CDC/ATSDR 27th Bi-Annual Tribal Advisory Committee Meeting
February 22, 2024
Transcript

0:00 – 0:27
Deputy Chief Bryan Warner: Good morning, yesterday, I know I want to say that I want to say thank you to our TAC delegation for being here and all of their technical advisors. And a special thank you to our CDC federal partners. It was a wonderful first day of meeting and I know that today will be much the same. And just happy to announce Dr. Dauphin made it here safe and sound. So welcome, Dr. Dauphin. Thank you.

0:28
Dr. Les Dauphin: Thank you, Deputy Chief.

0:30 – 0:40
Deputy Chief Bryan Warner: So, before we get started, we want to start this in the proper way. So I'm going to ask Second Chief Del Beaver to lead us in a blessing.

0:41 – 1:24
Second Chief Del Beaver: All right. Hello, Chief. If you would. If you pray, I'd ask that you just pray with me. So. So let's bow our heads and close our eyes. And let's pray.

Dear Heavenly Father, Lord, I thank you for such a beautiful day. I thank you, Lord, for allowing us just to wake up, Lord, and just to do your will today. And so, Lord, I just ask that you be with our actions, you be with our thoughts, and you be with our words, Lord, today, and that you just guide and direct us throughout this day and just keep us safe. And Lord, as we prepare to go home today, I ask that you just give us safe travels, Lord. And Lord, I just ask you to look after our families as we're away from them. Lord, look over our households, Lord. And Lord, just protect them, Lord. And Lord, again, I just thank you so much, Lord, for just giving us one more day to serve you, Lord. But, Lord, I just ask all these things in your Son's precious and holy name. Amen.

1:26 – 2:05
Deputy Chief Bryan Warner: Amen. Thank you, Sir. Well, we've got a full slate of items today, but I will again just a very appreciative of everyone's time and attention on these matters and so we'll we'll get started here.

Prior to getting this meeting started, I'd like to request that everyone attending in person please silence their phones. We really want to be respectful to those presenting today for everyone's awareness. This meeting is being recorded. I will now turn the meeting over to the Director of OTASA, Capt. Damion Killsback for a welcome and to initiate the roll call. Capt., you have the floor, Sir.

2:08 – 3:13
Capt. Damion Killsback: Thank you. Good morning. Welcome back to the second day of the TAC meeting. We have a captivating agenda prepared for you, featuring insightful presentations from subject matter experts across CDC. Their expertise will cover a range of topics that directly align with the priorities we've heard from you, our TAC members. As a reminder, we have asked our presenters to allocate sufficient time for dialogue and discussion to ensure we hear from the TAC. Your insights and perspectives are invaluable and we encourage active participation throughout the day's sessions. Thank you for your presence and active participation. We look forward to a day filled with engaging discussions and the invaluable contributions you bring to the table.

I'm going to initiate roll call for record keeping purposes when I call your respective area or name please respond with present. Alaska Chief Alicia Andrew, Albuquerque Councilman Conrad Jacket, Bemidji area Ms. Deborah Danforth?

3:13
Ms. Deborah Danforth: Present.

3:17 – 3:21
Capt. Damion Killsback: California Area Council Member Teresa Sanchez?

3:21
Councilmember Teresa Sanchez: Present.

3:22 – 3:25
Capt. Damion Killsback: Great Plains area, Jeralyn Church?

3:26 -3:30
Megan O'Connell: Megan O'Connell, proxy for Ms. Church.

3:35 -3:37
Capt. Damion Killsback: Navajo area, Ms. Kim Russell?

3:39
Ms. Kim Russell: Present.

3:41 – 3:44
Capt. Damion Killsback: Oklahoma area, Deputy Principal Chief Warner?

3:45
Deputy Chief Bryan Warner: Present

3:50 – 3:52
Capt. Damion Killsback: Tucson area Councilwoman Garcia?

3:56 – 4:00
Ms. Vivian Saunders: Alternate Vivian Saunders, Tucson area.

4:02 – 4:08
Capt. Damion Killsback: Thank you. National at Large Member Dr. Sharon Stanphill?

4:09
Dr. Sharon Stanphill: Present.

4:14 – 4:17
Capt. Damion Killsback: National at large tribal member, Legislator Connie Barker?

4:18
Legislator Connie Barker: Present.

4:21 – 4:25
Capt. Damion Killsback: National large tribal member Councilwoman Herminia Frias?

