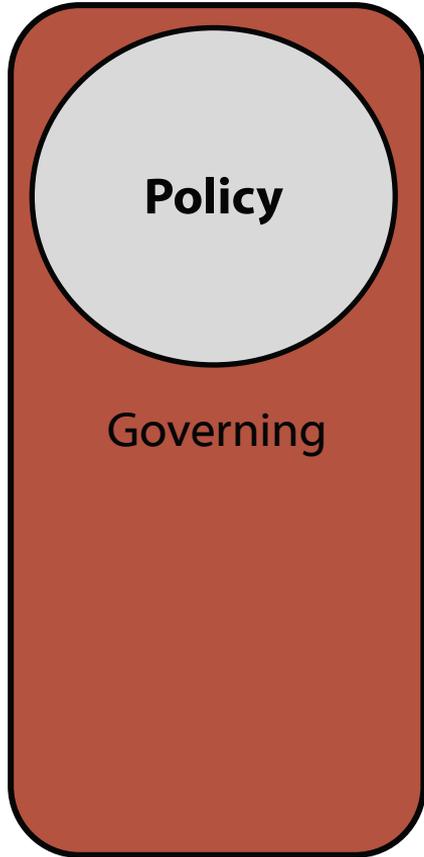
Focus Areas – Practice



Example Objective

Survey for existing materials that could be adapted, and develop toolkits, guidelines, assessments, and other resources that address worker safety, health, and well-being for practitioners in tribal communities.

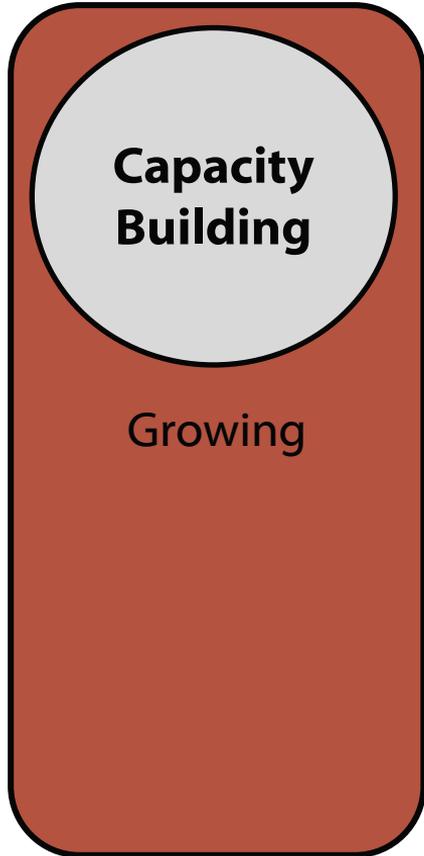
Focus Areas – Policy



Example Objective

Identify and assess the prevalence and effectiveness of existing occupational safety and health laws, codes, or policies in tribal communities.

Focus Areas – Capacity Building



Example Objective

Identify and evaluate data sources that can be used to describe occupational safety and health risk factors among AI/AN workers.

Steps to Develop the Strategic Plan

1. Conduct two workshops with tribal members and others to identify focus areas and key activities
2. Developed draft strategic plan
3. Conduct internal review
4. Conduct stakeholder review
5. Develop second draft plan
6. Clearance
7. Publication
8. Utilization and evaluation

How can the plan can be used?

- Guide efforts at the tribal, local, state, federal or organizational levels
- Incorporate plan elements into larger plans focused on the health of AI/AN.
- Steer partner development and collaboration

How can you get involved?

- Review the draft strategic plan
- Provide feedback on the content and approach described in the plan

If you are interested in reviewing the plan, please contact Elizabeth Dalsey.

303-236-5955

edalsey@cdc.gov

Questions?

Thank you!

Elizabeth Dalsey
303-236-5955
edalsey@cdc.gov

For more information, contact CDC
1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 www.cdc.gov

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.



CDC/ATSDR Updates

February 3, 2021

Alison Kelly

TRIBAL ADVISORY COMMITTEE BRIEFING

CDC'S ANNUAL BUDGET

BUDGET HIGHLIGHTS

<i>\$ in millions</i>	FY 2020 Enacted	FY 2021 Enacted
Budget Authority	\$6,839.946	\$6,963.296
Public Health and Prevention Fund (PPHF) Transfer	\$854.250	\$856.150
Agency for Toxic Substances and Disease Registry (ATSDR)	\$76.691	\$78.000
Energy Employees Occupational Illness Compensation Program (EEOICPA)	\$50.597	\$50.763
Nonrecurring Expenses Fund (NEF) Transfer	\$225.000	\$0.000
Total Program Level	\$8,046.484	\$7,948.209

- The overall funding level is an increase of +\$127M or 2% above the FY 2020 Enacted level, when adjusted to exclude one-time NEF funding received in FY 2020.
- Continues funding for core activities:
 - Ending the Epidemic – +35M to support CDC’s efforts to reduce new HIV infections
 - REACH – +4M to address racial and ethnic health disparities
 - GHWIC – +1M (part of the above 4M increase for addressing disparities)
 - PHHS Block Grant – supports public health needs at the state, territorial and tribal level
- Includes new funding:
 - Social Determinants of Health – +3M to support related activities at the STLT level
- Collaborate with TAC to further integrate Tribal communities’ needs and best practices for delivering tribal TA into CDC programs.

COVID-19 SUPPLEMENTAL FUNDING

Dollars in Millions

Activities	Coronavirus Preparedness and Response Supplemental Appropriations Act (P.L. 116-123)		CARES Act (P.L. 116-136)		Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139)		Coronavirus Response and Relief Supplemental Appropriations Act, FY 2021 (P.L. 116-260)		Total Funding
	Amount	Funds Availability	Amount	Funds Availability	Amount	Funds Availability	Amount	Funds Availability	
CDC Wide Activities and Program Support - State, Territorial, Local and Tribal Grants	\$950.0	9/30/2022	\$1,500.0	9/30/2024	-	-	\$4,500.0	9/24/2024	\$6,950.0
-- Tribal Allocation (non-add)	\$40.0	9/30/2022	\$125.0	9/30/2024	-	-	\$210.0	9/24/2024	\$375.0
-- Racial and ethnic minority populations and rural communities (non-add)	-	-	-	-	-	-	\$300.0	9/24/2024	\$300.0
CDC Wide Activities and Program Support - Global Disease Detection and Emergency Response	\$300.0	9/30/2022	\$500.0	9/30/2024	-	-	-	-	\$800.0
CDC Wide Activities and Program Support - Data Surveillance and Analytics	-	-	\$500.0	9/30/2024	-	-	-	-	\$500.0
CDC Wide Activities and Program Support - Infectious Diseases Rapid Reserve Fund	\$300.0	X-Year	\$300.0	X-Year	-	-	-	-	\$600.0
CDC Wide Activities and Program Support - Other Public Health Response	\$650.0	9/30/2022	\$1,500.0	9/30/2024	\$1,000.0	X-Year	\$4,250.0	9/24/2024	\$7,400.0
Agency for Toxic Substances and Disease Registry	-	-	\$12.5	9/30/2021	-	-	-	-	\$12.5
Total Appropriation Level to CDC	\$2,200.0		\$4,312.5		\$1,000.0		\$8,750.0		\$16,262.5

A total of \$375M allocated to build public health capacity during the COVID-19 response and recovery and support tribes and tribal organizations in carrying out surveillance, epidemiology, laboratory capacity, infection control, mitigation, communication, and other COVID-19 preparedness and response activities.

CDC PRIORITIES

Core Capabilities are Fundamental to Meeting Our Agency's Priorities:



World-class data and analytics provide actionable information to address health threats such as chronic diseases, opioid and other drug use



State-of-the-art laboratories identify causes of injury and diseases



Elite public health workforce provides expertise for conditions both rare and common



Rapid outbreak response protects Americans from food-borne and other illnesses



Strong global health capacity and domestic preparedness to address threats from disasters and infectious diseases



Advance approaches that support reducing health disparities and achieving health equity

Technical Assistance Discussion



Developing Guidelines for CDC Technical Assistance to and Programmatic Inclusion of Tribes

Georgia Moore, MS

Associate Director for Policy

CDC/ATSDR Tribal Advisory Committee Meeting

February 3, 2021

Congressional Language for Guidance Development

- **Tribal Advisory Committee**

The agreement directs the [CDC] Director, in consultation with the TAC, to develop written guidelines for each CDC center, institute, and office on best practices around delivery of Tribal technical assistance and consideration of unique Tribal public health needs. The goal of such guidelines should be the integration of Tribal communities and population needs into CDC programs. The Director shall report on the status of development of these written guidelines in the fiscal year 2022 Congressional Justification. (Page 44, P.L. 116-260, Division H, Joint Explanatory Statement)

Operational Questions

1. How and at what points does the TAC want to be engaged?

Draft ideas for key engagement points:

- Provide input to the approach and timeline for guideline development
- Review and provide feedback on reported activity progress
- Review and provide input on draft products
- Provide input/feedback on guideline implementation
- Provide input to a process for updating the guidelines over time

Operational Questions

2. How do we get started?

Draft ideas:

- CSTLTS collects any immediate input the TAC has during and after this meeting
 - Deadline for TAC input after the meeting?
- CSTLTS shares the consolidated input with the TAC and ideas for next steps
 - Deadline for CSTLTS to provide this information?

Discussion

Initial thoughts, preferences, and recommendations, for example on

- TAC engagement
- Content of guidance
- Stakeholders to engage
- Sources of information to inform the effort (e.g., best or model practices)
- Immediate next steps (previous slide)

For more information, contact CDC
1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 www.cdc.gov

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Centers for Disease Control and Prevention

Examples of Resources Available to State, Tribal, Local & Territorial Health Agencies

In addition to funding through grants, cooperative agreements, and contracts, CDC offers many other resources to public health agencies and organizations. Health departments and other partner organizations are invited to explore the resources below. Partners can also contact CDC's Center for State, Tribal, Local, and Territorial Support (CSTLTS) by calling 404-698-9246 or sending an email to CSTLTSfeedback@cdc.gov.

- **Assignees:** Apply to host a CDC-sponsored fellow or trainee. CDC offers [career training fellowships](#) through which CDC pays for the assignees to work in and serve health organizations in the field. The following is a list of the specific fellowships in which staff are assigned to work in state, tribal, local, and territorial public health agencies:
 - [Public Health Associate Program \(PHAP\)](#)
 - [Epidemic Intelligence Service \(EIS\)](#)
 - [Emerging Infectious Diseases Advanced Laboratory Training Fellowship](#)
 - [Preventive Medicine Residency and Fellowship \(PMR/F\)](#)
 - [CDC/CSTE Applied Epidemiology Fellowship](#)
- **Data for action:** Use data provided through CDC's National Center for Health Statistics (NCHS) to inform program development, implementation, and evaluation, and to make the case for programmatic and funding needs. NCHS is the nation's principal health statistics agency, providing data to identify and address health issues. [NCHS compiles statistical information](#) to help guide public health and health policy decisions. Collaborating with other public and private health partners, NCHS employs a variety of data collection mechanisms to obtain accurate information from multiple sources. NCHS's data provide a broad perspective to help us understand the population's health, influences on health, and health outcomes. See the NCHS Surveys and Data Collection Systems summary [fact sheets](#) for more information. Other sources include CDC's [Sortable Stats](#) and the [Data & Statistics](#) portal.
- **Workforce development resources:** Use CDC's free online [workforce development resources](#).
 - **CDC's Learning Connection:** CDC's Learning Connection can help you locate learning products and resources from across the public health community, including learning opportunities from CDC, other federal agencies, and federally funded partners, including many that offered free continuing education credits.
 - **CDC TRAIN:** To support workforce development, CDC offers free, 24/7 access to this premier learning resource for public health training. CDC partnered with the Public Health Foundation to develop CDC TRAIN, expanding access to education and training resources for



professionals who protect the public's health. Anyone can register for a personal CDC TRAIN account by visiting [CDC's Learning Connection](#). Once registered, users can explore a wide variety of training opportunities—including those related to HIV/AIDS, public health surveillance, developing program plans, and more.

- **Direct assistance:** At CDC, [direct assistance](#) is a financial assistance mechanism used primarily to support payroll and travel expenses of CDC employees assigned to state, tribal, local, and territorial health agencies that receive grants and cooperative agreements.
- **Short-term technical assistance:** CDC's Division of Scientific Education and Professional Development provides several opportunities for technical assistance available to health agencies.
 - **Epi-Aid:** Epi-Aid is a mechanism for public health authorities to request the short-term epidemiologic assistance of CDC's Epidemic Intelligence Service officers to respond to urgent public health problems, such as unexplained illnesses, infectious disease outbreaks, and post-hurricane effects. To request an Epi-Aid, call 404-498-6110 or email EpiAid@cdc.gov.
 - **Info-Aid:** Request assistance related to information systems, meaningful use requirements, electronic health records, and other health information technology activities. Public health informatics fellows collaborate with requestors and their partners to define the problem and work extensively with Public Health Informatics Fellowship Program staff to provide solutions or recommendations. *Public health entities that request Info-Aids must pay for travel and per diem of responding fellows.* To request an Info-Aid, call 404.498.6586 or email PHIFP@cdc.gov.
 - **Econ-Aid:** Request assistance related to quantitative policy analysis, health economics-based inquiries, and integrative health services research. Fellows from the [Steven M. Teutsch Prevention Effectiveness Fellowship](#) participate in the response as a part of their experiential training. *Public health entities that request Econ-Aids must pay for travel and per diem of responding fellows.* To request an Econ-Aid, contact Dr. Adam Skelton at 404-498-6786 or askelton@cdc.gov.
- **[Center for State, Tribal, Local, and Territorial Support \(CSTLTS\)](#):** CSTLTS was created specifically to provide assistance and support to state, tribal, local, and territorial health officials, including connecting health officials to CDC programs and staff when needed. The CSTLTS support line is 404-698-9246; the email address is CSTLTSfeedback@cdc.gov.
- **[On-TRAC: Online Technical Resource and Assistance Center](#):** CDC developed On-TRAC to provide health departments with a secure, user-friendly platform for requesting technical assistance from CDC subject matter experts on public health preparedness. In addition to tools and resources to support CDC's 15 [public health preparedness capabilities](#), On-TRAC offers answers to frequently asked questions, enhanced search engine capacity, expanded peer-to-peer exchanges (with regional workspaces), and many varied resources. *State, tribal, local, and territorial public health professionals must be registered to access On-TRAC.*

- **[Opioid Rapid Response Teams \(ORRTs\)](#)**: Specialized teams of public health professionals who provide rapid, short-term (28-day) support to jurisdictions experiencing spikes in opioid-related overdoses or closures of clinics where patients are prescribed opioid therapy. Rapid response teams offer technical expertise in epidemiology, clinical provider outreach, communications, policy and partnerships, community outreach, and capacity-building from CDC and the Commissioned Corps. The teams provide support to public health partners while also working to build the jurisdiction’s long-term response capacity.
- **Communication products:**
 - CDC offers free publications and educational materials:
 - **[CDC-INFO on Demand](#)**: Order or download books, fact sheets, pamphlets, and educational materials.
 - **[CDC Content Syndication](#)**: Import content from CDC websites directly onto your own websites or applications.
 - CDC provides updates to the field through a number of mechanisms, such as email updates, social media channels, and specialized communication platforms for health professionals:
 - **[CDC email updates](#)**: Sign up for updates in your particular areas of interest.
 - **[CDC Facebook, Twitter, LinkedIn, RSS feeds](#)**: Click or tap these icons at the bottom-right of the CDC home page to “Connect with CDC” through these channels.
 - **[CDC Newsroom](#)**: Get the latest breaking news and media updates from CDC. Users can access archives of CDC news releases, media advisories, and press telebriefings.
 - **[COCA \(Clinician Outreach and Communication Activity\)](#)**: COCA prepares clinicians to respond to emerging health threats and public health emergencies. COCA communicates relevant, timely information related to disease outbreaks, disasters, terrorism events, and other health alerts. [Sign up for COCA updates.](#)
 - **[CSTLTS News & Alerts](#)**: CSTLTS helps connect public health professionals with the latest CDC news, research, and releases via email alerts, news feeds, bulletins, and social media pages created specifically for public health professionals, including *Did You Know?*, *Public Health Law News*, the CDC STLT Connection Facebook page, and more.
 - **[Epi-X \(The Epidemic Information Exchange\)](#)**: Epi-X is CDC’s web-based communications solution for public health professionals. Through Epi-X, CDC officials, state and local health departments, poison control centers, and other public health professionals can access and share preliminary health surveillance information—quickly and securely. Users can be notified of breaking health events as they occur. Key features of Epi-X include scientific and editorial support, controlled user access, digital credentials and authentication, rapid outbreak

reporting, and peer-to-peer consultation. *Participation in Epi-X is limited to public health officials designated by each health agency.*

- **HAN (Health Alert Network)**: HAN is CDC's primary method of sharing cleared information about urgent public health incidents with federal, state, local, and territorial public health practitioners; clinicians; public health laboratories; public information officers. HAN collaborates with federal, state, territorial, and city and county partners to develop protocols and stakeholder relationships that will ensure an interoperable platform for the rapid distribution of public health information. [Sign up for HAN email updates.](#)

**Centers for Disease Control and
Prevention (CDC)**

&

**Agency for Toxic Substances and
Disease Registry (ATSDR)**

Tribal Advisory Committee (TAC)

Assistance and Resources

February 2021

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CDC Steven M. Teutsch Prevention Effectiveness (PE) Fellowship

Econ-Aid—Economics Assistance

What is an Econ-Aid?

An Econ-Aid (Economics Assistance) allows short term assignments for PE fellows—CDC’s data detectives—to provide analytic support in response to an urgent public health need. Econ-Aids are typically three weeks long.

How is an Econ-Aid requested?

To request an Econ-Aid, contact Dr. Adam G. Skelton, CDC Steven M. Teutsch Prevention Effectiveness (PE) Fellowship Lead by email, pef@cdc.gov, or by phone, 404-498-6786.

Who can request an Econ-Aid?

The following agencies may request an Econ-Aid:

- CDC/ATSDR and other federal agencies
- State and local health authorities
- Non-governmental public health entities

Why request an Econ-Aid?

Econ-Aids can help address urgent public health problems that require assessing the impact of public health policies, programs, and practices on health outcomes by evaluating their effectiveness, quality, and cost. Organizations requesting an Econ-Aid are able to build economics capacity through streamlined access to CDC staff with subject matter expertise.

What are examples of an Econ-Aid Activities?

In 2012, New Jersey Department of Health requested an Econ-Aid (along with an [Epi-Aid](#)) to conduct a cost-effectiveness analysis of the first three months of state-mandated newborn screening using pulse oximetry for the early identification of Critical Congenital Heart Disease (CCHD). The analysis found that this intervention was cost effective, averaging around \$14 per newborn. This is impactful because screening can help identify some babies with a critical CCHD before they go home from the birth hospital. This allows these babies to be treated early and may prevent disability or death early in life.

