



MARCH 2020

UPDATES ON TRIBAL PRIORITIES
THE CENTERS FOR DISEASE CONTROL AND PREVENTION AND
THE AGENCY FOR TOXIC SUBSTANCES AND DISEASES REGISTRY

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INTRODUCTION

On October 19, 2016, leaders from five Tribal Nations travelled to Atlanta, Georgia, and presented a set of documents to the Director of the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) that framed the priorities for their Tribal Nations during the administration change. On October 31, 2016, a quorum of the CDC/ATSDR Tribal Advisory Committee (TAC) adopted these documents as their Transition Priority Areas, making them official working documents of the advisory committee. The committee advised CDC and ATSDR that responding to these high-level priorities through regular updates was an expectation at future TAC meetings or more often, as needed.

CDC and ATSDR are committed to working with federally recognized American Indian and Alaska Native (AI/AN) tribal nations on a government-to-government basis, and strongly supports and respects Tribal sovereignty and self-determination. CDC's Office of Tribal Affairs and Strategic Alliances (OTASA), formerly CDC's Tribal Support Unit, has been tracking and monitoring CDC's and ATSDR's progression on these priorities. While some of these issues have been previously addressed in various ways (e.g., during TAC and other meetings, materials, and correspondence), this report consolidates and adds to that information. Below are the updates on progress toward the identified priorities within the context of CDC's and ATSDR's organizational structure and capacity.

BACKGROUND

In response to the October 19th engagement with elected tribal officials, then CDC Director and ATSDR Administrator Thomas Frieden, MD, MPH, sent a thank you letter to each representative who had been present. In the letter, Dr. Frieden acknowledged the recommendations and provided next steps toward achieving mutual goals.

Anne Schuchat, MD (Rear Admiral, USPHS, ret.), as the Acting Director, CDC, and Acting Administrator, ATSDR, attended the CDC/ATSDR TAC meeting held February 14–15, 2017. The TAC presented Dr. Schuchat with a letter confirming the TAC's commitment to strengthening meaningful engagement with CDC and ATSDR and expressing desired qualities in the next CDC Director and ATSDR Administrator. During the Summer 2017 TAC meeting in Sulphur, Oklahoma, CDC/ATSDR provided the TAC with a document summarizing CDC/ATSDR's response to TAC priorities. In December 2017, then CDC Director and ATSDR Administrator Brenda Fitzgerald, MD reaffirmed the agencies' commitment to working with Indian Country to address the public health priorities.

CDC Director and ATSDR Administrator Robert Redfield, MD, is aware of the current TAC priorities and recommendations. CDC remains committed to engaging with tribal stakeholders to advance the priorities and goals of Indian Country.

FUNDING PRIORITIES

Many TAC strategic priorities involve funding. CDC's and ATSDR's Congressional Justification and operating plans are posted on the CDC website every year.^{1,2}

CDC's program level appropriation for fiscal year (FY) 2020 is approximately \$7.97 billion, \$636.87 million above the FY 2019 enacted level. The appropriation included new significant investments in the nation's public health infrastructure, as well as, support for priorities identified in the FY 2020 President's budget request. Major increases included the following^{3,4}:

- \$140 million to reduce new HIV infections,
- \$85 million for the Infectious Disease Rapid Response Fund,
- \$75 million increase for global health security,
- \$50 million to support Public Health Data Modernization Initiative,
- \$20 million increase to reduce youth e-cigarette usage and continue momentum toward reducing tobacco use among all populations,
- \$12.5 million for Firearm Injury and Mortality Prevention Research,
- \$10 million for Suicide Prevention
- \$10 million for addressing the Infectious Diseases and the Opioid Epidemic, and
- \$6 million increase for the Section 317 Immunization Program

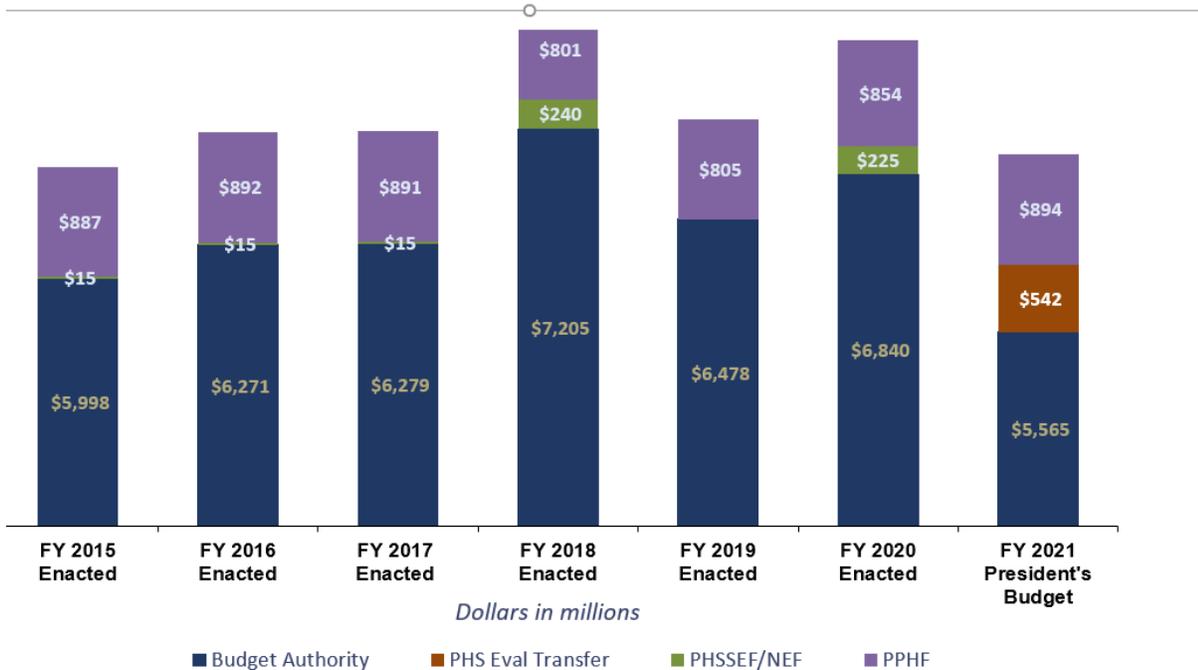
¹ <https://www.cdc.gov/budget/congressional-justification.html>

² <https://www.cdc.gov/budget/operating-plans.html>

³ Further Consolidated Appropriations Act, 2020. <https://docs.house.gov/billsthisweek/20191216/BILLS-116HR1865SA-RCP116-44.PDF>