4:26
Councilwoman Herminia Frias: Present.

4:29 – 4:31
Capt. Damion Killsback: National at large tribal member Second Chief Del Beaver?

4:32
Second Chief Del Beaver: Present.

4:35 – 4:51
Capt. Damion Killsback: National at large member Councilwoman Carrie Freeman. Ok, we have quorum. I'll turn the meeting over to Principal Chief Warner.

4:51 – 4:54
Deputy Chief Bryan Warner: Thank you, Outstanding. Thank you, Capt. Damion Killsback. And at this time, I would like to welcome Dr. Dauphin to provide an update on the CDC's 1803 Tribal Capacity Cooperative Agreement report and anything else that she sees fit.

5:07 – 7:52
Dr. Les Dauphin: Thank you, Deputy Chief Warner, and good morning, everyone. I am really delighted to be here in person and sorry I couldn't be here in person yesterday. I know that the meeting has been going extremely well and just appreciate everyone's engagement and input.

So, one of the things that I'd like to share about our tribal cooperative agreement is that we are now at a point where we are about to send out a request for centers, institutes and offices across the agency to invest in projects. So, this is a really good time where we do a call for support that will be going out soon. The updates that I have are that 32%, that's eight out of the 25 recipients are working towards closing out the five-year cooperative agreement. The remaining 17 recipients, that's 68% are working towards completing their approved activities through no-cost extension periods now and 2025.

The Public Health Infrastructure Centers division of Jurisdictional support is leading a project and manuscript development about the administrative efficiencies and effectiveness realized for the agency through the use of this funding mechanism. The team working on this project is currently drafting an approach for this project and plan to have a draft report that we can share with you for awareness in early spring. In August 2023, CDC launched a new five-year umbrella cooperative agreement which I think we reported on what we met during a monthly call for American Indian, Alaska Native, Tribal nations and regionally designated tribal organizations. The ultimate goal of this funding is improve public health outcomes and less lessen health inequities in Indian country. Recipients

received 208,000 each in base funding from our center to improve their capacity to develop, implement, and evaluate public health programs and services in American Indian, Alaska Native communities.

In addition, most recipients received supplemental funding for various projects including data modernization, injury prevention and control, wastewater surveillance and addressing cultural competency of healthcare providers serving American Indian and Alaska Native people. The total funding for year one is 26,000,000 and recipients have begun work on these projects. And now I'm happy to turn it back over to you Deputy Chief Warner.
7:55 – 9:12
Deputy Chief Bryan Warner: Thank you Dr. Dauphin for this important update. TAC members, we will have further opportunities to discuss this during the upcoming conference calls, but the floor is open for discussion.

TAC members attending the meeting virtually, please remember to use the raised hand feature or place questions in the chat box when you speak. Please remember to state your name twice and the area that you represent on the CDC/ATSDR TAC to ensure accurate notetaking. So I will open the floor for anyone that has any questions or concerns right quick. And like I said, we do have other time later to discuss this as well if you come up with something or your technical advisors.

So, all right, well moving right along at this time, I would like to welcome our first presenter for the session on the CDC budget. We are privileged to have Ms. Gallagher to share this update with us. So thank you Ms. Gallagher for joining us and she is the Acting Director of the CDC Office of Appropriations. Welcome.

9:19 – 36:30
Ms. Cathy Gallagher: There we go. I don't know why it would be red to indicate on. Thank you for having me here this morning. As just heard. I'm Ms. Cathy Gallagher. I'm the acting director for the Office of Appropriations. My office is responsible for pulling together the President's budget each year and also is responsible being a liaison with the Appropriations Committee as they consider the President's budget request. Next slide please.

So, I'm today I'm going to talk a bit about CDC's budget including sort of what goes into our role in creating the President's budget. Also, I'll talk some about FY24, the fiscal year we're in now, and perhaps a little bit about FY25. I can't say a ton about that currently because as you'll hear why later the President's Budget isn't released yet for the fiscal year 25. We'll get into that some and then also go into a little bit of detail about some of CDC's awards to tribes. And finally, any questions that you have and some information to connect with us. Next slide please and then next slide. Thanks.