Some other examples of Econ-Aid activities include:

- Performing cost analyses of public health responses, community mitigation guidelines, interventions, treatments, etc.
- Determining the cost-benefit, cost-effectiveness, comparative effectiveness, or cost-utility of a public health intervention or program
- Performing economic or policy modeling, such as sensitivity analysis, decision and probabilistic modeling, or simulation models

Are requesting organizations required to fund Econ-Aids?

Organizations requesting an Econ-Aid must pay all transportation, lodging, and per diem costs for the fellow. The PE fellow’s host office will pay all salary and benefits costs during the Econ-Aid assignment. Deployment of a PE fellow for an Econ-Aid is at the discretion of the CDC host office.

What is the role of the requesting organization during an Econ-Aid?

The requesting organization leads the Econ-Aid, unless it prefers other arrangements. The requesting organization:

- Collaborates with the PE Fellowship program staff on the Econ-Aid request
- Provides a clear definition of the problem that requires Econ-Aid assistance
- Provides access to local resources and stakeholders
- Provides a workspace, meeting space, incidental use of telephones and fax machines, and office supplies

For more information on Econ-Aids and CDC Steven M. Teutsch Prevention Effectiveness (PE) Fellowship visit <https://www.cdc.gov/pef/index.html>.



Centers for Disease
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and Laboratory Services

Requesting an Epi-Aid

Epidemiologic assistance from CDC



An Epi-Aid allows rapid response by CDC's Epidemic Intelligence Service officers in investigating urgent public health problems, such as infectious and non-communicable disease outbreaks, unexplained illnesses, or natural or manmade disasters.

What is an Epi-Aid?

An Epi-Aid is an investigation of an urgent public health problem, such as infectious or non-communicable disease outbreaks, unexplained illnesses, or natural or manmade disasters. When a public health authority requests assistance from the U.S. Centers for Disease Control and Prevention, an Epi-Aid allows rapid, short-term (1–3 weeks), generally onsite, technical assistance by Epidemic Intelligence Service (EIS) officers and other CDC subject matter experts. The focus of an Epi-Aid investigation is to assist partners in making rapid, practical decisions for actions to prevent and control the public health problem.

Who participates?

An Epi-Aid team includes at least one EIS officer and other CDC subject matter experts. This team joins local staff in the community where assistance is requested. The requesting public health authority provides overall leadership for the investigation, while the Epi-Aid team provides technical assistance.

Who can request an Epi-Aid?

Various officials with authority for public health can request an Epi-Aid.

- State and territorial public health authorities
- Local public health authorities, in coordination with the state authorities
- Elected tribal leaders of federally recognized tribes
- Foreign countries' ministry of health authorities
- Federal agency officials
- American military base commanding generals
- CDC's Vessel Sanitation Program officials

Can a local jurisdiction request an Epi-Aid?

Yes. CDC responds to direct requests from local jurisdictions. When a local jurisdiction requests an Epi-Aid, CDC is committed to ensuring the state is aware of the request and is appropriately engaged in the Epi-Aid. The EIS program frequently helps with coordination among the state and local jurisdictions and CDC programs.



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How can a public health authority request an Epi-Aid?

1. The requesting authority contacts the subject matter expert at CDC or the EIS program.
2. The CDC subject matter expert contacts the EIS program (or vice versa) to discuss the Epi-Aid request. Once CDC decides it can support the Epi-Aid, the CDC subject matter expert notifies the requesting authority.
3. If CDC can support the Epi-Aid, upon notification, the requesting authority emails an invitation to the CDC subject matter expert contact or to the EIS Program Chief at EpiAid@cdc.gov.
4. The EIS program approves the Epi-Aid.

How do Epi-Aids benefit public health?

An Epi-Aid benefits public health in several ways. Epi-Aids can:

- Increase the technical capacity and workforce available for rapid response
- Streamline access to CDC subject matter experts and laboratory resources
- Build epidemiologic capacity through collaboration
- Enhance public health relationships
- Contribute to practical understanding about the problem being addressed

What is the role of the requesting public health authority?

The public health authority provides overall leadership of the Epi-Aid investigation while benefitting from a collaborative relationship with the Epi-Aid team. The public health authority generally retains custody and control over all data collected as part of the investigation. After the Epi-Aid is completed, the public health authority often requests CDC's continued collaboration and assistance in data analysis, report writing, presentation preparation, and additional programmatic technical assistance.

How can I get more information?

For more information about Epi-Aids, call the EIS office at +1 (404) 498-6110, send an e-mail to EpiAid@cdc.gov, or visit the EIS website at www.cdc.gov/eis.

Quick Reference: Requesting an Epi-Aid

- Contact the CDC subject matter expert directly, *or*
 - Contact the EIS office
 - At any time: E-mail EpiAid@cdc.gov
 - During business hours (8:00 a.m.-4:30 p.m. ET): Call the EIS office at +1 (404) 498-6110
 - After business hours: Call CDC's Emergency Operations Center at +1 (770) 488-7100
-

Info-Aid—Informatics Assistance

Public Health Informatics Fellowship Program (PHIFP)

What is an Info-Aid?

An Informatics Aid (Info-Aid) is a mechanism that allows PHIFP fellows—CDC’s data detectives—to provide short-term technical assistance in the event of an urgent public health informatics need.

Who may request an Info-Aid?

The following agencies may request an Info-Aid:

- CDC/ATSDR and other federal agencies
- State and local health departments and public health agencies
- International health organizations
- Non-profit public health entities

Why request an Info-Aid?

Informatics is critical as public health agencies rely on robust information systems for core functions and services. Info-Aids can provide:

- Access to informatics expertise and technical support during public health emergencies
- Strategic planning and informatics evaluation to design and develop, or overall improve public health information systems
- Support of country-level health information systems for disease surveillance and outbreak response

What are examples of Info-Aids?

Some examples of previous Info-Aid activities include:

- Designing and developing an information system to support a CDC outbreak investigation of HIV clusters by standardizing data collected from multiple sources and developing a dashboard to generate a live information feed
- Facilitating the implementation and adoption of a health information system framework to standardize and integrate information systems across Kenya
- Developing software requirements for a field training program’s management information system to monitor and evaluate the impact of the program
- Establishing information systems for emergency operations to enhance acute watery diarrhea surveillance in Ethiopia

How is an Info-Aid request initiated?

The requesting agency should contact PHIFP@cdc.gov to request an Info-Aid. PHIFP program staff will provide additional details about the process.

How long will an Info-Aid last?

The length of an Info-Aid can vary based on the complexity of the request, but typically lasts between 2-3 weeks and can be extended if needed. After an Info-Aid, the requesting agency may continue collaboration for report writing, presentation, and follow-up projects.



PHIFP fellow and CDC Cairo office data manager collaborate on data management workflows for the International Emerging Infections Program. Cairo, Egypt.

Request an Info-Aid

E-mail: phifp@cdc.gov

Phone: 404-498-6586



**Centers for Disease
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PHAP

PUBLIC HEALTH ASSOCIATE PROGRAM

Training the next generation of public health professionals

Managed by CDC's Center for State, Tribal, Local, and Territorial Support (CSTLTS), the Public Health Associate Program (PHAP) is developing the next generation of public health professionals in state, tribal, local, and territorial public health agencies.

PHAP, a workforce development program, provides associates with hands-on experience in the day-to-day operations of public health organizations. Over the two-year program, associates complete a comprehensive training curriculum while working alongside other public health professionals across a variety of public health settings—state, tribal, local, and territorial public health organizations; nongovernmental organizations; public health institutes and associations; academic institutions; and CDC quarantine stations.

CSTLTS works closely with other CDC programs and the PHAP host sites to place, train, and mentor associates to support the frontline of public health. Since its inception in 2007, PHAP has placed more than 1,300 public health associates in public health agencies and nongovernmental organizations across 44 states, the District of Columbia, and the US territories, with 56% continuing to serve in positions at public health organizations.

Strengthening Public Health

Associates build workforce capacity and fill staffing shortages at their host sites while they gain invaluable hands-on public health experience working on some of the most pressing public health priorities, including:

Chronic disease prevention and health promotion

- Environmental health
- Global migration and quarantine
- Immunization
- Injury and violence prevention
- Maternal and child health
- Public health preparedness
- Prevention of STD, TB, HIV, and other communicable diseases

PHAP offers associates hands-on experience that can serve as the foundation for their careers in public health. PHAP graduates are then qualified to apply for public health positions at CDC and other public health organizations.

For more information about the Public Health Associate Program, visit www.cdc.gov/phap or contact program staff at phap@cdc.gov or 404.498.0030.



"PHAP has given me a wide range of applied experience in public health that is rare for a recent college graduate. I am very appreciative for the variation built into the PHAP curriculum because it gave me exposure to a wide array of public health programs and helped me build skills that will be important to any career in public health or service in my future."

– Former associate



"We love this program! We benefit from the associates' energy and expertise in public health, and in return, we provide great opportunities for them to do meaningful work."

– Former host site

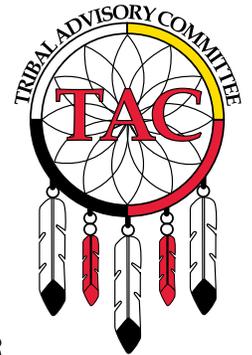


**Centers for Disease
Control and Prevention**
Center for State, Tribal, Local,
and Territorial Support

CDC/ATSDR Tribal Advisory Committee

About the Tribal Advisory Committee

The Centers for Disease Control and Prevention/Agency for Toxic Substances and Disease Registry (CDC/ATSDR) Tribal Advisory Committee (TAC) provides CDC and ATSDR with input and guidance on policies, guidelines, and programmatic issues affecting the health of American Indian/Alaska Native (AI/AN) tribes.



Purpose of the TAC

- Exchange information with CDC/ATSDR staff about public health issues in Indian country, identify urgent public health needs, and discuss collaborative approaches
- Provide guidance regarding government-to-government consultation between CDC/ATSDR and AI/AN tribes
- Ensure that CDC/ATSDR activities or policies that impact AI/AN tribes are brought to the attention of tribal leaders

Committee Composition

The TAC is composed of 16 delegates (and authorized representatives) from federally recognized tribes, each acting on behalf of his or her tribe. CDC/ATSDR has incorporated the Indian Health Services (IHS) Areas and the At-Large positions as members of the TAC to provide specific representation for the regional and national concerns of tribal governments.¹

- One delegate (and one authorized representative) from a federally recognized tribe located in each of the 12 IHS areas
- One delegate (and one authorized representative) from four federally recognized tribes-at-large

Delegates—elected tribal officials, acting in their official capacity as elected officials of their tribe, with authority to act on behalf of the tribe, and qualified to represent the views of the AI/AN tribes in the area from which they are nominated.

Authorized Representatives—elected tribal officials or designated tribal officials who are acting on behalf of the delegate and are qualified to represent the views of AI/AN tribes. Authorized representatives might include, but are not limited to, tribal health officers, tribal health system executive directors, and leaders of regional and national nonprofit corporations (501[c][3]).

Member Responsibilities

- Make a good-faith effort to attend all meetings and provide input, guidance, and recommendations to CDC/ATSDR
- Submit area reports to CDC/ATSDR, including information from area AI/AN tribes
- Disseminate information to local area AI/AN tribes

Meetings

- Two face-to-face meetings per year held in conjunction with formal CDC/ATSDR Tribal Consultation Sessions—typically one in Atlanta hosted by CDC/ATSDR, and one in Indian country hosted by a tribe
- Monthly conference calls

Designated Federal Official

José T. Montero, MD, MHCDS, Director, Center for State, Tribal, Local, and Territorial Support, CDC
Phone: 404-498-2208 • Email: tribalsupport@cdc.gov • Website: www.cdc.gov/tribal

¹ In accordance with the Federal Advisory Committee Act exemption of the Unfunded Mandates Reform Act and the 2010 HHS Tribal Consultation Policy



Center for State, Tribal, Local, and Territorial Support

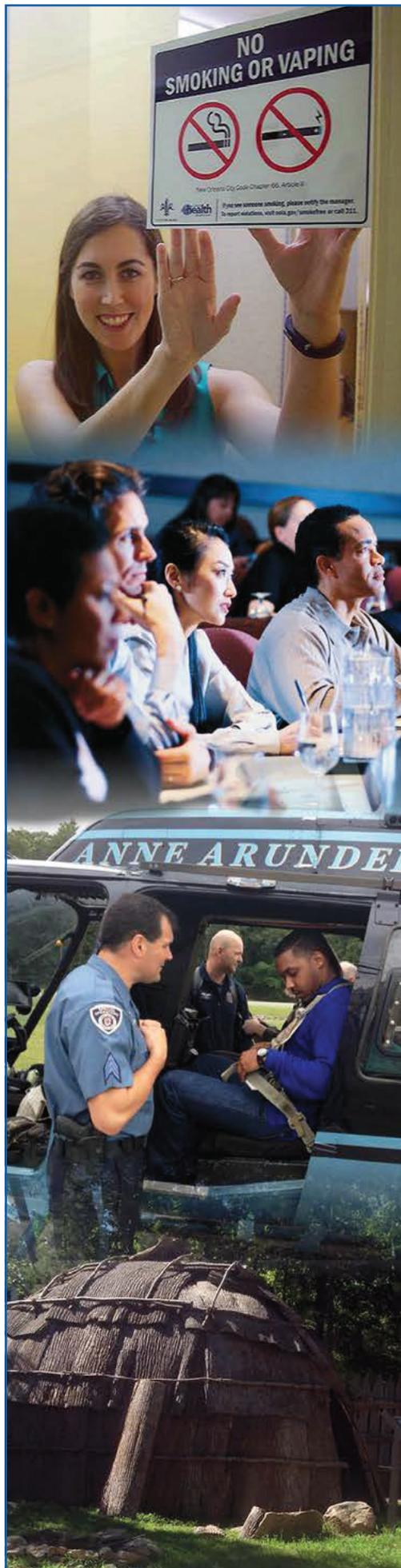
CDC's Center for State, Tribal, Local, and Territorial Support (CSTLTS) plays a vital role in helping health agencies work to enhance their capacity and improve their performance to strengthen the public health system on all levels. CSTLTS is CDC's primary connection to health officials and leaders of state, tribal, local, and territorial (STLT) public health agencies, as well as other government leaders who work with health departments.

What We Do

Improve health department capacity and performance

- Administer and oversee the **Preventive Health and Health Services Block Grant**, which provides all 50 states, 2 American Indian tribes, 8 US territories, and the District of Columbia with funding to address their unique public health needs in innovative and locally defined ways
- Enhance performance management capacity of public health departments and support STLT health agencies in meeting national standards and attaining accreditation
 - **National Voluntary Accreditation for Public Health Departments**
 - **Community Health Assessment and Improvement Planning**
- Advance the professional development and capability of the public health workforce
 - **Public Health Associate Program**
 - **National Leadership Academy for the Public's Health**
- Consult on policy and legal options that affect CDC health priorities
 - The **Public Health Law Program** advances the use of law as a public health tool by providing services and resources such as technical assistance, publications, legal epidemiology, and workforce development to CDC programs and STLT communities
- Coordinate support for CDC programs and policies that focus on American Indian/Alaska Native (AI/AN) communities
 - The **CSTLTS tribal support** mission involves working closely with AI/AN communities to coordinate activities, including implementing the CDC/ATSDR Tribal Consultation Policy and Charter and coordinating the CDC/ATSDR Tribal Advisory Committee
- Provide leadership for public health strategies, policies, programs, and systems improvements in the US Insular Areas
 - The **CSTLTS insular areas support** mission involves engaging with public health officials in the insular areas (five US territories and three freely associated states) to address public health issues in the region





Develop assessment and capacity-building tools, resources, standards, and practices

- Offer searchable grant and cooperative agreement information through the **CDC Grant Funding Profiles** tool
- Strengthen and enhance the infrastructure and capabilities of public health agencies and public health systems through coordinating various **funding opportunities** and through the **National Partnership Capacity Building Program**

Engage STLT health officials with CDC

- Host an **annual orientation for new health officials** to help newly appointed health officials learn about CDC and how it works and provide them an opportunity to collaborate with CDC leaders to support their work in public health
- Collaborate with health officers to identify **CDC and partner resources and technical assistance** to help address public health issues in their agencies and jurisdictions and to improve population health in their communities
- Promote timely news from across CDC with the weekly **Did You Know?** feature, informing public health programs and moving data and recommendations into action
- Offer the **Public Health Professionals Gateway**, a website developed specifically for health department staff that provides a central place to find many CDC resources

Contact CSTLTS

Direct Line for Health Departments: 404-698-9246

Email: CSTLTSfeedback@cdc.gov

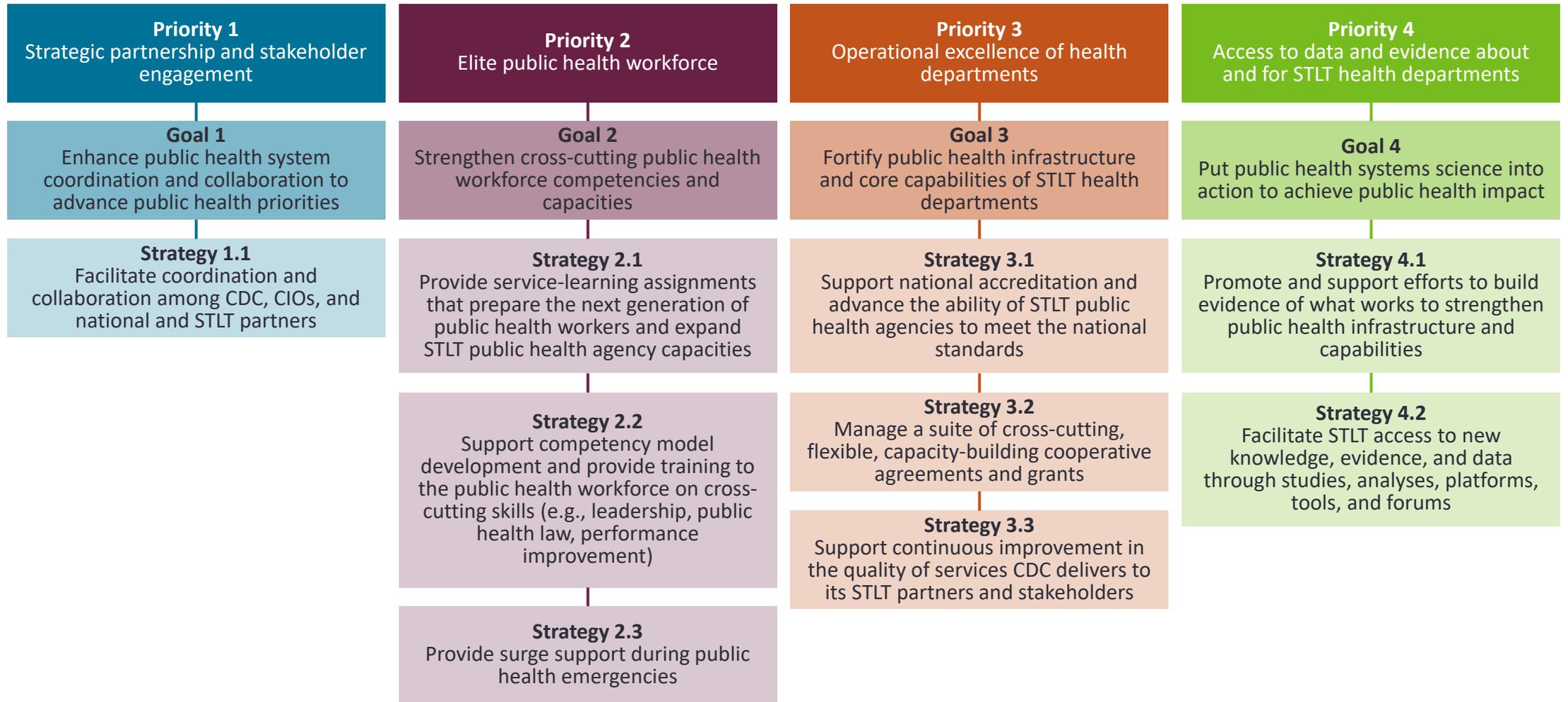
Public Health Professionals Gateway: www.cdc.gov/publichealthgateway

Centers for Disease Control and Prevention
Center for State, Tribal, Local, and Territorial Support

April 2019

Center for State, Tribal, Local, and Territorial Support Strategic Map

Improving Community Health Outcomes by Strengthening State, Tribal, Local, and Territorial Public Health Agencies



Office of Tribal Affairs and Strategic Alliances

Federal-Tribal Relationship

The United States has a unique legal and political relationship with Indian tribes, as provided in the Constitution of the United States, treaties, and federal statutes.

