CDC/ATSDR 27th Bi-Annual Tribal Advisory Committee Meeting

February 21, 2024

Transcript

0:00 – 1:07

Deputy Chief Bryan Warner: Here today amongst all of our tribal nations that are represented and moreover it is good to represent Indian country today. So I want to thank all of our TAC delegation for being here. Thank you for your technical advisors, those that you have brought with you and I want to thank you for the hospitality from our CDC officials and their guests that are here today. I want to thank NIHBAC and his team for being with us today and just a wonderful day outside. You know you, you take that time as we do amongst our families and everything. But when we come together during business hours, sometimes we don't take enough time to take a deep breath, look around and really express our appreciation to one another. So from myself, from Principal Chief Chuck Hoskins Junior, I want to say thank you from our tribal nation, the Cherokee Nation. Before we get started, I want to offer a prayer and I would like to call on our second chief, Del Beaver for the prayer. Thank you, Sir.

1:09 – 1:56

Second Chief Del Beaver: Hello. If you would, if you, if you are praying type, I'd ask that you'd join me in prayer this morning. And so, if you would, let's bow our heads and let's close our eyes. And let's pray. Dear Heavenly Father, Lord, I thank you for such a beautiful day. I just thank you, Lord, for allowing us to wake up, Lord, and just to feel the sunshine on our face Lord. And Lord, as we're here in Atlanta, I ask that you be with our families back home, wherever home may be. I say look after him, Lord. Look after us, Lord, as we're here. Give us guidance, give us direction, Lord, and give us wisdom. And Lord, again, I just thank you so much, Lord, for just all the blessings of life you have given us. Lord, I thank you, Lord, for your son, Jesus Christ Lord. And Lord again, I just thank you just for one more day that you have given us to serve you Lord. And Lord, I just pray all these things and your Son, holy and precious name. Amen.

1:58 – 3:20

Deputy Chief Bryan Warner: Hello, Chief. Thank you, Sir. Before we get started, I'd like to share some etiquette and guidelines for the CDCATSDR Tribal Advisory Committee meeting. These are just simple reminders all in person attendees. Must silence their phones to be respectful of the speakers. Members of the public may not speak during the meeting proceedings. All participants must keep their mic on mute during the meeting unless presenting or speaking. Members of the public may not discuss potential funding opportunities with TAC members during the event. For TAC members attending virtually when asking a question or making a comment, click on the Participants button at the bottom of the Zoom screen and select the Raised Hand option located in the right hand side of the screen. Alternately, you can enter your questions into the chat box. For participants joining us via Zoom, please ensure that your tribal position and tribe are included in your displayed name or instructions on how to change your name in the chat. And lastly, for everyone's awareness, this meeting is being recorded and meeting minutes will be available 90 days post the meeting. Now I would like to turn over the meeting to Dr. Dauphin. Dr. Dauphin, we appreciate you. You've been in our prayers. We understand that you're away today but thank you for your diligence. Thank you for your talent, your time and your dedication.

3:25 – 9:00

Dr. Leslie Dauphin: Thank you so much. Appreciate that, Deputy Chief Warner. Well, good morning, everyone, and welcome to the 27th CDCATSDR Tribal Advisory Committee meeting. I am Dr. Les Dauphin, the Director of CDC's National Center for State, Tribal, Local, and Territorial Public Health Infrastructure and Workforce, also known as the Public Health Infrastructure Center. It is an honor to serve as the designated federal official for the TAC and I extend a warm welcome and heartfelt gratitude to every one of you.

I want to begin by acknowledging the Muskogee Creek and Cherokee Nations whose indigenous lands house the CDC and ATSDR Atlanta campuses. Also, on behalf of CDC, I would like to recognize and commend our TAC Chair, Deputy Principal Chief Warner, and our TAC Co-Chair, Legislator Barker for their exemplary leadership and commitment to advancing the health and welfare of American Indian and Alaska Native communities through the TAC. Your guidance and expertise have been instrumental in shaping our collaborative efforts. I also want to recognize the TAC members. I express my sincere gratitude to each of you, the distinguished TAC members, for their dedicated service, unwavering commitment, and steadfast partnership as elected leaders representing your communities. Your presence and active engagement in this Tribal Advisory Committee meeting are invaluable. Together, we are united in our shared goal of improving the health outcomes and well-being of the vibrant communities across Indian Country.

I also want to recognize and thank Dr. Megan Nichols. I'm not sure if she's there in person, but Dr. Nichols served as the Acting Director of our Office of Tribal Affairs and Strategic Alliances from October 1st through February 4th. Her work with the TAC has been instrumental and I want to take a moment to acknowledge her contributions. Megan has improved the TAC member document delivery process, facilitated new member orientation, and led planning efforts for the upcoming biannual meetings. I also want to thank her for all of her diligent work in helping to reimagine our Office of Tribal Affairs and Strategic Alliances. Thank you, Dr. Nichols, for your leadership and partnership. Your contributions were invaluable, and I truly appreciate your efforts.

Now I am thrilled to announce that we have a permanent Director of OTASA, Captain Damion Killsback. He is the new OTASA Director. He joined our leadership team on February 1st. Some of you may remember him from his previous role as OTASA's Deputy Director. We are excited to welcome him back and look forward to his

contributions. Damion's previous leadership roles include serving as the Chief of Staff, Chief Executive Officer of the Northern Cheyenne Service Unit and Indian Health Service, Acting Director for the Division of Policy and Data at the HHS Office of Minority Health, and Senior Advisor for Tribal Affairs at OHMOMH. He played a crucial role in establishing the Center for Indigenous Innovation and Health Equity Tribal Advisory Committee. Damion received his doctorate pharmacy degree from the University of Montana and his master's degree in public health from American Public University. A proud member of the Northern Cheyenne Nation, Damion is the oldest of six, son of Jacqueline Limpy Tang, and happily married to Danielle Killsback, with whom he has four children. Welcome, Captain Killsback.
Now I'd just like to share a few program updates. CDC's centers, institutes, and offices continue to better understand the public health concerns and needs of tribal nations. Since our last meeting in September, we've held listening sessions on the joint CDC/ATSDR and HHS Environmental Justice Index tool, the newly formed CDC Grants Governance Board, the Advisory Committee for Immunization Practices on the updated recommendations for VAXELIS HIV vaccine and promoted other agency's activities like FDA's nutrition initiative and their front of package nutrition labeling. Listening session partnerships and tribal engagements like these are instrumental in enhancing our strategies at achieving more impactful public health outcomes. Our collaborative efforts have shared knowledge, resources, and expertise fostering a unified approach to addressing the health needs of American Indian and Alaska Native communities. We remain dedicated to deepening our partnerships with tribal communities, improving our engagement strategies, and ensuring our efforts aligned with the needs and priorities of tribal communities.
Now I'm delighted to turn it over to Captain Killsback to share some opening remarks with the TAC and provide an overview of our agenda for today. Again, welcome. We are delighted that you join us. Over to you, Captain Killsback.

9:03 – 13:33
Capt. Damion Killsback: Thank you, Doctor Dauphin. It's a pleasure to meet all of you. Thank you. I said in my Northern Cheyenne language, where I'm from White River District, descendant of Chief Don Knife. Good morning. I'm excited to meet all the TAC members and to all distinguished guest here, it's an honor to serve as your Executive Secretary for the CDC Tribal Advisory Committee and to be supporting Dr. Dauphin as her role as a designated federal official. I'm deeply committed to getting to know each and every one of you and getting insight into the unique challenges faced by tribal leaders. Moreover, I'm eager to collaborate the opportunities by maintaining and upholding the CDC/ATSDR charter, TAC charter. I look forward to fostering and sustaining our government-to-government relationship as we serve American and Alaska Native communities.
The organizational charts for CDC including the Public Health Infrastructure Center and the Office of Tribal Affairs and Strategic Alliances are enclosed in your packets. Our agenda includes a cultural enrichment activity on the first day, exploring the Emergency Operations Center, and a choice of you folks attendees to see one of three of the labs for CDC. On day 2, CDC experts will present on topics that all of you expressed interest in such as the building wastewater surveillance with tribal communities to strengthen public health, injury prevention, chronic disease prevention and a focus on diabetes education and tobacco prevention efforts. Throughout our time together, I hope that we all actively engage with the presenters and listening intently to the insights and feedback shared by tribal leaders. Your inevitable perspectives, invaluable perspectives will shape our collective efforts to protect and improve health for Americans and Alaska Native communities. I extend my deepest appreciation for your presence at this meeting. Today we once again we set out on a healthier, brighter future. Thank you.
We're excited about the future collaboration opportunities and are committed to make a meaningful impact on the health and well-being of tribal communities. I extend my deepest appreciation for your presence at this mean as we begin our journey on the way to a healthier, brighter future. Thank you Niyash. I also want to thank the American Indian, Alaska Native Hawaiian Coalition for their thoughtful gesture and providing the sachets as a gift. Today the sachets were made as a celebration for Don Satterfield's retirement. Don was instrumental in the Diabetes Ego book series and the Central Employee Organization. The AI/AN NH Coalition plays a vital role in fostering connections among AI/AN and NH individuals at CDC.
Now I would like to conduct roll call to begin TAC business. When I call your respective area or name. For the national large member positions, please respond with present. Alaska Area, Chief Alicia Andrew. Albuquerque Area, Councilman Conrad Jackett. Billings Area, Council Member Bryce Kirk. California Area, Council Member Teresa Sanchez. Great Plains Area, Jerilyn Church. Navajo area,

13:34
Ms. Kim Russell: Present.

13:39 -13:40
Captain Damion Killsback: Oklahoma area,

13:41
Deputy Chief Bryan Warner: Present.

13:46 -13:52
Damion Killsback: Phoenix area… Tucson area,

13:53 – 13:58
Chairman Nuvangyaoma: Stand by. This is Chairman Nuvangyaoma for Phoenix area. Thank you. Present."

14:01 – 14:02
Ms. Vivian Saunders: Vivian Saunders, Tucson Area.

14:11 – 14:16
Captain Damion Killsback: National Large Tribal Member Doctor Sharon Stanphill

14:17
Doctor Sharon Stanphill: Present

14:21 – 14:25
Captain Damion Killsback: National Large Tribal Member Legislator Connie Barker

14:26
Legislator Connie Barker: Present

14:30 – 14:34
Captain Damion Killsback: National Large Tribal Member Councilwoman Herminia Frias

14:35
Councilwoman Herminia Frias: Present

14:39 – 15:46
Captain Damion Killsback: National at large Tribal member Second Chief Del Beaver. National at large Tribal Member Councilwoman Carrie Freeman. Ok, I confirm that we have a quorum of nine that has been met at this time.
I will also provide a logistic review. So, the nearest restroom locations are going to be on either side of this room. For emergencies, if required to shelter in place, we will remain in this room. If required to evacuate, please head towards the double doors and an escort will lead you to the emergency area. There's water and refreshments at the back table here, near this entrance and a friendly reminder please the meeting is being recorded at all time. I will now turn the meeting back over to the TAC chair. Deputy Principal Chief Warner, thank you.

15:48 -15:49
Deputy Chief Bryan Warner: WA-DO. Captain Killsback. Thank you for the roll call. Yes, Ms. Danforth.

15:49 – 15:58
Ms. Debra Danforth: Bemidji Area representative here for Councilwoman Jennifer Webster. Bemidji wasn't mentioned, so I'm her alternate, Debra Danforth.

16:03 -16:10
Capt. Damion Killsback: I apologize. I think I yeah, I missed that. So, we have 10.

16:11
Deputy Chief Bryan Warner: 10. Yes, ma'am.

16:12 – 16: 23
Ms. Kim Russell: Good morning. Kim Russell with Navajo area., I think someone said, but not too sure, but I am here on behalf of President Buniger. Thank you.

16:24 -18:34
Deputy Chief Bryan Warner: All right. Well, thank you all again for the roll call and the logistical overview. And Captain Killsback, welcome back to the TAC, Sir. It's good to have you here. Now I will go over a few of the roles and responsibilities of the Tribal Advisory Committee. So basically, so please see the slide detailing the Federal Advisory Committee Act, also known as the FACA Exemption, and take a few moments to review. A copy of the FACA exemption is available on the HHS website. We will put a link into the chat. Although this is a public meeting, it is important to note that in recognition of this exemption, the public may not participate in any way. Please refrain from using the chat feature of the meeting platform for any other than technical issues such as a problem with audio or video. However, the CDC/ATSDR TAC members can give up their speaking time to the alternates to technical advisors or guests to speak on a TAC members behalf. Before speaking. We ask that members and alternates to announce their name and the area you represent to assist with the transcription services of this meeting. The purpose of the CDC/ATSDR TAC is to exchange information with the 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 and AN tribes, and ensure that CDC/ATSDR activities or policies that impact American Indians, Alaska Native Tribes are brought to the attention of tribal leaders. TAC members make a good faith effort to provide input, guidance and recommendations to the CDC/ATSDR and to disseminate information back to the local area tribes that we represent. I would now like to move forward within the agenda to begin discussions on the TAC business items. Captain Killsback and Dr. Dauphin I invite you both to join in for this discussion.

18:47 – 20:14
Capt. Damion Killsback: In your logistics e-mail. We provide an updated Centers, Institutes, and Offices resource guide via the File Transfer Portal, FTP site. This resource offers comprehensive information about each CIO, providing TAC members with electronic access to essential details that the OTASA team can maintain. It includes details such as the CDC director's name, contact e-mail, points of contact, organizational chart link

example, priority areas, technical assistance services, budget updates, Health Equity initiatives, Health Equity data collection efforts, and endeavors to enhance tribal data infrastructure. Additionally, this guide contains useful information about CDC leadership, senior leadership. We have received feedback from our TAC and Chair and Co-chair indicating that it would be beneficial to have this information accessible on the FTP site where we upload all meeting materials. Please note that we will update the guide and share these updates with you via the FTP site. To accommodate members who prefer printed copies, we have copies available at the TAC for TAC delegates who would like one. Please approach me if you are interested in receiving a printed copy. However, it's essential to remember that this information is readily available on the FTP site and will be regularly maintained there. Thank you.

20:16 – 21:02
Deputy Chief Bryan Warner: Thank you Captain Killsback for the update on the CIO resource guide. I'm delighted to hear that this information will now be available on the FTP site and maintained regularly. Given the fluid nature of information and added value of ongoing virtual updates, this is indeed a significant improvement. So, WA-DO to you. I'm pleased to introduce 2 esteemed presenters for an update on the Data Modernization Initiative. We are privileged to have the following individual sharing their expertise and insights. Mrs. Delight Satter, a Senior Health scientist from the Public Health Infrastructure Center, and Doctor Kucik, the Lead of the Data Modernization Implementation Unit. Thank you both.

21:05 – 30:28
Dr. Jim Kucik: Good morning. It's so wonderful to see so many of you. Again, really appreciate the opportunity to come and share some of our updates. My name is Jim Kucik. I'm a Senior Health Scientist in CDC's Ooffice for the Public Health Data Surveillance and Technology, affectionately called the Data Office. And we've only officially began operating as an office since the beginning of October. So, this is our first time at the TAC under our new office structure. The office was really established to operate as an enabler of public health data, working across all of CDC with a mission to promote response readyresponse-ready data and systems and improve access to and use of data to inform decision makingdecision-making. This morning we'd like to share some updates on how CDC is supporting data modernization in Indian Country and to share progress on our Tribal Data Modernization Toolkit project. Then I'll turn it over to my wonderful colleague Delight Satter to share an internal effort here at CDC to help us better plan and coordinate our support for improved tribal access and use of public health data.
Next slide please and you can advance again, I'll just start with some providing some updates on some of our more recent DMI and data monetization investments. Next slide please. So CDC continues to directly support and we've been expanding the number of opportunities for funding data modernization opportunities with tTribal pPublic hHealth and hHealthcCare pPartners. Since initially providing $750,000 across 3 Tribal Public Health Partners in 2020, the CDC has invested more than 7.6 million in tribal data monetization modernization projects across six different partners this past year. And I want to particularly call out the support of the Public Health Infrastructure Center in supporting some of the funding for these projects, in particular, the Office of Oral Health, which has been supporting a number of the activities. Some of the types of activities that our tribal partners have undertaken using these funds has been to build data infrastructure to improve the receipt and use of public health data, identifying the priority data sets and addressing governance issues within their tribes to gain and maintain access to data assets, developing and maintaining native workforce capacity to support data modernization and building capacity for electronic case reporting in a tribal public health agency or TEC.

I want to highlight just two specific examples because we really like to celebrate the successes of our partners when these funding opportunities come around. We want to make sure that people understand what data modernization is and what some of the opportunities are for you. Our partners in the Llittle Sshell Ttribe at Chippewa invested in a modernized data management system. They're now capable of managing, collecting, analyzing and sharing core public health data for all diseases and condition. This has given the Ttribe the capacity to track chronic diseases, identify vulnerabilities, provide individualized services to get members to life, saving treatments and as well as implementing new programs and services based on the information they now have generated and kept within this new data management system. The Wabaenaki Public Health and Wellness created the Wabaenaki Public Health Surveillance System. This includes data lakes in the cloud server environment. That's increased their ability to store and manage diverse types of data and has allowed them to bring in new data sources. And in the spirit of self-determination, they've used the DMI funds to access staff training and development for native staff in key areas related to data literacy, data analysis, data collection and databases. I'm happy to share a new and major investment that will benefit Tribal Public Health.
CDC has recently awarded $255,000,000 to three national partners to build four data Modernization Implementation Centers across the United States that will help drive progress across states, tribes, localities and territories in alignment with CDC's public hHealth data strategy. Specifically, these implementation centers will support public health to adopt industry backed consensus basedindustry-backed consensus-based solutions for modern data exchange that align with federal health IT policies and standards, and this includes participation and activities to enable a secure nationwide exchange of electronic health information. Of the four implementation centers to be established, one will be specifically dedicated in supporting tribes. The procurement process for the tribal implementation center is still underway and so we look forward to bringing more details and updates on the work of the implementation centers when that is awarded. Next slide please. And because data access is such a critical issue, I wanted to provide some exciting updates to the presentation that Doctor Sarah Sabania provided to you during the September TAC meeting on electronic case reporting. So for those of you who weren't at the meeting, electronic case reporting or ECR is the automated generation in transmission of case reports from the electronic health record to public health agencies for review and action. So in other words, a near real time exchange of data from healthcare to public. And since September, the very first two tribes have successfully connected and used electronic case reporting with Turtle Mountain now receiving data via electronic case

reporting and the Salt River Pima. Maricopa Indian Community has successfully connected just this month, and they're still waiting to receive their first case reports. Additionally, Turtle Mountain is using some of the DMI funds awarded this past year to acquire and implement a new disease surveillance system so that they can actually better use the data that they're now getting through electronic case report reporting, So matching building that data infrastructure at the same time they're increasing their data access. Our electronic case report team has also another project with the National Council of Urban Indian Health working with UIO's to begin sending ECR data to their healthcare facility from their healthcare facilities to public health departments.
And based on these experience, our colleagues at the National Indian Health Board with support from CDC is developing an ECR road map that'll really help accelerate tribal implementation of electronic case reporting. And that road map should be completed in July and with the added support of the new implementation center will really help scale up implementation among interested tribes. We encourage you to see Doctor Sabania and talk with her about details. Next slide please.
And now I'd like to just share some progress on a on our project to develop a DMI toolkit which I've been able to present on in the past to the TAC. Next slide please. So as a reminder, we've contracted with Chickasaw Health Consulting to develop a toolkit that tribes can use to assess to what extent they have the right people, processes and technology in place to access and use public health data to protect their communities. Over the last year, Chickasaw Health Consulting has assembled and engaged aA tribal expert work group to guide the development of that process, and I'd like to thank Doctor Stanphill and the others for their invaluable contributions as part of that subgroup. Next slide, The toolkit is a suite of four components to support the self-assessment with the central component being the data modernization questionnaire. Next slide please. This questionnaire is designed to guide a tribe through an analysis of the opportunities and roadblocks across several domains to provide the valuable information needed to plan and implement data modernization improvements. These domains cover issues related to internal data and IT governance policies influencing access to data, workforce capacity and what technology is in place or needs to be built to better use your data. Next slide please.
The questionnaire component has been completed and the Chickasaw Health Consulting Group is finalizing recruitment of a cohort of interested tribes and TECs to help pilot the tool. Next slide please. The pilot really is an important step in ensuring that this tool meets the needs of tTribal pPublic hHealth so we can make the changes needed where it might miss the mark. The desire is that the pilot participants provide diverse representation and Chickasaw Health Consulting has been reaching out to many tribes, finding willing participants, and we're almost at our ideal number. If you're interested, please let me know. The plan is that there will be a kickoff webinar with the pilot participants in the next month, with an anticipated 12 weeks needed to complete the guided self-assessment. After that we expect the toolkit will be ready for distribution and roll out. So we welcome your input on considerations for that rollout, how we can support the use of it, such as the need for technical assistance to help conduct the self-assessments or to support translating the findings into actionable data modernization plans for your tribes or TECs. So thanks again for the opportunity to present today and I'm happy to take comments after my colleague Dr. Satter has presented. You can advance two slides.