So, this slide is just a very high-level snapshot of CDC's annual budget. You'll see the last two years, fiscal year 22 and 23, as well as what the President's budget is for 2024 and Congress is still considering that budget request. The total amount requested, I mean the total amount we have currently is 9.2 billion and requested for fiscal year 2024 is 11.7 billion. That's made-up of several different funding streams. The 1st is our budget authority, that's our base appropriation, the resources that are appropriated directly to CDC to carry out the programs that we run. In addition to that, we have prevention and public health funds. Those resources are appropriated to HHS and then further delegated to CDC to run programming. And then finally, we don't currently have any of these funds, but they are requested for for FY24: our public health evaluation transfers. Those are some resources that are transferred within HHS to cover evaluation projects. Next slide, I'm going to spend a little bit more time on, on this slide.

This is a calendar, somewhat national calendar of a typical budget cycle. A couple of things to point out here before I go into it. You can note the gray line in the 2024 section around February. That's where we are currently. The green section indicates that we should be executing or spending money that was appropriated for this year. That hasn't happened because Congress hasn't completed their work to appropriate those resources. Instead, what we are able to spend right now is under continuing resolution which allows us to spend resources at the same level and for the same activities as were appropriated the in fiscal year 2023. So that's what we are continuing with now. So we can continue operations but can't make new commitments because we're under the regulations of the fiscal year 2023. Congress is still considering the appropriation for 2024 and currently where we the continuing resolution is slated to end on March 8th. So hopefully by that time we'll have an appropriation. Also, the red section which indicates when the President's budget is released, then you'll see in 2022, in 2023 that was released in February. That is typical that it's released right after the State of the Union where the President lays out administration priorities, including those priorities that'll be in the budget. The State of the Union address is not until March 11th this year, and I'm sorry, March 7th. And the President's budget is currently planned to be released on March 11th. So, we're just a little, but I had hoped to be breaking more new news in this presentation, but instead, it's probably it's similar to what has been in place over the last year. And so, you know really the timelines, the process here is consistent in terms of what we do and how we do it. And I'll go into a bit of that. The timelines are definitely not written in stone, and you know some years are typical, some years are not. Let's see in the next couple slides, I'm going to talk some more about what that process is it. Next slide please.

So in April usually we receive guidance, we CDC receive guidance from HHS directing us on how to go about thinking about our proposal for the President's budget is each year. So this is CDC's opportunity to work with the director, work with our national programs, take into consideration the public health data, the progress of our programs, and a number of other priority areas, and think through what our proposal will be to the Secretary for Budget Initiatives for increases for programmatic changes. And we'll pull together a document that is a proposal to the secretary, and we'll make our best case for the proposal that we're putting forward. We do that in accordance with the guidance that they present us. So that guidance can be related to funding levels. It can also be related to

policy or programmatic direction. So it varies from year to year. So we might see something that says--and way more words--we'd love to see what you think, it's important to do, but keep everything level funded. And we have some discretion at that point to think through where we would shift resources with the best of our knowledge and within our priorities to make that case. So, we in the around June, we'll submit that document, that proposal, to HHS for the Secretary and HHS leadership to consider. There's a good bit of back and forth between staff in my office and across the agency with the budget staff in HHS. They'll ask clarifying questions. They will push back. They will ask why something is there, why something is not proposed, why we made different changes, that kind of thing. And then the Secretary's budget staff will write recommendations for this consideration in June, sometime well June through August. There is a Secretary's Budget council at that time.

The CDC Director, sometimes with additional subject matter experts, will come and present the budget and again make the best case and answer questions from the Secretary and the counselors from HHS. They will take that information and consider it and get back to us with their decisions on what the on our proposal. Sometimes it—well, they never accept everything. We don't we don't get our way completely on everything. But there's an opportunity for them to, for us, when we get their response to our request to have a little bit more of quick back and forth. So we can do some appeal, make some adjustments, and see if we can come to a different negotiated agreement with them. And then they'll make their decision.

Once HHS makes their decision on the HHS justification, that part of the formulation cycle is over and we have a sort of a One - HHS perspective on what the budget proposal is. Then we start that process over again with the Office of Management and Budget, where we will, working with our HHS colleagues, make the best case for the proposals that were jointly negotiated between CDC and HHS to OMB. We'll have the same iterative process questions back and forth from our OMB examiners. They'll make the same kind of recommendation to the Director of the Office of Management and Budget, who has the full countries, the full, the full funding to budget to consider with other parameters that they need to work within. Then they will also pass back around the November to January. It used to always be in November. Annoyingly, right after Thanksgiving they've gotten away from that some. So it's November to January that we'll get information from the Office of Management and Budget passed back to us. And we have again a quick time where we're able to do some appeal and negotiation and then Office of Management and Budget will make their decision. And that's where we work to create what becomes the President's budget. That will be released typically in February, but not always. So this year hopefully it will be released next month in March.