The Centers for Disease Control and Prevention (CDC) is committed to working with federally recognized tribal governments on a government-to-government basis, and strongly supports and respects sovereignty and self-determination for tribal governments in the United States.

The Office of Tribal Affairs and Strategic Alliances focuses on activities that reflect the agency's role in helping to ensure that American Indian/Alaska Native (AI/AN) communities receive public health services that keep them safe and healthy.

Our Mission

Our mission is to affirm the government-to-government relationship between CDC and AI/AN tribes by advancing connections, providing expertise, and increasing resources to improve tribal communities' public health.

Our Role

- Principal advisor to policy-level officials about AI/AN public health issues
- Principal contact for all public health activities affecting AI/AN communities
- Coordinator for CDC and the Agency for Toxic Substances and Disease Registry (ATSDR) programs and policies that benefit or affect AI/AN tribes

Our Work

- Serve as CDC's principal point of contact for tribes and tribal-serving organizations (TSOs)
- Manage the CDC/ATSDR Tribal Advisory Committee
- Connect tribes and tribal-serving organizations to CDC and ATSDR programs
- Develop communication and information resource for tribes and TSOs
- Support and collaborate with TSOs and public health partners to improve tribal public health capacity
- Educate about tribal health issues, policies, activities, and strategies, while serving as a principal advisor to CDC leaders and staff
- Guide and coordinate CDC's tribal-related partnerships and activities with the US Department of Health and Human Services and other federal agencies

More Information

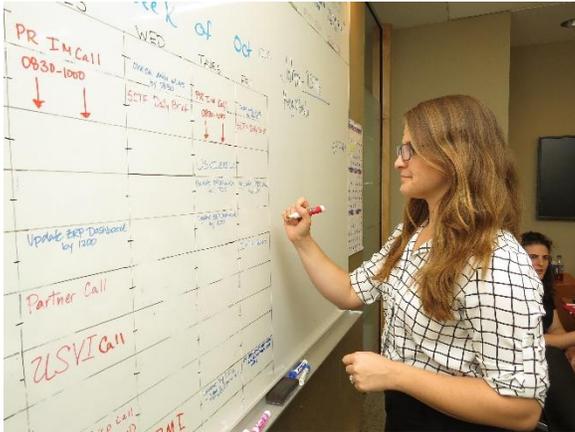
Contact the Office of Tribal Affairs and Strategic Alliances at tribalsupport@cdc.gov or visit www.cdc.gov/tribal



Preparedness Field Assignee Program

Division of State and Local Readiness, Field Services Branch

The mission of CDC's Preparedness Field Assignee (PFA) program is to support the public health preparedness and response capabilities of state, tribal, local, and territorial jurisdictions through the development of a knowledgeable, responsive, and effective public health workforce. To achieve this mission, the program places PFAs in Public Health Emergency Preparedness (PHEP) recipient jurisdictions around the country to serve three-year terms.



About the Preparedness Field Assignee (PFA) Program

The Preparedness Field Assignee (PFA) Program is managed by CDC's [Center of Preparedness and Response, Division of State and Local Readiness, Field Services Branch](#). It provides new graduates of CDC's Public Health Associate Program (PHAP) an opportunity to continue to strengthen skill sets acquired during their initial training. The PFA program recruits highly skilled PHAP graduates for placement in state, local, or territorial health departments to support public health preparedness and response activities.

Selected PFAs are matched with approved host sites. In partnership with PFA program leadership, these sites offer experience and mentorship that supports the continued development of a knowledgeable, responsive, and effective public health workforce while strengthening and advancing the capabilities of state and local public health systems. During their assignments, which typically last three years, PFAs can expect to work hand-in-hand with state and local partners, in an all-hazards approach to preparedness, as they grow and develop into public health leaders. Skills learned in the PHAP program are routinely applied with additional emphasis on building proficiencies in public health, program management and leadership, emergency preparedness and response, communications, and partnership development. In addition to cultivating early-career professionals equipped with the essential skills to advance their public health careers, sponsoring host sites gain a valuable resource that compliments, enhances, and expands their ability to meet priority preparedness and emergency response activities.

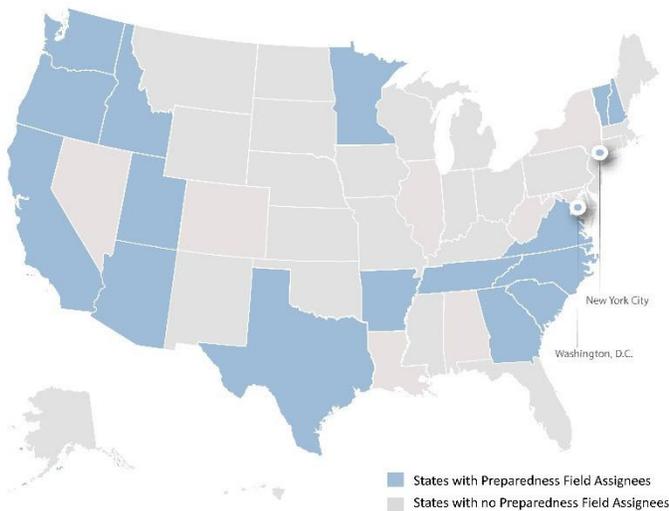
Supporting State and Local Preparedness

The Division of State and Local Readiness (DSLRL) created the Field Services Branch (FSB) to enhance the public health preparedness and response efforts of state, tribal, local, and territorial health departments through assignment of field-based staff, including PFAs and Career Epidemiology Field Officers (CEFOs). PFAs function as embedded staff to build and strengthen the capability of health departments to effectively respond to public health emergencies. Since its inception, the PFA program has successfully recruited and hired 59 PHAP graduates who have served in 29 states, four large metropolitan areas, and one U.S. territory, expanding the CDC preparedness field-based footprint.



Host Site Selection

The host site selection is a formal, competitive process that is open to all 62 CDC [Public Health Emergency Preparedness \(PHEP\)](#) recipients. Interested host sites can submit a proposal for up to two PFAs annually. CDC reviews and rates host site applications based on standardized criteria that evaluate the proposed scope of work, roles and responsibilities, local capacity for supervision and mentorship, and site-specific preparedness and response leadership and experience. Successful host sites are paired with incoming PFA recruits on the basis of staff availability, individual preference, and programmatic priorities.



Current PFA Investment

The PFA program currently has 19 field assignees detailed to state and large metropolitan public health departments to support and enhance efforts to build capacity to monitor, detect, respond, mitigate, and recover from infectious disease outbreaks, natural disasters, intentional acts of terrorism, and biological, chemical, nuclear, and radiological emergencies. In 2019, the PFA program recruited five new assignees for strategic placement within CDC's PHEP jurisdictions, which include 50 states, four metropolitan areas (Chicago, Los Angeles County, New York City, and Washington, D.C.) and eight U.S. territories and freely associated states (American Samoa, Guam, U.S. Virgin Islands, Northern Mariana Islands, Puerto Rico, Federated States of Micronesia, Republic of the Marshall Islands, and Republic of Palau).

For more information, please contact: dslrpfa@cdc.gov



Centers for Disease Control
and Prevention
Center for Preparedness and Response

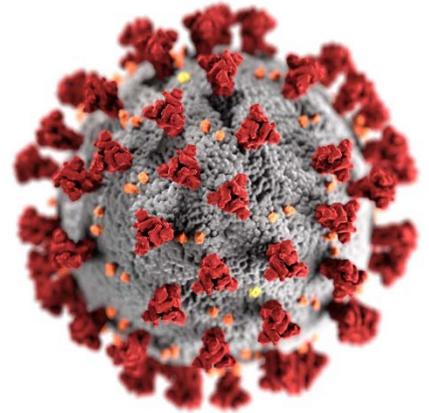
COVID-19 Update and Discussion

State, Tribal, Local, and Territorial Support (STLT) Task Force

CDC's Role in Supporting Tribal Nations in the COVID-19 Response

Margaret (Peggy) Honein, PhD, MPH

21st Biannual CDC and ATSDR Tribal Advisory Committee (TAC) Meeting
February 3, 2021



cdc.gov/coronavirus

CDC's State, Tribal, Local, and Territorial Support Task Force

Mission: rapid support to state, tribal, local, and territorial jurisdictions through:

- Ongoing **technical assistance**
- **Virtual training** on contact tracing, case investigations, and infection prevention and control
- Field teams for **outbreak investigations** in communities and congregate settings
- Best practices for **infection prevention** and control
- Digital platforms to support **large scale contact tracing**
- **Health communications** to support effective mitigation
- **Data analytics tools** and reports



Tribal Support Section

Key Objective: Provide technical assistance to American Indian/Alaska Native Communities



Contact Tracing



Mapping



Community Mitigation



Infection Prevention and Control



Data Collection and Analysis



Health and Risk Communications



Epidemiology and Surveillance Support



Response Management



Water, sanitation, and hygiene



Factors Contributing to Heightened COVID-19 Incidence and Mortality

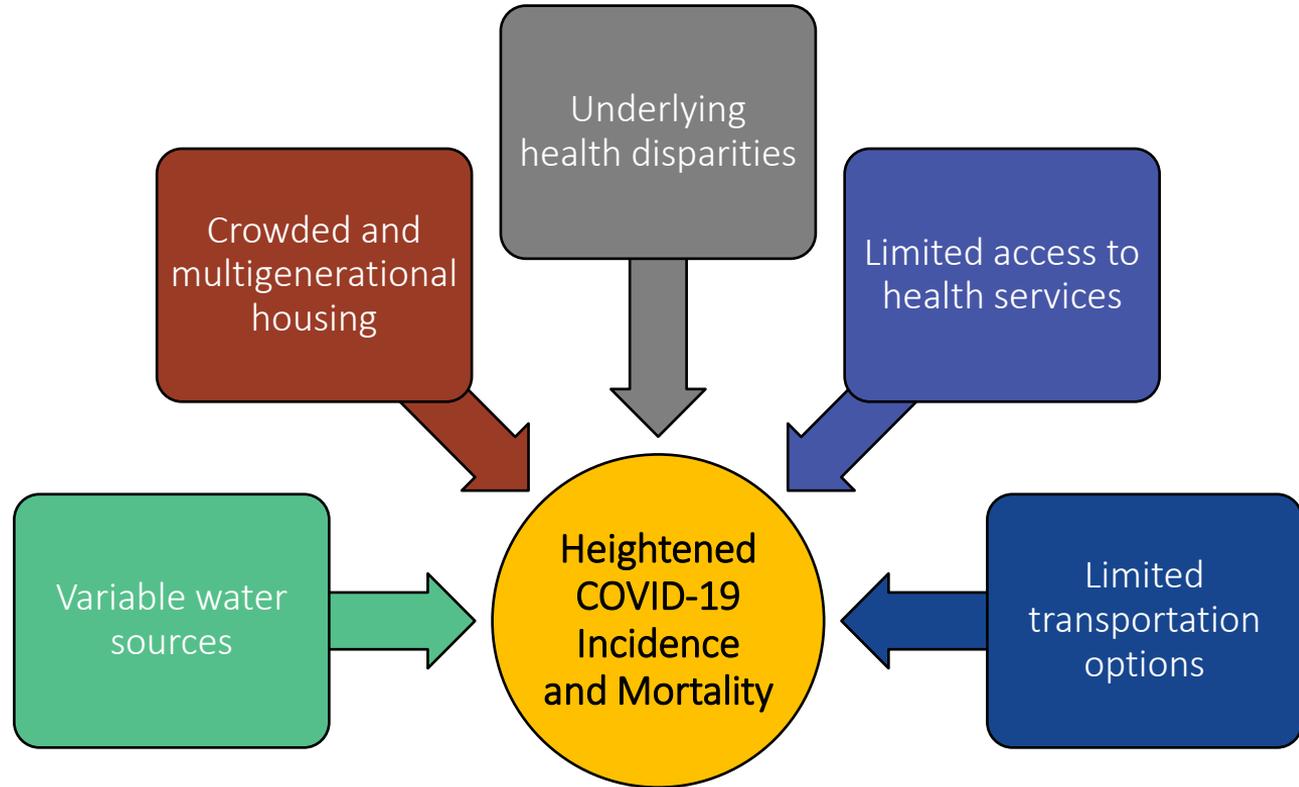
When compared with non-Hispanic White persons, American Indian/Alaska Native non-Hispanic persons are

1.8 times more likely to be diagnosed with COVID-19

4.0 times more likely to be hospitalized because of COVID-19

2.6 times more likely to die from COVID-19

Data Source: COVID-NET



COVID-19 CDC Deployments to Tribal Communities

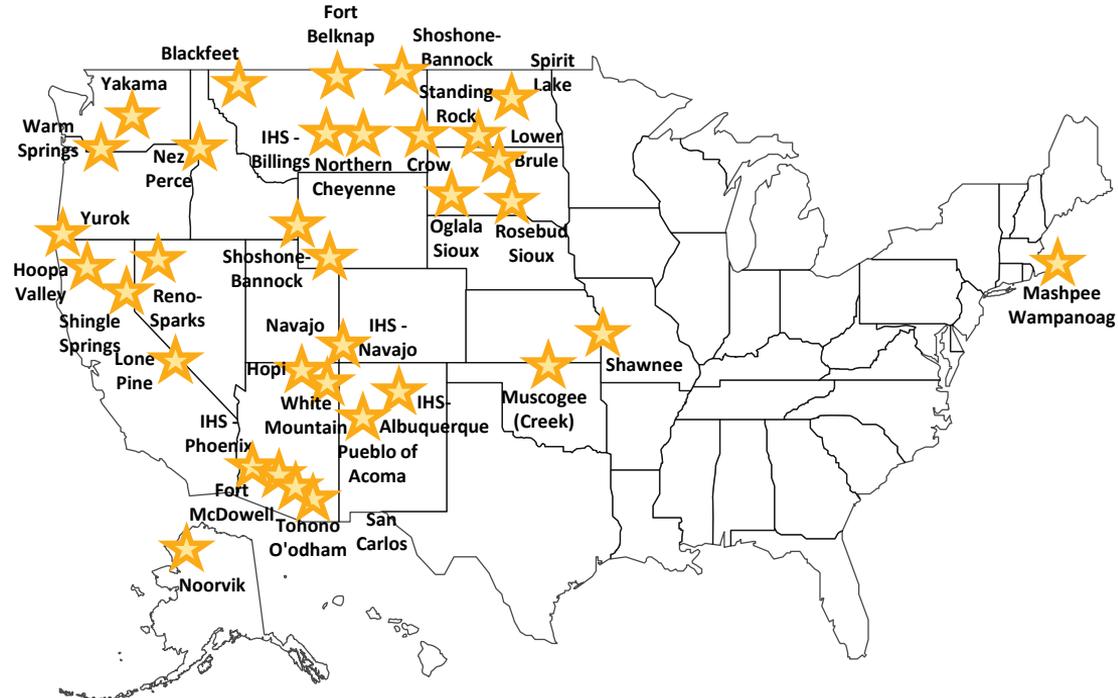
Cumulative Deployments

Tribal Deployments

52 teams total

280 cumulative staff
(field and remote deployers)

April 2, 2020 – January 25, 2021



How CDC Partners With Tribal Communities



Remote
Support

- Tribal Liaison Officers
- Tribe Specific Technical assistance (TA) plans
- Implementation TA
- Information sharing
- Linking to resources and contacts
- Training for developing and implementing a contact tracing plan



Protocol
Review

- Incident Command Structure
- Case management
- Contact tracing
- Reopening
- Recovery



CDC Staff
Deployments

- Epidemiological Teams
- Contact Tracing Teams
- Infection Prevention and Control Teams
- Incident Command Teams



CDC Liaison Officer (LNO) Workflow for EOC Deployments

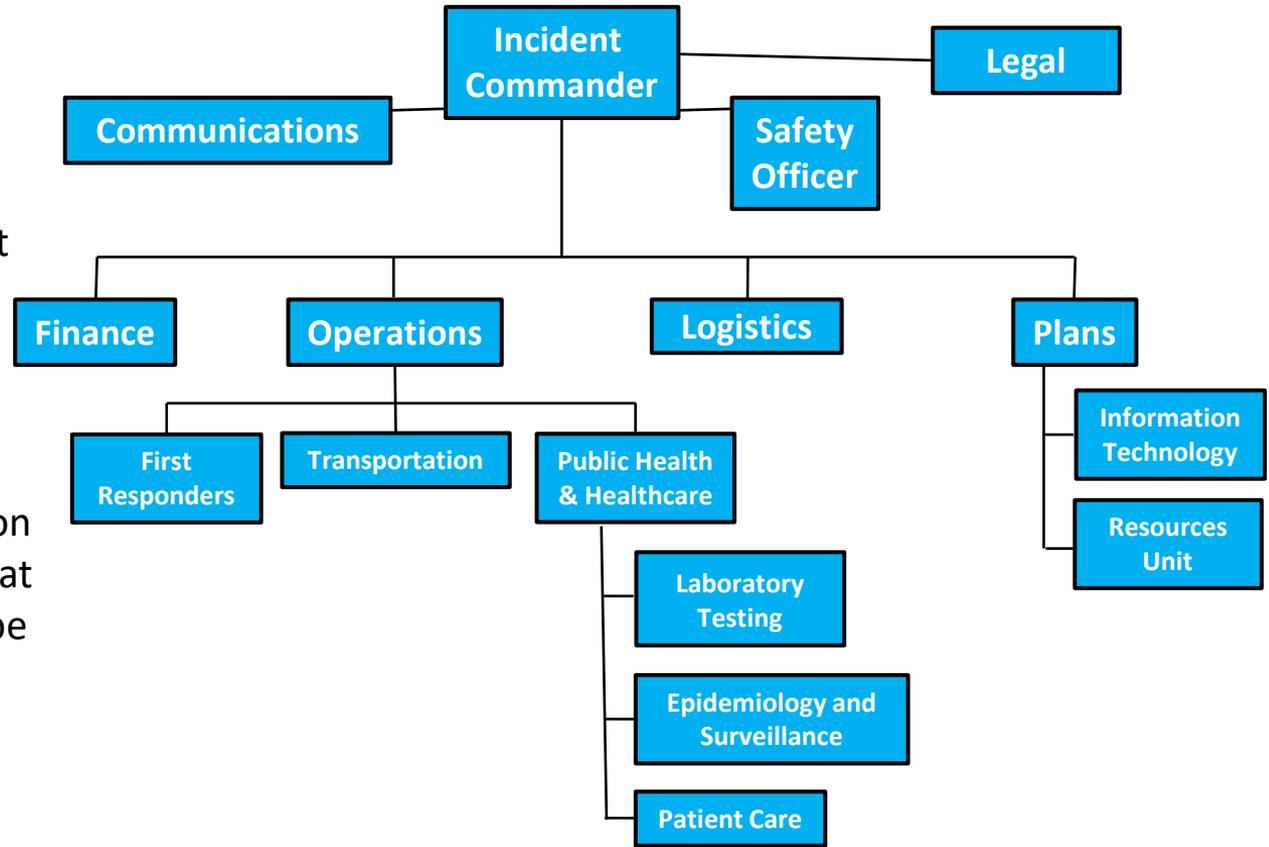


Increasing Emergency Response Capacity



Assisting with Incident Command Structure

- Identify a chain of command
- Establish routine incident command meetings
- Develop Standard Operating Procedures (SOPs)
- Encourage communication between all parties so that coordinated efforts can be more effective.