30:30 – 41:20
Dr. Delight Satter: Thank you so much. I didn't know you could speak that fast. I promise I won't be going that fast. I can't do it.
Good morning. My name is Delight Satter. I'm Unquan Klickitat from the Confederated Tribes of Grand Brown in Oregon. And I make my home in the beautiful homelands of the Muskogee Creek Nation here in the Piedmont Forest. I hope that when you woke up this morning, you heard the beautiful songbirds. They've returned. And maybe tonight you'll hear them. And maybe they'll wake you up again tomorrow at 4:00 AM and 2:00 AM. And throughout the evening, it's been my pleasure to work with Doctor Kucik for some time on the Data Modernization Initiative as well as his other colleagues in OPHDST. And I'm going to share with you I think some of the efforts that you know that we've been working on but with a little bit more detail. This is some of the work internal to strengthen CDC in our work across CDC's centers, institutes and offices coordinating some of our work on what we call a strategy or a road map for ourselves. And I promise at the end of my presentation I'm going to switch to some indigenous ways of knowing and share this same story with a little bit of a different style. So first we're going to do like he did and then we'll do our other way of communicating. So CDC has been working with a growing number of tribes and tribal epicenters as part of the data modernization initiative for the last four years. But we recognize that a number of CDC programs have also supported and supporting a variety of activities to help tribes better access public health data access and use. To better coordinate across the efforts to identify gaps and activities and to better align these efforts with CDC's public health data strategy, we sought to develop a cohesive road map that would allow us to be more thoughtful and deliberative in how we support tribal partners.
Now we want to be very clear, Jim and I, when we're talking about this strategy or this road map, this is distinctly different from the work of HHS around the tribal consultation or the tribal data policy. So keep in mind, we're using a lot of the same phrasing and terms, but there are different efforts. Let's see.
Next slide please. Here we have the slide briefly describing the purpose of the road map. The road map will help us implement an overarching framework that will guide outcomes and enhanced coordination across activities, partnerships and funding decisions within CDC and ATSDR. It will help us establish guiding principles, goals and objectives to guide progress and track success and promote accountability and foster transparency and collaboration when implementing data modernization with tribes. This effort was Co-led by OPHDST and CDC's Public Health Infrastructure Center, the same center that hosts the Tribal Advisory Committee. A Priority Action team was assembled from across CDC comprised of experts who are seasoned in supporting tribes access and use of public health data from a variety of disciplines such as opioid prevention, cancer prevention, STD prevention, adolescent health, etcetera. The Priority Action team has met multiple times over the past year to define the overall approach and to develop and validate overarching goals and objectives. And we're happy to share those goals and objectives with you today for your thoughts and feedback. Next slide please.

OK, these are the four primary goals of the road map as defined by that collaborative across our friends within the CDC. The goal of the road map cover broad areas in which CDC can support improved access and use of public health data to protect and improve the lives of tribal communities and native people. The goals are intended to lead to actionable milestones that we can accomplish in the short and longer term.
Goal #1 at the top focuses on how CDC can support the modernization of data infrastructure and capacity for tribes, urban Indian organizations, and tribal epicenters to access, collect, manage, analyze, and disseminate public health data. Goals under #1 might include supporting investments in tribes, UIOs and TECs for technical infrastructure improvements. Another example might be developing tools and resources to support data modernization in tribal public health.
Goal #2 has a focus on increasing public health data availability and accessibility for tribes, UIOs, and TECs to support public health decision making through the data sharing and dissemination. Objectives falling under Goal Two might include developing internal standardization data release guidance that maximize data access for partners, tribes, UIOs, and TECs. It could include implementing routine sharing of CDC held data with tribes on a schedule. It could include routinely producing and disseminating analytic findings on the American Indian, Alaska Native population from CDC held data to make data more accessible and available to tribal epicenters, to tribes, and to the public.
Goal #3 focuses on improving the quality of data so that data can be more useful for public health. Examples might include implementing public health vocabulary standards for capturing tribal affiliation and citizenship that align with the HHS policy. Improving quality and completeness of American Indian, Alaska Native tribal affiliation information in public health data might be another objective within that goal.
The last goal is focusing on ensuring the CDC and public health workforce has the knowledge and skills to support tribal, UIO and TEC data access and use. Objectives falling under Goal 4 might include supporting the implementation of strategies that encourage recruitment and retention of Native Data Modernization Initiative subject matter experts to CDC. It could include training and technical assistance available to centers, institutes and offices to implement their own tribal data strategies. It might include improving knowledge and understanding of agency, tribal data management policies for staff at CDC, and ensuring training and technical assistance are available to federal and nonfederal partners in the furtherance of tribal UIO and tribal epicenter and public health data access and use.
We've been, as you can imagine, we've been meeting and thinking a lot about how to improve data, public health, access to data for tribes, for the health and well-being of urban Indians as well. And it's been a wonderful collaborative over the last year. The road map is not intended to be a document that sits on the shelf. This is a, this would be a road map. Map it for a strategy for us to to stay active in continuing to meet our responsibilities related to data.
The next steps for us will be to identify meaningful milestones that we can accomplish in the next 12 to 24 months practically that's what we're up to now that was a very western way of sharing with you about the road map.
Now I am going to ask the Tribal Advisory Committee members to look in your little pouch and Doctor Belai and Dr. Killsback, you also have a little coin. So now we're going to go Indigenist tribal ways of knowing Native knowledge. OK, this is the US mints beautiful Sacajawea coin for this year. And you'll notice that there's a beautiful Eagle staff on the reverse side and the American flag. And this is symbolizing the 100th anniversary of American Indians gaining citizenship in the US So I wasn't there, but I'm on the other side of 50, So I was. My grandmother was six years old when she gained citizenship in the US, right. Now think about that. So we have this goal of having next steps for ourselves to improve as CDC in the next 12 to 24 months. But I want us to all, everyone in this room, everybody. And online in 100 years, where do we want to be? With public health data, what are we leaving for our descendants related to public health approaches? What data will they need? What information will they need to be strong and healthy? So I thought it was a perfect time to share this coin with you today to help us anchor ourselves in time and across generations. OK, so we want to build on our successes that we have shared with tribal partners over the last few years, as Doctor Kucik mentioned, so many examples of successes. And we want to continue to build capacity in Indian Country to effectively use data for public health action and to make these opportunities available for more tribes, tribal epicenters and urban Indian organizations. We have a short time with you today and we are so grateful to you for your thoughts and feedback on our work. And we will also have time to speak throughout the day about the HHS tribal data sharing policy. We are very grateful for your time and of course you know, personally I just can't be more thrilled that we're all sitting here talking about data, which I've been doing my whole life. I love data, I love public health data and it's just been an honor to work with you Jim. I'm very thankful.

41:24 – 42:19
Deputy Chief Bryan Warner: Thank you both Miss Satter and Dr. Kucik, very, very informative and thank you for your insightful presentation and WA-DO for the reminder of where we want to be from where we've come from. Now I'd like to invite all of our TAC members to share any further questions or comments regarding the Data Modernization Initiative presentation. The floor is open for discussions, TAC members attending the meeting virtually. Please use the Raise Hand feature or place questions in the chat box. When you speak. Please remember to state your name twice and the area you represent on the CDC/ATSDR TAC to ensure accurate note taking. So anybody that has any or TAC delegation that has any comments, questions or concerns, don't be shy. Yes, Sir. Second, Chief Del Beaver.

42:20 – 46:27
Second Chief Del Beaver: All right, I guess I'll break the ice and be the first one to speak on this thing. When we talk about data sharing it's I think we all agree that collection of information especially when it comes to health and well-being of our communities it is very important and we agree that you know information though has to be both ways it can't be a one way street. and so when we talk about information sharing with tribes I think it's very important that the CDC not that they don't do it, but really respect tribal sovereignty. We don't like to give out our information just willy nilly so to speak. I think there's it's been in the past some information that we have given out

has been used in a negative manner against us. And so we're very cautious whenever we share information. And so I would like to see that the CDC one acknowledged the sovereignty of the tribes. And then the specific data that we share with the CDC and that anytime the CDC is going to publish any of that data that the tribe share with the CDC that you get permission from the tribes first. We should see that data before it gets out to the public. And that we have a a true inherent right to decline. If that information to be out there, if it's specific, if a case is specific to the Musco Creek Nation then our nation should have that ability to decline if we want the information out there. And that goes for all nations. And so if there's specific information for regarding any nation then that tribal nation has its own sovereignty, and it should the information should be requested that would be shared. Because as you know just because something happens to 1 tribal nation and on the East Coast it doesn't mean it's going to happen where we're at in the Midwest, so you can't lump us in all under one under 1 banner of tribal nations.
So, so that's one, is that you know we want the CDC to acknowledge one our tribal sovereignty and each tribe is unique and the information that we give it needs to be make sure that it's protected at all cost And so and that and that really information is the two way street. You know that whatever information is going in we make sure we could see what information is going out before it hits the public. And, and also you know specifically just to my nation, Muskogee Creek Nation, you know we're we are a, we're not a public health authority but we're we are a tribal health system. And so it is my understanding that there is a maybe a different definition of the two. But and so even though we're not a accredited public health authority, we should be just looked at just as important as one, because we're a tribal health system. And so we have a lot of employees, we have a lot of patients coming in and out every single day. And so I don't see why there shouldn't be any designation as far as being treated differently between a public health authority and a tribal health system. And so it's really if we're putting data in, we should be able to get data out and we should be treated the same. But for now I think that's about all I have as far as the request and concerns. So, so I'll leave it.

46:32 – 46:36
Deputy Chief Bryan Warner: Thank you, Assistant Chief, any comments?

46:40 - 48:59
Dr. Jim Kucik: Thank you for those comments. Second, Chief Beaver, I think that when we as collectively were developing the road map that Delight spoke to, we went through and rounded those in some guiding principles and at the top of the list of those guiding principles for us was respecting tribal data sovereignty. So it is important to us. And as you know CDC and I and I know that the Director has spoken to the TAC on this before, is that the CDC as an agency definitely does respect tribal sovereignty. And so we want that to be one of our active guiding principles in everything that we do around supporting data modernization and data sharing. So I appreciate those comments.
I think that we also recognize that as you were saying that each tribe is unique. And I think as we reach out and engage, we definitely want to respect those differences. And really as subject matter experts come willing to work with you where you are recognizing that your unique needs and the public health functions that you have are different from other tribes, other TECs. And we want to make sure that the assistance that we're providing really is respecting the context of which you're performing your public health functions. So we respect and we certainly acknowledge the differences and as we scale up the technical assistance through the implementation centers that's really going to increase the capacity. And one of the guiding principles of that work is to meet our partners where they are as relates to the ability to receive data, to manage their data, to build the infrastructure needed to use the data. Because we know it's not sufficient just to turn on the faucet to have data coming in that you need to have the solid data infrastructure so that you can manage those data and of course use them to. No sense having the data if we can't use and to protect the health of the community. So we'll have that increased capacity to be able to do that. So we're looking forward to being able to share as I said more details on that as it surfaces it. Thank you for the comments.

49:02 – 51:54
Deputy Chief Bryan Warner: Thank you any other from the Tribal Advisory Committee? And also remember that you can yield your time to a an alternate or a technical advisor or a guest. I'll continue here a little bit.
Brian Warner, Deputy Principal Chief, Cherokee Nation, Oklahoma Area Delegate, you know we talked a little bit. I do appreciate coming from a being a former instructor of chemistry and microbiology examples really make the biggest difference. So I appreciate some of the examples that you've given on what you're doing on the Data Modernization Initiative. More specific elements, what different elements that you have would be helpful in the future. Because I think for me, you know, as a representative of the Cherokee Nation and all of our citizenry, I feel like I'm obligated to be able to explain a lot of what we're doing. And sometimes if we're not in that in that vein specifically if I can get more relatable examples of what we're doing, who you're doing these with that that helps so much because I'm thinking about the individuals that many may not know where Nicut, Oklahoma is or Greasy, Oklahoma. I want to be able to go down there and explain to them because they want to know why do you go to Atlanta why is this important. And I want them to understand the that our government-to-government relationships are so important, so more material that we can share with other leaders, more material that we can share with our health directors that will help that ultimate goal of that understanding. I feel like that's one of my main purposes is to help individuals understand what we're really doing, what's been done in the past, where we're at today. So I do appreciate though you, you both came with some very good information about the tribes that you're working with that the things that are underway. I would encourage this, continue to do that and even more detailed you know to a specific element of where I can take this back to our individuals that go out because we have a group of community health workers that we were able to at Lisa Pivot was able to capture a grant and we started to empower individuals that come from specific communities that then they work within their communities whether it's language, healthcare, career, whatever it is. I want them to understand really that public health is 80% of healthcare. The other clinical side of this is that umbrella that protects and I want them to you know, because they

hear data, they don't necessarily understand that data. Your personal data is one of the hottest commodities on the market today and that is something that is that we hold very sacred and so forth. Another, this is basically a pointed question of around the development of the implementation Center for tribes, like how do you plan to involve tribes and then basically who's doing, who's operating that center and I'll turn it back to you.

52:13 – 54:19
Dr. Jim Kucik: Well, thanks for those comments in the, in the question to your comments. We certainly do appreciate the need for more of that storytelling. We've been working with some of our funded partners over the last year to be able to tell those stories better because we know they resonate. We know that with some of our recipients, whether tribes or some of the TECs is that they're also looking to the experiences of other tribes, not necessarily through some of our state and local public health departments because as Second Chief mentioned earlier, those differences in the contextual factors that just differ. And so we've been thinking through and actually planning our first sort of learning community with our recipients to sort of share the knowledge about how they're using training to sort of upskill their native staff. And so having that forum just to share the various experiences that they've been able to use their data monetization funding to achieve with one another, I think is a powerful tool for the implementation centers. The CDC has awarded through a specific mechanism to three national partners and it's those national partners who are putting out the solicitation for the implementation centers themselves. So the national partners are that will be facilitating the tribal specific implementation center is a national network for public health institutes. And so they're just in the process now of putting that solicitation together. So we don't have information on who the awardee will be for that implementation center. But we do expect that that will be before the next TAC meeting that we will have decided on who that implementation center is and we'll be able to provide that information along with how we can actually plug you into the work of that implementation center because their work is to support data modernization within Indian country. Thank you.

54:19 – 55:46
Deputy Chief Bryan Warner: And just another just a friendly reminder that about you know going to the tribes early and often, I know you, you hear that a lot. But you know I feel like a very important piece of that, you know if it is something that is truly for tribes that that we have them in on the early onset so many times. And gosh, I'm still in my infancy stages when it comes to public health and understanding and being a part of this body. But I do understand in the past not so many times that was not done. And then we, you know tribes can feel slighted on the other end of that because we, you know as sovereign nations we understand our people, we hope that our leaders understand their people across the area. So just another friendly reminder of that as that could be the key piece, the key cog and the will to make sure that I know you the individuals that are going to be a part of that, they want it, they don't want to just work in vain, they want it to be successful. And I think when we come together, Cherokee Nation, we'd call it Gadougie working together that's that is the number one piece of our community values. And so with that involvement that will be paramount to success. Thank you. Any others? Do we have anybody online that Doctor Stanphill, what's that? OK. If there's not anybody else, I'll turn the floor to Doctor Sharon Stanphill.

55:53 – 58:01
Dr. Sharon Stanphill: Thank you. Chief Warner Sharon Stanphill, Portland area. And I'm the Rep at large. Thank you for CDC TAC. I really appreciate the presentation. It was lovely and I've had the opportunity to help with the tool kit. I think that we're on to something really good here and I think tribes are going to be grateful for that as we start to roll it out and pilot it.
If I could shift just a little bit to talking about epidemiology centers and data and access to data and some of these I'm asking these frequent these requests came from back in September and I wanted to ask if we have any answers to some of the questions that we addressed back then. As the CDC is aware the government, the GAO report of March 2020 two reported that most of our TECs, our tribal epidemiology centers face significant barriers to accessing data from CDC and from IHS. And despite being legally designated public health authorities, they're still having to wait months if not years to get some data that's vital. A lot of our tribes in the Northwest, we are building capacity to be able to do our own data at home, but we're still using our NW tribal epidemiology center and starting new projects. So we're having to utilize our TEC and it's becoming more and more difficult when they're not able to access data directly. They have to go through multiple agencies and centers to be able to get the data that they need. And so a couple of my request here is to ask again what additional steps has the CDC and the HHS taken to ensure that they can get direct access to public health data, not just our tribes in the Northwest and across the country, but for our TECs? And then the second question I have is how will the CDC data modernization initiative create simplified and direct access to tribes and TECs with the data that's held here at the CDC? Thank you.

58:13 – 1:01:30
Dr. Jim Kucik: I appreciate the questions and comments. I know that there is to be a set discussion sort of after this session to speak specifically to the HHS data sharing policy for which there was the consultation earlier in the month and then follow up. We can I think return to some of those comments specifically to that data sharing policy in in in response to the GAO report. As for what actions we're doing internally within CDC, the road map project that Delight was talking about is really central to that is understanding that a number of areas across CDC are responsible for helping you access and use data. We want to make sure that we are providing sort of a more internally excuse me coordinated front in doing that and so did the development of this road map is to do just that is understand how we position ourselves better as one agency not individual programs to tackle this issue of making sure that the data are available. Because we certainly share the frustration and it's been visible to all of us when requests first data come in and it can't be handled and we work to sort of navigate and support the release as appropriate of those data. But this is be the first time that we have sort of a road map where we can as an agency put forth a direction where we can actually be more strongly coordinated. Once the HHS travel data sharing policy

has been fully completed, CDC is then looking to then have an aligned data sharing policy developed internally here as well. We recognize that that will take some time and so the work of the priority action team to put together this road map is taking action right now. As Delight said. We want to make sure that we have specific goals over the next 12 and 24 months that we can be accountable for and assuring that we are doing what we can now to increase that access and the ease of use. Because we know that it is challenging to navigate throughout CDC to find where you can access the data, what data are available, what data elements are within those data sets. And we want to make sure that we can simplify and streamline those processes for all of you. I know initial steps were taken to develop some sort of web gateway and directions to pointed folks to in terms of requesting data. So that is up and running and I know that some requests coming through there have been assisted in making sure that those requests are fulfilled, and we look to sort of build that out and make it even a more streamlined and efficient process. Anything to add?