⁴ Joint Explanatory Statement (Division A) Funding CDC. <https://docs.house.gov/billsthisweek/20191216/BILLS-116HR1865SA-JES-DIVISION-A.pdf>

CDC Funding Levels – FY 2015-2021

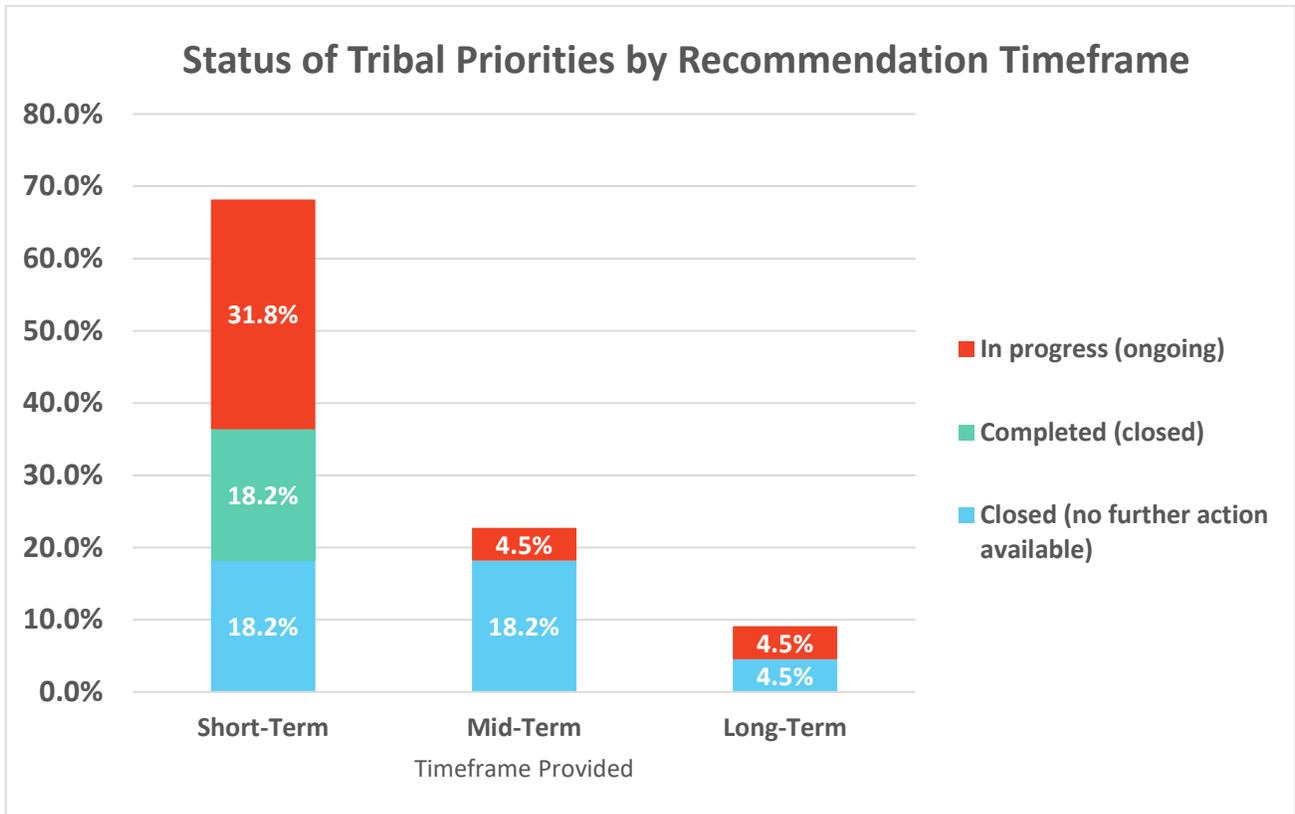


Notes: PHS Eval Transfer = Public Health Service Evaluation Transfer; PHSSEF/NEF = Public Health and Social Services Emergency Fund (PHSSEF) and Nonrecurring Expenses Fund (NEF); and PPHF = Prevention and Public Health Fund

CDC’s FY 2021 discretionary budget request is \$7 billion, a decrease of \$693 million (-9.0%), compared to the FY 2020 enacted level. It includes continued investments in domestic and global preparedness, rapid outbreak response at their source, state of the art laboratories, world-class data and analytics and an elite public health workforce. The \$7 billion does not include funding from ATSDR. It also makes significant investments to eliminate disease and end epidemics. ATSDR’s FY 2021 budget request is \$62 million, a decrease of \$14.7 million (-19%) compared to the FY 2020 enacted level. For more information about the FY 2021 budget proposal, CDC’s goals and objectives for the upcoming fiscal year, and comparative data for the previous, current, and proposed budget, visit www.cdc.gov/budget/congressional-justification.html. Once Congress passes an annual appropriations bill, agencies develop an operating plan based on the bill and relevant committee reports.

UPDATES ON TAC PRIORITIES

The following are CDC and ATSDR updates regarding the TAC Priorities. Progress toward each recommendation is categorized as one of the following: 1) completed, closed; 2) in progress, ongoing; and 3) closed, no further action available. As of February 2020, 18.2% are “completed, closed”; 40.8% of recommendations are “in-progress, ongoing”; and 40.9% are “closed, no further action available.” “Completed, closed” and “closed, no further action available” recommendations will be removed from future updates.



GOAL 1: MAKE FUNDING TO TRIBES SECURE AND SUSTAINABLE

1.A. SOLIDIFY DIRECT FUNDING STREAMS FOR TRIBES AND TRIBAL ORGANIZATIONS

Short-Term Recommendations

Create a policy that directs CIOs to allocate 2–4% of their total budgets for direct funding of tribal public health. *(Status: Closed, no further action available)*

There is no clear path forward to implementing this recommendation given CDC’s mission to serve the entire US population with appropriated funds, its complex organizational and budget structure, the variety of Congressional authorities and funding directives, and the variety and range of activities conducted to meet changing national public health needs over time. In addition, a large part of CDC funding is distributed through a competitive process; the agency cannot predict the outcome of those competitions ahead of time.