Deployment Spotlight: Hopi Tribe

Mounting a Robust COVID-19 Response



Door-to-Door Education & Outreach ("CHAC" Program)

CDC deployers supported the Hopi to

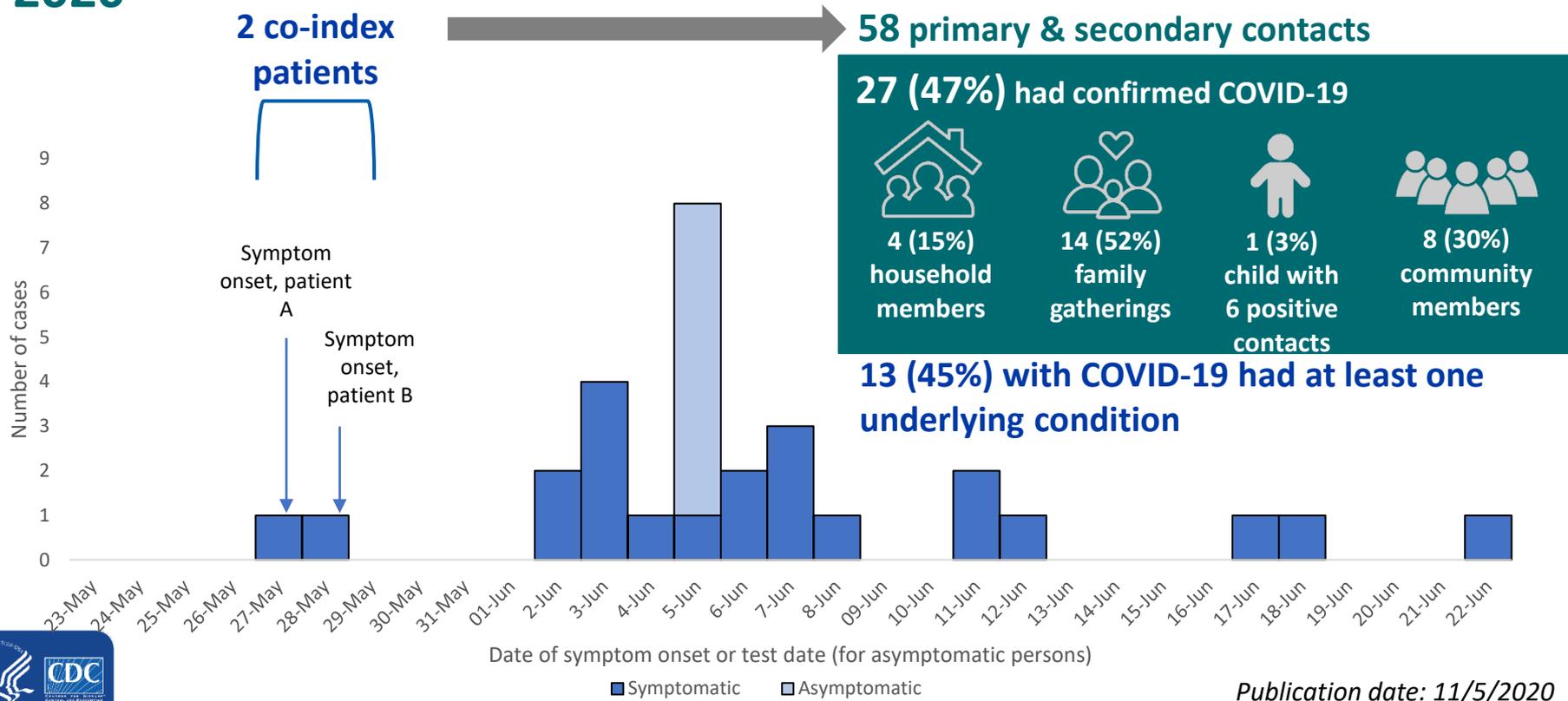
- Enhance epidemiologic reporting and data analysis
- Improve the existing incident command system
- Implement innovative communication strategies
 - Deliver health education and referral for testing through household visits called CHAC: Community outreach, Health education, Assessment for COVID-19, Connection to testing and care



Building COVID-19 Surveillance Capacity



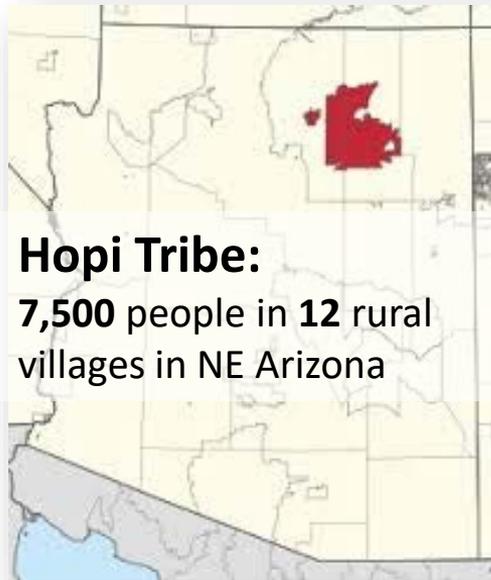
MMWR: A SARS-CoV-2 outbreak illustrating the challenges in limiting the spread of the virus among the Hopi Tribe, May–June 2020



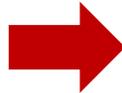
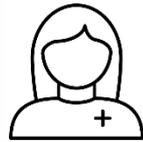
Publication date: 11/5/2020

MMWR: Development of an enhanced community-focused COVID-19 surveillance program—Hopi Tribe, 2020

The Hopi Tribe developed a community-focused program to enhance COVID-19 surveillance and deliver systematic health communications to their communities.



Surveillance:



Every household

- ✓ Screen for symptoms
- ✓ Recommend testing as appropriate
- ✓ Provide education

Field testing in 2 villages:



5 teams

Screened **141** people



<10 hours



5%

refusal rate



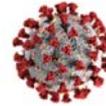
Publication date: 11/5/2020

Helping Improve Surveillance and Data Analytics

COVID ReportR: An RShiny Application

- What is it?
 - Self-contained app to clean, analyze, and visualize data
 - How does it work?
 - User inputs a standardized data extract (e.g., .xls downloaded from electronic health records)
 - App generates a (customizable) Word document with summary tables, figures, and text describing epi trends
- App is called by a single click, and all data remain local to the user's computer

Point & Click Interface



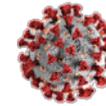
COVID ReportR: A COVID-19 Reporting Application

Overall Labs xls File:
 No file selected

Text Indicating Positive Result

Text Indicating Negative Result

Name of service unit (for report)



COVID ReportR: A COVID-19 Reporting Application

Overall Labs xls File:
 No file selected

Select desired reporting level

Service unit level report

Service Unit

Tribal level report

Tribe

COVID ReportR: Surveillance Report Output Example

**** Simulated data ****

Surveillance Report for TRIBAL NATION, 2021
 *SIMULATED DATA - This cover sheet manually updated

This is the Y1th surveillance report from My Simulated Fa data analysts and interpretations of data shared by My Site are the summary observations that may help guide the plan.

1. The number of COVID-19 cases in the past 14 days is pending tests for the past 14 days. **Case counts ahead of increase.**

2. There is an **increase** in SARS-CoV-2 test positivity (p-).

3. Percent positivity is **>20%** which may indicate **inadequate availability/capacity**.

Available data analysts demonstrate the following gating decisions **ARE NOT met** (as below)

- Downward trajectory (or near-zero incidence) of the period
- Downward trajectory (or near-zero percent positivity) of total tests over a 14-day period (flat or increasing)
- Test availability such that percentage of positive tests

Recommendations [CUSTOMIZE BELOW]

The reopening plan recommends a limited reopening of essential gathering to less than 10. The following reopening context and it is hoped that this will result in flattening the during reopening.

- Continue to monitor trends in cases and percent positive decisions.
- Implement enhanced surveillance to ensure early case management and rapid community level testing.
- Intensify communication efforts to communities to aid and make routine the behaviors of physical distancing and face coverings.

Surveillance Report No. YY
 My Facility (Simulated Data)

Executive Summary: Data through 2020-11-05 for TRIBAL NATION (Simulated Data)

Last 7 days		
New COVID-19 Cases	New COVID-19 Tests	Percent Positivity
2	6	33.3%

Over the last 14 days...

The number of new cases is: **very low**
 The percent positivity is: **increasing**
 Most new cases were in ages: **5 - 18, 40 - 49, 60 - 69, 70 - 79**

Newly identified COVID-19 cases since the epidemic began

Surveillance Report for TRIBAL NATION, 2021
 *SIMULATED DATA - This cover sheet manually updated

This report was last updated 2021-01-13. Data are current as of 05:30, and so any test results or orders were not updated in the system will not be included.

A few summary statistics for the entire service unit are:

- Overall, there have been 4054 SARS-CoV-2 tests on 3232 individuals and including tests run as part of
- Considering tests run as part of the same algorithm
- have been 2259 completed testing events ordered
- As of 2020-11-05, there have been 667 positive COVID individuals tested at My Simulated Facility.

The same summary statistics for the selected tribe(s) [T]:

- Overall, there have been 553 SARS-CoV-2 tests on 523 individuals and including tests run as part of
- Considering tests run as part of the same algorithm
- have been 523 completed testing events ordered
- As of 2020-11-05, there have been 146 positive COVID individuals tested at My Simulated Facility.

The remaining results in this report are shown for the 4 test results.

Key Figures

The following analyses are for the patient population of Changes in newly identified COVID-19 cases:

Overall, cases appear to be very low. It is important to look from the past 14 days that still have pending results, into test results.

The graph below shows the number of new COVID-19 cases along with the moving 3-day average (red line) and the 14 days is shown after the vertical dotted line, with the caution should be exercised when looking at the grey test results.

A second graph shows just the results for the past three trends easier as time goes on.

Analyses of COVID-19 Data from My Simulated Facility

This report was last updated 2021-01-13. Data are current as of 05:30, and so any test results or orders were not updated in the system will not be included.

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Newly Identified COVID-19 Cases by Day

Newly Identified COVID-19 Cases by Day Past 3 months

Changes in percentage of SARS-CoV-2 tests positive

Overall, percent positivity appears to be increasing among 14 7 days, average unsmoothed percent positivity was 21.7% and number of tests was 1. Over the past 14 days, the average was 20.8% and the smoothed average daily number of tests was 2.

Below we see the total number of tests ordered by day of collection the 3-day average percent positive by day of collection (blue percent positive (blue line). The past 14 days can be seen as a line. The past four days are shown in grey. Caution should be results during the past four days due to pending tests.

Another graph for the past 3 months is shown below this, to time goes on.

Number of SARS-CoV-2 Tests and Percent Positivity by Day

Number of SARS-CoV-2 Tests and Percent Positivity by Day Past 3 months

Percent Positivity by Month

Months	All
Jul 2020	34.0
Aug 2020	26.5
Sep 2020	21.6
Oct 2020	28.2
Nov 2020	58.0

Cases by Age

The figures below illustrate the age distribution of individuals with lab-confirmed COVID-19. These results are based on an individual's age of first confirmed COVID-19 diagnosis.

The median age of cases is 68 years. The minimum age of cases was 5, and the maximum age was 100 years.

Age Distribution of Cases by Month



Increasing Testing Capacity in Remote Areas



Deployment Spotlight: Increasing COVID-19 Testing in Remote Areas

BinaxNOW Testing

- Objectives for BinaxNOW deployments:
 - Reduce testing delays
 - Gather data from BinaxNOW rapid tests
 - Provide technical assistance to communities and Indian Health Service (IHS)
 - Determine feasibility of deploying antigen tests in field settings



Google Images

Health Communications Support



Deployment Spotlight: Shoshone Bannock Health Communications Support



Resources for Tribal Communities

The Tribal Support Section has prioritized creating print materials and social media messaging featuring imagery more resonant with American Indian/Alaska Native (AI/AN) cultures. Many of these are in development.



For Tribal Community Members and Leaders

Multi-generational and Shared Housing

Social distancing and coping for tribal communities

Tribal Funeral and Burial Practices

Pets and Other Animals

People Who Need to Take Extra Precautions

Coping with Stress and Anxiety during COVID-19

Reducing Stigma

Caring for Children

FAQs for Correctional and Detention Facilities

COVID-19 General Frequently Asked Questions

COVID-19 Resources for Tribes



Spotlight on Coloring Book

- Designed specifically for AI/AN-identified children and their caregivers.
- Addresses COVID-19 and mitigation measures in child-friendly terminology.
- Based on *Eagle Book* series and characters.
- Large and wide outreach to Native-serving organizations.
- Additional downloadable coloring and activity pages will be available.



How Can We Help?

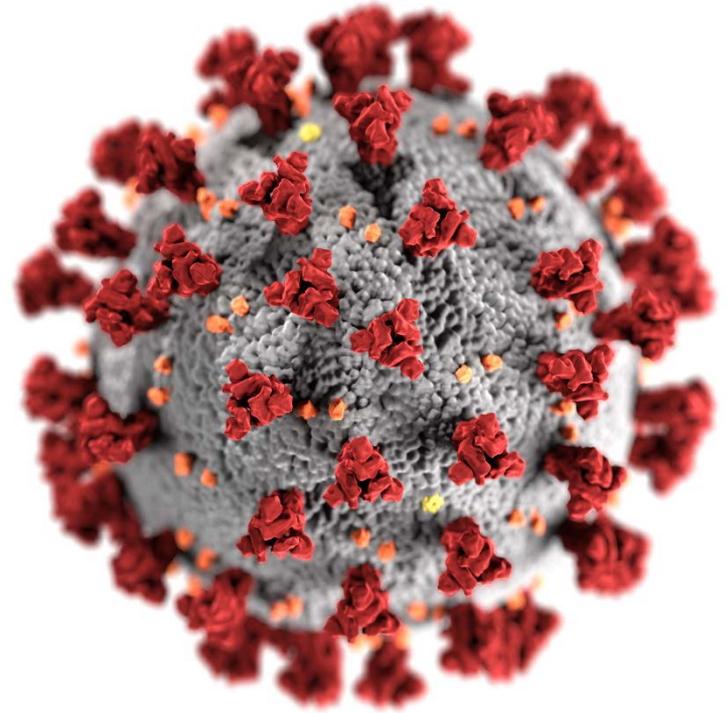
CDC Tribal Support Unit

eocevent362@cdc.gov

Or visit

www.cdc.gov/coronavirus/2019-ncov/community/tribal/index.html





For more information, contact CDC
1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 www.cdc.gov

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.



Additional Resources



CDC/ATSDR Tribal Advisory Committee Members

Area Office	Delegate	Authorized Representative
Alaska Area Term Expires: February 28, 2021	Alicia L. Andrew President, Karluk IRA Tribal Council <i>Native Village of Karluk</i>	VACANT
Albuquerque Area Term Expires: August 31, 2021	Selwyn Whiteskunk Tribal Councilman <i>Ute Mountain Ute Tribe</i>	Alston Turtle Council Delegate <i>Ute Mountain Ute Tribe</i>
Bemidji Area Term Expires: November 30, 2022	Robert TwoBears (TAC Chair) Legislative District V Representative <i>Ho-Chunk Nation of Wisconsin</i>	Wally Apland Director of Finance, Department of Health <i>Ho-Chunk Nation of Wisconsin</i>
Billings Area Term Expires: August 31, 2021	Byron Larson, MHA Rocky Mountain Tribal Leaders Council <i>Northern Cheyenne Nation</i>	VACANT
California Area Term Expires: November 30, 2022	Teresa Sanchez Tribal Council Member <i>Morongo Band of Mission Indians</i>	VACANT
Great Plains Area Term Expires: November 30, 2022	Monica Mayer Councilwoman, North Segment Representative <i>Mandan, Hidatsa, and Arikara Nation</i>	VACANT
Nashville Area	VACANT	VACANT
Navajo Area Term Expires: August 31, 2021	Myron Lizer Vice President <i>The Navajo Nation</i>	Jill Jim, PhD, MHA/MPH Executive Director, Department of Health <i>The Navajo Nation</i>
Oklahoma Area Term Expires: October 31, 2021	Bryan Warner Deputy Principal Chief <i>Cherokee Nation</i>	Lisa Pivec Senior Director of Public Health, Cherokee Nation Health Services <i>Cherokee Nation</i>
Phoenix Area	VACANT	VACANT
Portland Area	Stephen Kutz, RN, BSN, MPH	Sharon Stanphill, MD





CDC/ATSDR Tribal Advisory Committee Members

Term Expires: August 31, 2021	Tribal Council Member <i>Cowlitz Indian Tribe</i>	Chief Health Officer <i>Cow Creek Band of Umpqua Tribe of Indians</i>
Tucson Area	VACANT	VACANT
Tribes At-Large Term Expires: August 31, 2021	Doreen Fogg-Leavitt Secretary, Inupiat Community of the Arctic Slope Council <i>Inupiat Community of the Arctic Slope</i>	VACANT
Tribes At-Large Term Expires: August 31, 2021	Connie Barker Tribal Legislator <i>The Chickasaw Nation</i>	Darcy Morrow Tribal Council Member <i>Sault Ste. Marie Tribe of Chippewa Indians</i>
Tribes At-Large Term Expires: August 31, 2022	Trinidad Krystall Riverside San Bernardino County Indian Health Clinic Inc. <i>Torres Martinez Desert Cahuilla Indians</i>	VACANT
Tribes At-Large Term Expires: August 31, 2021	Richard Sneed Principal Chief <i>Eastern Band of Cherokee Indians</i>	Vickie Bradley, MPH, BSN, RN Secretary of Public Health and Human Services <i>Eastern Band of Cherokee Indians</i>



Tribal Advisory Committee Member Biographies



Centers for Disease
Control and Prevention
Center for State, Tribal, Local,
and Territorial Support



Alaska Area

Alicia L. Andrew

***Karluk IRA Tribal Council, Native Village of Karluk
President***

Alicia Andrew is the current president of the Karluk IRA Tribal Council in Karluk, Alaska. She has been serving on the Karluk Tribal Council since 1990. Karluk IRA Tribal Council runs all the Bureau of Indian Affairs programs locally, including the Roads Program, and is the only tribe on Kodiak Island that runs their own Indian Health Service contract. President Andrew is the Alaska Representative on the Alaska Native Health Board. The Karluk Tribal Council selected Ms. Andrew as the member representing Karluk Tribal on the National Congress of American Indians and National American Indian Housing Council. President Andrew attended Fort Lewis College in Durango, Colorado and returned to Karluk in 1989 to work on the oil spill clean-up efforts.