1:01:34 – 1:03:07
Dr. Delight Satter: Well, my additional comment, but you covered everything so well. Again, just to disentangle the GAO report the HHS policy from the work of this body public healthers inside CDC had already recognized there was a need to provide more coordination, support each other internally, learn from each other because you know, we are a whole bunch of centers, institutes and offices. And informally some of us knew who was where and how to connect with them and seek their expertise in supporting this surveillance program or that. But the the new goals around data modernization for CDC have brought that community of experts together in a new way and in with some shared goals. And then on top of that we have the support of things like the GAO report or the developing HHS policy which you know adds more to our internal efforts. I think that's just, I think that's about it that there will be more information later in the day. And then we can also work with the Office of Tribal Affairs and Strategic Alliances to ensure that you know who is leading the point for the agency in in responding to the HHS policy that would be helpful as well. Did we respond to your items?

1:03:13 - 1:03:31
Dr. Sharon Stanphill: Yes, thank you. I realize this is a separate initiative from the policy and such. I just wanted to it's still somewhat the same. It's data and it's sovereignty and I just want to make sure we don't lose sight of that in our project because this is going to this project will roll out to TECs and to tribe. So, thank you.

1:03:34 – 1:03:34
Deputy Chief Bryan Warner: Yes. Second Chief Del Beaver.

1:03:38 - 1:04:12
Second Chief Del Beaver: Thank you Chief Warner. You know, I can't stress enough and I don't, I don't mean to beat anybody over the head with this, but it's all about tribal sovereignty as elected officials and elected tribal leaders, that's my job is to protect tribal sovereignty at all costs. And so, it's nobody can tell our story except for us. And so that's why it's very important that information that we share is protected at all costs because that's our information. And so and Chair, if you may, can I allow one of my technical advisors to talk on the subject.

1:04:25
Deputy Chief Bryan Warner: Yes, you there's a microphone.

1:04:27 – 1:06:0417
Second Chief Del Beaver: Second Chief Del Beaver from the Muskogee Creek Nation. It's an honor to be here with you guys this morning and just to kind of give a real life scenario of what has happened to us at the Muskogee Nation as well as the other tribes within Oklahoma, just to kind of give you the magnitude of what can happen when data goes awry, if you will. Most recently this past year we had our own TECs there in Oklahoma do a mass production of the tribes data without tribal consultation and the use of our own tribal seal as it related to opioid abuse and overuse in the state of Oklahoma. I don't know if anybody is aware of the relationship that we have with our governor, Governor Stitt. It's not the best relationship. And then to add to many of the tribes in Oklahoma have a pending lawsuit and settlement ongoing right now as it relates to opioid use. And so the release and publication of such data without consultation, the potential harm instead of helpfulness that it can be to the tribes is very uncanning. It was unthoughtful. It was very disrespectful and it was something that as tribes we do not appreciate. We did share that with our TEC but that is 1 real life example that can happen. Should we utilize TECs to tell the story of the tribes when it is our responsibility, it's our story, it's our data, the lack of tribal consultation and where we are today. So I appreciate that, but oh,

1:06:17 – 1:10:27
Deputy Chief Bryan Warner: Anyone else to comment, anybody online, well seeing no comments or questions. I do want to thank Miss Satter and Dr. Kucik again for what a wonderful presentation and you know, lots of lots of good comments. And I want everybody to understand we, I think before you get in the car, when we're talking about a road map, we're headed somewhere. That ultimate thing is how do we get in there? And that's understanding of tribal sovereignty. Now how we go, it's a state function on how you get somewhere. It doesn't matter where you come from. It's matters how you're getting there. So our tribes and everything they get to determine who helps them and how they do what they want to do. But the main piece is to make sure that our tribes have been consulted, that sovereignty is understood and again excited about data. We need more people out there. This is why I want to understand more about data, what we can do with data. I want to thank Miss Pivot and her team back home and are working together group because I want more individuals like you two that understand data that work for our tribe that work with our government to go with our federal partners to understand that. So

we have to raise up so Delight in reference to what you were talking about, where do we want to be in the next 100 years? I need a whole lot more data, folks because you know, in our area, our neck of the woods, sometimes oil and gas it, it gets talked about a lot. But I want everybody to understand that that tribal data, it tells the story about you. So we need our kids. We need our youth to understand. So we need to push those individuals gently towards something that is very rewarding because then we're not just throwing a dart at a map. We have a strategy and what we want to do and sometimes our funding mechanisms instead of throwing money at something, we think this might be a good idea. A lot of the times data can tell us that it's a good idea or what which has the better probability of hitting the mark. So again, thank you to our presenters, thank you to those that have made comments very much, very much appreciated.
So at this time we'll be taking a brief break from looks like we're a little bit past 1015, so we'll break till 10:25. We'll reconvene and open the floor for TAC members. So, we will be back at 10:25 and start back with our TAC business at 10:30. So WA-DO and thank you for all that have joined us online. Again, remember that we are in a FACA exempt status, so Tribal Advisory Committee delegates, alternates, make sure that we follow that protocol.
So welcome back At this time. I would like to continue the TAC business part of the day and by opening the floor for discussion on the HHS tribal data policy, the CDC will take notes of what we share and we will continue this part as a discussion of TAC conference calls. The HHS data policy is included in your packet for easy reference. Your input is valuable as we delve into this and understand we have had several comments already, but we want to take a little more time to make sure that we get everyone's input. So the floor is open for any questions, comments and as you see on the board that is the business items and priorities update that we need to get through hopefully before our CDC Director gets here. Yes, Sir. Go ahead Captain Killsback.

1:10:30 – 1:33:55
Captain Damion Killsback: Thank you, Deputy Principal Chief Warner. So you are aware that we are actively recruiting for our TAC or CDC TAC membership? TAC is composed of 17 delegates and alternates and fairly recognized tribe each acting on behalf of his or her tribe. Fifteen of the 17 IHS service areas and national at large member delegate seats are currently filled. We were actively recruiting to fill the remaining vacant seats for Nashville and Portland, Portland delegate positions. Regarding the alternate seats, there are currently 9 vacant positions open in Albuquerque, Billings, California, Nashville, Portland and four national at large member on the ATSDR. It is imperative to highlight that the alternate alternates are now allocated to have tribal affiliation matching that of their delegate. For a comprehensive grasp of the alternate role, please refer to the charter which is included in your in your packet here. Information for the recruitment can also be found on the CDC Health, Tribal Health website. We'll share a link in the chat box.
If you know of any Tribal leaders in the areas that we would like to be, be great contributing members to the CDC/ATSTR TAC, please encourage the area to nominate him or her. For any TAC member who did who do not have an alternate we strongly encourage you to begin seeking elected officers of a tribal government or a designated representative in your respective IHS areas. Just a reminder that the TAC charter, a designated TAC delegate must be qualified to represent the same area as a TAC delegate, but does not have to have the same tribe as a TAC delegate. The TAC nomination process candidates must be nominated by an elected tribal leader via nomination letter. Submissions must be signed. Nomination letters on the official tribal nation letter head with the following information sent to the tribalsupport@cdc.gov e-mail box. Name of the nominee, nominees official title, name of tribal nation, name of nominee's election to official tribal position and term length, nominees contact information, e-mail, mail address, phone, fax and e-mail. Name of elected officers submitting the nomination, official title of elected officer not submitting nomination, contact information of for elected officers submitting nomination and or administrative officers that tribal government confirmation that the nominee has the authority to act on behalf of the tribal nations. Is qualified to represent the views of the tribal nations in order in the area for which he or she is being nominated.
Please be advised that no active subcommittees are currently formed at CDC/ATSDR TAC. Deputy Principal Chief Warner, we would like to allocate time to just discuss in the potential formation of the subcommittee to address a specific priority area identified by the TAC. If the need arises to establish the subcommittee will, we'd appreciate the opportunity to double to the possibility to define the scope of our discussion. I would like to yield the floor back to Deputy Principal Chief Warner.

1:14:00 – 1:15:27
Deputy Chief Bryan Warner: Thank you, Captain Killsback. And I want to back up a bit and make sure that our TAC delegation gets in time for the HHS tribal data policy. In your packet, if you can turn there, there's a Dear Tribal Leader letter explaining some of the things and we also understand that we had multiple consultations. But I just want to remind everyone that the CDC team will take notes of what we share and we will continue this discussion as part of our TAC conference call. So if there's any comments, any concerns regarding this and just to help everyone along, there's certain feedback on the following questions, which HHS divisions with tribes and TECs anticipate they will seek data from under the initial implementation of this policy. The policy will apply across the department. However, not all divisions have yet full assessment of whether they have custody or control of data covered by this policy. That's just one question. There's several others there. I want to make sure that we spend some time getting those notes and remember you can yield the floor to your technical advisor, So Captain Killsback.

1:15:29 – 1:16:55
Captain Damion Killsback: Thank you. During our last meeting, we explored the idea of adjusting the frequency of our monthly calls to better align with everyone's availability in 2024. The goal is to ensure that the majority can participate and contributed effectively. Instead of holding meetings every month for 60 minutes, we considered a more strategic approach, proposing to have bi-monthly meetings lasting 90 minutes, which will allow us to delve deeper into discussions. They make meaningful progress towards their goals and document results efficiently.

Based on our feedback received via the MS form, we refine the proposed meeting scheduled to include the four most popular options. Option one: Tuesdays from 2:00 to 3:30 PM Eastern Time the first week of each month. Option two: Tuesdays from 2:00 to 3:30 Eastern Time, Third week of each month. Option three: Thursdays from 4:00 to 5:30 PM Eastern Time, second week of each month, and the fourth option: Thursdays from 4:00 to 5:30 PM Eastern Standard Time, 4th week of each month. These options aim to accommodate the preferences expressed by all TAC members, ensuring optimal attendance and engagement during the conference calls. Deputy Principal Chief Warner, I would like to formally request that we elevate the discussion to a formal vote. This ensures that the decisions are made collectively and efficiently. I yield the floor back to Deputy Principal Chief Warner.

1:16:55– 1:19:22
Deputy Chief Bryan Warner: WA-DO Captain Killsback. At this time, I would like to give the TAC members the opportunity to ask questions or share comments regarding the cadence of a monthly call. TAC members attending this meeting virtually please use the Raise Hand feature and I want to remind everyone that a poll was sent out via e-mail. OK, if you have already completed that poll then you have casted your vote. If you have not filled out or you are unsure you can do a paper vote and a member of the OTASA group will pass that out to you. So that's just a reminder Anne Marie, go ahead thank you. And so we can do this and and you know obviously if I'll just give you one example, I, I like it everybody else to fill in the time and I'll make sure that I can be there.
You know that's kind of how I roll. So, if there are no questions, I'll kick off the voting process and ask you to fill out that survey and we can pick those up once you have completed those. And this just gives us the cadence of what we want to do and just being mindful some of these days work better for some than others. You know, we've got council meetings and each respective tribe operates a little bit differently from one another. So I try to make my schedule based on what everybody else needs to do. So you go right ahead and fill that thing out how you need to.
OK, So with that, once all the paperwork or the paper voting is completed, reviewed Captain Killsback and I will confirm the findings and share them with the larger TAC. Due to our packed agenda, we plan to present the results following an update on the 28th Biannual CDC/ATSDR meeting from Doctor Sharon Stanphill, Doctor Stanphill PHDRD, Chief Health Officer of the Cow Creek Band of Umpqua Tribe of Indians. The floor is now yours for an update on the 28th annual Biannual CDC/ATSDR TAC meeting. Doctor Stanphill

1:19:22 – 1:20:50
Dr. Sharon Stanphill: Thank you, Chief Warner. Sharon Stanfill Rep at large on the TAC, Cow Creek band of Umpqua Tribe of Indians. Thank you. Well, we are excited to host the next meeting. As you can imagine, it's a lot of work. We are located in Southern Oregon. That's our homelands and we are just really, really doing the best we can. We're working with our other tribes in Oregon as well as Emery. She's just been wonderful. We have most of logistics taken care of for your visit and for us to be able to share our homelands and to share some of the new programs that we have developed around not just public health. But around a natural resources fire mitigation and things like this that you might find useful and helpful in the Northwest. So we're super excited. We don't have the agenda ironed out. Of course, we're waiting until after this meeting and trying to gather what information we need to to be able to make sure that we have a robust agenda. And just a little bit to let you know, we at Cow Creek stood up a new public health department and we are, we're very close. We finished the pathways program. We're very close to being accredited with that program. So these will just be some of the highlights that we'll be sharing with you. We have a very nice tour that we're going to take you on and just show you some of our part of our homelands and our traditions and culture. So we're excited about that. If anybody has anything they'd like to make sure we don't forget, please see me because the six months comes quick.

1:20:58 – 1:22:30
Deputy Chief Bryan Warner: Any questions for Doctor Stanphill? I thank you Doctor Stanphill very much appreciative of you and your time your talent your dedication. Can't wait Oregon that it's beautiful year-round. So and we have many, many Cherokees in that area. So happy to get back up there and but so thank you all for participating in the voting process to determine the optimal cadence for the tax calls.
I think we'll, I'll see, we have not collected these votes. So if you are, if you have voted, we will collect those and tabulate that information. Once we tabulate these though, we'll make sure that everyone gets an updated calendar invite. That way we can get all this on everyone's calendar to make sure that we're operating in the best capacity that we can. Captain Killsback. I'll go ahead and throw it to you so we can continue on.

1:22:34 – 1:23:22
Captain Damion Killsback: Thank you. Deputy Principal Chief Warner, the 29th Biannual CDC/ATSDR TAC Meeting is scheduled to take place in CDC Atlanta, GA. Two potential meeting dates are under consideration for February 2025. Option one, February 19th through February 20th, 2025, which is a Wednesday through Thursday. Option 2, February 26th through February 27th, 2025, which is a Wednesday through Thursday. I would like to formally request we conduct a vote to determine the most suitable meeting date allowing ample time for planning processes. Thank you.

1:23:26 – 1:23:48
Deputy Chief Bryan Warner: OK. Miss Church, I believe you have your hand raised. OK, recommended February 26th and 27th. Thank you, Captain Killsback, how would you like to? Do we want to just option one,

1:23:55
Captain Damion Killsback: Yes Sir, I believe that'd be a efficient way to conduct the vote.

1:24:00 – 1:25:11
Deputy Chief Bryan Warner: Thanks. All those that would like to see option one, February 19th through the 20th. And if you do have any concerns on any of these dates, if you can see that far into the future of what might be going on, let us know. But option one right now is on the table. So those who would prefer option one, please raise your hand. Conrad Jacket. Raise your hand. Thank you. OK, option 2, February 26th through the 27th TAC delegation. Yep. Thank you. And Gerilyn Church also says the first date may conflict with IHS budget. So there you go. That was our. Yep. So that is perfect. So it looks like. Captain Killsback. If you want to go ahead and confirm what you've tabulated.

1:25:11 – 1:25:30
Captain Damion Killsback: Thank you Deputy Principal Chief Warner. Looks like we have 11 votes for option 2, which will be February 26th and February 27th of 2025 for the 29th Biannual CDC/ATSDR TAC meeting. Thank you.

1:25:31 – 1:27:31
Deputy Chief Bryan Warner: Thank you. And do we have a tabulation on our cadence yet? Not yet. OK, thank you. Well, I know I see it this time that we are awaiting the arrival of Doctor Cohen to give us the Director's update. During this time I would like to open the floor if anybody has any anything that they would like to talk about on the HHS data policy, anything that we've discussed thus far, remember that our CDC partners here are taking notes and they will take all things into consideration. So but I see none and I will go back over here doctor or excuse me Captain Killsback did talk about subcommittees. There are no active subcommittees that are formed. I know in our TAC monthly calls we talk a lot, a lot about a lot of different things. Is there anything that we can think of, You know it seems to me that the data piece cumbersome is not a good word for it, but I mean we want to get that organized there. There's some other things that may be on your mind may be coming from your point of view from your tribe or your area that may warrant a subcommittee that be formed. So I would like to allocate a little bit of time while we're waiting for any discussions on a subcommittee and may ask somebody from the CDC, Captain Killsback or anybody what that subcommittee formation would look like and the formalities of that. If anybody has any information on that, I would be all ears.

1:27:42 - 1:28:13
Captain Damion Killsback: Oh, thank you. So yeah, we'll have to look at in OTASA on what we can look at in terms of which center can help us with forming such a subcommittee. And so I'll have to take that back with my leadership and see how we can help support any type of foremost I guess formal formation of a subcommittee to help support whatever the TAC priorities may be. Sound like data is the is a big, the big issue right now. So we'll strategize with that. Thank you.

1:28:15-1:29:58
Deputy Chief Bryan Warner: Thank you, Sir. Yes. And it does data seems to be one that I think it would be very helpful especially for myself to have our technical advisors set on some type of subcommittee that they could be organized like that. That way we can get that grapple, that understanding and move forward and make sure that we get the vehicle right.
Well, moving on to our cadence of our, our TAC, the frequency, our calls. Excuse me, which day. It looks like the final option on our calls will be Thursday from 4:00 to 5:30 PM Eastern, the 4th week of the month. So that was the vote that was taken. And so again, that is Thursdays from 4:00 to 5:30 PM Eastern Time and that will be the 4th week of the month. So thank you all for voting and we will make sure that we get that information out to each and everyone. So, all right.
OK. Well, thank you all and for that promptly, right on time, actually 5 minutes early. So WA-DO for that. Thank you.
So I want to turn the floor over now to Doctor Mandy Cohen, MDMPH, Director of the CDC administrator for the Agency for Toxic Substances and Disease Registry. Yes. So thank you, Doctor Cohen, for joining us. And the floor is yours.