The following activities are feasible and have achieved results by CDC. To date, these activities have resulted in almost a doubling of cooperative agreement and grant funding to tribal nations and tribal organizations— from \$34.8 million in 2016 to \$66.2 million in 2019. These activities include, but are not limited to, the following:

- Soliciting input from tribal nations and tribal organizations to inform CDC program and resource strategies.**
 Individual CDC programs have been and are working directly with the CDC/ATSDR TAC and national tribal organizations to get tribal input to inform CDC program and resource development through TAC

meetings, listening sessions at national tribal meetings, site visits, and other means. For example, CDC/ATSDR held four listening sessions in FY 2019 (February–May) to collect and share tribal insights on environmental health concerns and innovative approaches to the issues that were discussed. These listening sessions were held during conferences that AI/AN leaders attended, including the Great Plains Tribal Water Alliance Spring Conference and the National Indian Health Board’s Tribal Public Health Summit. CDC/ATSDR will use the collected data to inform a regional/national tribal environmental health summit. Tribal leaders/representatives of multiple tribes were able to participate and share their experiences with environmental health issues in their community.

- **Working to increase tribal eligibility and competitiveness for CDC notices of funding opportunity (NOFOs).**
 - **Creation of tribal-specific funding mechanisms (for more information, see <https://www.cdc.gov/tribal/consultation-support/funding/>)**
 - CDC has created four funding mechanisms exclusive to tribal nations and tribal organizations: 1) Good Health and Wellness in Indian Country, 2) Tribal Epidemiology Centers Public Health Infrastructure, 3) Tribal Practices for Wellness in Indian Country, and 4) Tribal Public Health Capacity Building and Quality Improvement Umbrella Cooperative Agreement. CDC created these programs as a direct result of CDC/ATSDR TAC and other tribal recommendations for mechanisms with tribal eligibility only and for mechanisms that allow for culturally appropriate activities.
 - The Tribal Public Health Capacity Building and Quality Improvement Umbrella Cooperative Agreement enables any CDC program to more easily provide funding to collaborate with tribal nations and regional tribally designated organizations to improve the tribal public health system.
 - CDC used several of these mechanisms to provide tribal nations and tribal organizations with the first funding to address the opioid epidemic in Indian Country.
 - The National Indian Health Board and the National Council of Urban Indian Health are funded through CDC’s National Partnership Umbrella cooperative agreement, “Strengthening Public Health Systems and Services Through National Partnerships to Improve and Protect the Nation’s Health” (see <https://www.cdc.gov/publichealthgateway/partnerships/capacity-building-assistance-OT18-1802.html>). Any CDC program can fund these national partners to provide technical assistance to the tribal nations and tribal organizations and these partners can sub-award funding to other tribal entities as appropriate to the work. In addition, non-tribal organizations are providing sub-awards to tribal organizations (i.e., CDC funded the National Network of Public Health Institutes is working with Seven Directions: A Center for Indigenous Public Health to support CDC in convening webinars and an in-person meeting for 25 tribal grantees, funded by the CDC).
 - **Implementing NOFO guidance and development process that inspires consideration of tribal nations and tribal organizations for eligibility and focus of activities.**
 - The Department of Health and Human Services (HHS) has a grants policy that states: “It is HHS policy to maximize competition for discretionary grants to the greatest extent practicable” (<https://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf>). When limiting competition is necessary, HHS and CDC have a rigorous process for approval of the limited-eligibility justification.
 - CDC’s Program Performance and Evaluation Office (PPEO) provides CDC/ATSDR staff with standardized guidance and tools for developing NOFOs. The guidance specifically asks developers to consider eligibility for tribal nations or tribal organizations.
 - During the planning stage of high-priority NOFOs, PPEO coordinates a review and discussion of the NOFO outline, which includes eligibility and application review

criteria. These meetings include representatives from PPEO, CDC's Office of Financial Resources (OFR), CDC's Center for State, Tribal, Local, and Territorial Support (CSTLTS), including OTASA, and key CDC program officials developing the NOFO (e.g., NOFO author, leaders, policy unit, and evaluation representatives). NOFO developers are specifically reminded to consider tribal eligibility—to the maximum extent possible, based on the program's authority and appropriations.

- OTASA provides technical assistance to any CDC program about tribal public health infrastructure, priorities, and tips for addressing tribal inclusion to inform NOFO development.
 - CDC and ATSDR NOFOs are reviewed and cleared at multiple levels of the agency (programmatic, policy/legal, scientific, and grant management reviews). In addition, high-priority NOFOs are reviewed by HHS and sometimes the Office of Management and Budget (OMB). The review includes a check of eligibility criteria, especially if the NOFO does not specify full and open competition.
 - CDC works diligently to maximize competition or to limit eligibility to only tribal entities to support tribal nations and tribal organizations wherever possible. After NOFO development, OTASA staff volunteer to serve on application objective review panels to the greatest extent possible to ensure the appropriate technical evaluation of tribal applicants.
- **Working to improve tribal health data for program and resource decision making at all levels of the public health system.**
- Racial misclassification could result in underestimation of death rates for AI/AN people. CDC is working with the National Council of Urban Indian Health (NCUIH) to improve data quality through interventions at the local level where death certificates originate. NCUIH has conducted listening sessions to identify root causes and potential solutions to the issue of misclassification of AI/AN data with medical examiners and began additional listening session with funeral directors in August 2019.
 - CDC is working on compiling national health indicators on AI/AN people to address a gap in data access and communication around of AI/AN health status at the national level. There are websites that contain data that can be analyzed to assess AI/AN health status and sites with limited AI/AN health statistics. There is no site, however, that provides charts and graphs that display various national health statistics comparing AI/ANs with other races and the trends over time. This information is intended to convey health patterns to tribal leaders and members quickly. Once the data has been published on CDC's Tribal Health website (<https://www.cdc.gov/tribal/index.html>), CDC would like feedback about the usefulness and presentation of the information to develop information that tribal leaders and communities can use to target their resources and interventions.
 - CDC is working with the National Indian Health Board to collect information on tribal public health systems to understand how they may improve the health status and combat health disparities among tribal populations. Prior to the current Public Health Indian Country Capacity Scan (PHICCS), the last time data specific to tribal public health was collected was in 2009 and disseminated in 2010. The 2010 profile provided a baseline of comparison for the public health capacity of the tribes with state and local health departments as well as future assessments like the PHICCS tool. Identifying a need to expand and build upon this baseline, especially in the fields of key public health activities (e.g., prevention, surveillance, screenings, and environmental health services), public health workforce, and public health accreditation, in order to provide a more recent, more comprehensive picture of the capacity of public health in Indian Country, the PHICCS survey was launched in

November 2018 and closed on July 31, 2019. The information collected from the scan is being used to develop a report that will support and guide tribal essential public health service work in the areas of public health practice, technical support, and assessing issues related to improving Indian health.