Albuquerque Area

Selwyn Whiteskunk

***Ute Mountain Ute Tribe
Tribal Councilman***

No biography available.

Bemidji Area

Robert TwoBears (TAC Chair)

***Ho-Chunk Nation of Wisconsin
Legislative District V Representative***

Robert TwoBears is the District V Representative of Ho-Chunk Nation predominantly in Wisconsin, Nebraska, and Iowa. He is a member of the Housing Committee and is the second presiding officer for the Health, Social Services, Insurance Committee, and Finance Committee. Additional services and affiliations for Mr. TwoBears include serving as an alternate on the Indian Health Service Budget Formulation Team. Mr. TwoBears' area of interest includes the opioid epidemic.

Billings Area

Byron Larson

***Northern Cheyenne Nation
Rocky Mountain Tribal Leaders Council***

As a health care professional, policy analyst, and citizen of the Northern Cheyenne Nation, Byron Larson has continuously promoted health equity and social justice for American Indians and Alaskan Natives (AI/AN). Mr. Larson has developed a broad body of knowledge in health care financing and service delivery, managed care and risk based contracting, epidemiology and evaluation, health promotion and disease prevention, and public health practice and research. In his advocacy for AI/ANs,

he has been successful at working collaboratively with tribal, state, and federal partners to identify, prioritize, and promote tribal public health capacities including design and development of health promotion and disease prevention systems to promote policy, system and environmental interventions in native populations. He has also formally and informally represented these interests with the Centers for Disease Control Office of Minority Health, Substance Abuse and Mental Health Services Administration, the National Institutes of Health's Institute on Minority Health Disparities of Health, the Indian Health Service's Division of Epidemiology and Disease Prevention, regional and national health boards, and native and non-native health institutes. Mr. Larson graduated with a Bachelor of Science in sociology from North Dakota State University and a Master of Science in health services administration from University of Washington.

California Area

Teresa Sanchez

Morongo Band of Mission Indians

Tribal Council Member

An ardent champion for improving Native American health care and creating opportunities for Indian youth, Teresa Sanchez was elected to the Morongo Tribal Council in 2019.

Sanchez has been a member of the Riverside-San Bernardino County Indian Health, Inc. (RSBCIHI) Board of Directors since 2010 and served as the board president from 2016 to 2018. She is currently the board's vice president. The organization delivers multi-disciplinary health care, dental, behavioral health, diabetes prevention and other services aligned with tribal cultural values to more than 18,000 clients at seven clinics stretching from Barstow to the Torres-Martinez Indian Reservation. Sanchez previously worked for RSBCIHI's Purchased and Referred Care Department for eight years.

Over the past five years, Sanchez has testified before Congress and met with numerous federal lawmakers in her work to help shape national health care policy for Indian Country, including efforts to secure more equitable health care funding for the nearly 725,000 American Indians and Alaska Natives who live in California.

Sanchez is a member of the Community Health Aide Program Tribal Advisory Group with the federal Indian Health Service; the California Area Tribal Advisory Committee for the California Area Indian Health Service; and the Sacramento-based California Rural Indian Health Board, where she is also an appointee to a subcommittee exploring the impact of the opioid crisis on native populations.

Sanchez previously served on the Morongo Education Committee which supports the Morongo School, the nation's first college preparatory academy on an Indian reservation. She also served on the tribal Election Committee.

Born in Indio, Sanchez's family moved to the Morongo Indian Reservation when she was a teen. She worked in Morongo's tribal administration prior to launching her career in health care. Sanchez has three children and seven grandchildren.

Great Plains Area

Monica Mayer

***Mandan, Hidatsa, and Hidatsa & Arikara Nation
Tribal Council Member***

Councilwoman Monica Mayer, M.D. “Good Medicine” represents the residents of North Segment on the Tribal Business Council of the Mandan, Hidatsa, & Arikara Nation, the largest community on the Fort Berthold Indian Reservation in mid-west North Dakota. She is also a member of the Hidatsa Prairie Chicken Clan.

Dr. Mayer has over 20 years of clinical healthcare experience all in the Great Plains Area of North Dakota, South Dakota, and Nebraska, working for direct patient care in clinical and an ER setting. She has administrative experience as Chief Medical Officer for critical access center, Belcourt Hospital, and the Great Plains Area (Deputy Acting). Most recently, she implemented a Home Health program specific for North Segment, and is collaborating with MHA Chairman Mark Fox and The First Lady of ND Kathryn Burgum on drug and alcohol treatment and recovery initiatives.

Dr. Mayer is a lifelong resident of New Town and attended Edwin Loe Elementary and graduated from New Town High School in 1978. She obtained an Associate of Arts in Business Administration and holds a Bachelor’s of Science in Education. Councilwoman Mayer received her Doctorate of Medicine from the University Of North Dakota School Of Medicine and is a Family Practice Physician. She is also a Peacetime Veteran, honorably serving from 1984-1990 with the U.S. Army Reserves.

Dr. Mayer is dedicated to improving the overall Healthcare, Education, Law Enforcement, and Commerce of the North Segment Community. She also serves as the Chairwoman of the MHA Nation Economic Development Committee, Health & Human Committee, and the Education Committee. “I am committed to upholding a healthy, safe, and clean community.”

Nashville Area

Vacant

Navajo Area

Myron Lizer

***The Navajo Nation
Vice President***

Myron Lizer was elected vice president of the Navajo Nation with President Jonathan Nez in 2018. Vice President Lizer excels in the business arena with a pedigree in building relationships and promoting higher levels of professionalism and excellence in working with tribal entities, and in the private sector. He also contributed to the 2012 Navajo Tribal team that promoted partnering with the Nation of Israel in advancing business and economic relationships and developing the understanding that Israel and the Navajo Nation share a lot of the same hardships and opportunities as a First Nations people.

Mr. Lizer has contributed to his community by leading financial literacy courses across the Navajo Nation and leading other future business owners in Indian entrepreneurship—helping other Native Americans write business plans thus qualifying participants for business start-up loans and consideration for grants and capital investors for aspiring entrepreneurs. Before he was president of Navajo Westerners Ace Hardware Stores and Lumber Yards, Mr. Lizer was an accountant for the Southern Ute Growth Fund, the money-generating arm of the Southern Ute Indian Tribe in southwestern Colorado.

Mr. Lizer earned his Bachelor of Arts Degree in Business Administration from Fort Lewis College in Durango, Colorado in 2006.

Oklahoma Area

Bryan Warner

Cherokee Nation

Deputy Principal Chief

Bryan Warner is the Deputy Principal Chief of the Cherokee Nation. Prior to June 2019, he has served on the Cherokee Nation Tribal Council for District 6, a position he held since 2015. Mr. Warner holds a Bachelor of Science degree in biology from Northeastern State University and a Master of Education degree from East Central University. He is employed at Carl Albert State College and has served as a full-time science instructor and is now Sallisaw Campus Director. Mr. Warner's civic and volunteer experience includes time served as Ward 3 City Commission for the City of Sallisaw, leading local youth in church as well as coaching youth league baseball and football. He also works closely with the Sallisaw MainStreet Organization and is a member of Sallisaw Lions Club, is on the board of Directors for Sallisaw Youth League and the Sallisaw Youth and Recreation Commission.

Phoenix Area

Vacant

Portland Area

Stephen Kutz, RN, BSN, MPH

Colwitz Indian Tribe

Tribal Council Member

Stephen Kutz has served as a Tribal Council Member for almost 20 years and is currently serving as Tribal Council Chair. He received his Bachelor of Science in Nursing from Eastern Washington University and has worked as a nurse for 46 years. He received his Master's in Public Health from Tulane University in 1992. He served 20 years on active duty as a nurse in the U.S. Army with 13 of those years spent in Preventive Medicine and Community Health. He also worked for over 12 years in a County Health Department in Washington State as Director of Public Health Nursing while also serving as the Health Department Director for eight years. He has worked for this Tribe for 14 years, for five

years he managed the Medical and Mental Health Clinic in Longview Washington as well as the Mental Health Clinic in Vancouver and Seattle, three years as Deputy Director, and now executive Director of the Cowlitz Tribe Health and Human Services Department. He is involved deeply in Indian health and social services programs and policy formulation at the local, state and national level at numerous levels as demonstrated by his involvement on regional, statewide, and national committees and boards. He is an alternate delegate to the Affiliated Tribes of Northwest Indians along with National Congress of American Indians and serve as an alternate Delegate to the Northwest Portland Area Indian Health Board. He has served as their delegate to the HHS Health Research Advisory Committee where he served as the co-chair and has served on the IHS Budget Formulation Committee for 6 years. In the past he also served as an Alternate National Delegate to the HHS (STAC) Secretary's Tribal Advisory Committee. He also serves as a delegate to the Washington State American Indian Health Commission and serves as the elected Chair and is on the board of directors. He also serves as the co-chair of the Foundational Public Health Advisory Committee that is working with the Washington State Department of Health, Local County Public Health and Tribal Public in increasing State funding to the State Public Health System. He is also a delegate to the Washington State Indian Policy Advisory Committee to the Department of Social and Health Services who has further assigned him to represent them on the Behavioral Health Advisory Committee to the Division of Behavioral Health and Recovery. He currently works on the State Mental Health Committee that is advising the state in their efforts to redesign how Medicaid mental health services are delivered to AI/AN. He is a board member of the Southwest Washington Regional Health Alliance, the Accountable Community of Health for SW Washington. He has been appointed by the Governor to the State Board of Health representing Tribes and has served for 9 years. The State Board of Health has appointed him as their delegate to the governors' Council on Health Disparities. He summarizes his Public Health experience consists of 13 years in the Federal sector (US Army), 12 years in County Public Health, and 14 years in Tribal Health. He is currently (since March 2020) running the Incident Command for the Cowlitz response to Covid-19.

Tucson Area

Vacant

Tribes At-Large*

Doreen Fogg-Leavitt

***Inupiat Community of the Arctic Slope
Council Secretary***

Doreen Fogg-Leavitt is the Council Secretary for the Inupiat Community of the Arctic Slope (ICAS), elected August 2018. She is the Executive Director for the Native Village of Barrow Inupiat Traditional Government since November 2018. Secretary Fogg-Leavitt was formerly the Director of the North Slope Borough Department of Health & Human Services from 2011 to 2016. She graduated from Carroll College with a nursing degree in 2001. Secretary Fogg-Leavitt has held various roles employed as a public health nurse, nurse manager, and on national and statewide boards.

Connie Barker

Chickasaw Nation

Tribal Legislator

Connie Barker is a Tribal Legislator for the Chickasaw Nation. She has served the Pickens District since 2008 and has previously held both Secretary and Chairperson positions. Mrs. Barker is a member of the Legislative, Human Resources, Education, Health, and Tribal Historical Preservation committees, as well as the Tribal Co-Chair for the Tribal Leaders Diabetes Committee, a national committee dedicated to the treatment and prevention of diabetes in Indian Country. She currently serves as Health Committee Chair and serves on multiple other committees. Mrs. Barker is a graduate of Murray State College and an Honor Graduate of the first Leadership Love County Class of 2004.

*There are currently two Tribes At-Large vacancies.

Trinidad Krystall

Riverside San Bernardino County Indian Health Clinic Inc.

Torres Martinez Desert Cahuilla Indians

Trinidad Krystall, is a member of the Torres Martinez Desert Cahuilla Indians and mother of three. She attended Venice High School and received a scholarship to attend the University of California Los Angeles. After graduating from U.C.L.A. she worked as a musical performer, theater sound designer and photographer. She eventually accepted a position with the State of California in insurance claims management with the Department of Industrial Relations. Presently, she works on special projects as an executive producer for classical music recordings on the Vivace label. Since 2018 she has been a RSBCIHI Board Delegate and Alternate for Torres Martinez Desert Cahuilla Indians. She is grateful for the many opportunities She's had to serve her tribe. Some of the positions she's held are; Executive Director of the Torres Martinez Gaming Agency, Torres Martinez Gaming Commission Chairwoman, Tribal Council Proxy for two years, TM TANF Advisory Board member. In 2019 she served as a Delegate on the California Rural Indian Health Board and currently is a member of the Centers for Disease Control (CDC/ATSDR) Tribal Advisory Committee. She is passionate about health and wellness and strive to serve her native community to the best of her ability.

Richard Sneed

Eastern Band of Cherokee Indians

Principal Chief

Richard Sneed is the 28th Principal Chief of the Eastern Band of Cherokee Indians. He is a graduate of Cherokee High School in Cherokee, North Carolina and a graduate of Universal Technical Institute in Phoenix, Arizona, and Southwestern Community College in Sylva, North Carolina. He holds a North Carolina teaching license in industrial arts and taught vocational classes at Cherokee High School where the National Indian Education Association recognized him as National Classroom Teacher of the Year. Principal Chief Sneed is a veteran of the United States Marine Corps and he has served as the senior pastor of the Christ Fellowship Church of Cherokee. Principal Chief Sneed and his wife Trina reside in the Birdtown Community of the Qualla Boundary where they raised their five children.



Speaker Biographies



**Centers for Disease
Control and Prevention**
Center for State, Tribal, Local,
and Territorial Support



Rochelle P. Walensky, MD, MPH
Director, Centers for Disease Control and Prevention
Administrator, Agency for Toxic Substances and Disease Registry



Rochelle P. Walensky, MD, MPH, is the 19th director of the Centers for Disease Control and Prevention (CDC) and the ninth administrator of the Agency for Toxic Substances and Disease Registry. She is an influential scholar whose pioneering research has helped advance the national and global response to HIV/AIDS. Dr. Walensky is also a well-respected expert on the value of testing and treatment of deadly viruses.

Dr. Walensky served as chief of the Division of Infectious Diseases at Massachusetts General Hospital from 2017 to 2020 and professor of medicine at Harvard Medical School from 2012 to 2020. She served on the frontline of the COVID-19 pandemic and conducted research on vaccine delivery and strategies to reach underserved communities.

Dr. Walensky is recognized internationally for her work to improve HIV screening and care in South Africa and nationally recognized for motivating health policy and informing clinical trial design and evaluation in a variety of settings.

She is a past chair of the Office of AIDS Research Advisory Council at the National Institutes of Health, chair-elect of the HIV Medical Association, and previously served as an advisor to both the World Health Organization and the Joint United Nations Programme on HIV/AIDS.

Originally from Maryland, Dr. Walensky received her bachelor of arts from Washington University in St. Louis, her doctor of medicine from the Johns Hopkins School of Medicine, and her master of public health from the Harvard School of Public Health.

José T. Montero, MD, MHCDS
Director, Center for State, Tribal, Local, and Territorial Support



José T. Montero, MD, MHCDS, is the director of CDC's Center for State, Tribal, Local, and Territorial Support, where he oversees support to the US health departments and those serving tribal nations and insular areas. He provides leadership for key activities and technical assistance designed to improve the public health system's capacity and performance to achieve the nation's goals in population health. With his team, Dr. Montero leads efforts to create communities of practice where CDC's senior leaders work with the executive leaders of the public health jurisdictions, key partners, and stakeholders to identify new, improved, or innovative strategies to prepare the public health system to respond to changing environments.

Previously, Dr. Montero served as vice president of population health and health system integration at Cheshire Medical Center/Dartmouth-Hitchcock Keene. In that capacity, he helped

the healthcare system advance its Healthy Monadnock population health strategy. Key components of this process were improved partnerships with all organizations engaged in addressing social determinants of health for the population served and development of a sustainability pathway for the region's population health strategy.

For seven years, Dr. Montero served as director of the Division of Public Health Services at the New Hampshire Department of Health and Human Services (DHHS). In that role, he led the delivery of high-quality, evidence-based services and prompt response to public health threats and emerging issues in the state. Dr. Montero was credited with maintaining New Hampshire's reputation as one of America's healthiest states. He oversaw the development and implementation of policies that advanced a healthier population, as well as the development of the state public health improvement plan and its implementation at the regional level. Under his leadership, DHHS developed a systematic approach for collecting, using, and disseminating actionable data and improved coordination between public health and health care. In New Hampshire, Dr. Montero also served as chief of New Hampshire's Bureau of Communicable Disease Control, deputy director for public health emergency preparedness and response, and state epidemiologist.

Dr. Montero has extensive experience in public health leadership and in the prevention and control of infectious diseases. His major academic and practice interests are related to social determinants of health, public health systems, and the integration of public health and population approaches into clinical practice.

Dr. Montero has held many national and regional committee leadership positions, including serving as president of the board of directors of the Association of State and Territorial Health Officials (ASTHO) and chair of ASTHO's Infectious Diseases Policy Committee. He worked closely with CDC as a member of the board of scientific advisors for the Office of Infectious Diseases, as a member of the Social Determinants of Health Think Tank, a subgroup of the STLT Subcommittee to the Advisory Committee to the Director of CDC, and as a member of the CDC Advisory Committee to the Director of CDC to prevent tuberculosis in healthcare settings. He has also served on the federal Advisory Committee on Immunization Practices, the National Academy for State Health Policy, the National Academies of Medicine, Sciences, and Engineering Roundtable on Population Health Improvement, the New Hampshire Citizens Health Initiative, Dartmouth Medical School's Leadership Preventive Medicine Residency Advisory Committee, and the Foundation for Healthy Communities.