1:30:01- 1:51:25
Dr. Mandy Cohen: All right. Well, hi, everyone. Good morning. Good to see everybody. Thanks for having me in person, Deputy Principal Chief Warner. I appreciate that. I want to acknowledge our team who is here that supports all of our tribal work. I don't know if I see Doctor Dauphin, I just walked in. Oh, she's in, in, in and out. Oh, there she is. Hello. Who is my who has just been such a wonderful leader and continues to be just in her leadership of the infrastructure center. A great partner to all of those who we're working with. Wanted to say hi to my friend Connie, who I'm going to be visiting next week in Chickasaw. And sorry I missed you because of the snow the first time. But second times we're going to, we're going to get there. Yes, all right. Historic snow kept me away from Chickasaw couple weeks ago, but we're going next week. But it's great to be here for my first in person meeting just in by way of introduction, if that's OK, Deputy Principal Chief, since my first time with the committee, just a little bit about me and my background. So I'm a physician by training. I'm a primary care doc. But I've spent most of my career in the government space working either for the federal government or the state government. I was here working at the Centers for Medicare and Medicaid Services during the implementation of the Affordable Care Act. I ran the insurance exchanges. I was at the Innovation Center and ultimately was Chief of Staff and Chief Operating Officer for CMS over 7 or 8 years. And then I went to North Carolina where I was Secretary of Health and Human Services in North Carolina for five years. Opportunity to work with many different tribes in North Carolina, spent significant amount of time out in Cherokee in North Carolina and working there. They've made some incredible investments in their health infrastructure there, and I was I had stepped down from that role after

5-5 years, 2 pandemic years, and got a phone call asking if I would consider coming back here. And it was an easy well after I talked with my husband, it was an easy yes after talking about the family implications.
But I'm so grateful to be back in government service and working at CDC on such an important mission to protect the health of this country and really the world and grateful to be with you this morning. I want to make sure that you hear directly from me to since it is my first meeting to reaffirm the commitment of our government-to-government relationship on behalf of CDC. I know there's been a lot of good work and I think actually CDC is very good at we do a lot of global work and government-to-government interactions and I think we bring that asset to this work as well. I want to make sure you hear from me that we support and respect tribal sovereignty and self-determination for tribal governments in the United States. And I look forward to making sure that we have great collaboration as we all work to protect and improve health across all of our the folks that we serve.
So I thought I would start by talking a bit about our priorities for 2024. I wanted to spend some time celebrating what we did in 23, but I think best to look ahead to 2024 and maybe I'll throw in a few ways in which I'm proud of, proud of the team as we're going forward. You know we have 4 priority areas and the first one is as we come out of the pandemic and have learned some very important lessons about how we can be the most effective CDC possible. One of the most important is that we CDC operate as one team and that we focus on collaboration, equity and accountability. We know that we have to be great partners. We cannot. Protecting health is a huge and enormous mission. We cannot do alone. That has to be a partnership and collaboration, whether it's our government-to-government priority partnership and our tribal partnerships or ones with our states, the healthcare industry, the private sector or others. We have to do that collaboration. Equity needs to be at the center of all of the work that we do. CDC is grounded in that. I'm actually incredibly proud to join that organization and I see equity embedded in every piece of the work that we do. And I want to talk about some of the ways in which I was really proud to see that equity work shine, particularly related to tribal, tribal work and accountability. Impact matters, right? And moving the needle to improve and protect health is what we need to hold ourselves accountable to. We have to recognize the unique public health needs of American Indian and Alaska Native communities as we do that work. And we are certainly committed to making sure that we have regular and robust tribal engagement. And I know that our new leadership is going to make sure that we can continue some of the important work that we've done together whether that's the Healthy Tribes program or the Tribe of Public Health capacity building and quality improvement cooperative agreements that structure that allows us to do our work together or others. And I'm going to talk about related to our data work or grants governance board to make continue to make improvements. These are all part of the foundation of us, CDC being a great partner to our tribal, our tribal communities.
The other priorities for us as we work forward are to think about making sure we are ready to respond to any health threats whether that's a respiratory virus or a wildfire. We need to make sure that we have the core capabilities or the infrastructure to respond to any of those threats and we cannot do that. Again, if we do not have partnership, I want to acknowledge the incredible work that tribes did during the COVID pandemic. I saw it first hand in North Carolina. But I've certainly heard from our teams about how much work has gone in to protect your tribal communities. The vaccination work that was done is really incredible. So thank you for that. And so how do we take that and think about what is the readiness and response that we can continue to do together as we look forward road into 2024 and beyond. The good news from a from a COVID perspective is we are in a different place. Luckily, we not only have the tools to protect folks like vaccination and testing and treatment, but we also know from the science we have underlying immunity across a population that were 98% of us have either gotten vaccinated or had COVID. And that puts us in a different place in how we can think about COVID going forward, which is great. But we need to make sure that we are continuing to use those tools. So as we think forward to the future, how do we continue to have vaccines not just scientifically available but actually truly accessible to folks? I think you know the CDC stood up in record time the Bridge access program that allowed for free COVID vaccines. I know we worked very closely in partnership with tribes and the Indian Health Service and others to make sure COVID vaccine was available. And for the first time we in this season we had vaccines against RSV. And as you know RSV is something that impacts our Alaska Native and American Indian populations in a different way. We know that babies that are American Indian or Alaska Native have higher risk of having bad outcomes if they get RSV. We see it in our data. Again that is CDC data and work that we've done together to understand that. And so when this year for the first time we had an RSV immunization for our babies, I was really proud of the team to make sure that we were doing focused work with with you all to make sure we were recognizing that disparity that was out there in terms of severity of disease for RSV. But that when. So for example, we reached out and you all gave us input ahead of our vaccine advisory committee meeting to make sure that they recognize that difference and it got embedded into the recommendation. That came out for babies and young children. And so it meant that every child through the VFC program who is under 20 months can receive a shot for free. And that is different than the general recommendations for the population, which is any child under eight months. So we recognized a difference in the disparity. We use that data to make different differentiated recommendations and that flowed through our work and our operations. And then you may know we had some supply challenges with that RSV immunization this past year. So the manufacturer did not make enough supply. And so when we saw that again recognizing the disparity in which the virus impacts our American Indian, Alaska Native populations, CDC immediately went to make sure that we could get that immunization to those communities in a preferential way. So we wanted to make sure that even with that limited supply that we still got the supply to those who are at higher risk. And I know that again that was a great partnership and a way in which you are seeing our data, our partnership and then the operations all come together to make sure that our tribes are represented, are seen in all of our policies and recommendations and most importantly that our children are protected. So I was really proud of that work and again thank you for that that partnership. And I hope you will just see that as an example of how we can continue to do our work in terms of response effort together to actively work with our colleague, all of us to make sure that we are doing it. I think that is something we need to take now for example to our work in syphilis. We also know there is a disparity there and how can we also use our data, statistics, collaborations to make sure

that we are reaching appropriate populations. So that's one big area of work, our readiness and response that we do here at CDC and again takes partnership.
The second area of focus is around improving mental health and particularly making sure that we are getting upstream and preventing mental health challenges and particularly preventing overdoses and preventing suicides. We are making where as in the response area that is where CDC is certainly the quarterback mental health. As you know there are a lot of important partners across the United States government who are thinking about improving mental health right here at HHS whether it's SAMSA, HERSA, CMS, all thinking about improving mental health. But CDC has a unique role to play in improving mental health by bringing the best data, evidence and best practices to bear and partnering with folks. And so we're making sure that we can partner together, that you all have the best data and evidence and tools to protect your communities from overdose, suicide, and other mental health challenges. The last area of focus is in supporting young families. So we had response and readiness improving mental health. And the third area focus is supporting young families. And this is where I think our prevention work really shines. We are Centers for Disease Control and Prevention and IT We need to get upstream to make sure that our communities are the most healthy they can be, whether that's protecting mom while she's pregnant or having her baby and thinking about maternal mortality. I know at at your last meeting you got an entire briefing on that maternal mortality review. So thinking about protecting mom during pregnancy or it's making sure our our kiddos get their routine vaccination. The good news is we continue to see high vaccination rates. 94% of children are getting their vaccinations, but we cannot take our eye off the ball. are seeing in the news the cases of of measles and others we don't want to forget, but we also have to make sure that our parents are the caregivers are also healthy, right? So thinking about are we supporting our parents, making sure we're doing things like diabetes prevention, making sure that we are doing that work on smoking cessation, right. So that is where this work goes. To support young families really helps us. So those are the three areas of main focus. After focusing on making sure CDC is the best partner it possibly can be to you all.
I wanted to touch on two other issues, just knowing that there were questions the last time. And so maybe I could talk about those two areas in anticipation of some questions here. One is around data and the other is around the grants process. And I met with STAC leaders at the HHS STAC meeting and we talked specifically about these two issues amongst others. And I continue to appreciate the feedback and conversation. First around data access, I really appreciate you all leaning in and helping improve our data access and quality and giving feedback. Particularly when there we needed to hear some hard feedback where policies may have been going in the wrong direction and we needed to you know maybe put that aside and start over and that's OK and say what do we need to do. We I think are investing in the tribal epidemiology centers and trying to understand the complexity of then in yet introducing yet a new entity into the to the mix on the data quality and data sharing issues. So need to work through that, but we're putting a lot of focus on improving our data infrastructure that I think lifts all of us as we do that work. And so I want to say out loud that we recognize the importance of sharing data with our tribes and making sure that we can get to a place where where you are seeing the data you need for your communities to keep them healthy. And so we are working on ways to streamline our processes to respond to data requests as well as our tribal epicenters so that we can facilitate that data access and transfer in a timely way. We continue to support from a dollars perspective investment in some of the data modernization efforts. And I know you're going to hear more about it or I don't know if it where in the agenda it was, but from our head of our data work from from Doctor Jen Laden, but we are continuing to provide some investment of dollars. We provided $750,000 across 3 tribal public health partners in 20 since 2020 and we've invested more than seven and a half, $1,000,000 total across 26 partners, but made additional investments this past year. I know that there's been some great work. I had some examples from the team around Northwest Portland area Indian health Board that implemented A strategic framework for guiding the future of data modernatization or the little shell tribe that invested in modernized technology as a foundation to manage that data or the other work that we're seeing across tribes. And you know we recently you know that CDC participated in a tribal consultation on that draft tribal data management policy. And I just want you to know that we we heard that input from tribal leaders regarding their tribal data use and access concerns. So like I said, we we're hearing that feedback and really are thinking about it. That was an HHS data piece and I think we are learning lessons from even that feedback to HHS as we work on our data and tribal data management policy here. And so you're going to hear more about that, but we hear folks on needing to make sure that data accessibility is part of what you what you need on the grant side. I want to acknowledge the feedback that we have heard that the grant process itself has been burdensome. I know Doctor Dauphin has shared with the TAC that we did establish an internal grants governance board to look at how we can streamline and improve the process. I know they held a tribal listening session on December 6th to receive input some of the things. So you know that are on my radar and I heard about the need for to account for the differences in tribal governance as well as the delivery systems. So that we just have to think differently about how the funds flow as well as the models of how we think about that together. So again this is going to need to be a collaborative process because we we of course because we all, we all have folks who are, are our bosses. We certainly need accountability for those dollars. But we have to recognize the differences in how you all and the tribes are working and we want to be good partners there. So I wanted to commit to you about how we will continue to work on improving that process. That is not something that is exclusive to tribes. We want to be improving that grant process for our state partners and our local localities as well and but we have more work to do. So thank you for all of that feedback.
In closing, again, I just wanted to reinstate how important the government-to-government relationship is with our Tribal Nations and reaffirm our commitment to open and transparent communication. I wanted to thank our teams at CDC. Again, I think they are continually working hard to represent the feedback that you're hearing and to work through and solve problems. And with that, why don't I stop there, and I welcome feedback and input from leaders. And then I'm certain I will learn even more next week when I'm on the ground in Chickasaw.

1:51:31 - 1:57:44

Deputy Chief Bryan Warner: Well, thank you, Director and from the TAC delegation of all of us, it's an honor to have you here and we're very appreciative of your time. And you know, there's so many things. Before I open the floor up to the TAC delegation, I just have a few comments and things to say.

As you may know, Tribal Nations are sovereign governments obviously recognized under the Constitution of the United States. Treaty statutes, executive orders and court decisions has the population with many of the most severe health inequities and the only population for the United States for which the United States has legal responsibility for health. The CDC leadership must continue to prioritize its relationships with tribes and improving the health of our people. However, there there's been times where we may have experienced or heard of experiences or examples where the CDC operating divisions either neglect tribes or engage inappropriately with Indian Country. We just we feel strongly that more training and strengthen policies and commitment are needed across the board to ensure that all CDC directors and their staff understand and prioritize the government-to-government relationship and the federal trust responsibility for Indian health. We feel that the purpose of the CDC Tribal Advisory Committee is to be one of the tools used to facilitate to government-to-government relationship your good faith. Robust engagement with the TAC is an excellent way to lead by example and demonstrate that Tribal Public Health is a priority for the CDC.

I have a few other things that I would like to add. We First, the CDC must consult with the tribes on the execution of Executive Order 14112 and reform agency policy to design and administer federal funding and support programs for tribal nations in a manner that better recognizes and supports tribal sovereignty and self-determination. This means providing direct funding when possible and working with Congress to revise any legislation that stands in the way of promoting tribal self-determination.

Now second and I call this the, it's kind of the one-size-fits-all thing that we've found ourself in when it comes to tribal, public health infrastructure funding. All of our tribes that are represented here are unique. When you, when you think about Indian Country, I want you to think about the totality of the United States, all of that land that exists that is Indian country. So when you visit and you drive you are an Indian country. And when you I appreciate you going to the Chickasaw Nation and encourage you to go see other nations. Because when we start talking about funding, you don't always think about money. And money is not the root of all evil, but the love of money is the root of all evil and we don't want to fall into this, these pitfalls and so forth. So when you think about tribal public health infrastructure, I still want you to think about that tribal government because that tribal sovereignty is what dictates out of that. And then you know we have these function, these things that were set up like tribal epicenters. We have our tribally led organizations, NIHB for example. These organizations are very important to what we do. Some tribes when you think about tribe funding you think about that direct funding to the tribe and we want to make sure that we ensure that we always instill that idea because tribes know best what to do with their money and other tribes need it at this moment in time. Public health capacity is different for each tribe. Some are on a on a level just just because of the fact of where they were situated and what's happened to them. Other tribes need that help. So I want to make sure that that that is the overarching thing when it comes to implementing the growth necessary to build our public health institutions. You think about a tribe, the funding that's troublesome sometimes is when we see funding that goes to help tribes that goes to a nontribal organization that becomes problematic. That's up to each individual tribe when you when you think about that. So that direct funding stream to these tribes is very important when you talk about our government-to-government functions when it becomes funding.

Third, we feel the CDC must use every tool available to improve tribal access to essential public health data including ensuring any new or revised data use agreements with the with States and other jurisdictions support that other jurisdictions support tribal sovereignty and tribal public health data access. When I think about data use agreement, we, Lisa Pivot and our team at the Cherokee Nation has been interested in looking at these data use agreements because we understand you have them for the States and states often do not have to have the tribes come to the table but they yet they get to use our data. But when we to get the funding we've got to go see you know information from the States and sometimes it just depends on the the relationships that are going on a lot of times in that and I know our time is of the essence and I know many others have things that they want to say.

Lastly, the CDC must elevate and prioritize relationship with tribes though through improved consultation, engagement with Tribal Advisory committees and by elevating the Office of Tribal Affairs and Strategic Alliances within the Office of the Director. You know, I was looking earlier Director calling at the number of vacancies that are within OTAs and sometimes that becomes problematic. I don't know what that issue is, but I feel like if we elevate this and we have that under the office of Director, I, I think some of the cumbersome things that we all encounter will become less cumbersome overtime and less bothersome. Those are just some of the topics that I have and I do want to before I go to our other TAC delegation, I want to give Doctor Dauphin a moment of time. Yes, ma'am. Thank you.

1:57:44 - 2:00:38

Dr. Les Dauphin: Thank you Deputy Chief. I really appreciate it And Doctor Cohen want to thank you for your leadership. We are very fortunate and that we have a director that is so supportive of CDC's work with tribes and tribal serving organizations and actually demonstrating her commitment to support tribes and TSL's through her presence and engagement and making clear expectations, setting clear expectations for CDC leaders, particularly our center and our work across the agency. I did want to just speak on two of the topics that Deputy Chief Warner raised just for awareness of all for all the 1st is realm OTASA and I thank you Deputy Chief, for raising and elevating that. We do have a number of vacancies in CDC's Office of Tribal Affairs and Strategic Alliances and I want to highlight that one of the reasons in which you see that we have vacancies is that, one, we want to make sure that we get the right support to help with what you mentioned in educating and working with our colleagues across the agency and in that government-to-government space and in the interagency space. The second is I wanted to highlight that we've actually allotted more positions to the office because we recognize that we needed more staff to support this important work. So that is another reason why you see the vacancies there. We are delighted that under Captain Killsback's leadership that we will be able to attract and retain the right staff to help

our Office of Tribal Affairs and Strategic alliances be helpful. I did want to also raise the point about strengthening our interagency relationships. One of the things that we've been able to do recently and also with the support of Doctor Cohen is affirming our relationships at the interagency level. When we met last at our TAC meeting, it was raised that CDC should be out working more with other agencies like the Indian Health Service Services and CMS. On working on policies and practices that will benefit tribes and tribal serving organizations, I wanted to tell you that we have heard you and since that time, CDC has been engaging very closely with IHS. In fact, just last week we met with them to talk about some of our work in the immunization space. So I did want to address that before we get on to our tribal leaders. I know that Doctor Cohen is here for a moment and I just wanted to say publicly to all of you that we are really fortunate to have a director that's really showing and demonstrating her commitment to our work in this space through her time and effort and through her leadership. And Deputy Chief, I will turn it back over to you to facilitate questions from our TAC members.

2:00:45 - 2:01:22
Deputy Chief Bryan Warner: Yes, thank you. Doctor Dauphin, much appreciate it as always. Your comments are always very much on point. Director Cohen, do you have any comments before I turn it? OK. All right. TAC delegation, the floor is open. So remember if you are on virtual, please use the raised hand function. Also reminder, state your name, the area that you that you represent. And at one more reminder, you can defer your time to a technical advisor. So the floor is open. Doctor Stanphill.

2:01:23 - 2:03:29
Dr. Sharon Stanphill: Thank you, Chief Warner. Thank you for attending. Appreciate it. And happy to get to know you better and to know your investment in your dedication to Indian country. I'm Sharon Stanphill. I'm the Chief Health Officer of Governmental Affairs for the Cow Creek band of Umpqua Tribe of Indians. And I'm the Rep at large on the TAC. And the first thing I wanted to bring up I think kind of the foundation of the TAC and I want to re-emphasize what Chief Warner stated about the foundation of this TAC and the value and expertise that we bring. It's just it's just one piece of the government-to-government. It doesn't by any means substitute for government-to-government relations and consultation with nations urbans and confer and such. But it is one means and I appreciate that we have this committee something that is, really important is because we do we wear a lot of hats and we come and we're trying to bring our expertise here and help represent our nation's is financial support to technical advisors. And with us in the room is our Northwest. I mean I'm sorry our national Indian Health Board and these folks help us. They invest nearly $100 probably more than that to get us prepped for each of our meetings. They help our Co-chairs. They help our TAC members. They provide us. We have caucuses. We prepare talking points and we get ready for the meeting so that we can use have good use at the time and they used to in the past we funded them the CDC and that hasn't happened. The vast majority of the work they're doing is currently going unfunded. It would really be great if we could have a commitment that they could be funded, that we would have their time and getting ready for meaningful engagement, that we could have that commitment from the CDC for our technical advisors. Thank you.
2:03:32 - 2:03:39
Deputy Chief Bryan Warner: Thank you. Doctor Stanphill. Any of our other TAC delegation? Yes, Sir.
Assistant Chief Del Beaver.

2:03:42 - 2:06:40
Second Chief Del Beaver: Good morning. Doctor Cohen, I appreciate you being here this morning and just this this group's probably going to get tired of me saying this. But if I'm going to say it once, I'm going to say a dozen times it's about tribal sovereignty. And you know, there is a trust responsibility that the federal government has to all native nations and that while I'm sure tribal epicenters have served a purpose, you know, we're not a tribal epicenter we are a health system. You know we have, we have a very robust health system and I can't speak on behalf of the other tribes in Oklahoma, but I can just, I can attest to them though just by my viewpoint and my perspective And that and I think a lot of tribes would agree with me that back in Oklahoma when COVID came down and the vaccines came down, the tribal nations were the first ones to give out the vaccine and we did it in a better manner. We were more in a better-expedited manner than the state did. We were at the forefront of these things. And so that to me that's a that just gives credence to that. When there's something wrong in our communities, the first ones to know is us, not the state, but it's us. There's not private entities investing millions of dollars of healthcare into our rural areas. It's the tribal nation investing millions of dollars into rural areas and nobody else for 10 years. There's rural hospitals closing in Oklahoma while the tribal Nations were opening health clinics in Oklahoma. So. So if you want to talk about investment into our communities, it's the tribal nations. And so I was looking at the CDC's mission and help us help you. That's what it boils down to. If you want to know what's going on at the local level, it's the tribes that's going to know and nobody else. And so because really that's our mission is to protect our people and to serve our people. And so, so this goes right along with the CDC's mission that this goes hand in hand in what in what we want to achieve. And so if that line of communication directly to the tribes can be improved however that may look, it would help the CDC's mission. I guarantee it. And so, so I just would like to say that on record is that the tribes know what's best for our people. The tribes know what's best for our communities. And if you want to know CDC wants to know, come ask us. That's all you have to do. But like I said, yes, if you just observe and and from our viewpoints and Chief Warner you can attest to that also. Tribal nations, we are it when it comes to rural healthcare in Oklahoma. WA-DO.

2:06:40 - 2:06:43
Deputy Chief Bryan Warner: Thank you. Second Chief. Yes, Mrs.Frias.