Just a couple of things. I mean this is kind of a lot of what could be boring step-by-step processing things. But I think the point that is important for folks to realize is that this is an iterative and negotiated process that that we work in partnership up sort of up the chain in the executive branch to come to an agreement. But that once in that everything up to the publication of the President's budget is strictly embargoed. So, the only thing you'll ever see, the only thing we'll ever be able to discuss are those final decisions 'cause that's the administration's policy budget policy and programmatic policy that the other parts of that are deliberative, and we're we aren't able to discuss that. Sorry. Next slide please.

So, this slide talks more talks some about the activities that we what we do once the President's budget is complete. So, it's moving from creating the proposal to promoting the proposal to directly Congress and then also to folks in the community, to our public health partners, to our currently funded programs to describe what the proposal is. So, after the release we will have lots of meetings with members of Congress and their staff, lots of back and forth with the Appropriations Committee staff partners. Also, during this time, just usually March and April, we'll be up on the Hill doing their their Hill days, doing individual outreach, particularly focused on appropriation members. Then there is, typically, I think always a secretarial budget hearing before the Appropriations Committee where the HHS Secretary will describe the proposal in a very formal way to the Appropriations Committee. CDC sometimes has a budget hearing and sometimes we don't. Sometimes they just look to the Secretary for that and then we have the less formal questions requests for briefings where we're able to provide additional detail answer their questions for them to consider what their decisions will be. Typically, the House and Senate markup mark up their budgets. This means they're coming up with their individual sort of draft appropriation bills and language. And then there's usually by June, this is not really even usually anymore, because they really don't make this by June most times. But in the summer, there's a conference where the House and Senate Appropriations Committee will come together. They'll consider the differences in their budget levels and their policy direction and in their bills and come to a come to a decision on what the final bill will be. That again hasn't happened on in a timely way in many years just a few points on the legislative branches process. Congress doesn't follow the president's budget. I think it best it is a guideline for them. It's an important consider. It's an important statement to Congress, both a budget statement and a policy statement from the administration. But it's not something they take and use as a blueprint for sure. So, they have their own priorities. They have the responsibility to think about the priorities of their constituents. They hear from advocates and all of that goes into their decision making on the policy direction and the budget levels for not just for CDC but every bill that they consider. So, it's important that they hear from you all and they really do listen I mean at this time as they're deciding and the good news with pushing off a decision on a and an appropriation is that there's longer for folks to reach out to their members of Congress to advocate for the public health priorities and programs that are important to you. So, the other thing I want to point out, and this is the purpose of like, why did I get this tiny, tiny list of numbers? I did decide not to try to, like, hurt your eyes by putting this on slides. But this is, and this is the operating for CDC's, the operating plan for CDC. The reason I handed it out is because it shows the very detailed level that Congress dictates our budget. So, every single line with a dollar amount here indicates a directive from the appropriation committee on the amount of money that we need to spend in that programmatic area. So, there there's very little flexibility in most of these budget lines for CDC to show discretion on where the funding or how

the funding will be used. We're really held to, we're definitely held to these amounts and also guided by the direction that is in the appropriations bill language which is law and then also further guided in the appropriations report language, which is very, sometimes very detailed and very directive guidance on how on congressional intent on how CDC should spend the resources that are appropriated to us. And you know I will say the report language it is not part of the law, but we do take it extraordinarily seriously because it is congressional and it does show congressional intent. Some of the language can be is very directive and it and that it says we direct CDC to do this in these ways. Others are more suggestive, but we really pay attention to that to make sure that we are carrying out the intent of Congress which is their role. And then I guess the final thing is in, and this is sort of set-in stone, is that the new fiscal year starts on October 1st. So, whether or not we have an appropriation, the fiscal year starts on October 1st and we would either be working under a continuing resolution as we are currently or there have been a few times in recent years where there was a government shutdown to use the newsy term for it where we're operating with we can't operate. But when we don't have an appropriation to operate under. Next slide please.