Dr. Montero holds a medical degree from the Universidad Nacional de Colombia. He specialized in family medicine and completed his residency at the Universidad del Valle in Cali, Colombia. He also holds an epidemiology degree from Pontificia Universidad Javeriana in Bogotá, Colombia, received his certification of field epidemiology from the Colombia Field Epidemiology Training Program and a master of healthcare delivery science from Dartmouth College.

Jenna Meyer, MPH, BSN (CDR, USPHS)

Acting Director, Office of Tribal Affairs and Strategic Alliances, Center for State, Tribal, Local, and Territorial Support



Commander Jenna Meyer, MPH, BSN, is the acting director of the Office of Tribal Affairs and Strategic Alliances within CDC's Center for State, Tribal, Local, and Territorial Support. Commander Meyer is a Commissioned Corps Officer in the United States Public Health Service. She received her master of public health in maternal child health from the University of Minnesota and her bachelor of science degree in Nursing from the University of Missouri – St. Louis. She is an international board-certified lactation consultant, certified in public health, and certified in maternal newborn nursing.

Her previous assignment was as a public health advisor to Shaping Our Appalachian Region (SOAR). During her four years with SOAR, LCDR Meyer helped bring attention to rural health, assisted in strengthening the local response to opioid use disorder and its consequences, and facilitated opportunities to build the capacity of the public health system in Appalachia Kentucky. Prior to this assignment, CDR Meyer spent eight years working for the Indian Health Service in both urban and rural areas. During that time, she worked as an obstetrical nurse, lead coordinator for the Baby Friendly Hospital Initiative, and as director of Quality Management. Throughout her career, CDR Meyer has worked closely with federal, state, tribal, and community partners to advance public health and welling being through collaboration, innovation, communication, and focus on prevention.

Nathaniel Smith, MD, MPH

Deputy Director for Public Health Service and Implementation Science



Nathaniel Smith, MD, MPH, is the Deputy Director for Public Health Service and Implementation Science (DDPHSIS) at CDC, where he leads, promotes, and facilitates programs and policies that identify and respond to public health threats, improve health domestically and internationally, and puts science into action. Prior to his role as deputy director, Dr. Smith served as director and state health officer for the Arkansas Department of Health (ADH) and as secretary of health. As such, he was a member of the governor's cabinet and provided senior scientific and executive leadership

for the agency. Dr. Smith also recently served as president of the Association of State and Territorial Health Officials.

In his role as director and state health officer for ADH, Dr. Smith also oversaw the delivery of over 100 services through the main office in Little Rock and over 90 local health units in each of the state's 75 counties. These services included immunizations, WIC, outbreak response, vital records, chronic disease prevention, preparedness and emergency response, injury and

violence prevention, and suicide prevention. Additionally, Dr. Smith previously served the ADH as Branch Chief for Infectious Diseases, State Epidemiologist, and Deputy Director for Public Health Programs.

Dr. Smith received a bachelor's degree from Rice University in Houston, Texas, and a master of arts from Dallas Theological Seminary, also in Texas. He completed his doctor of medicine from Baylor College of Medicine in Houston and his master of public health from the University of Texas School of Public Health, Houston. Dr. Smith is board-certified in internal medicine and infectious diseases and holds voluntary faculty positions in the Division of Infectious Diseases at the University of Arkansas for Medical Sciences College of Medicine and in the Epidemiology Department at the College of Public Health. His clinical interests include HIV, global health, and emerging infectious diseases.

Dr. Smith is also an ordained minister in the Anglican Church. He and his wife served as medical missionaries at Kijabe Hospital in Kenya. During that time, he served in several different roles, including chief of internal medicine, medical intern program director, and infectious diseases consultant. He also served as country medical director for the University of Maryland School of Medicine in Kenya and Senior Medical Technical Advisor for the AIDS Relief program in East Africa. Dr. Smith and his wife have four children adopted from Kenya.

Alison Kelly, MPIA

Director Office of Appropriations, Office of Financial Resources



Alison Kelly is the director of the Office of Appropriations. Prior to coming to OFR, she served as the associate director for policy in CDC's Center for Global Health (CGH). In this capacity, she was instrumental in the stand up of CDC's \$600 million global health security program. Kelly's previous leadership positions within CGH included serving as director of the Overseas Operations Office and acting principal deputy of the Division of Global HIV/AIDS. She also served overseas as business service officer and deputy director for the HIV/AIDS program in CDC's office in Beijing, China. Prior to her assignment in China, she served as CDC's strategy and innovation officer for the Coordinating Office for Global Health (COGH). Kelly has been with CDC for over 20 years, and has held management and policy-related positions in the National Center on Birth Defects and Developmental Disabilities, National Center for Chronic Disease Prevention and Health Promotion, and the National Center for Environmental Health. She has also worked in CDC's Washington Office. In 1992, Kelly received her master's degree in international affairs and pacific studies from the University of California, San Diego. She specialized in economic policy and an emphasis in program design and evaluation. She has a bachelor's degree in psychology and Asian studies from Dartmouth College.

Elizabeth Dalsey, MA

Health Communication Specialist, National Institute for Occupational Safety and Health



Elizabeth Dalsey is a health communication specialist at the CDC National Institute for Occupational Safety and Health (NIOSH) in the Western States Division. She began work at NIOSH in 2006 after receiving her master's degree in communication from Michigan State University. She currently conducts communication activities and outreach for the to promote NIOSH knowledge, interventions, and technologies. Elizabeth also manages NIOSH's American Indian and Alaska Native Initiative.

Georgia Moore, MS

Associate Director for Policy, Center for State, Tribal, Local, and Territorial Support



Ms. Moore has worked in communications, policy, program management, and strategic planning at CDC since 1996. Since December 2009, she has served as the associate director for policy in the Center for State, Tribal, Local, and Territorial Support at the Centers for Disease Control and Prevention (CDC). She leads and advises on strategy and budget formulation, performance measurement, risk and issues management, and policy efforts. She also guided development and the continuing implementation of CDC's Grant Funding Profiles activity. She holds bachelor's degrees in biology and journalism and a master's degree in microbiology.

Peggy Honein, PhD, MPH

Director, Division of Birth Defects and Infant Disorders, National Center on Birth Defects and Developmental Disabilities



Margaret (Peggy) Honein, PhD, MPH, is an epidemiologist and director of the Division of Birth Defects and Infant Disorders at CDC's National Center on Birth Defects and Developmental Disabilities. In this role, Dr. Honein oversees efforts to promote healthy birth and optimal development for all children. She previously served as the Chief of CDC's Birth Defects Branch.

Nancy Messonnier, MD (CAPT, USPHS, RET) **Director, National Center for Immunization and Respiratory Diseases**



Nancy Messonnier, MD, is the director of the National Center for Immunization and Respiratory Diseases (NCIRD) and is currently leading CDC's efforts on COVID-19 vaccines. In late 2019, Dr. Messonnier directed NCIRD to activate a center-based response to an unknown respiratory disease in China that later transitioned to a full agency response to the COVID-19 pandemic. In the COVID-19 response, Dr. Messonnier is leading the effort to support the COVID-19 vaccine program in the areas of distribution, administration, implementation, safety, and access for hard-to-reach populations, with the goal of ensuring that a safe and effective COVID-19 vaccine is available to every American who wants one.

Since becoming director of NCIRD in 2016, Dr. Messonnier has been a champion for the prevention of disease, disability, and death through immunization and control of respiratory and other vaccine-preventable diseases. Dr. Messonnier spearheaded CDC's Vaccinate with Confidence initiative, which works with national organizations to strengthen public trust in vaccines and prevent vaccine-preventable disease outbreaks by advancing three key priorities: *Protect Communities, Empower Families, and Stop Myths*. The initiative includes activities aimed at reaching communities with low flu vaccination rates or high likelihood of COVID-19 complications, such as African American and Hispanic communities.

Dr. Messonnier began her public health career in 1995 as an Epidemic Intelligence Service Officer in what is now the Deputy Director for Infectious Diseases and has held a number of leadership posts across CDC. She served as acting director for the Center for Preparedness and Response for four months in 2019, deputy director of NCIRD from October 2014 to March 2016, and led the Meningitis and Vaccine Preventable Diseases Branch in NCIRD's Division of Bacterial Diseases from 2007 to 2012.

Dr. Messonnier has extensive experience in prevention and control of bacterial meningitis and, among other accomplishments, played a pivotal role in the successful public-private partnership to develop and implement a low-cost vaccine to prevent epidemic meningococcal meningitis in Africa. More than 150 million people in the African Meningitis Belt have been vaccinated with MenAfriVac since 2010, with remarkable impact. Dr. Messonnier has also been a leader in CDC's preparedness and response to anthrax, including during the 2001 intentional anthrax release and in evaluating simplified schedules for use of licensed anthrax vaccine.

Dr. Messonnier has written more than 140 articles and chapters and has received numerous awards. She received her bachelor of arts from the University of Pennsylvania and doctor of medicine from the University of Chicago School of Medicine and completed internal medicine residency training at the University of Pennsylvania.

CDC/ATSDR Tribal Advisory Committee (TAC) Meeting

October 15–16, 1:00–6:00 pm (EST)

Virtual Zoom Meeting

The Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) hosted a Tribal Advisory Committee (TAC) Meeting on October 15–16, 2020. The meeting was open to the public.

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TAC Member Attendees

President Alicia Andrew
Native Village of Karluk
 Alaska Area Delegate

Legislator Connie Barker
The Chickasaw Nation
 Tribes At-Large Delegate

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

Councilman Stephen Kutz, RN, BSN, MPH
Cowlitz Indian Tribe
 Portland Area Delegate

Byron Larson, MHA
Northern Cheyenne Nation
 Billings Area Delegate

Lisa Pivec
Cherokee Nation
 Tribes At-Large Authorized Representative

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

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

Deputy Principal Chief Bryan Warner
Cherokee Nation
 Oklahoma Area Delegate

Absent

Affiliation/Tribal Area	Name	Title
<i>Ute Mountain Ute Tribe/Albuquerque Area</i>	Selwyn Whiteskunk	Tribal Councilman
<i>Eastern Band of Cherokee Indians/Tribes At-Large</i>	Richard Sneed	Principal Chief (TAC Co-Chair)
<i>The Navajo Nation/ Navajo Area</i>	Myron Lizer	Vice President
<i>Inupiat Community of the Arctic Slope/ Tribes At-Large</i>	Doreen Fogg-Leavitt	Secretary

CDC Attendees

Romanadvoratrelunder (Romana) Allison, MPH
 Public Health Advisor, Office of the Director (OD), Center for State, Tribal, Local, and Territorial Support (CSTLTS)

Kayla Anderson, PhD
 Epidemiologist, Morbidity and Behavioral Surveillance Team, Surveillance Branch, Division of Violence Prevention (DVP), National Center for Injury Prevention and Control (NCIPC)

Danielle Arellano, MPH
 Public Health Advisor, State, Local & Tribal Support Team (SLTST), Program Implementation and Evaluation Branch (PIEB), Division of Injury Prevention (DIP), NCIPC

Theresa Armstead, PhD
 Evaluation Team Lead, Performance Development, Evaluation and Training Branch (PDET), Division of Performance Improvement and Field Services (DPIFS), CSTLTS

Coretta Bailey
 Public Health Analyst, Office of Appropriations, OD, Office of Financial Resources, Office of the Chief Operating Officer (OCOO)

Shimere Ballou, MPH
 Public Health Analyst, Office Policy, Planning & Evaluation, OD, Center for Preparedness and Response (CPR)

Nicole Barron
Public Health Advisor, Health Department
Program Branch (HDPB), Division of Program and
Partnership Services (DPPS), CSTLTS

Sherri Berger, MSPH
Chief Operating Officer, OD, OCOO

Kelly Bishop, MA
Public Health Advisor, OD, Division of Population
Health (DPH), National Center for Chronic Disease
Prevention & Health Promotion (NCCDPHP)

Amy Branum, PhD
Statistician, OD, National Center for Health
Statistics

Sharunda Buchanan, PhD
Director, OD, NCEH, DDNID

Ashley Busacker, PhD
Field Assignee, Field Support Branch (FSB),
Division of Reproductive Health (DRH), NCCDPHP

Kimberly Calloway, DVM
Public Health Associate, FSB, DPIFS, CSTLTS

Alicia Cardwell-Alston (CTR)
Senior Health Communication Specialist, OD,
CSTLTS

Sarah David Carrigan, MPH (CTR)
Health Communication Specialist, OD, DRH,
NCCDPHP

Captain Carmen Clelland, PharmD, MPA, MPH
United States Public Health Service (USPHS),
Director, Office of Tribal Affairs and Strategic
Alliances (OTASA), CSTLTS

James Beck (CTR)
Senior IT Specialist, OD, CSTLTS

Dimple Bhat, MPH
Oak Ridge Institute for Science and Education
(ORISE) Fellow, OD, Division of Overdose
Prevention, NCIPC

Breanna Branche
Public Health Advisor, Field Services Branch,
DPIFS, CSTLTS

Patrick Breysse, PhD
Director, OD, National Center for Environmental
Health (NCEH)

Rebecca Bunnell, PhD, MEd, ScD
Director, OD, Office of Science (OS), Deputy
Director for Public Health Science and
Surveillance (DDPHSS)

CDR Renee Calanan, PhD
USPHS, OD, National Center for Emerging and
Zoonotic Infectious Diseases (NCEZID)

Christa Capozzola
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Thomas Clark, MD
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Karla Checo
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Branch, DPPS, CSTLTS

Anthony Colbert, MBA

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Julie Cox-Kain

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Katherine Lyon Daniel, PhD

Associate Deputy Director for Public Health Service and Implementation Science

Teresa Daub, MPH

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Yvette Diallo

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John Dreyzehner, MD, MPH

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Nurse, PIB, DSLR, CPR

Robert Redfield, MD

CDC Director/ATSDR Administrator

Karen Remley

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(CAPT, USPHS, retired), Director, Division of Immunization Services, NCIRD

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Associate Director for Science, OD, CSTLTS

Andrea Zekis

Health Communication Specialist, OD, CSTLTS

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Sherrie Aazami

Rhonda Beaver

Bridget Canniff

Desiree Coyote

Vanesscia Cresci

Christine Crossland

Devin Delrow

Julia Dreyer

Mary Evens

Kimberly Fowler

Leanne Guy

Karrie Joseph

Sujata Joshi

Ciara Kohr

Mark LeBeau

Keely Linton

Nina Martin

Beth Michel

Theda New Breast

Sunny Stevenson

Rachel Tenorio

Lisa Thompson

Victoria Warren-Mears

Tiana Woodward

Sara Zdunek

Thursday, October 15, 2020

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

- **Deputy Principal Chief Bryan Warner** provided the opening blessing.
- **Dr. José Montero, Director, CSTLTS, CDC**, welcomed everyone to the 20th Biannual CDC/ATSDR TAC Meeting and introduced the new TAC members, nonfederal partner guests, and CDC leadership attendees.

- **Commander Jenna Meyer, Deputy Director, OTASA, CSTLTS, CDC**, conducted the roll call. A quorum was present to conduct necessary business.

1:20 PM–TAC Business

Facilitator

- **Representative Robert TwoBears** (Ho-Chunk Nation): Legislative Representative, Ho-Chunk Nation, Chair, TAC

Nominations for TAC Chair and Co-Chair

- Representative TwoBears asked TAC members for nominations for new TAC chair and co-chairs.
- Byron Larson made the motion to re-nominate the current TAC chair, Representative TwoBears. TAC members unanimously approved this motion.
- For co-chair nominations, Mr. Larson asked about re-nominating someone who was not on the call, such as re-nominating Principal Chief Richard Sneed. Councilman Stephen Kutz made the motion to hold the nomination for a later meeting, where Principal Chief Sneed can be present. President Alicia Andrew seconded the motion, and the TAC members unanimously approved this motion.

Proposed Dates for Winter 2021 TAC Meeting

- For the next TAC Meeting (Winter 2021 TAC Meeting), Councilman Kutz made the motion to hold the meeting during the first week of February, and Deputy Principal Chief Warner seconded the motion. The motion was passed to hold it in the first week of February 2021. This meeting will be conducted virtually due to the COVID-19 pandemic.

Roster

- Representative TwoBears opened the discussion to the TAC to discuss the roster, membership, recruitment, and bylaws.

TAC Roster Discussion

Question from Captain Clelland:

- Captain Clelland asked TAC members for input on the TAC bylaws, roster, and recruitment.

Discussion (input from multiple TAC members):

- Mr. Larson discussed the 1994 Federalist Act. This particular legislation piece identified tribal organizations as voting representatives on the committee.
- A sub-group of the committee unanimously voted to have the 1994 Federalist Act of the Bureau of Indian Affairs be the defining act that highlighted tribal organizations' role as voting representatives on the committee. Mr. Larson explained that the CDC/ATSDR TAC felt the list of tribal nations from the Federalist Act of 1994 was an important list for TAC members to be pulled from.
- Mr. Larson identified that the TAC felt the necessity for elected officials, or a tribe, to have ability to appoint another elected official to ensure that the TAC had equitable coverage across the country.
- Deputy Principal Chief Warner echoed Mr. Larson's response. Deputy Principal Chief Warner also stated that the committee came to a consensus that they follow guidelines put forth by the 1994 Federalist Act.

Response from Captain Clelland:

- Thank you for this feedback. For CDC to have an Unfunded Mandates Reform Act (UMRA) exemption, the TAC must be represented by an elected tribal official or their designated representative.

Charter

- Captain Clelland opened the floor for TAC members to comment on the proposed TAC Charter draft. OTASA first received the draft TAC Charter in February 2019 and updated the Charter per TAC and internal CDC comments. OTASA provided the edited version of the draft to the TAC in February and March 2020.
- Councilman Kutz proposed to review a crosswalk between new draft charter and the 2013 charter at another time. TAC members unanimously approved this motion.
- A crosswalk will be developed by CDC and provided to the TAC to show the edits between the original 2013 charter, the 2020 draft charter, and the TAC charter revisions received from the TAC. The charter discussion will be tabled for a later time when the crosswalk can be reviewed.

January and March TAC Letters

- Captain Clelland highlighted the TAC's request for a workgroup to support the TAC. Captain Clelland noted that CDC is aware of the request from the TAC to have a workgroup and the agency is supportive of this. CDC staff are currently working with a national partner to make sure that the workgroup is identified.
- The CDC received two letters from the TAC that highlighted areas of concern. Some of the main concerns outlined in the letter included lack of funding, consultation sessions, and engagement efforts between CDC and tribal nations. Based on these concerns, CDC has increased its engagement efforts with the TAC and Indian Country. Some examples include CDC's Tribal Consultation efforts with all 10 US Department of Health and Human Services (HHS) regions to highlight the National Diabetes Prevention Program accomplishments and prospected changes.
- CDC also provided direct engagement with tribes during the COVID-19 pandemic through participation in vaccine planning sessions, response efforts, and listening sessions.
- CDC has helped to develop the Star Books and provided feedback to best promote healthy practices among children.