Ensure the continuity and potential expansion of the Comprehensive Approach to Good Health and Wellness in Indian Country program. *(Status: In progress, ongoing)*

CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) leaders, staff, and partners have provided continuous education and information about the *Healthy Tribes* program. They update decision makers about the *Healthy Tribes* holistic approach and impact on addressing the burden of chronic disease in AI/AN communities. Since the program portfolio includes three distinct cooperative agreements, one of which is GHWIC, the program title has changed from Good Health and Wellness in Indian Country (GHWIC) to "Healthy Tribes." Though the language in FY20 appropriations refers to GHWIC, it supports 1) Tribal Epidemiology Centers for Public Health Infrastructure; 2) Tribal Practices for Wellness in Indian Country; 3) Expansion of GHWIC to include four Urban Indian Organizations and a GHWIC Coordinating Center awardee. Additional funds from divisions across NCCDPHP (Office of Smoking and Health, Division of Nutrition Physical Activity and Obesity Prevention, Division of Heart Disease and Stroke Prevention, Division of Diabetes Translation, Division of Oral Health and Division of Population Health) specifically support the continuation of GHWIC in a new NOFO. Taken together, these three cooperative agreements broaden our reach within Indian Country and offer an opportunity for growth and increased impact.

While GHWIC is eliminated (zeroed-out) in the President's FY 2020 and proposed 2021 budget, the House of Representatives' Committee on Appropriations included \$32.0 million within Racial and Ethnic Approaches to Community Health in the FY2020 appropriation to significantly expand the GHWIC program.

Overview of *Healthy Tribes* Portfolio and Funding:

- NCCDPHP's *Healthy Tribes* program seeks to promote health, prevent chronic disease, reduce health disparities, and strengthen connections to culture and community practices that improve health and wellness among American Indians and Alaska Natives.
- NCCDPHP has a long history of working in Indian Country and in 2014 increased our investment by launching Good Health and Wellness in Indian Country. This initial funding was a commitment from NCCDPHP to reach this important population, but without dedicated funding, it isn't a sustainable model. The more recent appropriated funds allow the program to grow, build capacity and infrastructure in Indian Country and foster sustainability.
- In FY2020, *Healthy Tribes* is providing approximately \$34.5 million to more than 100 tribes, tribal organizations and tribal epidemiology centers.
- The *Healthy Tribes* program includes a robust portfolio that funds tribes, tribal organizations, urban Indian organizations, and tribal epidemiological centers through three cooperative agreements. These cooperative agreements work synergistically to build upon and inform strategies to improve health outcomes across Indian Country including strengthening public health Infrastructure; expanding the evidence base; and learning from innovative practices including cultural adaptations.
 - **Tribal Epidemiology Centers Public Health Infrastructure** – funds 12 Tribal Epidemiology Centers and one Network Coordinating Center to improve delivery of public health functions to and with the tribes and villages in their region and build public health infrastructure in tribal communities.

- **Tribal Practices for Wellness in Indian Country** – funds 21 tribes and 15 urban Indian organizations to support approaches to strengthen cultural practices and traditions that build resilience and connections to community, family, and culture, which over time, can reduce risk factors for chronic disease. This program will expand the evidence-base for cultural adaptation and inform the work of Good Health and Wellness in Indian Country, Tribal Epidemiology Centers Public Health Infrastructure, and other programs across CDC and the Federal Government that work with tribes. The approach was guided by the CDC Tribal Advisory Committee and refined over a year of discussions with Native cultural advisors.
- On September 30, 2019, the **Good Health and Wellness in Indian Country** program launched a new cooperative agreement. This cooperative agreement builds on the lessons learned from the first Good Health and Wellness in Indian Country NOFO, as well as the work with the Tribal Epidemiology Centers and the newly funded Tribal Practices program. This NOFO supports implementation of evidenced-informed, culturally-adapted:
 - system-wide changes to prevent obesity, such as improving tribal food and beverages programs and by improving land use design to connect activity friendly routes;
 - system-wide changes to prevent and control commercial tobacco use, such as implementing commercial tobacco free policies in public places and by providing referrals to evidence-based cessation treatment;
 - clinical linkages to support type 2 diabetes prevention and expand access to the National Diabetes Prevention Program in tribal communities;
 - clinical linkages to support heart disease and stroke prevention and expand access to screening and self-management and treatment programs;
 - Tribal Coordinating Center to expand the evidence-base and support program evaluation and communication activities.
- With the additional \$5 million investment executed in FY 2020, the Good Health and Wellness in Indian Country program has the opportunity to further expand its evidence informed activities and strategies to 29 awards including 12 Federally-recognized Tribes and Alaska Native Villages; 4 Urban Indian Organizations; and a minimum of 12 to 13 Tribally-designated Organizations. These funds will also support a sub-award structure that will reach a minimum of 52 smaller federally-recognized Tribes and Alaska Native Villages, though the reach is expected to exceed 100 smaller tribes.
 - Approximately 70% of AI/AN people live in urban settings. CDC learned that only funding tribes directly as with the current GHWIC cooperative agreement was missing much of this population. With increased funds, CDC added 4 Urban Indian Organizations to address this need.
 - With additional funds, CDC funded a Tribal Coordinating Center to support a Community of Practice for tribal awardees to learn from one another, have professional development opportunities from a tribal provider, and have culturally adapted communications and evaluation support.

Mid-Term Recommendations

Dedicate 2% of each CIO's internal operating budgets to be used to directly fund tribes, tribal organizations, and tribal health entities. (Status: Closed, no further action available)

CDC cannot commit to this recommendation. Intramural funding is spent on basic operational functions for the agency (e.g., salaries, benefits, rent, utilities, office supplies, management and administrative activities, and programs and services directly provided by CDC). CDC strives to maximize its extramural investments as much as possible; most CDC funding is provided to the field (approximately 78%).

Submit language to Congress to authorize tribally specific line items. *(Status: Closed, no further action available)*

CDC's primary tool for proposing new and updated programs and activities to Congress is the annual Congressional Justification (budget request), which can be found at www.cdc.gov/budget/congressional-justification.html. Throughout the Congressional Justification, CDC provides Congress with descriptions of new and continuing programs that, as applicable, specifically target tribal nations and tribal organizations or include tribal nations and tribal organizations among the entities eligible for funding. Congress then decides CDC's funding amounts, purpose, and the time that funds are available.