One more, and this just shows, I've already been over this a little bit, but the total request for FY24 was $11.6 billion and that is an increase of 2.32 point, 4 billion over the 2023 enacted level. We also proposed mandatory funding, some mandatory funding. Those would be for the Vaccines for Adults program, which is a one point, basically a billion dollars and $12 billion over the next 10 years. Also, the Vaccines for Children program $6.2 billion. We have mandatory funding for the World Trade Center Health program as well as a proposal for mandatory funding for HHS-wide Pandemic Preparedness at 6.1 billion. Next slide and as I've already said our current status is that we're working this the slide we turned in the slide before the 1st continuing resolution expired. So, it is not February 2nd, it was February 2nd. Now we're under this new continuing resolution which expires on March 8th. The top line numbers for each of the appropriation bills have already been negotiated. So, the appropriation subcommittees have their overall budget numbers to be considering how that's distributed among the various agencies and programs that they're responsible for. And then we are, you know, basically playing a little bit of a waiting game for the budget to the appropriation to be decided, answering still a bunch of questions from the appropriations committee staff as they try to clarify, clarify their positions and come to a negotiated settlement. And then again FY for the President's budget for fiscal year 25, you'll see that on March 11th. I had hoped to be able to talk more about it today. Next slide please.

In the next few slides, I just wanted to talk a little bit more about some of the awards to tribes that we currently have. And then you'll hear more about this or you probably heard more about this yesterday and hear some more about from programs today. The CDC provides funding to tribes, tribal serving organizations and urban Indian organizations through a variety of cooperative agreements. We have $136 million, the more than $106 million awarded to tribes and tribal organizations in 2023 and three million in addition to the 2023 appropriation. An additional 3 million in supplemental appropriations and the supplemental appropriations are right now primary primarily resources that we received to address the coded pandemic. And so those are monies that are on top of our regular appropriated dollars. Next slide please. So, we fund in in addition to these larger agreement, the property of agreements, we fund tribal organizations through many areas, maybe most areas in CDC. I'm not going to read through each one of these, but this is sort of an example of all of some of the areas that receive or that that grant resources out to tribal organizations across the agency. And again, you'll hear from many or have heard from many of these groups already. Next slide please.

So just some examples of the reach of the resources. In 2023, the tribal practices for Wellness in Indian country, which is $5.3 million funded 23 tribes and 13 urban Indian organizations. The Tribal Epidemiology Centers, I'm sorry. Public Health Infrastructure had $6.8 million funding 12 Tribal Epidemiology Centers and one Network Coordinating Center. The Tribal Overdose Prevention Program in 2023 provided $11.26 million to 16 recipients, and the Good Health and Wellness in Indian Country program provided 19.3 million to 12 tribes for Indian for urban Indian organizations and 11 tribal organizations. Next slide. It's an example from the public infrastructure and capacity to grant. The Oregon Health Authority's Public Health division allocated $4 million to 10 recipients from their Public Health Infrastructure grant award, including nine federally recognized tribes, 1 Indian Urban Indian Organization and which was the Native American Rehabilitation Association. Next slide also CDC this year launched a new five-year umbrella cooperative agreement that was launched August 29th. It's to improve tribal public health infrastructure and services to tribal communities and to implement foundational public health capabilities to strengthen assessment, surveillance, public health preparedness and response, policy development, communications, community partnerships, organizational competencies, and accountability and performance management. That grant will also implement data modernization activities to develop and deploy scalable, flexible, sustainable technologies. It will implement public health programs and services to comprehensively meet tribal public health needs and implement workforce activities to develop and maintain a diverse workforce with cross cutting skills and competency. As of October, this year, CDC has provided nearly $26 million to 26 federally recognized tribes and regional tribal tribally designated organizations. Next slide, I think that's my last slide. So, you can see how to connect with us through the link there. Also, if you are participating remotely or if you want to see more information about CDC's budget, our operating plans for or our President's budgets from past years, you can go to cdc.gov/budget. All of that information is there or just I usually just Google CDC budget and it pops right up as the first thing. For more information there. I'm happy to take questions if there is time.

36:31: 37:10
Deputy Chief Bryan Warner: Thank you, Ms. Gallagher, great presentation. I would like to invite all of our TAC members to share any further questions or comments on the CDC budget presentation. Remember, if you are attending virtually, please use the raised hand feature. And when you speak, remember to state your name and the

area you represent so the floor is open to the TAC delegation. Also, a reminder that you can yield your time to your alternate or a technical advisor or a guest. So I will open the floor. Yes, Dr. Sharon Stanphill.