TAC Letters Discussion

Comment from Representative TwoBears:

- I am aware and understand that, at times, CDC's responses to the letters can take time. However, sometimes I fear that our requests and concerns are not taken into consideration and responses from the CDC are not being provided in a timely manner.

Question from Mr. Larson:

- Thank you, Captain, for including the letters in the packet today. I think that letters are indicative of where we were. I think the biggest issue is that our workgroup is not commissioned. Has it been suspended? When, if at this point, are we going to get the workgroup back, funded, and staffed?

Response from Captain Clelland:

- CDC is supportive of a workgroup and is working toward making sure that it is adequately set up and staffed. The workgroup is in the works for the near future.

Comment from Mr. Larson:

- In terms of the TAC and the workgroup, I just want to make it clear that the National Indian Health Board are not elected officials, so the TAC should be the one who decides how the TAC workgroup seats people. There has been a lot of discussion about the tribes not being involved in those discussions and populating that committee.

3:00 PM–CDC Budget Update

Presenters

- **Alison Kelly**, Director, Office of Appropriations, OFR, CDC

Opening Remarks

- Ms. Kelly, Director for the Office of Appropriations, OFR, CDC, provided updates on CDC's budget. She was also joined by Christa Capozzola, Chief Financial Officer, OFR, CDC, and Sherri Berger, Chief Operating Officer, OCOO, CDC.
- For fiscal year (FY) 2020, CDC ended with an enacted appropriation of \$7.969 billion, which is about a \$6.45 million dollar increase from 2019.
- In FY20, the Good Health and Wellness in Indian Country (GHWIC) received an increase of \$72,000. CDC is continuing to show support for this important initiative in Congress.
- For FY21, there is a recommended 9% reduction from the FY20 enacted amount \$7.969 billion. The Drug Free Communities program has also been proposed to move to CDC for FY 2021.
- Ms. Kelly added that CDC is operating under a continuing resolution until December 11, 2020.

TAC Budget Discussion

Comments from Councilman Kutz:

- I would like to discuss funding for public health infrastructure in Indian Country. Tribal nations do not acquire funding for infrastructure from the Indian Health Service (IHS); however, it is critical to prioritize infrastructure. Some tribal nations may have additional funding, but this is not the case for all tribal nations. The TAC is requesting for CDC to have conversations about future budgets so that issues are addressed in the future.
- Tribes receive funding due to events, but when there is a resolution, the funding for infrastructure depletes. CDC and the TAC need to work together for more longevity in infrastructure funding.

Response from Ms. Kelly:

- Thank you for this information on prioritizing infrastructure. CDC recognizes the challenge that comes with lack of funding for comprehensive public health infrastructure. Most funding is directed to a specific disease or a risk factor.
- During the COVID-19 pandemic, Congress has recognized the need for direct funding and created a direct funding opportunity to address COVID-19. This direct funding opportunity allows CDC to make a case moving forward that investing in infrastructure is a path toward a high-quality public health system. This is something to build on, and CDC looks forward to having more of those conversations with the TAC going forward.
- I want to echo the insights that Councilman Kutz provided on the supplemental funding. As we move from emergency to emergency and receive supplemental funding to handle the emergency, it creates a fiscal cliff, making it hard to manage a public health workforce. That is the kind of strategic thinking CDC trying to do now in the face of having received resources for COVID-19. The agency needs to look at how to make this sustainable in the long term.

Comment from Mr. Larson:

- Developing infrastructure for the tribes is important. Tribes are sovereign entities and should have resources to do long-term work in public health, not just during a response. The spikes in COVID-19 cases in Indian Country are due to a lack of infrastructure. Once the COVID-19 funding goes away, the work on infrastructure will go away, too.
- How much funding did the CDC Foundation receive that was geared towards American Indians and Alaskan Natives (AI/ANs)?

Response from Ms. Kelly:

- I am not familiar with the CDC Foundation funding information at this time, but I will investigate this question.

Follow-up Comment from Mr. Larson:

- I am aware there are CDC Foundation resources for each individual area. I have heard that there are roughly five CDC Foundation employees who have gone into the field through the Tribal Epidemiology Center (TEC). How much does it cost to fund one of these employees?

Response from Ms. Kelly:

- I will investigate this and get back to you through Captain Clelland or Dr. Montero. CDC and the TAC need to figure out how to make this sustainable. Educating and informing Congress about how the appropriations have been used would help. The direct funding offers a great opportunity to talk about the work the funding has enabled, and the need for that kind of work to be sustained in the long term.

Comment from Mr. Larson:

- CDC could take immediate steps to allocate funds through the 1802 cooperative agreement. The scopes of work currently listed are items that tribes or TECs could complete. The cooperative agreement is an opportunity for direct funding.

Comment from Captain Clelland:

- We will follow-up with the Emergency Operations Center (EOC) regarding your question on the CDC Foundation as the initiative was through the EOC. We will reach out and follow up with you.

Comment from Chairman TwoBears:

- Why has CDC not asked tribal nations directly about the success of programs? It seems that there is limited consultation on successful programs that are working in Indian Country. For example, the CDC funding that goes to the TECs and Great Lakes Inter-Tribal Council, Inc. (GLITC). The programs through the TECs and GLITC have not always been successful.
- In the past, tribal nations have seen CDC reduce funding on programs that we see as a success. The TAC would like to see CDC consult them for guidance on successful programs or justifications on the budget that is presented before Congress.

Comment from Captain Clelland:

- Thank you Chairman TwoBears for those comments on the issue of the TECs and their lack of support for your area, but also on identifying how the efforts from CDC to engage on successful programs does not appear to be reflected in budgets, presentations, and the information we present to the TAC. CDC will take this information back and look to see how we can identify strategies to address this.
- CDC is seeking input from the TAC on Trial Practices for the Wellness in Indian Country cooperative agreement that will be coming up next year. We would like to receive input on how the cooperative agreement can be improved. Advice and recommendations from the TAC will be incorporated. We will make sure that we start to improve the conversation between CDC and the TAC on activities that are successful within Indian Country.

Comment from Mr. Larson:

- There appears to be excessive travel and trainings on behalf of individuals in the TECs. I believe there needs to be a level of monitoring on behalf of CDC of the TECs to ensure that the travel is appropriate.

Comment from Chairman TwoBears:

- For a closing comment, I would like to request that CDC set aside funding for tribes in their annual budget justification.

Comment from Councilman Kutz:

- I believe Mr. Larson started a conversation that we may want to explore later. We discussed concern at the Tribal Caucus this morning on how effectively TECs were representing the tribes they are serving in certain areas. Although we are currently in a budget discussion, TECs are represented in the budget, and some of the tribes feel there is a disconnect that's happening between the tribe and the TEC. I would like CDC to find a place in the conversation this week for a discussion on this topic.

3:30 PM—Listening Session on COVID-19 Funding

Presenters

- **Stacey M. Jenkins**, MPH, CHES, Director, DPPS, CSTLTS, CDC
- **Jim Crockett**, MPA, Deputy Director, DPPS, CSTLTS, CDC
- **Teresa Daub**, MPH, Public Health Advisor, HDPB, DPPS, CSTLTS, CDC

Opening Remarks

- Ms. Jenkins opened the discussion by highlighting CDC's COVID-19 funding streams and awards. As of September 30, 2020, the CDC COVID-19 funding for Indian Country totaled more than 208 million.
- Three funding mechanisms managed by CSTLTS have been focused on identifying COVID-19 activities and providing funds to address surveillance, epidemiology laboratory capacity, infection control, and mitigation. CDC is committed to using the funds to address COVID-19.
- There is still \$14 million available for AI/ANs to address the pandemic. CDC is seeking recommendations from the TAC on how best to utilize these funds.

TAC Questions and Discussion

Comment from Captain Clelland:

- CDC is seeking out suggestions and recommendations from TAC members on how they prefer the \$14 million to be spent to support Indian Country.

Question from Ms. Krystall:

- Is the \$14 million through direct funding or through grants? What can the funding be allocated towards?

Response from Ms. Jenkins:

- The funding is from the Coronavirus Aid, Relief, and Economic Security Act (CARES) Act and can be distributed through grants or cooperative agreements. The funds can be used for, but are not specifically limited to, epidemiology work, surveillance, and lab capacity building. The funds exclude direct clinical services and favor public health activities.

Question from Representative TwoBears:

- Is guidance being issued around what the money can be used for?

Response from Ms. Jenkins:

- We can send you a quick summary of what's allowable.

Comment from Deputy Principal Chief Warner:

- Funding tribes directly can help capacity building for future public health concerns that may affect tribes in remote areas. Additionally, one of the things that would be useful right now is to use part of that \$14 million to have CDC staff go directly to the field and provide support for tribes.

Deputy Principal Chief Warner ceded his chair to Lisa Pivec.

Comment from Ms. Pivec:

- One of the things that we're trying to explore, and haven't found dollars to explore yet, is cross-sector development in public health, healthcare delivery, social services, and infrastructure development. This is going to take some time, but we're already exploring it. We would like to reexamine what public health means to tribes and how that is executed in Tribal Country.

Ms. Pivec ceded her chair back to Deputy Chief Warner.

Comment from Councilman Kutz:

- There seems to be a concern between the funding that goes back and forth between tribes and TECs. Perhaps IHS and CDC do not have visibility on this disconnect.

Councilman Kutz ceded his chair to Ms. Warren-Mears.

Comment from Ms. Warren-Mears:

- I would like to clarify the work on the TECs. The TECs are organized differently across nations, but the common denominator is the various funding streams, one of which is the TEC Public Health Infrastructure funding received from CDC. We receive additional funding for TECs through IHS.
- Beyond the requirements of those two awards, TECs have been directed by tribes in their regions to address items at their request. It is unfortunate that tribes do not feel supported by their TECs. When approaching activities in our region, we work to first identify if tribes do not have their own infrastructure to do the work.
- In terms of awards, we are receiving the money under a resolution of approval from tribes and distributing the funds back to tribes. Greater than half of the funding received goes directly to tribes. Our region feels completely supported and is grateful for the support of our tribes.

Ms. Warren-Mears ceded her chair back to Councilman Kutz.

Comment from Councilman Kutz:

- Further conversation is warranted with CDC to ensure TECs are in alignment to support tribes.

Comment from Mr. Larson:

- The IHS has a subcommittee to discuss concerns Indian Country faces between AI/AN organizations regarding funding mechanisms. It would be beneficial for CDC to develop a committee with tribes and national organizations to help address some of the concerns the TAC has identified.
- Given that there are 574 tribes, it can be difficult to allocate funding to tribes equally, given the limited amount of funding and extensive resources needs. A committee can help voice how to allocate funding and address tribes' needs.
- A committee can also help foster a trust relationship between the TAC and other organizations.

Comment from Ms. Jenkins:

- CDC's cooperative agreements go through an objective review panel, and we would like your feedback on this review process.

Comment from Mr. Larson:

- I think dispersing the funds through cooperative agreements is a good idea, but the practicality of all tribes having a cooperative agreement may be difficult to do. Several of the tribes are anticipating having the funds dispersed through the 1803 cooperative agreement. I would like to see the OT18-1803 cooperative agreement expanded to many nations.

Comment from Captain Clelland:

- If TAC members have further input, please provide it in writing to CDC within a week from the TAC Meeting so we may get the funding out to Indian Country as needed.

TAC members can submit comments/recommendations pertaining to the funding by October 23, 2020, to the tribalsupport@cdc.gov.

4:10 PM—Violence Prevention Convening Session

Presenters

- **Nina Martin**, National Indian Health Board
- **Theda New Breast**, Native Wellness Institute

Opening Remarks

- Ms. Martin provided an overview of the Violence Prevention Project. The project began a year ago to get a better understanding of the effect of violence in tribal communities, as well as a deeper exploration of barriers, protective factors, and preventive strategies that are either currently employed or could be employed to reduce violence.

- Short videos were recorded from some of the participants of the program so that they could share their voices. There is importance in storytelling and generational sharing. The program emphasizes that bringing back language helps create a connection to culture. Healing through stories are preventive strategies that have not only prevented violence but also healed trauma.
- Engaging the men of the community is critical to reducing violence. Men can be allies to help improve strategies to reduce violence.

Violence Prevention Convening Session Discussion

Question from Representative Robert TwoBears:

- I had a question about the sustainability of the program. Are most of the funding sources from CDC? Are the tribes co-funding some of these projects?

Answer from Nina Martin:

- From our end, this is very early in the process, so all our funding predominantly came from CDC, but this is the beginning. Eventually we do hope to see an opportunity where there could be prolonged and sustained engagement with tribes on work with this.

Answer from Theda New Breast:

- Several of those involved in the program have gotten very skilled at bringing in four or five different types of funding resources from the Substance Abuse and Mental Health Services Administration, from Department of Justice, from other Department of Health and Human Services branches, but this is where the funding trauma came from. They were branching out, trying to get all these of these sources of funding, when they would rather just have one source of funding. They were spending much more of their energy trying to get different streams of funding.

Comment from Councilman Kutz:

- I want to thank you for this presentation because this is some of the hardest work that we need to do in our community, and we need all the resources we can develop as well as expertise to help us do it. I really look forward to how we can develop best practices together on dealing with this in our communities. It is important to document that indigenous knowledge is considered best practices, because what works in our community is not always viewed as a best practice by SAMHSA for reimbursement.

Comment from Captain Clelland:

- Thank you for that presentation. It is really enlightening, and some aspects are groundbreaking. We certainly want to acknowledge the effort and the time spent on this and the fact that it can create change in Indian Country. I wanted to make some remarks about our former TAC chair. This was part of his vision when he worked to help establish the Tribal Behavioral Health agenda and the continuation of that work through the TAC, not only with this, but with the missing and murdered Native Americans and the adverse childhood experiences presentation which will be see tomorrow. And then the efforts of CDC's National Center for Injury Prevention and Control stepping up to help provide funding to many of these areas of impact in Indian Country.

5:20 PM–Tribal Practices for Wellness in Indian Country

Presenters

- **LCDR Shannon Saltclah, PharmD, CPH (Navajo Tribe)**, USPHS; Healthy Tribes Program, NCCDPHP, CDC
- **David Espey, MD**, Director, Healthy Tribes Program, NCCDPHP, CDC

Opening Remarks

- Dr. Espey summarized the Healthy Tribes Program's three cooperative agreements. These agreements include Tribal Epidemiology Center Public Health Infrastructure, which supports data, health

surveillance, other core public health services; GHWIC, which aims to prevent obesity, diabetes, heart disease, and stroke; and Tribal Practices for Wellness in Indian Country (TPWIC). The TPWIC cooperative agreement will be the focus of the conversation today.

- Dr. Saltclah showed the seven strategies that have been used in TPWIC. The TPWIC program came about through three different meetings that were held between CDC and cultural advisors to help shape future CDC opportunities for supporting tribal practices. Specific language was crafted, including seven strategies with cultural elements: Family & Community, Seasonal Practices, Social & Cultural Activities, Tribal Collaborations, Intergenerational Learning, Traditional Healthy Foods, and Physical Activities. Some activities in the TPWIC program included teaching traditional ways of life and learning about healthy food options through fish camps, drum-making classes, and other classes that target younger tribal members to pass down traditional ways of life. Through some of these activities, tribal members are also learning their language and connecting with their community and their culture.
- Dr. Saltclah asked for input on this cooperative agreement and the seven strategies prior to writing the second round of the cooperative agreement. CDC heard from the TAC recommendations that one of the strategies address sustainability.

Tribal Practices for Wellness in Indian Country Discussion

Comment from Representative TwoBears:

- In reference to the seven strategies, has it always been just seven, or were there other categories that were proposed before?

Answer from Captain Clelland:

- As mentioned earlier, the convenings were held over three separate meetings, with each of those meetings adding significant portions to the development of the seven strategies. During the second meeting, many themes were suggested. During the third meeting, these themes were put into areas that had commonality, and from there, the seven strategies were decided.

Comment from Mr. Larson:

- I would consider adding something around sustainability, such as linking to production through the US Department of Agriculture Farm Bill.

5:50 PM–Day 1 Meeting Summary

Presenters

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

Closing Remarks

- Dr. Montero provided summary highlights of the meeting and, on behalf of CDC, thanked everyone for attending and participating throughout the meeting. Dr. Montero also mentioned a future meeting to include the TAC Charter and funding.
- Representative TwoBears thanked the TAC for participating and providing input and closed the meeting.

Friday, October 16, 2020

1:00 PM–Opening Blessing, Welcome, and Introductions

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

1:30 PM–COVID-19 Vaccination Discussion

Presenters

- **Melinda Wharton, MD**, Director, Immunization Services Division, NCIRD, CDC
- **Molly Evans, MD, MPH**, USPHS, Medical Officer, HIV Care and Treatment Branch, Division of Global HIV and TB, CGH, CDC

Opening Remarks

- Dr. Wharton provided an overview of current COVID-19 vaccine planning assumptions, the vaccination program interim playbook, and potential COVID-19 vaccine distribution scenarios for tribal nations.
- The proposed distribution model identified that tribal nations are to decide their preference for vaccine allocation and distribution. The options include receiving the vaccine at the facility level through a state/local immunization program or through IHS. Written feedback was received from two separate regional consultation calls on September 24 and September 28 and is currently under review.
- CDC received input regarding the importance of understanding tribal sovereignty and how it relates to the vaccine distribution. This includes considering direct delivery to the tribal nation and identifying that tribes have sovereignty to allocate the vaccine as they best see fit.

TAC Questions and Discussion

Question from Councilman Kutz:

- Is the plan to have the vaccine distribution through McKesson nationally?

Response from Dr. Evans:

- We have been looking at the existing mechanisms in place. The state and IHS programs already exist and have been efficient for delivery mechanisms of vaccines. We are still reviewing everything and looking at all the possible options.

Question from Councilman Kutz:

- I have received vaccinations directly in the past from the federal warehouse, McKesson, IHS, and through local and state public health departments. McKesson does not understand the separation between the state and tribes and that tribes are a separate sovereign entity. We need for CDC to explain that to McKesson.

Response from Dr. Evans:

- It would be helpful to set up a phone call to discuss these details that would be specific to your tribal nation and go through the different reporting requirements that are necessary. Thank you for alerting us to those concerns regarding McKesson.

Comment from Councilman Kutz:

- Idaho does not particularly work well with tribes. I want to make sure that if the decision is to work with McKesson, that CDC explains that McKesson needs to return our calls and talk with tribes as sovereign entities.