Long-Term Recommendations

Evaluate progress of agency efforts to dedicate and direct funds to tribes and tribal organizations. *(Status: In progress, ongoing)*

Every year, CDC produces a funding profile and related materials for AI/AN tribal nations and tribal organizations. The reports are available on CDC's Tribal Health website at <https://www.cdc.gov/tribal/consultation-support/funding/index.html>. Progress has been reported in TAC meetings during a CDC budget session and/or within the briefing materials provided to the TAC via thumb drive. The report includes information on grant and cooperative agreement funding amounts and trends over time, which mechanisms/NOFOs were used, and CIOs that provided the funding. It also includes total CDC funding through contracts to tribal nations and tribal organizations. For example, the profiles show that CDC and ATSDR have nearly doubled direct grant and cooperative agreement funding to tribal nations and tribal organizations from 2016 (\$34.85 million) to 2019 (\$66.22 million). CDC plans to continue these reports and is open to input on how to improve them.

Construct a dedicated budget line for tribal public health activities. *(Status: Closed, no further action available)*

CDC's current budget structure—which is mostly based on disease or public health issue area, and not specific population, is directed by Congress. CDC cannot commit to this recommendation.

1.B. INCREASE ACCESS TO AND OPPORTUNITIES FOR TRIBES AND TRIBAL ORGANIZATIONS TO COMPETE FOR FUNDING

Short-Term Recommendations

CDC should adopt a policy that creates a process for proactive review of CDC funding opportunity announcements to help ensure tribal inclusion and relevance. *(Status: Completed, closed)*

CDC works diligently to maximize competition to support tribal nations and tribal organizations wherever possible. There are multiple policies and systems in place that address this recommendation:

- HHS has a grants policy that states: "It is HHS policy to maximize competition for discretionary grants to the greatest extent practicable" (<https://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf>). When limiting competition is necessary, HHS and CDC have a rigorous process for approval of the limited-eligibility justification.
- CDC's PPEO provides CDC/ATSDR staff with standardized guidance and tools for developing NOFOs. The guidance specifically asks developers to consider eligibility for tribal nations or tribal organizations.
- During the planning stage of large and high-priority NOFOs, PPEO coordinates a review and discussion of the NOFO outline, which includes eligibility and application review criteria. These meetings include representatives from PPEO, CDC's OFR, CSTLTS, including OTASA, and key CDC program officials developing the NOFO (e.g., NOFO author, leaders, policy unit, and evaluation representatives). NOFO

developers are specifically reminded to consider tribal eligibility—to the maximum extent possible, based on the program’s authority and appropriations.

- OTASA provides technical assistance to any CDC program about tribal public health infrastructure, priorities, and tips for addressing tribal inclusion to inform NOFO development.
- CDC and ATSDR NOFOs are reviewed and cleared at multiple levels of the agency (programmatic, policy/legal, scientific, and grant management reviews). In addition, high-priority NOFOs are reviewed by HHS and sometimes OMB. The review includes a check of eligibility criteria, especially if the NOFO does not specify full and open competition.
- After NOFO development, OTASA staff volunteer to serve on application objective review panels to the greatest extent possible to ensure the appropriate technical evaluation of tribal applicants.

CDC should create a policy that mandates all NOFOs to include language that clearly includes federally recognized American Indian and Alaska Native tribes, tribal governments, and tribal organizations as eligible entities for direct funding except where specifically prohibited by legislative action. *(Status: Closed, no further action available)*

Each funding opportunity is unique. Factors CDC considers in budget and program planning include but are not limited to Congressional legislation, appropriations, directives, and priorities; Administration and HHS priorities, guidance, and directives; and data on the status of the public health system and population health as well as evidence on public health strategy effectiveness. CDC cannot commit to this recommendation.

As described in the response to the recommendation directly above, HHS currently has a policy in place that includes CDC regarding consideration of tribal nations and tribal organizations for NOFO eligibility and what is required for review and clearance of NOFOs when there is not full and open competition. In addition, HHS Operating divisions must make clear when tribal nations or tribal organizations are eligible to apply. The “Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards” specifies the following in Appendix 1 to 45 CFR, paragraph C.1 (https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75&rgn=div5#ap45.1.75_1521.i):

C. ELIGIBILITY INFORMATION

1. *Eligible Applicants—Required.* Announcements must clearly identify the types of entities that are eligible to apply. If there are no restrictions on eligibility, this section may simply indicate that all potential applicants are eligible. If there are restrictions on eligibility, it is important to be clear about the specific types of entities that are eligible, not just the types that are ineligible. For example, if the program is limited to nonprofit organizations subject to 26 USC §501(c)(3) of the tax code (26 USC §501(c)(3)), the announcement should say so. Similarly, it is better to state explicitly that Native American tribal organizations are eligible than to assume that they can unambiguously infer that from a statement that nonprofit organizations may apply. Eligibility also can be expressed by exception, (e.g., open to all types of domestic applicants other than individuals). This section should refer to any portion of Section D. specifying documentation that must be submitted to support an eligibility determination (e.g., proof of 501(c)(3) status as determined by the Internal Revenue Service or an authorizing tribal resolution). To the extent that any funding restriction in Section D.6 could affect the eligibility of an applicant or project, the announcement must either restate that restriction in this section or provide a cross-reference to its description in Section D.6.

CDC should adopt a policy that requires that states receiving CDC funds actively interface with federally recognized American Indian and Alaska Native Tribes within their state boundaries as part of the funded program and activities. *(Status: Closed, no further action available)*

A blanket policy requiring states to actively interface with federally recognized tribal nations within their state boundaries as part of every CDC-funded program and activity is not feasible. CDC cannot commit to this

recommendation. However, CDC can and does encourage states (and other recipients) to include tribal nations in planning and implementing NOFO activities, and to share NOFO resources whenever possible. CDC can promote tribal involvement through NOFO language, for example, encouraging the primary applicant to partner with stakeholders and to describe those partnerships in the application, sometimes requiring letters of support or concurrence with the application, having application evaluation criteria pertaining to partnerships (i.e., the stronger the partnerships the higher the application score on that element), and requiring reporting of partnerships and sub-awards in annual reports. OTASA is developing guidance that CDC programs can use to strengthen cooperative agreement/grant requirements for state accountability for tribal engagement.