37:13 – 39:38
Dr. Sharon Stanphill: Thank you, Chief. Sharon Stanphill, Chief Health Officer of Governmental Affairs for the Cow Creek Tribe and Rep at large for the TAC. First, first question off, as I thank you for your presentation, as you were going through it, a lot of things were going through my head. And the first is I wanted to ask if the CDC, I'm sure you're aware of President Biden's executive order that came out in December regarding reforming the federal funding and how all the agencies and HHS, will do this to promote a new era of tribal self-determination? And so first of all, I just want to kind of start with that because this has huge implications and I sure hope the CDC will be a leader in taking these next steps to help us assure that we're, we fully interpret and follow this executive order as you're getting ready to prepare your budgets for 2025. Tribes are preparing for 2026 right now. But I just wanted to lay that as the groundwork because without that the rest of what I'm going to say probably, you know, wouldn't make sense. I hear you saying that the line items in your budget are pretty much set. They need legislative changes, which is exactly what needs to happen. So just a few things. I believe according to OMB, tribes receive about 1% of the CDC budget, less than 1% point, 7%. We're asking for 10%. We've been asking last September. Tribes in the Northwest and across this country are asking for more funds so that we can stand up our own public health departments and not have to go through the state and not have to go through say other tribal organizations even or non-tribal organizations. So that's one thing I want to ask is that you'd be able to work directly with US versus the state. Many of us have compacts and contracts, would like to see those funds go directly into the those agreements. But just really want to make sure that as you design and you look at your budgets as you're moving forward that you would remember this, that this executive order is now in place and that it's to be followed. And that we really hope that you will invest in our public health infrastructure and help us be able to do the work we need to do. So, I'll, I'll stop there.

39:42 – 39:49
Deputy Chief Bryan Warner: Thank you, Dr. Stanphill. Anyone else? Second Chief Del Beaver.

39:54 – 41:30
Second Chief Del Beaver: Good morning, good morning. I appreciate your presentation. You know, one of the things that when we create our budget. Let me introduce myself: Del Beaver, the second chief of the Muscogee Creek Nation out of Oklahoma. One of the things that we do whenever we create our budget is that you know, we bring all our directors, and our secretaries, and we go over their budget and then we put our budget together and then we submit it to our National Council for approval. Similar to what y'all do. It seems like we're all similar. But one of the old sayings that we have is, what you know: to see what matters most to an organization, you look at where they spend all their money at. And for the tribes to be less than 1% of CDC's budget, I'm not saying we have to be 50% of the CDC's budget, but that's kind of where how we determine what matters most to us. So, so that being said, you know being less than 1% of CDC's budget, how do you determine how much it allocated for tribes and how what goes into that process? Who are you talking to? You know what kind of feedback are you looking for? Because it sounds like that, you know, if we're asking for 10% set aside for CDC's budget and we're only getting less than 1% and, then there's a disconnect somewhere. And so, so, I would just like to know what is the process of who are you bringing to the table that represents the tribes that say, hey, we need more than .07%.

41:31 – 43:27
Ms. Cathy Gallagher: I think I can speak to some of the things. I don't know that I'm privy to everything. I think meetings like this are critically important for these decisions. So, hearing from you yesterday and today all of our programs, hearing from you yesterday and today and in the future is important information for us to have. Similarly, I think and I'm sure you do this reaching out to the other decision makers in in HHS and OMB and importantly with Congress and I think having that layered approach, it is really important to give that information. And then we also work once the resources are with CDC, each program will work to determine how best to reach populations as possible. And sometimes that is through direct funding, some of the grants through direct funding, sometimes that is through state health departments. And a lot of times that's determined by the amount of resources those individual programs have and the scope of the scope of their mission, what they need to, what they need to accomplish and getting direction from a variety of areas. And you know I think and then these other the cooperative agreements that were announced last year and just now are also an opportunity there are more cross cutting to provide some flexibility and some additional resources, some higher level of grant resources available to tribal communities. And then so I just think I'll stop there, I don't know.

43:32 – 43:54
Second Chief Del Beaver: So, would it be, is it just for clarity? Is it our responsibility to make sure our congressional leaders know that there's a barrier here legislatively and that we need to go to our congressional delegates, which is not a problem, and we have a good relationship with our congressional delegates? Or is it the CDC's responsibility to go to bat for us?