Response from Dr. Evans:

- I wanted to point out that the vaccines will be shipped directly to the site, but the ordering will be done with CDC. So, it might be helpful for CDC to set up that call with you to discuss the ordering process because I don't know if McKesson will be able to take calls.

Question from Representative TwoBears:

- Do we know when we will have the vaccine plans available to view?

Response from Dr. Evans:

- IHS will consider the feedback from the tribes before sending CDC their plan. We have our tribal team reviewing the state plans to ensure that documented conversations with tribes from the states are there. Their plan is posted on [the IHS site](#).

Question from Legislator Connie Barker:

- At what point does a clinic or tribe need to purchase the cold storage?

Response from Dr. Evans:

- The reason we are not asking states or tribes to purchase storage equipment is because the vaccine will be shipped using dry ice, and the storage container it is being distributed through should keep the vaccine cold for up to 10 days. IHS and states are also assessing storage capacity.

Question from Councilman Kutz:

- Will you prohibit tribes from helping each other?

Response from Dr. Evans:

- Tribes have sovereignty to allocate the COVID-19 vaccine as they best see fit. If tribes decide to share with other tribes, there would not be restriction on that once vaccines have been distributed.

Comment from Councilman Kutz:

- You should note the ability for tribal nations to share resources if necessary, in the plan specifically, so tribes are aware.

Deputy Principal Chief Warner ceded his seat to Ms. Pivec, Oklahoma Area Authorized Representative, for the remainder of the day.

Captain Clelland noted that as with other presentations, TAC members can submit comments/recommendations pertaining to COVID-19 vaccination planning by October 23, 2020, to tribalsupport@cdc.gov.

2:30 PM–Star Collection Book Review

Presenters

- **Rachel Kossover-Smith, MPH, RD**, Public Health Advisor, Division of Injury Prevention, NCIPC, CDC
- **Laura M. Mercer Kollar, PhD**, Behavioral Scientist, Division of Violence Prevention, NCIPC, CDC

Opening Remarks

- Dr. Kollar summarized the history of adverse childhood experiences (ACEs), and Ms. Kossover-Smith addressed the purpose behind the Star Collection books. They reviewed some of the different Star Collection books viewing options and engagement opportunities through social media.
 - These collections highlight cultural protective factors like community, connectedness, and language. They focus on how to be a good friend and aim to emphasize strengths-based messaging and the resiliency present in AI/AN communities.
- Ms. Kossover-Smith provided details about the specific books, “Friendship Makers” and “Stars Who Connect Us.” She emphasized that it is important to promote protective factors that can reduce the risk of violence.
- The “Stars Who Connect Us” focuses on specific cultural protective factors, such as community, which build on the connection to tribal leaders’ language, participation, tribal ceremonies, and spirituality. The “Stars that Connect Us,” and additional materials, should be available by September 2021. “Friendship Makers,” another book in the Star Collection, focuses on the qualities of a good friend and seeking help from elders in the community for advice.

- Each book contains an educator guide for teachers, community center staff, and parents. The collection also includes coloring pages and other activities for children.

Ms. Kossover-Smith provided the Stars Collection website link: www.cdc.gov/injury/tribal/starcollection/.

TAC Questions and Discussion

Comment from Councilman Kutz:

- Can CDC send out an email link to the Star Collection books website?

Answer from Commander Meyer:

- We will send that out.

Comment from Captain Clelland:

- I would like to extend my thanks to everyone, not only for book development, but for some of the storytelling as well. The book is in its final form as we aim to help support tribal communities and the prevention of ACEs and development of healthy behaviors.

3:00 PM–CDC Director/ATSDR Administrator Updates

Presenter

- **Robert Redfield, MD**, CDC Director/ATSDR Administrator, CDC

Opening Remarks

- Dr. Redfield discussed CDC's response to the COVID-19 pandemic and highlighted CDC's efforts to support TECs and Indian Country.
- There are long-standing systemic health and social inequities that put some racial groups, ethnic groups, and minority groups at increased risk of getting COVID-19 or experiencing severe illness, regardless of age.
- CDC is conducting multiple activities to support tribal nations during the COVID-19 pandemic:
 - The EOC has a dedicated Tribal Support Section that provides case investigation and contract tracing, community mitigation, surge staff, epidemiology surveillance, mapping support, data analysis, infection prevention, water control, sanitation, hygiene support, health risk communication support, and response planning protocol policy guidance.
 - CDC currently has 18 teams deployed for on-site technical assistance, with 18 more in the process of being deployed. CDC has consulted with more than 215 tribes to date.
 - CDC has developed tribal-specific guidance documents and shared COVID-19 data with TECs every two weeks.
 - CDC has reached out to the individual tribal nations as well as hosting National Tribal and Urban Indian listening sessions and HHS regional tribal consultation sessions.
 - To improve data collection, CDC has provided extensive COVID-19 case data to TECs. This includes access to the National Notifiable Disease Surveillance System data set and regular updates on COVID-19 cases to all TECs.
 - CDC continues to ensure that TECs can access data on more than 120 other diseases and conditions.
 - CDC remains committed to improving tribal health. This year, CDC provided more than \$208 million in funding to tribes and tribal organizations supported through supplemental appropriations, including the CARES Act. This investment during their response to COVID-19 builds on an increase in funding to tribes in recent years that has doubled from \$34.8 million in 2016 to \$66.2 million in FY 2019.

- The COVID-19 Incident Management Structure has also designated a Chief Health Equity Officer to ensure the response identifies and addresses health disparities uncovered during the COVID-19 response.

TAC Questions and Discussion

Question from Ms. Krystall:

- I would like to know, in addition to the COVID-19 funding increases CDC has given to tribes, if CDC still plans on continuing the funding for the regular programs such as GHWIC.

Answer from Dr. Redfield:

- CDC has continuing resolutions right now through December 11, 2020, and it is our intent, based on Congress, to continue to fund these programs.

Comment from Councilman Kutz:

- The ongoing relationship with the tribes and senior leaders is important. Working with CDC and IHS to ensure that travel programs have public health infrastructure in their communities to deal adequately public health concerns is beneficial to tribes, and many tribal programs lack these infrastructures. We would like to have conversations with you on how we can get such initiatives in the budget and work with CDC, Congress, and governors to make this happen.

Comment from Dr. Redfield:

- I appreciate all of your comments. This is a complex process. I am hopeful that we will get some traction to that request in 2021.

3:40 PM—Senior Leadership Roundtable Discussion

Presenters

- **Christa Capozzola**, Chief Financial Officer, OFR Director
- **Robin Ikeda**, Associate Director for Policy and Strategy
- **Laurie Ishak**, Associate Deputy Director, OADPS
- **Celeste Philip**, Deputy Director for Non-Infectious Diseases
- **Ellen Wan**, Associate Deputy Director, DDNID
- **Michael Iademarco**, Director, CSELS
- **John Dreyzehner**, Director, CPR
- **Mark Davis**, Branch Chief, DSLR CPR
- **David Hunter**, Branch Chief, CBB, CPR
- **Karen Remley**, Director, NCBDDD
- **Karen Hacker**, Director, NCCDPHP
- **Craig Thomas**, Director, DPH, NCCDPHP
- **Patrick Breysse**, Director, NCEH
- **Jonathan Mermin**, Director, NCHHSTP
- **Jennifer Madans**, Acting Deputy Director, NCHS
- **Debra Houry**, Director, NCIPC
- **Thomas Clark**, Deputy Director, Division of Viral Diseases, NCIRD
- **Nathaniel Smith**, Deputy Director for Public Health Service and Implementation Science
- **Katherine Lyon Daniel**, Associate Deputy Director, DDPHISIS
- **Amy Branum**, Acting Associate Director of Science, NCHS
- **Rebecca Bunnell**, Director, OS
- **Renee Calanan**, Health Equity Coordinator, NCEZID

Opening Remarks

- CDC senior leaders provided important highlights and updates pertaining to CDC tribal programs and activities. Updates included information related to capacity building, program development, data integrity, and funding.
- CDC leaders emphasized the importance of evaluating programs and presenting the successes and impacts of these programs.

TAC Questions and Discussion

Question from Representative TwoBears:

- CDC has talked about GHWIC historically being cut from the President's budget. I want to know how the TAC can work with CIOs to strengthen programs and how the director can advocate on those budgets.

Response from Ms. Capozzola:

- There is various input from multiple partners and political factors when developing CDC's budget. The opportunity to clearly present how additional funding can make an impact should be outlined through data. Congress is making important decisions and tradeoffs between different types of programs that can be funded. The more information there is about the success of a program, the better the chance of securing funding for these programs to maximize opportunities.

Comment from Dr. Bunnell:

- Some tribes have done excellent work in documenting the impact of programs from funding streams. Evaluation of programs can help demonstrate their value and convince stakeholders that the investment is worth the funding.

Comment from Dr. Breysse:

- We can talk to Congress about what we're doing, but it's on us to develop programs that have an impact. We must showcase the impact by having awardees speak about success stories to help build momentum for continued funding.

Question from Dr. Philip:

- Are there examples related to any activities around COVID-19 where you could highlight how funding or programs were able to impact tribal nations? That might be a way of making the case to build on what CDC has been able to do through the supplemental funding.

Question from Ms. Krystall:

- There have been many fires recently in California, and a lot of them are in tribal areas. Can a division do follow-up on the citizens who live in those areas to help mitigate smoke-related health issues?

Response from Dr. Breysse:

- Yes, please follow-up with me by email, and we can discuss technical assistance on wildfires and smoke-related issues.

Comment from Councilman Kutz:

- It is difficult for me to understand population health in a diverse Indian community, where our tribal members are scattered across the United States. I am interested in having some conversations around how we might be able to data-mine the Indian health system to take a look at a broader patient population that is not a consolidated community.
- I was also thinking about the work with the Navajo community on their water systems and the importance of sharing this work with other areas in need, like Alaska. Typically, in region 10, there are villages in Alaska that do not have adequate water or sewage systems. How do we build that same public health capacity within smaller tribes?

Response from Dr. Breysse:

- I will have our program that works with water think about possible options and follow up with you.

Comment from Dr. Calanan:

- The Arctic Investigations Program (AIP) focuses on documenting the health consequences of households that lack in-home sanitation services along with the state of Alaska Division of Health. AIP continues to work with tribal, state, and federal partners to promote improvements in water and sanitation services to the nearly 20% of rural Alaskans and circumpolar populations who lack in home services.
- AIP recently published a report showing that residents without water service appear to be using soda and other sweetened beverages as substitutes for drinking water. This can cause potential negative consequences to oral health, body mass, and chronic conditions.
- In 55 communities throughout southwest Alaska, depending on the types of water sanitation service they had (fully piped water, sewer, small vehicle haul systems, and communities that self-haul water), we found that higher levels of water service coverage were associated with lower incidence rates of visits for several infectious disease categories.

Comment from Dr. Montero:

- Please share the sanitation data report so CDC can share this information through OTASA’s weekly newsletter.

4:50 PM—Tribal Testimony

Testimony from Ms. Pivec:

- This virtual meeting provides a way forward in making future in-person meetings more interactive and effective.
- There needs to be cross-sector collaboration for public health delivery and improving infrastructure. How do we take that cross-collaboration model in tribal communities? Understanding how many dollars a tribe invests in that over time and looking at that as seed money to where we are at in investing on our own. We need a plan on funding for TECs as they can help become great resources for governance. We need to hold those TECs accountable for building that infrastructure as well. We need to figure out a way to put together a workgroup to better challenge CDC. A neutral third party would be helpful for this. We as TAC members need to be more engaged in planning the TAC Meetings.

Testimony from Ms. Krystall:

- Direct funding to tribes needs to be a priority for CDC. The primary focus of CDC should always be the tribes.

Testimony from President Andrews:

- There was a surge in COVID-19 cases yesterday in one of the villages, and we are very concerned. COVID-19 has caused a large concern with economics in our area as well. A lot of businesses have been depleted due to COVID-19. In the Delta area of Alaska, there’s been a surge in cases, and we are pretty concerned about them. In the Kodiak area, nothing has been shut down, but we have not heard about anyone in the area dying from COVID-19. The deaths we do hear about, we are unsure if they are dying from COVID-19 or something else. There are concerns about the regular flu as well.

Testimony from Councilman Kutz:

- There are individuals from CDC making sure tribes are being represented, and we are thankful that those people are there. We would have like broader representation, but it’s so hard to pull people together with so much going on right now.

Testimony from Ms. Krystal

- *Ms. Krystal ceded her seat to Mark LeBeau with for tribal testimony.*

Testimony from Mr. LeBeau

- I am the Chief Executive Officer of the California World Indian Health Court, and we have the honor and responsibility of working closely with 59 federally recognized tribes throughout the state. This includes down in the desert area of central California and the rural and frontier regions of northern California.

- There is a need for additional support through CDC to ensure that the state of California has been adequately supplied with enough COVID-19 vaccines for all tribes and tribal healthcare systems.
- Due to the long-term efforts of tribes working in partnership with IHS and CDC, as well as other agencies, there are existing tribal clinic healthcare infrastructure services that are in position to assist with vaccination. They just need prioritization.
- There are existing tribal infrastructure services that are positioned to assist with vaccination distribution in California and they need to be prioritized. I don't think the state of California has done a good job of engaging tribes in required government-to-government consultations session and the development of state vaccine plans they are planning to send to CDC.
- There are about 40 tribes seeking to be re-recognized as this population tends to be high risk and over age 65. This should be taken into consideration regarding vaccine planning and prioritization when serving Indian Country.

5:50 PM—Summary, Closing Prayer, and Adjournment

Presenters

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

Closing Remarks

- Dr. Montero provided summary highlights of the meeting and 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.
- Representative TwoBears expressed thanks to the TAC for participating and providing input during the meeting.
- Captain Clelland closed the meeting with prayer.

Appendices

Appendix A: Acronym List

ACEs	Adverse Childhood Experiences
AI/AN	American Indian/Alaska Native
AIP	Arctic Investigations Program
ATSDR	Agency for Toxic Substances and Disease Registry
CARES Act	The Coronavirus Aid, Relief, and Economic Security Act
CDC	Centers for Disease Control and Prevention
CGH	Center for Global Health
COVID-19	2019 Novel Coronavirus Disease
CPR	Center for Preparedness and Response
CSELS	Center for Surveillance, Epidemiology, and Laboratory Services
CSTLTS	Center for State, Tribal, Local, and Territorial Support
DCPC	Division of Cancer Prevention and Control
DDID	Deputy Director for Infectious Diseases
DDPHSIS	Deputy Director for Public Health Service and Implementation Science
DIP	Division of Injury Prevention
DPH	Division of Population Health
DPIFS	Division of Performance Improvement and Field Services
DPPS	Division of Program and Partner Services
DRH	Division of Reproductive Health
DSLRL	Division of State and Local Readiness
DVBD	Division of Vector-Borne Diseases
DVP	Division of Violence Prevention
EOC	Emergency Operations Center
FSB	Field Support Branch
FY	Fiscal Year
GHWIC	Good Health and Wellness in Indian Country
GLITC	Great Lakes Inter-Tribal Council, Inc.
HDPB	Health Department Program Branch
HHS	Health and Human Services
IHS	Indian Health Service
NCBDDD	National Center on Birth Defects and Developmental Disabilities
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCEH	National Center for Environmental Health
NCEZID	National Center for Emerging and Zoonotic Infectious Diseases
NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
NCIPC	National Center for Injury Prevention and Control
NCIRD	National Center for Immunization and Respiratory Diseases
OADPS	Office of the Associate Director for Policy and Strategy
OCOO	Office of the Chief Operating Officer
OD	Office of the Director
ORISE	Oak Ridge Institute for Science and Education
OS	Office of Science
OTASA	Office of Tribal Affairs and Strategic Alliances
PDETb	Performance Development, Evaluation and Training Branch
PIB	Program Implementation Branch
PIEB	Program Implementation and Evaluation Branch

RZB	Rickettsial Zoonoses Branch
SLTST	State, Local & Tribal Support Team
TAC	Tribal Advisory Committee
TEC	Tribal Epidemiology Center
TPWIC	Tribal Practices for Wellness in Indian Country
UMRA	Unfunded Mandates Reform Act
USPHS	United States Public Health Service

Appendix B: TAC Roster

Area Office	Delegate	Authorized Representative
Alaska Area Term Expires: February 28, 2021	Alicia L. Andrew President, Karluk IRA Tribal Council <i>Native Village of Karluk</i>	VACANT
Albuquerque Area Term Expires: August 31, 2021	Selwyn Whiteskunk Tribal Councilman <i>Ute Mountain Ute Tribe</i>	Alston Turtle Council Delegate <i>Ute Mountain Ute Tribe</i>
Bemidji Area Term Expires: August 31, 2020	Robert TwoBears (TAC Chair) Legislative District V Representative <i>Ho-Chunk Nation of Wisconsin</i>	Wally Apland Director of Finance, The Ho-Chunk Nation Department of Health <i>Ho-Chunk Nation of Wisconsin</i>
Billings Area Term Expires: August 31, 2021	Byron Larson Rocky Mountain Tribal Leaders Council <i>Northern Cheyenne Nation</i>	VACANT
California Area	VACANT	VACANT
Great Plains Area	VACANT	VACANT
Nashville Area Term Expires: August 31, 2019	Richard Sneed (TAC Co-Chair) Principal Chief <i>Eastern Band of Cherokee Indians</i>	VACANT
Navajo Area Term Expires: August 31, 2021	Myron Lizer Vice President <i>The Navajo Nation</i>	Jill Jim, PhD, MHA/MPH Executive Director, Navajo Department of Health <i>The Navajo Nation</i>
Oklahoma Area Term Expires: October 31, 2021	Bryan Warner Deputy Chief <i>Cherokee Nation</i>	Lisa Pivec Senior Director, Public Health, Cherokee Nation Health Services <i>Cherokee Nation</i>
Phoenix Area Term Expires: February 28, 2022	VACANT	VACANT

Portland Area Term Expires: August 31, 2021	Stephen Kutz, RN, BSN, MPH Tribal Council Member Executive Director, Health and Human Services <i>Cowlitz Indian Tribe</i>	Sharon Stanphill, MD Chief Health Officer <i>Cow Creek Band of Umpqua Tribe of Indians</i>
Tucson Area	VACANT	VACANT
Tribes At-Large Term Expires: August 31, 2021	Doreen Fogg-Leavitt Secretary, Inupiat Community of the Arctic Slope Council <i>Inupiat Community of the Arctic Slope</i>	VACANT
Tribes At-Large Term Expires: August 31, 2021	Connie Barker Tribal Legislator <i>The Chickasaw Nation</i>	Darcy Morrow Board of Directors Member <i>Sault Ste. Marie Tribe of Chippewa Indians</i>
Tribes At-Large Term Expires: August 31, 2022	Trinidad Krystall Riverside San Bernardino County Indian Health Clinic Inc. <i>Torres Martinez Desert Cahuilla Indians</i>	VACANT
Tribes At-Large	VACANT	VACANT