1.C. REPORT ON FUNDING RESTRICTIONS IN LEGISLATIVE LANGUAGE

Short-Term Recommendations

CDC should provide a list of the funding opportunities and indicate which ones are restricted from providing direct funding to Indian tribes and/or tribal organization, which ones are not, and the sources of any restriction(s). Tribal leaders have asked, and now reiterate a request for CDC to provide information on which funding streams are restricted from directly funding tribes and tribal organizations. *(Status: In progress, ongoing)*

CDC is taking steps to gather and share the information, as it is not readily available through automatic reporting from any financial/accounting system. OTASA has committed to and is providing weekly updates on current funding opportunities for tribal nations and tribal organizations via the “OTASA Weekly Updates” email (a subscription service). The email includes links to open NOFOs, which provide detailed information on eligibility requirements. If eligibility is limited by statute, the NOFO will include information on that statute. It is also important to note that there are sometimes additional requirements that affect eligibility and CDC may not always know what the full eligibility pool is. Therefore, it is up to the potential applicant to determine if the organization is “fully eligible” in terms of the criteria and to provide the required documentation to CDC where a final determination is made.

During the Winter 2019 CDC/ATSDR TAC Meeting, CSTLTS verbally shared with the TAC the general results from an analysis of FY 2018 CDC/ATSDR domestic NOFOs; 74 NOFOs were tracked (new, continuation, and supplemental). Tribal nations were eligible for 56 of the 74 FY 2018 NOFOs. Statute limited eligibility for 7 NOFOs; tribal nations were eligible for 4 of these. In total, tribal eligibility was restricted by statute in only 3 cases.

In addition, CDC has provided an analysis of previous fiscal year’s NOFOs either as a presentation during the Winter TAC meetings or on the TAC members’ thumb drives. Below is a snapshot of that information:

- **CDC-RFA-TP17-17010201SUPP18: Hospital Preparedness Program—Public Health Emergency Preparedness Cooperative Agreement**
 - Statutes: Hospital Preparedness Program (HPP) § 319C-2 of the Public Health Service (PHS) Act (42 USC § 247d-3b) as amended; Contingent Emergency Response Funding (HPP only) § 311 of the PHS Act ((42 USC §243)) subject to available funding and other requirements and limitations; Public Health Emergency Preparedness (PHEP) § 319C-1 of the PHS Act (47 USC §247d-3a) as amended; and Contingent Emergency Response Funding (PHEP Only) 317(a) and 317(d) of the PHS Act [42 USC § 247b(a) and (d)] subject to available funding and other requirements and limitations.

- Eligibility: Limited to recipients previously awarded under CDC-RFA-TP17-1701: Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Cooperative Agreements.
- **CDC-RFA-OT18-1805: Preventive Health and Health Services Block Grant—2018**
 - Statutes: Public Law 97-35; 42 USC § 300w-320w-10; 45 CFR Part 75 and Part 96
 - Eligibility: All provisions and requirements of Preventive Health Services Block Legislation, Public Law 97-35, 42 USC § 300w-320w-10, 45 CFR Part 75 and Part 96 remains in effect. Applications received through the Block Grant Management Information System (BGMIS) will be used as the basis for the award.
- **CDC-RFA-DP18-1810: State Actions to Improve Oral Health Outcomes**
 - Statutes: 42 USC 247b-14 directs CDC to enter into cooperative agreements with state, territorial, and Indian tribes or tribal organizations.
 - Eligibility: State governments or their bona fide agents (includes the District of Columbia)
- **CDC-RFA-DP18-1814: National Organization for Chronic Disease Prevention and Health Promotion**
 - Statute: § 317(k)(2) of the Public Health Service Act, 42 USC 247b(k)(2)
 - Eligibility: Small businesses; special district governments; city or township governments; public and state-controlled institutions of higher education; private institutions of higher education; nonprofits having a 501(c)(3) status with the IRS, other than institutions of higher education; Native American tribal organizations (other than federally recognized tribal governments); public housing authorities/Indian housing authorities; county governments; Native American tribal governments (federally recognized); nonprofits that do not have a 501(c)(3) status with the IRS, other than institutions of higher education; state governments; and independent school districts. The statutory authority § 317(k)(2) of the Public Health Service Act, 42 USC 247b(k)(2)] does not allow for-profit organizations to be eligible.
- **CDC-RFA-DP18-1816: WELL-INTEGRATED SCREENING AND EVALUATION FOR WOMEN ACROSS THE NATION (WISEWOMAN)**
 - Statutes: Congressional statute not specified
 - Eligibility: Native American tribal organizations (other than federally recognized tribal governments), county governments, state governments, and Native American tribal governments (federally recognized). Eligibility is limited by Congressional statute and applicants must be recipients of National Breast and Cervical Cancer Early Detection Program (NBCCEDP) funding. WISEWOMAN is authorized under NBCCEDP to expand screening services inclusive of cardiovascular risk. WISEWOMAN program participants must be eligible for NBCCEDP to receive WISEWOMAN services; therefore, only organizations who are currently receiving NBCCEDP awards may apply. These include: state and local governments or their bona fide agents (this includes the District of Columbia, the Commonwealth of Puerto Rico, the US Virgin Islands, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau), American Indian/Alaska Native tribal governments (federally recognized or state-recognized), and American Indian/Alaska Native tribally designated organizations.
- **RFA-DP-19-001: Health Promotion and Disease Prevention Research Centers**
 - Statutes: §1706 of the Public Health Services Act, as amended, 42 USC 300u-5, academic health centers, as defined in 42 USC 300u-5(d) and §799B, as amended 42 USC 295p; Accreditation is defined by §799B (1) (E) of the Public Health Services Act.
 - Eligibility: Competition is limited to accredited schools of public health, and accredited schools of medicine and schools of osteopathy that offer an accredited Preventive Medicine Residency program.
- **CDC-RFA-CE18-1801: Domestic Violence Prevention Enhancement and Leadership Through Alliances Impact**

- Statute: The Family Violence and Prevention Services Act (FVPSA) statute (42 USC § 10414) authorizes the Domestic Violence Prevention Enhancements and Leadership Through Alliances (DELTA) initiatives through cooperative agreements with state domestic violence coalitions, administered by CDC’s National Center for Injury Prevention and Control (NCIPC), via a separate line item appropriation.
- Eligibility: As provided for in 42 USC § 10402, to be eligible, an organization must: 1) be a State Domestic Violence Coalition; and 2) include representatives of pertinent sectors of the local community, which may include: a) healthcare providers and state or local health departments; b) the education community; c) the faith-based community; d) the criminal justice system; e) family violence, domestic violence, and dating violence service program advocates; f) human service entities such as state child services divisions; g) business and civic leaders; and h) other pertinent sectors. For a list of HHS-designated State Domestic Violence Coalitions, see: <https://www.acf.hhs.gov/fysb/state-dv-coalitions>. If the applicant’s organization is not on this list, the applicant must provide a paragraph describing how they meet the above criteria. The term “state” means each of the several states, the District of Columbia, the Commonwealth of Puerto Rico, and, except as otherwise provided, Guam, American Samoa, the US Virgin Islands, and the Commonwealth of the Northern Mariana Islands. A “bona fide agent” is an agency/organization identified by the state as eligible to apply under the state eligibility in lieu of a state application. If applying as a bona fide agent of a state or local government, a legal, binding agreement from the state or local government as documentation of the status is required.