43:57 – 45:09
Ms. Cathy Gallagher: I think it's both. Both. I think it's both our the constraints that we have sometimes depend on what is in the president's budget. It's our responsibility as part of the executive branch to support the President's budget. We have some so, so we have to sort of carry out and promote what is there. There is some flexibility within some of the directives where we would be able to provide and do provide additional information to them that would inform their, you know, their decision making on direction to us. I always think it's important for individuals and groups to reach out to Congress. It matters. They work for you, for the public, and their

responsibility is to represent their constituency and you're an important constituency of them and also again important for these kinds of meetings broadly with the agency and also with individual programs to continue that conversation.

45:12
Deputy Chief Bryan Warner: Yes, Miss Danforth.

45:14 – 46:31
Ms. Deborah Danforth: Thank you, Ms. Deborah Danforth Bemidji area representative and the TAC alternate for Councilwoman Jennifer Webster for the Oneida Nation. Thank you again for your presentation. I would just like to again echo some of the sentiments that have already been said and that is, you know, it is it's extremely frustrating to see that as nations we're only less than 1% of the CDC's budget, yet we're the population that has the most health disparities and the most underfunding in the entire country. I think, you know, one of our gentlemen that spoke yesterday talked about how the per capita cost for prisoners in the federal prison system is greater than what tribes have for their individual constituents. I think the important thing is that I want to echo is just that. I think we've come a long way. Thank you to Dr. Dauphin for her leadership here and representing the tribes. But I also think that it's important to note that it took us 20 years to get advance appropriations for IHSI Hope it doesn't take us 20 years to get 10% from the CDC budgets. Thank you.

46:33 – 46:37
Deputy Chief Bryan Warner: Thank you. Thank you. Miss Danford. Yes, ma'am, Miss Russell.

46:37 – 50:32
Ms. Kim Russell: Good morning. Ms. Kim Russell, Executive Director for the Department of Health, representing President Buu Nygren, the President of Nomination. I had mentioned yesterday that I worked for state government. I worked for state government for almost 10 years. And so I would see the inner workings of how state government received funds. And as tribal people, tribal liaisons of our different agencies, we would see the funds. And we knew they weren't going to the tribes. We just knew because we didn't have the influence to make those decisions, even though their own data says we have the highest health disparities and all the different categories that they're supposed to be addressing their own state data. So, so my point is around really, how do you work with the with the state so that they serve all of the people that they are listing within their grant applications that they are going to serve? Right. How do you do that? Because again, being from state government, we weren't in positions of authority to insist on that. Really. It was, it was really up to those state leaders where they wanted to put money. And so when it comes down to when they applied for money through all the different the HHS agencies, they list us in there. Yeah. So just maybe some recommendations. A lot of the times we see this, the funding come out and we're like, where did that funding come from and how come we're not part of it. We could have used it so desperately if you could perhaps require, and this is in your authority, require, those that states submit a letter indicating that they've consulted with tribes whether or not they would like to be a part of these grant applications. Until there is direct finding that is one option to address that. And if they are not going to be participating at just does it just at least indicate that they have tried to consult with tribes? And if tribes do want to be a part of that, what is their plan? So, a little bit more than just a letter of support. You know what is really their deliberate actions to work with tribes so that that funding, because it's not coming directly to the tribes, get to the nations. The other thing I want to mention coming from a big tribe is when we get a grant funding that's like three $400,000. It's really not worth it, right, because we have a big infrastructure to support that. When the funding is so small, we look away because it really will not address the needs that we have. The other issue and I meant I saw in here in the folder here about Oregon Health Authority and how that they were willing to share the wealth with some of the tribes in Oregon. So that's a good example of how a state should work with tribes, but that doesn't happen all the time. So, my message being within your authority, how do you ensure that states are working with tribes in these areas? And again, you know you'll get their data, it's their own data that they publish every year and it's going to be American eating populations that have the highest disparities in these areas, but they're not addressing them the way that they should be. The second thing I wanted to mention was one of your grants are strengthening public health systems and services in any Indian country grants. I applaud you in terms of getting specific funds out to tribes, but that's on a five-year cycle. And I guess my question is for those tribes that aren't able to come in, in this five-year cycle, when will that open up again? I hope it's not in another five years because now there's five years that we cannot be a part of that.