2:06:43 - 2:09:35
Councilwoman Hermina Frias: Good afternoon or good morning. Thank you Doctor Cohen for joining us today. I'm Councilwoman Hermina, Frias TAC delegate at large and also council member for Pascua Yaqui Tribe. I just want to, I know that you talked earlier about the grants process and you know, you talked a little about, you know, you understand the burdensome process around that. But I just want to emphasize a little bit about that too. Because you know, going back to also what Second Chief was talking about as tribal governments and sovereigns. You know, we still, I don't think it's still recognized about how burdensome it is. You know that there isn't that passed through and we're still not recognized as sovereigns in some in, in, in some sense when it comes to that, that we still have to go every year and go back in or when the grant expires and ask for this funding again. When states are just getting passed through or for funding. And it is burdensome. Because if you don't understand the process as a tribal leader, they've got to go back and they've got to reapply and they've got to go through a whole tribal council meeting and you've got to get all of these things done in a short timeline sometimes. And I, you know, as our tribal council, we're pretty efficient. You know, we have regular council meetings and we can get stuff done. But you know things happen and it is burdensome. So, the fact that it's not recognized as that we are sovereign and that the states are in these in logistical matters like this is it is still unbelievable. So, I just want to emphasize that because we are talking about public health, we are talking about people, and I know you understand that. And you know when it comes to these resources and this funding, it's about what we're doing to take care of our people. And so, it's about what we're doing as leadership to ensure that this is a process that's taken care of and so that the people that are actually doing the work are taking care of our people. So what is it that we need to do to ensure that we can finally get that pass through and we don't have to go back after the grant expires and that it is the same process that states have been getting every single time and that equity that has been talked about is really there. Thank you.

2:09:38
Deputy Chief Bryan Warner: Thank you Council Lady Frias any other of our tribe.

2:09:44
Dr. Mandy Cohen: Do you want me to maybe

2:09:46 – 2:09:48
Deputy Chief Bryan Warner: Yes, yes. Yes ma'am. The floor is yours.

2:09:48 – 2:11:55
Dr. Mandy Cohen: So maybe just a few to respond first to Doctor Stanphill. Thank you for that. Let me go back to the team and understand sort of the history and where we are and, but I hear your request and I also wanted to thank you for recognizing the link to the health system investments within the tribes. I did see that firsthand when I was in Cherokee like they made some incredible investments. So, I have firsthand witnessed that. I will say that is a place CDC needs to get better across the board whether it's with our tribal health systems or the healthcare system in in our states as well. So, thank you for highlighting that. I think it's really important and hear you and saying we know where the challenges are and how do we make those links together and thank you on the grants process, I want to better understand the differences on how the state process works and I'm going to get into a little bit more of the details because I will say I hear from my state partners that it doesn't work well for them either. So I need to so we're we need to make progress across the board and I will say coming from the state I think there are improvements across the board but I'm hearing you say we even need to get to a parity from that process. So let me under I'll understand that a little bit better and I know Doctor Dauphin and the team will dig into this with this review board and to understand how we can you know and help us figure out how we can find the right middle ground here of making the process easier but still having the visibility and the accountability as we do right because I have to go and answer to Congress for the dollars that that we're spending and so making sure that we can find that that balance and I think that it that is doable with good communication and so here you on those issues.

2:11:56 – 2:12:02
Deputy Chief Bryan Warner: Thank you, Director. Anybody else? Any more comments? Yes, Legislator Barker,

2:12:02 – 2:14:10
Legislator Connie Barker: Connie Barker, Chickasaw Nation Tribal Co-Chair and representing nations at large. Doctor Cohen, I'd like to thank you again for the attempt to try to get to Oklahoma. To come see Chickasaw Nation back when we only one day of the winter we had ice and it happened to be on that day. So, we're going to try that again. But I appreciate the effort you made to come and see firsthand how tribes take care of their own and you know, just bragging on the Oklahoma tribes, you know, for their healthcare. I have worked 40 years in private healthcare and I can tell you tribal health is some of the best in the United States. They do, you know, they drill down to the patient as being like you said a person, you know what's wrong physically, what's wrong emotionally, what's wrong, you know, holistically. They just put so much time and effort into treating that citizen as the only citizen there in you know seeking health care. So, you know I just really want to brag on our Oklahoma tribes for what they do. And just you know to say some of the some of the smartest people I know are tribal citizens. You know they're educated. They want to put time and give back to support their citizens and their tribal nations. So, coming to visit, I want to thank you again for that. Look forward to being able to show you the hospital and brag a little bit about the new hospital we're building because we do see the need in Oklahoma for additional health care for our tribal people. And so hopefully we'll get to emphasize that. And just want to thank you again. And I realize that you have a huge job. You don't have to answer only to tribal governments but also to, you know, Congress. And I realize that, you know, that's a mess right now. Sometimes, you know, your hands get tied there. But we do

appreciate the effort that you're putting in. We hope that we'll be able to work together, government-to-government, and looking forward to doing that. Thank you.

2:14:14 - 2:14:18
Deputy Chief Bryan Warner: Thank you, Legislator Barker. Anyone else? Yes, ma'am. Miss Russell.

2:14:18 - 2:18:21
Ms. Kim Russell: Thank you, Chief Warner. Kim Russell, alternate for Navajo Nation. I'm the executive director for the Navajo Department of Health. Coming from my tribe, Navajo, we're a huge nation. We span three states, New Mexico, Utah, and Arizona. Our population is upwards of 400,000. So, we have a huge population to serve in three different states. So, you can imagine that the various jurisdictions that we have to consider not only state but counties, county jurisdictions. I just inquired with my staff as to what is the presence of CDC and within our nation. And of course, you know you heard of all the what we had to go through with COVID. That's still something we are recovering from, we are still healing from. And I know it'll take many, many years for us to do so. And one grant we have for $300,000 and then the other one's probably about the same amount. And that doesn't make sense to me. I don't think that's anywhere near equity. So, from my nation, we have a huge need for support. I think it was mentioned earlier the technical assistance that we need, of course our partners of National Union Health Board, but just any other expertise that we could have to build that public health infrastructure would really be welcome from our nation. We have infrastructure that's really never been invested in. And when we talk about the disparity in funding between state governments and tribal governments, I used to work for state government for 10 years and all the time. That's what we saw. We saw funding come to the state and as tribal workers, tribal advocates within state government, we could just see that money sit there and go out to counties and it would bypass our tribes all the time. It was mentioned earlier as well that the state and counties use our population numbers for grant grants, right. We, I, I come from one county, Apache County from my nation and over I'd say 8 tenths of that county is Navajo Nation and also the population. But the numbers that come for that county is that whole population, right? So, we can see that inequity there when it comes to funding. So, my request really is just, I think it's already been said, is just to treat us. That's sovereigns first of all. I think that's what we've heard time and time again and we'll continue to say that. But we're here today and I guess the request from my nation being the big one of the biggest nations, is how can we really be at a level of funding and technical assistance so that we can build our infrastructure? We really are lacking. I've been with my tribe for about 8 months now, coming from state government to here, so I can compare the two and we really are lacking. It's really hard for us to talk at the same level with them, but we really try to do so. And I'll give you an example. I want to talk a little bit about our workforce as well which includes the public health infrastructure. In regards to our public health workforce, we are we are hurting in that area. One of the areas would be like an epidemiologist. You know all the talk we had today about data, I am hurting and looking where epidemiologist. So if there's any support you could provide our nation in that regard that would be very, very helpful to our nation. But again, you know, just in closing, we just really want to work with CDC in a very meaningful way and I'm going to take a look at what we have funding for this year and I hope to see that funding increase with your commitment from the agency here and with all of the different offices you have. So thank you.

2:18:24 – 2:18:32
Deputy Chief Bryan Warner: Thank you, Miss Russell, anyone else? Well Director, do you have any comments?

2:18:32 – 2:19:35
Dr. Mandy Cohen: Well just to reiterate this is incredibly helpful. I want to say I hear you on the importance of the government-to-government the sovereignty piece and you know on each of the topics no matter what it is that is the through line as we work through and I know that our team and Doctor Dauphin is like incredibly tuned to that and sensitive to it but it's it is really helpful for me to hear even again right because I have a mental model of how we did some of our work in North Carolina. And I know that is to your point like there is not a one-size-fits-all it is and that folks are at different levels of maturity and investment in their programs And so how do we both think about running a national program and getting to the individualized nature of what is needed for each of the tribes. So that's work to do. I want to take that back for the for the team and I know we we have we have some some work to do So this is incredibly helpful and again looking forward to learning even more next week when I'm on the ground in in Oklahoma.

2:19:47 – 2:20:00
Deputy Chief Bryan Warner: Well, thank you, Director. And you know before we my final comments, I want to say my apologies to Doctor Dauphin. I stole her introduction to the director here. So Doctor Dauphin, I promise I'll make it up to you.

2:20:04 - 2:20:09
Dr. Les Dauphin: Thank you Deputy Chief. I appreciate all that you do in our partnership. That's fantastic.

2:20:10 - 2:23:52
Deputy Chief Bryan Warner: But no, Doctor Dauphin has been remarkable and in her position she takes time. We have monthly calls with Legislator Barker and myself to make sure that we get in tune with what we need. You know, I want to put this thought in your mind of, you know you've got a great opportunity here. I know, I know the gravity of the position that you're in, nobody can understand it more than you and those that have came into this. But the opportunity to find that added value in that big time value across the United States, across Indian country that partnerships with tribes, our government-to-government relationship, some of our the initiatives they are paramount that the more that we foster these relationships the more success that you will have the more success

that your departments will see and the more the better that we'll all feel the healthier our the entirety of our nation. I want you when you think about Cherokee community values that God do gets working together to for the greater good. But that entire list of Cherokee community values is all about loving one another as you love yourself. One of the ones that sticks in my mind is hold one another's existence and high regardless, stingy with one another's existence just as a mother is with a child. And that's so important that embodies everything. That's not just Cherokee community values. As I start to listen to all of our other tribes, they have the same regard for our native community, our other native neighbors and cousins and our other non neighbors. And because when you look through the pandemic and how tribes really lifted up that area. But again, I just want to say thank you for your, for your time, for your talent, your dedication, your presentation was wonderful and I don't know if you understand the level of how important it is for your presence here today that is, that is big time and we always want to welcome you to any of our monthly calls, I understand busy schedules and everything, but please and thank you for taking that time to come to Oklahoma and so forth and that level of understanding. But we all have a great opportunity to see a lot of success and a lot of success is depended on tribal members that have worked as employees for the CDC. We've already heard presentation this morning and so forth. So it's really exciting the difference that we can make as Miss Satter said in the next 100 years where are we going to be? What do we want to do? So again, WA-DO from me to you.
So before we break for lunch, we'll be taking some group photos. I know everybody's excited, right? Group photo time. The OTASA team will guide us to the designated location for pictures. Then the TAC is invited to join CDC leadership for a networking lunch and escorts will guide us to the lunch area for TAC members in the CDCbstaff that opted to pre-order lunch. Your lunch will be set out at the lunch area. Your name will be clearly labeled on the item so that I do not get your food. And OK, in order to get that final order, as a reminder to all TAC members and their representative teams, If you're not already signed up for one of the three lab visits as a part of the cultural enrichment activity, please do so now, Each lab tour can only accommodate a total of 15 people, so thank you for your attention. So now we are adjourned for lunch. We will return back sharply and promptly at 1:00, But let's go take a group photo. So WA-DO.

BREAK. RECORDING STOPPED

RECORDING STARTED

0:00 – 0:38
Deputy Chief Bryan Weaver: I had a good lunch and a special thank you to Captain Killsback for throwing me his lunch today. He's such a gentleman. Very honorable thing to do, Sir. I owe you so. I appreciate that. WA-DO So, during our last biannual meeting, we discussed the idea of having tribal presentations at today's meeting where the TAC would present to CDC leadership on tribal sovereignty aiming to further enhance our government-to-government relations. So first off, I'd like to extend a personal thank you to Legislator Barker or my TAC Co-Chair and Miss Lisa Pivot, the Oklahoma area alternate for identifying 2 distinguished leaders as presenters. Now at this time, I want to throw the floor over to Legislator Connie Barker.

0:45 – 1:32
Legislator Connie Barker: Thank you, Chair. At this time, I would like to introduce our next speaker. Our first presentation will be delivered by Mr. Stephen Greetham, Special Counsel for the Chickasaw Nation, on the topic of strengthening our relationship, Tribal sovereignty, the government-to-government dynamic, and effective public collaboration with tribal nations. You can find Mr. Greetham's full bio in our meeting packet via the File Transfer Protocol site provided in the e-mail logistics. Without further ado, I'm honored to introduce Mr. Greetham who represents the Chickasaw Nation but comes from all over the United States. Right now he's located in North Carolina, just leaving the great state of Oklahoma, but I'm happy he agreed to be here today to share his expertise on government-to-government relations. Thank you.

1:34 – 44:39
Mr. Stephen Greetham: Thank you very much. Then thank you for the invitation to come and visit with you. I do feel like I need to raise my hand and swear an oath in this setting. But my comments are going to aim a bit more toward the conversational. And I certainly invite the actual tribal leaders in this room to chime in and correct or use the Q&A to expand at any point that's appropriate. I should ought to start my thing.
There we go. All right. So, I'm Steve Greetham. I am not native. I am a New Englander, raised by Canadians who went to law school to do environmental law and got bored to tears and through my own studies kind of came across, like Columbus discovered Indian law. And it spoke to me in a way that other topics in law school simply didn't. The complexity of the issue, the histories that were involved, the humanity that was involved. Pretty much every justice issue that comes up in the law plays out within federal Indian law in a fascinating and very compelling way. I ended up I've worked for 25 years as a lawyer only for tribal governments and only in Indian country. And in making that point, I want to emphasize you know, tribes and Indians are not the same thing. As a lawyer, I represent tribal governments. I represent the institutions where the tribal sovereignty is housed and exercised. And I work with tribal leaders who are among some of the hardest working people I've ever encountered. Some of us were talking about this at lunch. I am. I'm generally in awe of the amount that tribal leaders have on their plates. And when I sit in and I'm meeting like this and the acronyms alone kind of leave me in the dust. And I think about all the different topics that folks have to engage in on behalf of their tribal community to represent and to carry that information back to the community and leaderships. It's an awesome responsibility. So, it's it is. I think it's an honor to CDC that you all are doing this and you're doing it without any compensation, but just out of your commitment to your tribal community. So, I think that's amazing.
In my presentation here, I'm going to speak as a lawyer and as a non-native lawyer and as a non-native lawyer who's worked in New Mexico and Oklahoma. So, people talk a lot about the diversity within Indian country and

that's a very true thing. There are 38 federally recognized tribes in Oklahoma alone. So, when you talk about that government-to-government relationship, it takes a different flavor depending on which tribe you're working with. And there's over 570 tribes. So my experience is going to necessarily be narrow, but my goal is to provide kind of a useful overview of the law, starting with some critical history and starting with some local history here in Atlanta. And I think it's an important conversation to have in a place like Atlanta and I'll get into that. I'm also gonna talk about I'm, I'm gonna probably talk about tribal sovereignty less in terms of the legal doctrines but more as it's relevant to talk about the government-to-government relationship and particularly the relationship between federal government institutions and public health and tribal populations and give some examples both bad and good on that.

So without further ado my, my wife who I like to refer to as my better three quarters long ago, she transcended being my better half. But she is a Chickasaw woman. She is a native historian and scholar and she teaches a lot of history and one of the more compelling points I think she makes when she talks to her students is 100 years really is not that long a period of time. Her great Aunt Hattie, who passed away just a couple years ago, was born in Indian territory prior to Oklahoma statehood and lived well into the 21st century. She lived to be 105. And I think anyone it's worthwhile to go through an exercise, think of the oldest person you've ever personally known and think about what the world was like when they were younger and then think about who is the oldest person they likely knew. And it really only takes a couple of people and you've just traveled 2-3 hundred years back in time. And in my experience, tribal communities are storytelling communities and the stories that are told in community gatherings around dinner tables are often those histories and it's that those stories that kind of provide a glue for the community to hang together. So we're here in Atlanta in the state of Georgia, and just a couple, 100 years ago this was a rather violent location when it comes to native nations. This map shows you the original territories for Seminole, Creek, Choctaw, Chickasaw, Cherokee, Quapaw, Osage, and the Illinois Confederacy. And you can see that swath of color in between the colonial presence that was expanding throughout the United States. Five of these tribes, the so-called 5 civilized tribes, were at the heart of Andrew Jackson's removal policies. When I was preparing to come out here, I looked up just on a hunch, and the city of Atlanta was founded in 1827. That was the same year that the Chickasaw Nation signed its removal treaty. That was in the middle of the coercive removal of Creek and Cherokee people from their original homelands. And Atlanta is not kind of one of those grand damn cities of the south like Savannah or Charleston. It was a beachhead that was founded right here on the boundary of Creek and Cherokee Nations. So as the native populations were forcefully expelled from the eastern half of the country, the state of Georgia was well positioned to exploit those lands to expand the practice of enslaving human beings for labor and to use stolen land in violation of treaty and otherwise. It was a coercive act and the act of removal to physically like to ethnically cleanse an entire sweeping landscape. It's hard to overstate the trauma that that causes. What happens when you have a wholesale relocation of populations. I think the CDC, some folks might have some good insights on that, but you lose your most vulnerable populations, your elders and your youth, your past and your future. And this happened to each of these nations stripped from their original homelands and forcibly relocated. Let's talk about kind of what was going on in the in the build up to that in the early 1800s the Creek Wars were fought along the Alabama Georgia border and that was a military resistance to the what was presumed to be the coming removal and the continuing expansion of non-native populations.

Other side of the coin War of 1812, the Chickasaw and Choctaw nations were fundamental to the United States victory in the War of 1812. The United States Army had to travel across the Chickasaw and Choctaw nations to get to New Orleans to fight in the Battle of New Orleans, which was a pivotal battle that ultimately meant that the US won that war and repelled Britain. Meanwhile, in Florida there were the Seminole Wars started in the early part of the 1800s and extended into the 1860s when we talked about government-to-government honestly, all of these are an example of a government-to-government relationship. War is a government-to-government relationship. It's as between 2 sovereigns who are clashing with each other. Military cooperation is a government-to-government relationship. Unfortunately, the reward for all of the tribes following that was to follow through on Georgia. In particular, Georgia pushed aggressively to get these tribes removed from this area. For anyone who studies US constitutional history, Georgia would only ratify the US Constitution on the federal promise to remove the indigenous populations of this part of the world. So when the removal came to be largely through state coercion and federal ambivalence, if not complicity, it was fulfilling a promise made to the state of Georgia. And then each of these tribes ultimately were marched, boated, rode horses, took trains, steamboats ended up in Indian Territory and an area now called Oklahoma. So the first removal occurred in the 1830s, eighteen 40s, right after getting to Indian Territory, the US Civil War breaks out, and much of that was fought in the Indian Territory. So immediately upon arrival, there's warfare. There's also epic drought. After the Civil War the US coerced a new set of treaties and they opened the lands of the tribes in Oklahoma, then Indian Territory to the railroads. After 1866 you started having railroads bisecting the treaty homelands that had been promised to the tribes in compensation for their original homelands. And with those railroads came hordes of nonnatives. And within 10 -15 years the tribal citizens were minorities within their own lands. And as soon as that was the case, politics being what they are, agitation began and the nonnatives who settled in Indian territory organized to for the state of Oklahoma to enter as the 46th state in the union. That history is a rear wheel and anyone want to go spend couple weeks in Oklahoma, you'll see it's also very current. There's still a lot of the residuals of this history that are still being battled out in the courts. They're battled out in the politics every day and it induces within the tribal advocate and tribal leadership community a sense of urgent protection of what tribes have.