GOAL 2: ENSURE A TRIBAL VOICE IN THE LARGER CDC SYSTEM

2.A. CONTINUE AND EXPAND ENGAGEMENT WITH TRIBAL NATIONS

Short-Term Recommendations

CDC should strengthen the individual CIO’s engagement with Indian tribes by creating a tribal liaison position within each CIO. *(Status: In progress, ongoing)*

Although not every CIO has the resources to create a dedicated Tribal Liaison position, a few CIOs (e.g., NCCDPHP and NCIPC) are convening internal tribal public health workgroups to strategize how to better work with and provide resources to Indian Country. OTASA has convened an agency-wide network of CIO representatives to discuss tribal public health priorities and recommendations and potential policies, activities, and strategies to address those issues and priorities. OTASA provides CIOs with strategies to increase support of, and collaboration with, tribal nations, tribal-serving organizations, and public health partners to improve tribal public health capacity—and to connect tribal nations, tribal-serving organizations, and other public health partners with CDC and ATSDR programs. In addition, OTASA will continue to meet with CIO leaders about tribal public health priorities and strategies to address AI/AN public health needs.

CDC should continue to fund, support, and use the CDC/ATSDR TAC. *(Status: In progress, ongoing)*

CDC and ATSDR continues to support the TAC. Over the past years, OTASA has worked with the TAC to improve and expand current TAC activities. OTASA would like to work with the TAC on an annual collaboration plan that includes communicating more frequently and that identifies ways and specific activities the TAC and CDC can better engage and collaborate with one another and other tribal entities to improve the health of tribal nations.

CDC should commit to open and engaging communications among the CDC/ATSDR TAC, CDC director, and CDC senior-level employees, including an annual, in-person meeting between the director and the TAC. *(Status: In progress, ongoing)*

CDC senior leaders are committed to attending TAC meetings whenever they are able. In cases where they are unable to attend, they send the next senior leader available. In times when the TAC is doing a deeper dive into specific programs, CDC strives to have the agency's senior lead for that program there to discuss the program and answer TAC questions. OTASA will continue to work with the CDC director's office and other CIO offices to ensure senior leaders and program leads as needed are notified to attend the TAC meetings in-person (especially ones held in Atlanta, GA) as early as possible.

CDC should commit to following up on tribal priorities and requests that may be presented during CDC TAC meetings, Tribal Consultation Sessions, and/or direct tribal requests in a timely manner. *(Status: Completed, closed)*

OTASA has developed a system for monitoring and tracking TAC requests and CDC and ATSDR responses to continue improving the timeliness and quality of responses provided to tribal nations while increasing sustainable public health capacity within tribal nations. The system design allows for coding each recommendation or request to the 10 essential public health functional areas and updating the record with the appropriate CIOs' input and response. OTASA is continuing to review and improve the system to ultimately be able to identify frequency and type of incoming requests, monitor CDC responses to requests, and identify patterns or trends in requests over time. This information is used to inform CIOs about areas to target in future funding opportunities to improve tribal public health systems.

OTASA works with other CIOs and the TAC to address the Tribal Priorities. Biennially, OTASA will provide an updates document on the Tribal Priorities. Moving forward, the document will provide CDC and ATSDR updates on Priorities that are currently "in progress, ongoing," until those priorities are deemed "completed, closed" or "closed, no further action available."

Mid-Term Recommendations

Create an advisory body composed of representatives from federal tribal advisory bodies. *(Status: Closed, no further action available)*

CDC cannot create an interdepartmental federal tribal advisory body, as CDC is not the lead HHS agency for tribal affairs. CDC recommends contacting the HHS Office of Intergovernmental and External Affairs (IEA)'s Tribal Affairs component with this request. IEA Tribal Affairs is the official primary point of contact for tribal nations and tribal organizations wishing to access HHS and is therefore the best place to start discussions about an HHS inter-departmental tribal advisory body.

2.B. INSTITUTE CDC POLICIES THAT INCLUDE TRIBAL INPUT AND INCLUSION AT ALL LEVELS

Short-Term Recommendations

CDC should use the TAC to advance the mission of CDC and to gather input on internal CDC policies that may have tribal implications. *(Status: In progress, ongoing)*

CDC has and will continue to engage the TAC in CDC operational policies that impact tribal nations, such as the CDC/ATSDR Tribal Consultation Policy. Building on those activities, CDC can utilize the TAC conference calls to provide the TAC with an overview of the types of CDC operational policies, the operational policy process, and discuss TAC engagement when relevant. Some CDC policies of public interest are available at www.cdc.gov/maso/CDCPolicy.html.

CSTLTS participates in CDC's Operational Policies Workgroup and provides input to new or updated policies and can help identify when the policies might affect tribal nations. During operational policy training, CDC staff are encouraged to consult with CSTLTS on obtaining tribal input to any policy that would affect AI/AN people.