Second, Chief Beaver made the comment earlier. I think Deputy Chief Warner made the same comment. The job of a tribal leader is to protect sovereignty. And that is not just a buzz phrase. That is a remarkably challenging proposition. What does that mean? What does that mean in a complex environment where most of your neighbors now are not citizens of your tribe? Where most of the land has travelled out of the hands of the tribal government? The people still exist, but the legal context in which they exist has been radically altered because of circumstances that were outside of tribal control, another aspect of history that is completely relevant to where we are. Chief John Ross was the head of the Cherokee Nation during removal, and he was a staunch opponent to removal for as long as he could. The state of Georgia used its laws. It basically outlawed being a tribal official. It was a violation of state

law to be a Creek or Cherokee official. Any non-Indian who wanted to do business within either of those tribes lands had to swear a loyalty oath to the state of Georgia, so on and so forth. And it was part of using the legal system to coerce the tribes to giving up. And it combined with Atlanta as the beachhead, a massive onslaught of nonnatives moving in on tribal lands. That was a decision point for how to handle it. Chief Ross made the historic decision to go to court and it's interesting to put yourself in his position back in the 1830s. No tribe had done that before. That was the US court system. The tribes were considered essentially foreign nations at that time. So why? Why would a tribe seek relief within the legal system? Because he's because he believed in the law. He was a highly educated, highly successful guy who looked at the world around him and said law is now shaping everything. So the Cherokee Nation went to the US Supreme Court and sued the state of Georgia, and that resulted in an landmark decision. Cherokee Nation versus Georgia. Easy to remember. And I believe it was 1832. I'm trying to sketch that later the Supreme Court closed the doors to the nation based on some legal gymnastics, basically said, you know, the Cherokee Nation couldn't go to the Supreme Court with these complaints against the state of Georgia. But in doing so, the court excoriated the state of Georgia that ruling makes for wonderful reading if you're interested in this history. As far as the lengths that the state went to try to exterminate the tribes in denying the tribe access to the legal system, though, the court also just kind of riffed a bunch. It's called dicta, but it's basically the intellectual musings of the court, and it's out there and it's like, what is a tribe? And the court went through the history of colonization of this nation, the treaties, the dealings between tribes and the European colonial powers, how Congress had dealt with the tribes. And it came to a very clear conclusion. The Cherokee Nation is a sovereign. It is a polity that's made-up of a distinct people that have the fundamental right to self-determine which is at the heart of sovereignty. Self-determination as a community. It then closed the doors and left the Cherokee to their fate. Couple years later Cherokee regrouped. They found someone who would satisfy the court's test and the theory one the state of Georgia was acting illegally. No one's ever been able to track down whether he said it. But it's generally credited, credited to President Jackson saying, well, the court has made its decision, let's see it enforce it and removal continued apace after the court victory. So here you had Chief Ross making I think a hopeful act of going into court as a sovereign saying we're entitled to certain rights under our treaties, we're entitled to certain treatment and pushed until they got the court to agree with them. And it still didn't matter, removal still occurred. But Chief Ross also used the Cherokee Nation at that time, published its own newspaper, and it was very active in kind of the culture scene in New York and DC in making sure folks understood what was happening here. And the treatment of the Cherokee Nation at that time became a national issue on par with like debates about the border today. And it was seen as something that would characterize the nation, the United States forevermore.

Those are the roots of tribal sovereignty not as an idea but as a legal doctrine. The since what they're referred to as the Marshall trilogy, there's 3 rulings that were orchestrated by Chief Justice John Marshall the first Chief Justice of the US Supreme Court and they lay down kind of the basic foundations of federal Indian law. And I'll hit just the highlights on it, but one tribes are sovereign. They are a polity that pre-exist the United States Constitution. They do not derive any power from the United States, but they derive their power from their own existence. Just like any other nation. There is a government-to-government relationship that is primarily if not exclusively tribal, federal. Of course tribes have government-to-government relations with States and other governments. But there's a special relationship with the federal government, and it includes what's referred to as the trust responsibility. The courts over the generations have looked at how the United States has treated native populations, how many treaties have been violated, how many unilateral acts have been done to injure tribal interests. And the court as a matter of just legal doctrine says, you know, of course we're not going to challenge that the United States has this power because as John Marshall referred to it in his first decision in the trilogy, these are the courts, the Conqueror. You know my paycheck says U.S. Treasury on it. I can't exactly turn around and bite the hand that feeds me. So, I can only do so much as an officer of the court system. But over time they recognize with that power came a responsibility. And in the exercise of that of what's referred to as plenary authority in Indian affairs that's resides in Congress, the United States has legal obligate, not just moral legal obligations. That are articulated in case law and statute. As far as how they deal with tribes and tribal sovereigns, the as I already noted, the core element of day-to-day tribal sovereignty is the right to self-determine and that's something, especially for federal employees, really kind of meditate on that. What does what does self-determination mean? And what does self-determination mean as an individual versus as a community and as a community that's endeavoring to hang together? When we talk about kind of the law that applies to sovereignty generally here in the US, we kind of have to break it down into a couple different levels. Tribal sovereignty is no different from the principles that apply in international context. The biggest difference is that there's no supervising legal authority to enforce the rules of international norms and practices of international relations. That comes down to war or treaties back to the case prior to removal. But the language of sovereignty is basically presumes that the sovereign is the chief is the big dog within some subject matter area or geographic area. In the United States, everyone likes to talk about cooperative federalism and they talk about the bifurcated system of federal and state governments. That's true. That's what the Constitution kind of mostly does, is manage the relationship between the federal government, the state government and then deal with government individuals. But the Constitution also speaks to tribes. It the when you contrast the Articles Confederation that preceded the Constitution with the Constitution itself, it's explicit. Congress is the one who has authority in in Indian affairs, not the states, and that through the treaty power, the executive branch has exercised A substantial amount of power. But the states have no authority and those are the rules that have generally been applied. The federal state relationship is framed by the US Constitution. The federal government derives its power from all the states that agreed, so it's going to delegate it up and it's the predominant authority with regard to the subject matters of international relations and then certain enumerated powers. The states are seen as having this organic sovereignty, something that exists because they're there. The but their powers too are limited. By joining the Constitution, by joining the United States, they recognize the supremacy of federal law, including the specific enumeration of federal authority with regard to tribal affairs. And they also limit themselves through their own state constitutions and codes. Tribes, like states, have that organic sovereignty. It's not there's a misperception I often encounter dealing with kind of opposing counsel. The federal government has never given the tribes anything. It's only taken

it away and the tribes organic sovereignty was whole and complete, but it's been whittled away through the federal government's malevolence and inaction. There are the 2 great pillars there. Congress has a plenary authority and has exercised it robustly. I'll get into that in a in bit but all of it ejects the state and that's where I think you're also going to find sensitivity from tribal leaders when they turn to their federal agency and the federal agency is prioritizing working with States and then tribes become something of an afterthought. The tribes are the ones that have the government-to-government relationship. The feds have the trust responsibility to the tribes.
The states obviously have a compact United States where no one's excluding them. But the tribes can't turn to the States and work with them in the same way that they have to work with their federal trustee and there. So those when you hear from the leaders, they've got to go back to their constituents and their communities, that's the conversation that's happening when they when they fly back home. To there's a, almost nerd it out and start bringing up a lot of review article that I really like. But I forgot I wasn't talking to a bunch of lawyers. But the key to understanding the difference between the federal-state and the federal-tribal relationship. All of the rules for the federal-state relationship were laid out in the constitution. They were pact in agreement for the tribes. It wasn't so much. It's really been through the power of colonialism and now colonialism's kind of a vogue word in the academy right now so on and so forth. And I'm talking about it in the raw sense of the colonization of the lands that were Georgia to create the state of Georgia. And that is a more amorphous, softer kind of body of law because it changes. And when there are fights, tribes have to go into other sovereign courts to essentially have their own sovereignty weighed and measured, which is a difficult proposition. It's not a proposition that the state, states or the federal government ever had to face. Forget about the law. Already touched on this, but sovereignty's kind of also become a word like freedom or liberty. You know, everyone's for it. Three blind men and an elephant, though, can't agree on what it looks like. There's, it's a term that's often invoked more for its rhetorical value than its tangible legal value. Strip everything else away. Sovereignty is about a socially coherent, politically political collective. Every tribe I've had the honor to work with, one of the first things I always try to do is just learn the tribe's history and it's the looking particularly at the intergovernmental relations because that's where I work and it's always the same story. And I always take away from that kind of being stunned that the tribe's still there. And the fact that the federal and state systems have thrown so much at these tribal governments and this social collective has continued to cohere and to continue to hold on to that sovereignty and to provide for itself being its citizens is a remarkable story. And it's something that when working with the Federal Trustee, the federal trustee I think has, and this would be more of a moral, not a legal obligation, but some obligation to sit down and familiarize yourself with those stories as well. The treaties, the statutes Congress enacted to deal with those tribes and to familiarize yourself both with the nuances and details of that relationship and then how that interrelates to the programs that you're administering. Because it might seem far removed, but it's not. There's a straight line that connects kind of that history and relationship through the programs that are operated today. While the language of sovereignty can kind of get broad, it's still the language we use for intergovernmental relations. And in a high-functioning dynamic, you're going to see a lot of substantive relational respect. Not just the shibboleth of kind of nodding to consultation or nodding to yes, there's a special relationship, but a dynamic living relationship that is really between and among actors who are trying to pull in the same direction. And if they're going to start pulling cross purposes, they'll sit down and figure it out. But it's pluralistic. It recognizes the separation between communities while making room for common interests when it's poorly functioning. See Oklahoma. It gets abusive and there's a denialism, or there's acting on ignorance or thinking that it's really not that important. And sometimes that dysfunction can be passive through not really dealing with the complexity of the issue. It's not easy. It's hard, but we'll get to the motivation for why you need to do it anyway, So beat some of these points already.
Next slide, I'm going to give you a quick crash course in the history of federal Indian policy. I'm going to just jump to that. But bottom line is the U.S. has changed its mind a lot in how it wants to deal with tribes and it's not figuring out a coherent policy from day one to day now has had consequences and it has created a remarkably complex legal landscape that whether we recognize it or not, we navigate every day. The tribes are aware of it. They've got to deal with it every day. The trustee isn't always and the states certainly aren't, but we've got to kind of move through it. If we're going to have an effective government-to-government relationship we've got to deal with kind of the complexity that the tribes are having to deal with.
Just to simplify this, here's a non-scientific through line but these are the major policy eras of federal policy and dealing with tribes. I won't go into the details of each policy era. Google it you can find a good summary. Bottom line is that the federal government is vacillated between working with tribes as tribes versus working with Indians as individuals and whenever the United States has opted to bypass or disregard the institutional structure that a tribe has organized for its own affairs, it has gone poorly. For tribes, the loss of lands occurred through allotment and assimilation, through termination through the Indian Wars of the John Wayne era. That is what seems to be what most people are familiar with when they think of American Indians. The legacy of those failed policies was the decimation of tribal populations, the expropriation of tribal wealth and the imposition of disabilities on tribal to peoples within the legal system to protect their own interests. Major turn around in that came in starting in 1968. We're not out of any, like, generosity of spirit. But the United States looked at the long history of its failures and so we got to change course, and it started. And as a good yellow dog, Democrat from Massachusetts, it pains me to say this, but Richard Nixon really was the one who first started turning that around by working with Taos Pueblo to return sacred lands that had been taken away by administrative Fiat. And then by declaring an end to the termination era and declaring that henceforth the United States was going to work on a government-to-government basis with tribal nations that kicked off kind of a renaissance in DC. It led to the self-determination legislation in 1975 that first dealt with education, housing, healthcare and started to it authorized federal agencies if they were operating a program, the primary beneficiary of which was a native population. To turn that program over to the tribes and the tribal health systems that most tribes have now come through the takeover of federal programs to provide health benefits, health services to native populations and experience has been Tribes have done a heck of a lot better job than the federal government ever did and success built upon success. Professor Joe Kalt. He's an economist with Harvard and he recently published an article he looked through and he was like trying to determine what the policy impact has been from the self-determination era and controlling for things like

gaming, controlling for things like location and all the rest of that. There is one single factor that has led to increased tribal incomes, tribal health outcomes, tribal education and that is federal self-determination policies getting out of the way and then supporting a tribe to provide for its own. It has good policy impacts and it is not even a close question. So that self-determination era, that government-to-government relationship bring that back to the fore, has been the one thing that has allowed tribes to kind of no longer have to constantly be shielding themselves from abuses from the federal trustee and instead focus on getting the work done on behalf of their tribal peoples. Your director is going to be going out to Chickasaw we're talking about over at lunch. Like the list of stuff we want to show her is pretty long and I think it will blow her away from senior housing to education to after school programs. The daycares to it is far and wide and it's not just for the tribe. The tribal investments in a context like Oklahoma spill over into investing into nontribal stuff. Each of these tribes are Building Schools, water and wastewater systems not just to benefit a tribal population, but to benefit these communities. And guess what? They're doing it without a tax base. They're doing it through ingenuity, working with federal programs, economic development to create resources to then invest in their own homeland in the future.

So let's shift and talk about kind of some examples of relations across the sovereign line. This gentleman who was named Ishi, which he was the last surviving of the Yahi of the tribe in California. And he showed up out of the woods in 1911 out there in California and he instantly became kind of a national figure. He became an object of study. He was considered the quote last real Indian wandering out of the woods. He was essentially adopted by some anthropologists. He lived in the University of California Hospital and Museum and he was put on display. He died five years after he emerged from those woods. He's not really well known at that building, that's the museum building that he lived in. He was a human being who was simply converted into an object of study. I'm going to mispronounce this name, but the Borez Report 1977. the US Controller completed a study based on complaints and was looking at federal health programs and health services and their interaction with tribal populations. The use of Indian boarding school kids to test drugs for different treatments without any parental consent. And the federal position at that time was we don't need to talk to the parents, we're the guardian for these kids. We get to make the decisions for everybody involved. Complete objectification and dehumanization of those children and that was in the 70s. More problematic, IHS's forced sterilization or unconsented sterilization of native women of childbearing years without any real evidence or work on consent. This now, we're in the 70s. I'm willing to wager the majority of the people in this room. I probably shouldn't say this, I'm going to offend some people, but the at least half the people in this room were probably alive in the 70s. So now we're talking about stuff that's occurred within living memory, within this room. And so when the feds show up to talk about healthcare issues, there's an experience of abuse and objectification that the feds have some obligation to recognize and figure a way past and through. There are folks on the other side of the conversation that want to work with you, but they also want you to know the story and to respect what's happened. Because when they go back to their constituents, their constituents are gonna be remembering these stories as well. Those were real abuses, and they're not ancient history. Governor Noem up in South Dakota during the COVID outbreak. Tribe shuts down checkpoints on the highways because they're trying to protect their elders. COVID was spreading through the community, and they were trying to limit the introduction of the virus. What does the state governor do? She turns it into a political theater event and attacks the tribe for its public health measures. The these. I mean if this goes on today in Oklahoma, it's a constant fight and often times the tribes will look around and be like where's our trustee? We need you to back us up here. We need you to come in here and recognize the seriousness of the programs we're trying to operate and the shared policy goals of keeping people healthy positive examples. There's a tendency in and with good reason, but to focus on the victim aspect of America's treatment of indigenous peoples. But like I said, when the tribes are still here and not only that, they're doing a hell of a lot. Many of you I hope are familiar with the IHS Chickasaw Nation joint venture to build an 80-bed hospital in ADA. OK. It is the premier healthcare facility anywhere in Southeast Oklahoma. I can say that because Choctaw's not here. No, just kidding. The, it serves as the Indian Health Service facility for all native folks living in Southeast Oklahoma. We're now building another hospital, even bigger one in Newcastle, also in partnership with the Feds. This is what should be this is the stuff we should be doing, figuring out ways to leverage kind of tribal expertise, federal expertise and resources to partner to expand services to these populations. Cherokee Nation and OSU creating a medical school that is specifically serving tribal folks to go out and provide health care in tribal communities. This, this is purely anecdotal on my part, but I went to a dinner the other night and I met a whole bunch of kids at UNC. They're all native kids and about 3/4 of them were going into public health and it struck me that it was. Part of the legacy of COVID, these were kids who saw what their tribe was doing for their community and they were like, huh, public health is cool. I want to do this. I want to give back. And it was, it was a very, I was really happy after this dinner and stuff like this. Building the tribal bandwidth for these types of professions creates hope and opportunity for the next generation of folks who are coming up and eases the workload for the feds. If you look at this over a long arc, the feds have a very clear interest in tribes being able to take care of their own, and so do the states. So when we get, when we're able to get the bureaucracy and the politics out of the way, there are, there's no end of the kind of partnerships we can form. Somebody, and it might have been Doctor Cohen or Doctor Cohen, but the in Oklahoma we had a COVID denying state governor who seemed intent on erecting barriers for folks to get access to vaccines. The tribes led on that. The tribes were the one who leveraged their access to getting vaccine doses and opened it up to everyone. I don't know if I'm going to be able to read this. I'll have to read it off here. My eyes are getting bad, but this is a tweet that this is a I'm just going to read it. I just got a vaccine appointment with the Chickasaw Nation who is now vaccinating any educator in Oklahoma. I am so overwhelmed with the historical weight of a removed native nation providing this settler with a life-saving vaccine. And as of the time, I took this screen cap that was retweeted 3842 times and Chickasaw wasn't the only one doing it. We all were. And the latest example, maybe not purely in the public health space, but a number of states have rejected the summer food program for at risk kids. The Osage Nation, Muskogee Creek Nation, Choctaw Nation, Cherokee Nation, Chickasaw Nation have now all stepped in and working with their federal partners, are keeping that program available for hundreds of thousands if not millions of kids throughout Oklahoma. So when federal agencies are looking at their mission, their program, the politics between the federal and state governments can often get in the way. But the tribes are invested in their

own continuance, their own communities, their own survival, and make excellent partners the figuring out. And I commend CDC for convening this TAC, the one acronym I feel confident of after this morning. But we need more of it, a lot more of it. And we need patience and we need commitment and engagement and only good things will come of it.
So just some closing thoughts. Bottom line is sovereignty is and and government to government stuff isn't about generosity. It's not about magnanimity on the part of the United States. It's the law. And tribes have spent generations fighting ever since John Ross went to the US Supreme Court to have the law stand up and protect the rights that the tribes are entitled to under this federal system that they didn't choose but is here, they fully participate in it. Now no one's going trying to roll the clock back, but it's the law. And when you really look at it, when the feds work within that system, you get better results. And again, it's not even a close question. It improves all of our outcomes. So I have to my last comment is it feels so strange making these comments when I'm staring at tribal leaders. I'm not talking to you, but I really appreciated the opportunity invitation to come out here and visit and to let me ramble on it. It's about this subject. It's critical.
44:42
Legislator Connie Barker: Thank you so much. Thank you, Stephen. Even though there are many tribal leaders in this room, there are some who are not and that was our goal was to share tribal history, share tribal position and to help our agency partners understand what it means at home. We're talking about government-to-government relations. And so thank you. You, you actually did a wonderful job. You know as tribal leaders we still learn new things, you know every day. And so I just want to thank you once again for being here and for doing this, doing this presentation. So once again, thank you, Stephen.

45:19 - 45:36
Deputy Chief Bryan Warner: Are there any immediate comments from TAC members or CDC leadership? Yes, Doctor Dauphin.

45:38 – 45:58
Dr. Les Dauphin: Thank you, Deputy Chief and thank you Legislator Barker. I just want to say on behalf of CDC and our Public Health Infrastructure Center, we really, really appreciate that fantastic presentation. So I'm sorry I could not be with there with you in person, but I did want to say it was a fantastic presentation and we really appreciate it. Thank you.

46:00 – 48:45
Deputy Chief Bryan Warner: Thank you Doctor Dauphin. Anyone else? Well, I know we've got time to let this marinate and let it soak in as we like to say. And many of these stories, this is just one area of Indian country. Understand that to the CDC leadership there's tribes represented all over the United States and each one of them have a story much like this. Some very similar some very different. But yet the outcomes have all been the same. So I know, Connie, I said I don't know that we need a break, but I think if we would take a 10-minute break at this time and come right back because we have one more presentation. But before we go on break, I just wanted to again thank Stephen Greetham. Thank you, Sir. Always a pleasure. You are a, you're a fine gentleman, Sir. Very much appreciate it.
I want to remind everyone that during the break, please take a moment to sign up if you haven't already done so for the lab tour of your choice as a part of our cultural enrichment. You've got the enterics, you've got the mycotics and you've got the waterborne diseases. So, these terms will be provided to give you an exclusive glimpse into the cutting edge research and operations conducted in these specialized laboratories and offer a deeper understanding of the CDC's crucial work in addressing these different forms of disease, if you will. So please do that. So, let's take a short break and we will reconvene at 2:00 sharp for Admiral Weeks. So WA-DO.
Back after the break and just one piece of information. I believe I've been told that all the laboratory tours are full, so that's good news. They've also attempting to adjust the temperature in here. Also, good news, got some warm water over there if you've got a tea bag or whatever you need. So, we've got all kinds of good stuff going on here. But again, I want to say coming out of the break, thank you to Stephen Greetham for his presentation. And now I would like to introduce Admiral Kevin Meeks, MPH, the Deputy Secretary of the Chickasaw Nation Department of Health. So, what our second presentation is entitled Charting the Course, Exploring the Interplay of Health Boards, Tribal Epidemiology Centers, and Sovereign Tribal Governments and Indigenous Health Governance. You can find Admiral Meeks full bio in our meeting packet and via the file transfer portal site provided in the e-mail logistics. Without further ado, I am honored to introduce Admiral Meeks. Admiral, you have the floor.

48:47 - 1:37:19
Admiral Kevin Meeks: Thank you Deputy Chief, "Chuck Ma" to hold support. Kevin Meeks, Deputy Secretary of Health, Chickasaw Nation. It is good to be here. Thank you for to the TAC for inviting me here. Thank you to CDC for hosting this meeting. Some very important topics are being discussed and it it is my honor and privilege to be here. First thing I'd like to say is forget this title It has a little bit to do with what I'm going to talk about but it's it my talk has deviated just since this morning as I was working through preparing this presentation. Over the last few weeks I kind of changed course five or six times and I've changed twice since I got here this morning. So we're we're still gonna try to get through it. Second thing I'll say is I kind of feel like the fifth string left fielder following the all-star shortstop here to my left. I can promise you I will not be as eloquent as Stephen Greetham and not as knowledgeable but I will tell you what I think I know and I'll adlib the rest. So should be no surprise.
Well, I'm gonna talk about some relationships and some history as well. It's all tied back to sovereignty. This is a layman's definition of sovereignty. We heard the legal definition and some great explanations of sovereignty from Stephens. Outstanding presentation. But sovereignty is inherent in the society that has that sovereignty. We can say it a lot of different complicated ways, but that pretty much sums it up for me. We found this in a book called American Indian Tribal Governance and you can look up all kinds of definition but it is we didn't earn that

sovereignty as Chickasaw Nation or as other tribes. We were not given that sovereignty. We've had that sovereignty since we have been here and we've never let it go. We're gonna talk about some attempts here in just a minute to take that from us and Mr. Greetham mentioned some of those but we'll talk about talk about a few going forward. You know this particular slide violations of tribal sovereignty could be a tax on tribal sovereignty could be ways to get rid of tribes and these are just a few. Deputy Chief mentioned every tribe has its story and every group within tribes has their story and each individual tribal member tribal citizen has their story as well. I'm going to tell you a little bit of my story as it relates to these it's a Chickasaw perspective. I'm a Chickasaw citizen not necessarily here representing the Chickasaw Nation. But I'm representing myself, my 32 years of experience with Indian Health Service and working with tribes, and now with my three years of working with my tribe and Chickasaw Nation. But starting with the succession treaties as far as I could tell, Mr. Greetham may be able to correct me but every treaty entered into by the Chickasaw Nation with the exception of 1 resulted in them losing land, having less land than before. The exception to that is when we finally made the move to what is now Oklahoma. We settled with the Choctaw Nation and so we actually gained land and later we divided that land up. We had to purchase our own reservation in Oklahoma at that time. But that's the only one that I could find where we actually gained instead of lost. I don't know. I'll just tell you my perspective. I think that's a pretty sad commentary on the whole idea of treaties. The whole idea of Indian relations with the federal government. We've already heard about the Indian Removal Act which was passed in 1830. Stephen mentioned a lot of what I'm gonna talk about and other people throughout the morning. But that's ok we're not trying to beat people over the head with these thoughts and with these ideas. But we do want to impress the importance of this history, the importance of different perspectives about the same history. The Indian Removal Act was passed after the Supreme Court ruled that Georgia had no right to try to rule over first American tribes. In this case, it was the Cherokee Nation and Andrew Jackson is credited with that that famous quote. They made their ruling. Let them try to come and force it. There's a book, if you haven't read it, if you are interested in this period of time, it's called Unworthy Republic. It is an incredible expose over the corruptness, the lying, the double dealing and the immense amount of money that was made by individuals, institutions and banks during that time with that land that changed hands, how it was magnified dollars for pennies. It is a very honest, forthright accounting of that. And if you are interested, I really encourage you to read that book. You know, Chickasaw Nation was one of the first tribes to sign the treaty that resulted in the removal. That that treaty was taken back a year or two later when Chickasaws determined that there was no land suitable that they were they were going for. That was a provision within that first treaty. They renegotiated another subsequent treaty and then finally started their moving process to what is now Oklahoma, about 1837-1838. Other tribes had gone before, and one or two tribes were moved afterwards. But that whole thing was about that southeastern part of the United States that you saw in the earlier presentation with that immense swath of land. Georgia, Tennessee, Mississippi, Alabama, and the States and the settlers thereof wanted that land to increase monetary profits and they didn't care who wanted to be there. Andrew Jackson almost ran part of his presidency on removing tribes from that part of the United States. There are a few people that that try to make Andrew Jackson's preference for that out to be a hero. That he was trying to protect the tribes, that he knew if he would have that they would have stayed there. We would have stayed there under state control, that the tribal system as we know it would have went away and pretty soon there would be no more forced Americans. They're in the distinct minority. I think if you read your history books and you look at that time, you'll see that Andrew Jackson had no love for Native Americans and could care less whether they were able to make it into the future or not. And as far as he was concerned banishing them, my term, not anybody else's, to Oklahoma was a way to get rid of the travel program problem. Not to protect them in any sense of the word. During the removal of Chickasaw Nation we paid for our own removal. Other tribes had different types of assistance. But the Chickasaw Nation actually paid for their removal out of the profits or return I guess on the sale of their land, on the sale of their animals and their equipment and things like that. There was immense loss of life, probably proportionately not as much as some other tribes who were forced marched during bad times of year. During that time there was drownings, people died from disease, people died from starvation. And yet the forced marches continued. When the Chickasaws got there, the US government tried to make us become part of the Choctaw Nation. We were settled in the western part of the Choctaw Nation, in the southern third of what is now Oklahoma. We ought, I think, if memory serves me, one representative on the Choctaw Council to voice Chickasaw concerns. Well, guess who won those votes? If there were differences in opinion about what was good for those two tribes, eventually Chickasaw has petitioned the US government and received that treaty that allowed us to operate as our own government and get our own lands. But once again, we had to pay for that land. That land was not given to us. We had to pay the Choctaw Nation for the western 2/3 of that southern third of what is now Oklahoma. There are many more things that happened in the late 1800s that some would view as a means to extinguish tribes and get rid of the Indian problem that we can just skip ahead and move up to statehood. Oklahoma became a state in November of 1907 and the reservations as we knew them went away, or at least we thought we went away. There's been some decisions in the last few years that that changed that perspective in a great deal. But when Oklahoma became a state, our tribal governments went away, Our tribal lands went away, and that was a sad time. In fact, we were not allowed to, I think this applied to all five of the civilized tribes, we were not allowed to elect our own tribal leader. The president appointed tribal leaders 2 years at a time and that's what they did from 1907 up until the early 1970s when we were finally allowed by the federal government to elect our tribal leader. Everybody. Well, I'm, I'm assuming that everybody, certainly most of us have heard of the boarding school. And as we heard just a minute ago, it didn't end in the late 1800s, early 1900s. It extended on through the 70s and the 80s and people are suffering that. We're not talking ancient history. Most of us who are citizens of our tribes know people who went through this and we understand that many of them underwent horrors that we will not talk about here while they were at those boarding schools. My grandmother was sent to a boarding school against her will, against her parents will when she was seven years old. Now that school, Bloomfield Academy burned a few years later and she didn't have to go back but she would tell us stories of not being able to speak their language and a lot of other things a lot worse than that and that my grandmother and you'll see her picture in just a few minutes. She, is my, was my direct connection to my tribal heritage, to my tribal lineage. And she was, we'll talk about her in just a little bit. Oh, yeah. On the slide. It's called the assimilation

effort. It was a relocation effort where Indian individuals and families would be gathered up and they would be sent to large metropolitan areas, Chicago, San Francisco, Los Angeles, et cetera. Because the government believed that, well, if you can't make a living in southern Oklahoma, or if you can't make a living in southwestern South Dakota on the Pine Ridge Reservation, we'll send you to a big place that has lots of jobs and lots of opportunities. And sure enough, some tribal members succeeded in that environment, but others were just lost by the wayside. And we can't account, we don't know what happened. They were not able to adjust to that life. It's very similar. It's an adult version of the childhood version of the boarding school era sent them where they had no connections. They had no connection to the ground, they had no connection to the people. It was a terrible time and all of these things I'm convinced. Well, I won't say it that way. I'll say a lot of these things may have been conceived thinking that it was a good idea for individual tribal citizens as well as tribes to grow a little bit. But the result was it was always trying to make the tribes themselves less powerful, to have less influence, and to eventually go away. There are countless, countless other stories that we can tell from the beginning of this country till now, with the broken treaties, the broken promises. And I'm not trying to make y'all feel bad for tribes. I'm not trying to make you feel bad as individuals. I'm just painting the picture here, but that's what we came against, Governor Anatubby told a very, Governor Anatubby's governor of the Chickasaw Nation. He told a very moving story back at a leadership meeting right before Christmas. And the Chickasaw Nation is not supposed to be here. And he went through step by step on attempts to do away with the Chickasaw Nation over and over and over. And yet we are still here. He it was not only moving to those of us who were able to hear that, It was moving to Governor Anatubby himself when he talked about the trials and tribulations. Yet we are still here. It is not that far away. These are the people I come from. It's my great-grandmother, Uncle. Bottom right is my mom. Up in the upper left is mom with her sister and brother-in-law, Grandpa and Granny Parker. Granny Parker standing off on the right with one of my cousins there sitting on Grandpa's lap. Granny Parker experienced a lot of what we just went through. Like I said, she went to boarding school. She was born in Indian Territory before Oklahoma became a state. She was a direct benefactor as well as victim of the Dawes Act and the enrollment and the land allotments where they, you know, in her case and her family's case. Those land allotments were scattered throughout the Chickasaw, but they were not together, so the family would stay together. Her allotment was up by Alonso, Oklahoma. Her mother's was somewhere else. One of her siblings was way down at Ardmore, OK, and southern Oklahoma, and it was meant to break the family up and to just disintegrate that structure that kept the tribe strong. But she overcame, as did the rest of Chickasaw Nation, Choctaw Nation, Cherokee, Seminoles, Creeks, and other tribes. And there are some more pictures. If you hear a little emotion in my voice from time to time and when you're talking to tribal members and tribal citizens about anything related to their tribe and their tribes history, you may detect sometimes passion, sometimes anger, sometimes frustration, emotion of some sort. It's because this is very personal to us and it is not ancient history. It's today's history and these when we operate our hospital, when we operate our health system, we're doing that for our grandparents and our aunts and our uncles, our cousins, our parents, our brothers and sisters, our kids, our grandparents, our grandkids and those that will come after them. And so we're trying to do the best we absolutely can do to carry that tradition forward and not carry that past with us in a bad way, but to recognize where we came from and what our ancestors went through. I was talking to our medical staff leadership a month or two ago at a medical staff leadership retreat in Oklahoma City and was telling a longer story of the Chickasaw Nation, going back to when Chickasaw Nation became Chickasaw Nation and settled in what is now Northern Mississippi. And I tried to impress on them. And I'll try to impress everybody here, that that we are the people that my ancestors prayed for that would help our citizens and our tribes flourish in today's environment. And everyone in this room has a piece of that prayer. Some of us are working directly for the tribe, working in that health system or working in public health or serving as a tribal leader. Others of you, and I'm talking to our CDC colleagues and counterparts, view are directly and indirectly helping the tribe fulfill its destiny. And you and we are the people that my ancestors prayed for as they came across the Trail of Tears as they established themselves in Oklahoma, as they saw their lands further taken away after the Civil War in Oklahoma, as they went to those boarding schools they endured. So, we could be here. So, when we talk about tribes and the business of being a tribal government and offering those services to our citizens, we want you to understand why we are so passionate about what we have accomplished and what we're going to accomplish in the future. And we want you to know that while we're going to do everything we can to do it ourselves, we embrace partnership with our federal partners. We could not have accomplished what we've accomplished so far without a very close and unique relationship with the Indian Health Service. We could not have accomplished a lot of what we've accomplished as a nation without a close relationship with the Department of Interior, Bureau of Indian Affairs. And we want the same kind of relationship with CDC and everybody else that the tribe partners with for the benefit of our tribal members and our tribal citizens. Picture in the upper left is my great-grandmother, that's my grandmother in the top center. She has a unique name is named Baijima, not a Chickasaw name. Nobody knows where it came from. Some, some people called her Jim, my grandpa called her Jim, some people called her Baiji. Some people tried to pronounce Baijima and they usually fell all over themselves and most people just called her Granny Parker and got away with it. So, she was a wonderful church-going Christian lady that loved her family and she was my connection to my tribe's past and what little I know about our tribes and men's history, much of it came from Granny Parker. The upper right and lower left is my mother who is still alive. She just lives about 150 yards from us and she's a very proud Chickasaw citizen as well. And so, I wanted to give you a picture of the past, where we came from. But there's the future down below. So, there's my daughter, one of my daughters and one of my granddaughters. And that's who we do all this for. It's real people making up, in my case, the Chickasaw Nation. In your case, Cherokee Nation, Muskogee Nation, and on and on and on. And the tribes that are represented here on this TAC, they have similar stories, not the same, but they have their story and they have the reason that they are fighting for what they believe is right for their people, for their tribe and for their nations. And we are inviting our CDC colleagues and counterparts to help us accomplish what we need to accomplish to help our nation's flourish.

That's enough about Kevin. So, one reason I've slipped into this rest of this presentation, there were some commonalities with public health authority and we're here with CDC and we're here about public health authority, especially just coming out of COVID and all the things that were associated with that. And you can read that big

long definition and what is it for? It's really about protecting the public health. It's an agency of the United States government, a state, a territory that finally gets to tribes that's responsible for public health matters. Some people think we can't be responsible for public health matters. The state of Texas refused to recognize tribal sovereignty during COVID and do not participate with the tribes there within the state's borders. There are other governors across the country that refuse to recognize tribes or tribal TECs and other groups that's having any kind of public health authority and hindered the efforts to respond to that public health crisis that we know is the COVID pandemic. But we're going to talk a little bit about public health authority as it applies to the federal government, particularly IHS, since that's where I came from. I don't know if you've read that boring thing that we call Kevin's bio, but I did 32 years as a commissioned officer working for Indian Health Service all across the country. I would not trade for that time and the experiences that I've had, but that's where some of this is going to come from. So most of you know this, you know where does public health authority come from? A lot of times we think it comes from a statute or an act of Congress. That is where the TECs Public Health Authority came from, a regulation, which is not a federal law, by the way. A lot of people confuse regulation with the statute regulation, not a federal law. Regulation is a rule that's promulgated by an agency. It has legal force, but it is not federal law. And in spite of what agencies may tell us from time to time, those regulations are a whole lot easier to change than it is to get a new federal law passed through Congress. It's just a lack of willingness to change that regulation. And then there's an executive order in the authority that comes directly from the president. So Indian Health Services what we'll who we'll pick on now is anybody from IHS here nobody will admit it. I was the only one guy such as Damion I had to embarrass Damion and I wanted to congratulate the captain on his new appointment and he come to CDC. They know we're excited for you to have this new position. We know you're going to do well and we want to make you a success but if you're a success we think we're going to be a success too. But you know, I just is the primary federal agency tasked with the responsibility to provide health care to American Indians, Alaska Natives or first Americans. A lot of people, particularly those in Congress and OMB want to blame the Indian Health Service for every ill that has affected every American Indian living in the last 50 years. Well, IHS didn't come into being till 1955, so I'm not sure that that is a fair assessment. But one thing that we need to remember and one thing I want my CDC colleagues to hear that the treaties that the tribes made with the federal government or vice versa, we're not limited to what is now Indian Health Service and what is now the Bureau of Indian Affairs. Those treaties were between those tribes and the United States government and the whole force of the US government is supposed to be available to live up to those treaty obligations. But too often we find out that that's not the case. It's IHS's fault of the condition of some of our reservations in the Northern plains and the Northwest and the Southwest and the Southeast. But where are those other federal agencies that should be there to help with transportation issues, to help with school issues, to help with jobs issues, and so on and so on? And those social determinants of health that when it comes to tribes, are often so easily swept aside and just said, well, that's the way it is. It's been that way for 100 years, but it doesn't have to be that way forever. And with a little assistance from the right agencies within the federal government, those tribes will be able to rise up themselves and accomplish great things. But it's going to take everybody working together. They've been put in a bad place. They've had things taken away. We have had things taken away and it's going to take everybody to bring those things back. IHS typically delegates public health data request to TECs interestingly enough and when you look at the, I found it interesting when you look at the, it's not an application, it's a proposal to request data from Indian Health Service. No place on that form is there a box for travel, concurrence or tribal approval or tribal agreement. It's between the TEC most often and IHS and tribes are left completely out of the picture. Unless there is a unique special relationship between TECs and the tribes, and some to be frank, sometimes there is, sometimes they're not. There's not. IHS has some public health authority within that agency. We operate public health departments for those remaining direct service locations, and they do a lot of public health work in response to public health emergencies. And they're public health authority comes from their position as an agency within the federal government and within the laws that established IHS. Then we move along the tribal epidemiology centers or TECs and we all know about ICHIA, right. The Indian Healthcare Improvement Act, it had been strung along and every few years would have to be reauthorized and reauthorized. This, this is kind of a bad choice of words with, this slide. It wasn't really a reauthorization in 2010, it was when ICHIA was made permanent as part of the Affordable Care Act. They acknowledged tribal epidemiology centers as public health authorities, but their public health authority was limited to data and being able to meet the qualifications of HIPAA without going through as business associates and all of that kind of stuff that HIPAA law requires with a lot of that data exchange. So, so they have public health authority and that is given to them, awarded to them by federal law, continue with tribal epidemiology centers that, you know, if there's the overarching thing with ICHIA, Congress declares it is a policy of this nation and fulfillment of its special trust responsibilities. And we've heard a lot of people mention that special trust responsibility and legal obligation to Indians to ensure the highest possible health status for Indians and urban Indians to provide all necessary resources to affect that policy. And I could take off on this and use the remainder of my time to talk about that highest possible health status for Indians. And I'll just, I'll probably move on to the, I will move on to the next slide after I say one thing. If that's the case, put your money where your mouth is. Government because IHS and tribal health programs are funded at about 50% of what the level of need is Federal. Federal prisoners in the Bureau of Prison System get more per capita funding, almost twice as much as the first Americans do on a per capita basis. Federal prisoners are not served under a federal trust responsibility. Continuous tribal Epidemiology centers that their public health authority is limited to deal with HIPAA. That health information is transferred to them to do the research that they want to do. Continuing with TECs, the law directs Secretary of the Department of Health and Human Services to grant TECs access to data. And that is in several citations that I saw. And that comes right out of the law, right? The Secretary can provide data to those TECs, but who do the TECs work with for and whose authority do they use? They have their own public health authority, but they are supposed to be working locally within tribal jurisdictions to get that data and perform those studies and conduct that research if you will, for those tribes that they serve in their particular area. If you remember the law originally established 1 Tribal Epidemiology Center to be placed in each area. So those centers were established. I think we're coming up on 26-27 years of the establishment of TECs and they have done a good job. I'm not here to beat up TECs any more than I'm here to