2.C. ADVANCE CDC TRIBAL BUDGET FORMULATION

Short-Term Recommendation

CDC should develop a policy for CIOs to interface with tribes during the internal budget formulation and budget recommendation process. *(Status: Closed, no further action available)*

CDC cannot commit to this recommendation. CDC's internal budget formulation and budget recommendation process, as with all HHS agencies, is embargoed until the President releases the budget proposal, usually in February each year. As a result, CDC has no formal budget consultation process for external stakeholders prior to internal budget formulation; however, all CDC stakeholders are invited to provide continuous input to CDC program and resource strategies. Examples of ways CDC stakeholders are invited to engage include, but are not limited to, the following:

- Advisory committees, such as the CDC/ATSDR Tribal Advisory Committee. The increased engagement of CDC CIOs with the TAC is a primary objective for improving tribal inclusion in budget formulation consideration by CDC/ATSDR programs.
- Federal Register Notices soliciting input on programs, guidelines, regulations, etc.
- CDC surveys of public health system and population status and needs
- Dialogue at briefings and other meetings, conference calls, listening sessions, site visits
- Correspondence
- Solicitation of CDC grantee challenges and success stories that inform future decisions

CDC and ATSDR are significantly different in focus and statutory authorities than some other agencies that tribal nations work with, especially those agencies authorized to provide for direct clinical and social services to the public. These differences affect what can be done and how it can be done. By mission and statute, some other agencies' programs serve a sub-set of the population based on social and economic factors in a way that CDC and ATSDR do not. However, we are committed to exploring how to increase engagement of tribal nations with CDC in providing input to program and resource strategies.

Mid-Term Recommendation

Pilot a budget formulation project that seeks tribal input at the local level. *(Status: Closed, no further action available)*

As stated above, CDC's budget formulation process differs from the Indian Health Service's (IHS's). The increased engagement of CDC CIOs with the TAC is a primary objective for improving tribal inclusion in budget formulation consideration by CDC programs. OTASA explored and provided additional ways to strengthen this dialogue for the TAC meetings and Biannual Consultation Session, especially those held in Atlanta, Georgia. For example, OTASA is using the TAC conference calls for information-sharing among the TAC and CDC staff developing funding opportunities and providing the TAC with discussion topics and materials to take back to their representative regions, and to gather information and advice to present to CDC/ATSDR at the in-person TAC meetings.

Long-Term Recommendation

Formalize and support a tribal budget formulation process. *(Status: Closed, no further action available)*

CDC cannot commit to this recommendation. CDC's internal budget formulation and budget recommendation process is embargoed until the President releases the budget proposal. As a result, CDC cannot have a formal budget consultation process for external stakeholders prior to internal budget formulation. Although CDC is unable to formalize a tribal budget formulation process like IHS, CDC welcomes tribal engagement in its budget formulation and initiative development. CDC requests further guidance from the TAC on strategies, attributes, and options CDC CIOs can use to plan programs and write funding opportunities that best suit tribal nations and tribal organizations. The guidance would pertain to the common building blocks for program and funding planning that are eventually operationalized in CDC NOFOs. OTASA suggests adding discussion of this recommendation to either the TAC conference calls and/or an in-person TAC meeting.

2.D. CDC DIABETES PREVENTION PROGRAM CERTIFICATION REQUIREMENTS

Short-Term Recommendation

CDC should deem the Special Diabetes Program for Indians as providing CDC Diabetes Prevention and Program services. *(Status: Completed, closed)*

Tribal programs supported by the Special Diabetes Program for Indians (SDPI) are eligible to apply for CDC recognition for their type 2 diabetes prevention programs through the National Diabetes Prevention Program (National DPP). CDC has been working to make the recognition process more seamless for SDPI and all tribal programs working to establish or maintain CDC-recognized programs to prevent type 2 diabetes among people at risk. IHS has confirmed with CDC that the collection of outcome data from programs participating in the SDPI Diabetes Prevention Demonstration Project and Initiative has concluded; thus, there is no longer an overlap between IHS reporting requirements and CDC requirements for recognition.

In recognition of the expertise of tribes and tribal organizations that participated in the SDPI Diabetes Prevention Demonstration Project and/or Initiative, CDC—with input from the Indian Health Service—implemented an exception to allow these Tribal, Urban, and IHS sites to advance automatically to the preliminary level of recognition under CDC's Diabetes Prevention Recognition Program (DPRP). This exception was effective in October 2019. Preliminary recognition will enable these organizations to apply to become Medicare Diabetes Prevention Program (MDPP) suppliers without having to wait until a completed participant cohort is available for evaluation (typically 18-24 months). CDC will be seeking tribal consultation on proposed revisions to the Diabetes Prevention Recognition Program Standards and Operating Procedures later this year.

2.E. SUPPORT THE IMPLEMENTATION OF CULTURAL AND TRADITIONAL PRACTICES

Short-Term Recommendation

CDC should include language in their NOFOs that recognizes the value and applicability of cultural and traditional practices as viable grantee activities. *(Status: In progress, ongoing)*

Over the past few years, CDC has taken active steps to learn about and incorporate cultural and traditional healing practices into programs and NOFOs. Tribal leaders, traditional healers, and tribal public health

practitioners helped CDC craft seven strategies that NCCDPHP and CSTLTS have used in developing the following cooperative agreements:

- Good Health and Wellness in Indian Country [2014–2019 and 2019–2024 NOFOs]
- Building Public Health Infrastructure in Tribal Communities to Accelerate Disease Prevention and Health Promotion in Indian Country—Tribal Epidemiology Centers Public Health Infrastructure [2017–2022]
- Tribal Practices for Wellness in Indian Country [2018–2021]
- Tribal Public Health Capacity-Building and Quality Improvement Umbrella [2018–2023]

Including language on cultural and traditional practices as applicable “promising practices” or “evidence-informed” interventions is best considered within the development of each NOFO, instead of standard template or required language for all NOFOs. To increase awareness of the seven strategies, OTASA and NCCDPHP have proposed presenting these at a future CDC policy lecture series. OTASA is working on additional avenues to educate CDC staff on the importance of using these seven strategies in their work with Indian Country.

Mid-Term Recommendation

CDC should work with tribal recipients and other appropriate federal divisions to create evaluation guidelines that can be used with AI/AN programs when seeking to evaluate the effectiveness of culturally based and grounded programming and activities. *(Status: In progress, ongoing)*

CDC agrees that more data is needed on the effectiveness of culturally based and grounded programs and activities, and that improving evaluation of AI/AN programs is important to that effort. CDC will follow up with the TAC about obtaining additional guidance on these issues through a TAC meeting or other venue.

2.F. TRIBAL BEHAVIORAL HEALTH AGENDA

Short-Term Recommendation

Use the Tribal Behavioral Health Agenda as a guide for collaboration and planning. *(Status: Completed, closed)*

Through a cooperative agreement (OT18-1802: Strengthening Public Health Systems and Services Through National Partnerships to Improve and Protect the Nation’s Health), CDC is funding the National Indian Health Board to conduct a literature review on public health research and practice that can inform ongoing and future tribal public health activities and decision-making at the federal level. The literature review will include the substantive and translatable findings from the Tribal Behavioral Health Agenda.