beat up anybody else. TECs have done a good job with the resources provided to them and they've stood up. They provide a valuable service. But we're going to talk how to leverage those efforts with the tribes and try to try to make more than they could have accomplished by themselves. You see what those seven core functions evaluating data and programs, identifying health priorities, making recommendations for health service needs, making recommendations for improving healthcare delivery systems, providing technical assistance, providing disease surveillance. How do they decide which one to work on and how they how do they decide what to work on within those to ask the same question as CDC. When you're looking at these epidemiology concepts here, how do you decide what to work on behalf of Indian country. How does CDC decide what to work on, on behalf of the tribes within the Oklahoma City area or where the aid of service unit, the home of the Chickasaw Nation.
We're gonna look at things just a little bit left-handed here in just a second. So the secretary we believe has the authority to provide requested data to his TECs, right where that's quoted a lot. And TECs have the authority to request that data and to conduct that research or those studies. What I discovered in preparing for this presentation, a thing that I have never paid attention to before and before, all of that authority for TECs to do their thing and for the Secretary to provide his thing. There's a little clause in in consultation with and on the request of Indian tribes, tribal organizations, and urban tribal organizations, Each TEC established under their sections shall. And then it moves into those seven functions. It all starts with the tribe and the tribe's needs requesting, at a minimum, agreeing to what data is going to be provided to. I believe I'm not an attorney and I'm sitting by one and hopefully he doesn't slap me if I speak, speak out of place. But I believe that even applies to the secretary and his release of that data, because this comes first in the law and everything else falls underneath it. But nobody looks at it like that. TECs request data all the time and never get permission from tribes that they are doing it because they believe that that is the best what they should be doing. The secretary provides data without consulting with the tribes. But I think in 1621, in consultation with and on the request of Indian tribes takes precedent of any data request and any supplying of that data to that requester. And this all goes back to the sovereignty discussion. It all go. That's where all this falls to. It's the tribes should be taking the lead not the federal government and not the TECs. When tribes, and we'll have a slide in just a minute about Public law 93638 or the ability of a tribe to contract or contact with the US government to provide the services that before were provided by the federal government. Why? Why was that authority given to them? Why was that ability to contract or contact with the government to provide health service given to the tribes in the 1st place? Because tribes know best what their people need and is to make local decisions at the local level to benefit the local population. No more one-size-fits-all with decisions made in the Ivory Tower or Washington DC or Bethesda, MD or all of Indian Country at one time. Because the needs of the Chickasaws Nation are different, can be different than that of the Cherokee Nation, which can be different from that of the Blackfoot tribe, which can be different from those tribes up in Alaska. And it's up to the tribes to determine what those priorities are so that they can best serve their people. We talk about consultation. Everybody's got a different version of consultation. There's the official version of consultation, the legal definition of what constitutes tribal consultation and how can we accomplishment that and document that and I would argue probably wouldn't need consultation if we just have communication and real communication where each side listens to the other and tries to understand the other's perspective in order to do the right thing. But because we have trouble doing that, we have consultation and it's a big thing. It is a big thing to have tribal consultation, especially if you want to try have tribal consultation with 560 something tribes at once. It's a big thing just to have tribal consultation with all the tribes in the state of Oklahoma or the Oklahoma City area. It's almost just a big thing to have a tribal consultation with just one tribe. But who, when our federal partners are working on an issue that's going to affect a group of tribes, those tribes that are going to be affected should be consulted with, should be communicated with. So you can get that local input, that local perspective to include in that federal decision. Tribes want to take care of themselves, their own people. Sometimes it is the federal interpretation of law and regulations and policy that prevents tribes from doing that. We want out from under that. In many cases, those tribes who choose to remain under federal control, that is their right to choose that and they should be treated with just as much respect as the tribes who choose to run their own health system. It's all about sovereignty, the respect of and the understanding for tribal sovereignty, the position that those tribal leaders are in Some somebody, I think it was you Stephen, talked about how much tribal leaders are involved in. I'm not small tribe, big tribe, medium tribe. It doesn't matter. They're, they are involved in every aspect of that tribal operation and that frankly I don't know how they do it. There is a lot that they have to take care of. They want to do it in partner with us. They want to do it in partnership with the federal government, but they want it in the best interests of their people. So now we have tribes and public health authority with the tribes. So it would stand to reason, right, that if a tribe can assume operation of a health system from the federal government, which includes public health, that the tribes would automatically have public health authority. I may have missed it, but I looked in every Indian law that I could find and nowhere did I find a federal law that says tribes have public health authority. But I believe it is inherent in the sovereignty that those tribes possess, especially when they are running their own health programs that they have assumed from the federal government that public health authority comes with them. It comes with that responsibility. I used to get in trouble when I was area director for IHS. My legal counsel down in Dallas. Would I? I would look and say, well, this law doesn't say I can't do X that's not enough. Federal law is permissive law. Unless it says you can do it, you can't do it. So I wonder how many of our federal partners, not necessarily in this room, but of all the agencies, if it doesn't say that tribes are public health authorities, does that mean that we're not going to treat tribes like public health authorities? They have to have that authority if they operate their health system. They have to have that authority if they are the sovereign nations that we say now. But the law doesn't give us that nomenclature. It doesn't give us that title. But I would hope that CDC, HIS, BIA in some cases and other federal agencies would look at tribes, especially those tribes running their own health system, that they do have that public health authority and they have that ability to manage those public health emergencies and respond to those public health emergencies in their area. We talked about Governor Nome in South Dakota and getting mad at the Cheyenne River Sioux Tribe for wanting to shut down the highway. You know, Navajo Nation shut down some major highways during COVID to protect their people. That tribe that inhabits the Grand Canyon shut off access to that reservation to protect their people. So they weren't exposed to COVID. And those were public health actions

taken by tribal leadership in the best interests of those tribes and of those people. That's the public health authority that we have to have.
We talked about COVID response the in Oklahoma, the state system and the county system fell apart during COVID. And if it was not for the tribes, the hit on Oklahoma citizens, including tribal citizens. I hate to imagine what that would have been. Chickasaw Nation itself vaccinated people from over 38 states because they couldn't get their vaccination in their home state. We had people flying into Oklahoma City driving to Chickasaw Nation because they couldn't get vaccinations in their home state. We opened up vaccinations to everybody regardless of whether they were a tribal Indian beneficiary or not and eligible for Indian Health Services. We opened up our hospital because the state and county hospitals were overflowing with intensive care patients who couldn't breathe because of COVID. And we opened it up to what are nonbeneficiaries or non-Indians in order to protect all of the state and not just our local people. We were the partners. We led the effort. I know that our fellow tribes in Oklahoma, they took care of their region of the state when the counties couldn't do it. I can't understand why we were not formally being given the name public health authority to manage our public health affairs. I would argue that we do, and I would ask that we be treated like we do in every case, big and small, just kind of stating what I said. Public health authority was not explicitly listed anywhere I could find in the Federal Register. So ICHIA talks about the unique needs and priorities of tribal communities. And once again, it's really another way of talking about sovereignty and the authority and responsibility of tribal governments to take care of their own people. And I hate to keep repeating it over and over and over, but with different ways of saying the same thing, My hope is that it will make an impact on the way that our government partners make decisions in the future. And that there will be a bigger appreciation of what sovereignty really is and maybe understand just a little bit better of what our tribes are trying to accomplish and why Tribes have inherent authority of sovereign nations to protect and promote the health and welfare of our people. That's what public health authority is all about. We're not trying to exclude people, we're trying to protect people and I can promise you, if we protect our people as Chickasaws, as Cherokees, as Muskogee, as Choctaws, as Seminoles and other tribes, it's going to spill over and it's going to protect our nontribal citizens as well, Governor Hannah Tubby says. Over and over, a rising tide lifts all boats and when Chickasaw Nation is a success, Pontotoc County is a success. When Pontotoc County is a success, South Central Oklahoma is a success and it just breeds success wherever it touches. We talked about in Self Determination Education Assistance Act and I will, I will tell my federal colleagues when I transferred back to Oklahoma City from Alaska in 1995, that was in the beginnings and the heyday of self-governance and the federal programs, the federal government, frankly, we were offended that the tribes thought they could do a better job than us and we resisted that and we were scared of that. We were fighting for our jobs, if you want to know the truth. And so there were lots of discussions that were very spirited during that time. And it took us a time frame of about six or seven years to finally understand what we're trying to communicate today about sovereignty and the responsibilities of those tribal governments. Whether tribes choose to compact or contract or whether those tribes want to stay with the federal delivery of health care, that is tribal self-determination. That is the tribes right to decide. And it wasn't up for us to decide if a tribe could do it or not. It was their right to decide. So, when it comes time to enter in those discussions with tribes, don't be offended that they are coming for you or coming for your job. That's not what it's about. That is just that tribal leader and that tribe, that tribal government, their expression of wanting to take care of their own to do the right thing. We talked about government-to-government relations. I hope and I pray that we all understand what that means. And maybe especially with Stephen’s presentation and the discussions this morning that government-to-government and tribal sovereignty maybe have taken on a little bit bigger, clearer meaning for those of us who engage in those discussions, those are not just words and anybody can just say those words. They're, you know, we call them buzzwords if we want to, but the meaning behind them is deep. And when we look at those pictures of my people from yesterday, from 50 years ago, from 75 years ago, that's why that's why those words are there. Those words are connected to those people and what those people went through so that we could have the life that we're having today. More government-to-government relations. What? Where? So where did this take us? We're, I am not trying to beat up TEC, not trying to beat up CDC, not trying to beat up IHS. But I want us to look at things in a new light and figure out how we can move forward to do bigger and better things for the benefit of tribal citizens.
That last bullet is the point I wanted to get to. It's a new paradigm of tribes first, allowing tribes to lead with tribal initiatives, tribal perspectives, tribal priorities, instead of tribes responding to somebody else deciding what those priorities are. And if that's not sovereignty or an example of sovereignty, I'm not sure what is. Tribes should be taking the lead. And now I'll turn the tables to my tribal partners here at this table. And that puts a big responsibility on us and you as the de facto tribal leaders and the and the and the TAC of being able and willing to effectively communicate what those priorities are. Your perspective is invaluable. And your federal partners need to hear that from you loud and clear and on a regular basis so that they can work with you to identify those. Because if we don't speak because the tribes and the federal government's going to do what the federal government does based on what they think is best, not because they're jerks, just because they're tasked with doing something. And for our federal partners, I'll know that sometimes you're in a bind because what Congress may tell the CDC you're going to do, what CDC leadership may tell you what you're going to do is in direct conflict with your relationship with tribe. I get that. I hope my tribal partners get that. You got to. Sometimes it hurts and sometimes there are consequences. And they're not necessarily just consequences, but I would just ask you to do what's right on behalf of our government's responsibilities or tribes, and to do what's right no matter what the cost. And eventually it's going to go throughout the entire organization and the government is going to start treating tribes the way tribes should have been treated all along so that tribes can grow and prosper. We've got a few more slides I'm going to skip through because I've talked a lot longer than what I thought I was going to talk. But we just want to partner for the benefit of tribal nations. And I hope with what Stephen has said, Deputy Chief and 2nd Chief have said has given you a perspective on tribal sovereignty and tribal partnership that maybe you didn't have before. We appreciate everything you do. We look forward to continue collaboration with you as we grow, as we work with each other to further Indian health and our tribal governments across the country. So I will stop now and be quiet. I could go on for a long time. It's hard to encapsulate this in a 45 to 55-50 minute presentation. Hope

you'll forgive me for rambling around, but thank you for your attention. I appreciate all of you and thank you for what you do.
1:37:22 – 1: 38:37
Deputy Chief Bryan Warner: WA-DO, Admiral Meeks. Thank you Sir, for delivering that, great presentation. And I want to open the floor to a larger group of the TAC or CDC officials. If anybody has any comments, obviously we can continue to talk about this for quite some time. So anybody have any comments or questions? OK, thank you both again, everybody. One more round of applause. Okie dokie. Well, we right now, we'll take a break until 3:00. They want everybody back in this room at 3:00 because at three we're going to depart as a group for the emergency operation center where our escorts will kind of divide us up into whatever lab that you're going to go to. I don't know about Y'all, but I'm excited. But before I go to that, I want to turn the floor to Captain Killsback for some information. Thank you.

1:38:39 - 1:39:53
Captain Damion Killsback: I know earlier we was a talk about forming A subcommittee. I just want to make sure that we reaffirm the language of the charter about how subcommittees are formed with the TAC chair and the Co-chair in consultation with our designated federal official Doctor Dauphin. Both may form subcommittees comprised of TAC delegates or their alternates as needed to accomplish the functions of the TAC. To satisfy the UMR exemption, the members of the subcommittee must be either a elected tribal leader acting in the official capacities, or designated employees of that of an elected tribal leaders with authority to act on their behalf, or a representative of a National Association designated by tribal leaders to act on their behalf. So committees 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 a the CDC/ATSDR was to make sure we're clear about that's in the charter. So we know we talked about subcommittee formulation earlier. So I was to make sure with that in mind as we move forward to work together. Thank you.

1:39:55 – 1:39:55
Deputy Chief Bryan Warner: Thank you Captain. So we will break now for and then like I said, yes Sir.

1:40:03 - 1:40:51
Dr. Belay: No, I just, I just wanted to thank you Chief Warner about the day for your leadership. There was a lot of good discussions that happened today from you know, CDC presentations and also the presentations we heard today. And and these are important things for us to keep in mind as we're moving forward. And thank you for sharing the history, the background for us to move forward. It's very important to know where we've been so that would be effective in going forward. And Admiral Meeks for your sharing your personal stories in reminding us of the public health authority in how that would help us with the government-to-government relationship. So I just wanted to thank you. Chief Warner and the presenters.

1:40:51 - 1:41:09
Deputy Chief Bryan Warner: WA-DO Doctor. Thank you. Thank you. So again break. Now remember after the lab we will come back, we will reconvene here to close out the day and get a summary from Doctor Dauphin. So we are on break back here at 3:00. We're going to go check out some enterics, mycotics and waterborne diseases causing agents, yes.

BREAK. RECORDING STOPPED

RECORDING STARTED

0:00 – 0:35
Deputy Chief Bryan Warner: Full cultural enrichment activities. I appreciate being able to see the emergency operations center and the lab tour that we took was, absolutely wonderful! So, again, just very privileged and blessed to be able to do that. So, before we, I know we have closing prayer and adjourn. But before we do that, I want to turn it over. Is Dr. Dauphin. Is she on the line? You want to do it tomorrow morning. Okay, Okay Do you want to do it Doc?

0:41
Dr. Belay: The summary I could do is a summary for today, and then Dr. Dauphin could do it for tomorrow morning. Okay?

0:41: 0:57
Deputy Chief Bryan Warner: Okay, All right. At this time. I would like to turn over the doctor to Dr. Belay and let you do the summary for, sir.

0:57 - 4:48
Dr.Belay: Thank you. Thank you Deputy Principal Chief, thank you, everyone. I think we had a very productive day. We started out by summarizing the drive on the Data Modernization initiative by Dr. Kucik, who, I don't think, is here, and Delight Satter. Thank you so much. It's very nicely summarized. The roadmap that was developed in that roadmap is very specific. It has four specific goals including increasing the data infrastructure and capacity among tribal organizations. In data availability and access, which--as you pointed out--we need a lot of work to make sure that data access is available for tribal organizations to the communities as we needed. In the third goal, they identified was increasing or improving the data quality in interoperability of systems. In the fourth goal, they

mentioned was to try to increase the skills and the capacity, and the public and the workforce, including the workforce. I have CDC. To be able to support tribal organizations. So those four goals are roadmap for us to take us to where we would like to be in terms of data, modernization initiatives for tribes. And then we had the Doctor Cohen join us today that was a big privilege for us to have the director actually interested in what we are working across Indian country. There is a lot of commitment from the top leadership at CDC. I can tell you that we have regular touch base with them to make sure that we're making progress on our government-to-government relations. She outlined four priority areas for the agency. I don't want to go into a lot of details. But the four priorities included, improving mental health with emphasis on drug dose, prevention of drug, prevention of drug, drug overdose. She also mentioned readiness and response in supporting young families which are identified. CDC priorities in all centers across the agency are working on those priorities and at the core of all those is health equity. Across the board, in how we can work with tribes to address those priorities. And then we heard we had a very important session with Admiral Meeks and Mr. Greetham was very, very informative going through the history and the background, and for us to learn from the past, which is very, very critical. Also, they also told us about the public health authority for different at different levels, including for tribal governments, which is very important for us to know. And the other thing they outlined is the legal framework for us to work with, with tribal government. It's not just an option, but it's a legal, there is a legal framework for us to utilize. So, these were very important presentations today. I here. I believe they're very successful, and I hope you all enjoyed your visits to the laboratories and the Emergency Operation Center today. So, thank you, everyone.

4:51 – 4:54
Deputy Chief Bryan Warner: Thank you, doctor. I appreciate that summary. Now I want to turn it back to Captain Killsback for some more information.

5:00 – 6:13
Captain Damion Killsback: Thank you, Deputy Principal Chief Warner. So please join us, for at 5:30 for continued conversation network of the schoolhouse brewing across from CDC campus at Emory Point. This is the Gymnasium Schoolhouse brewing all TAC members, PHIC Center leadership, CDC Leadership, presenters and members of OTASA are cordially invited to join us. Please visit the registration table for details. We have inserts in your meeting packet TAC members. We recommend utilizing the hotel shuttle service to Emory Point. Once we adjourn here; we will have escort helping us with this transition. We also have Dr. Megan Nichols. Sorry, Dr. Megan Nichols can help escort people here, directly from, directly to the venue. I will have to go back to the hotel to change out a uniform, and will see you guys as well. So, if you guys need a ride we'll get a shuttle, and we can all meet. They will have some refreshments there, as well as an ability to order food with a QR Code download. So, thank you.

6:15 – 7:10
Deputy Chief Bryan Warner: Thank you, Captain. And again, I just want to thank everyone for their time and their attention today. A lot of information in a day's time. But remember, as we kind of move forward, and we continue to encourage one another, those monthly calls are so important to keep this thing moving. We're talking about looking at potential subcommittees on data, modernization with the leadership that we have at the table, and with our technical advisors out there we would be lost, So WA-DO to each of you, from whatever tribe or wherever you serve, even if you're a non-tribal member as you heard from Mr. Greetham today, there is a lot that we can learn from one another if we just stay open about where we're at in our mindset, and where we want to go. So I know everybody is like hurry up, deputy, so I want to turn it over to a legislator, Barker, and she's going to close us out in prayer.

7:11 – 8:03
Legislator Connie Barker: CDC Auditorium: Thank you, deputy. If you just pray with me. Oh, gracious and otherwise Heavenly Father, we just come to you getting thanks for this day Lord, we come to you giving thanks for the presentations for the information that we were given. Father God knowing that you created each one of us to be equal. And Father God that we just know that our tribal members expect to be treated that way. Father as we go our separate ways, we ask that you continue to watch over us, bless us, keep us safe. We also want to thank you, Father, for our partners here at the CDC. As we just get a frontline, look at the things that they do to keep our country and our people safe. And, Father God, we ask that you continue to be with our military as they're out there also, Father working to keep us safe, and you just wrap your arms around them and watch over them. Father God, just be with us the rest of this evening. These things we ask in your son's holy name. Amen.

8:04 -8:15
Deputy Bryan Chief Warner: Thank you, Legislator Barker. Well, thank you. Tomorrow we will continue starting at 9 A. M. And conclude at 5. So, we are adjourned.