50:36 – 51:24
Ms. Cathy Gallagher: Some of your questions aren't best for me to answer because they're more programmatic and individual programs who manage those grants, provide direction through their funding announcements and also further direction support with their project from their project officers working directly with grantees and in the communities to provide that direction. On your last on your last question, what you know when would be the opportunity for additional applicants. I think if we were to get additional resources that that would be the next opportunity and that could happen on a different timeline.

51:26 – 52:06
Ms. Kim Russell: May I request maybe at our next meeting some of how CDC is going to address really working with tribes. You know, I hate to say it here and then we come back again, and it's not being addressed. So Capt. Damion Killsback like I'm wondering if that you could do that. You know what are the efforts that CDC is going to undertake so that at least you know the state pass through that there is a deliberate effort for states to work with tribes. Well, what is it that you are going to administratively put in place so that when they do apply for these millions of dollars, there's effort to reach out to the tribes within their state. My request. Thank you.

52:07 – 52:09
Deputy Chief Bryan Warner: Thank you. Miss Russell, Dr. Dauphin.

52:09 – 53:43
Dr. Les Dauphin: Just thank you for the comments and especially for the recommendation recommendations are really helpful. I appreciate the one about a letter and consultation that when we're engaging on funding that they're that that states or recipients are looking at having a A letter, submitting a letter. I don't know how we implement that, but that's something we can certainly look into. And I think yesterday there was a presentation that we have an update on our grants Governance board as an internal body where we can discuss things just like this. So, I'm not an expert in this area, but regarding specific guidance and language that we can put into our notice of funding opportunities, this might be actually something that we can look at. So, I will check. I'm going to accept responsibility for checking into this one and getting back.

The second thing I did want to say is about the cycle for our grants and cooperative agreements. Those are constraints that we have. So, a 5-year cooperative agreement is a 5-year cooperative. We're actually going to have a presentation by Ms. Stacey Mattison Jenkins, there who is the Director of our Division of Jurisdictional Support where the tribal cooperative agreement resides and is managed. So, you'll hear more about that and where there are opportunities and certainly these are the kinds of topics we can discuss during our monthly meeting. Thank you. I hope that was helpful.

53:43 – 53:46
Deputy Chief Bryan Warner: Miss Russell, one last thing. I'll get to you, Miss Frias.

53:46 – 54:37
Ms. Kim Russell: Thank you. Chief. So, thank you for committing to do that. So again, you know I work for state government. One of the things that we did recommend to our state government is just this, you know, ensure that when counties apply for grants from state government that they've at least consulted with tribes and if they want to be a part of that grant, they indicate how that didn't go very far. So, we could not ensure that at the state level but because you are the grantor, that's something that you can do. And then of course, you know, I'm looking forward to the presentation, but now that there's five years that we're not, if there's any other ways that we can be a part of the work that's happening within those five-year cooperative agreements, we would. I'd love to talk to you more about that. Five years is going to go by again and then we're 25 years behind, right. We added another five years. So, but thank you.

54:37
Deputy Chief Bryan Warner: Thank you. Miss Frias.

54:42 – 56:25
Councilwoman Herminia Frias: Yes, thank you. Thank you for your presentation on the budget. Appreciate that. It's always good to know where the money is right or isn't. But one of the things that yesterday we had a couple of good presentations and one of them was on strengthening travel sovereignty. And I don't know if you were there or you got to listen to that. But I think one of the important things to one of the important things to know is you know the tribes that are compacted and the tribes that are 638 and to understand how important it is for that direct funding. Because there are opportunities to do direct funding for those tribes because we've already gone through those hurdles. And so you know we talk about direct funding and we talk about how you know states are getting direct funding. And you know, I know we have a presentation later today with the emergency preparedness and yesterday we had took a tour with the emergency preparedness and we all have taught about how the tribes have done such an amazing job with COVID and we have and we did and so the funding can go directly to the tribes and we have also have you know compacts. So how can we get that direct funding to the tribes that are already practicing this. You know we have the financial systems and the governance to be able to do this, but we're not doing it when it comes to federal funding, through HHS. So, we need to set up that system. We need to set it up. So, I want to I just want to reiterate what we've been saying over and over and over again is let's set it up, you know with emergency preparedness, skip the state. You know the tribes have already set up that system and starts you know with 638 tribes with compacted tribes just we've already we have that system set up.

56:48
Deputy Chief Bryan Warner: Thank you thank you Dr. Stanphill.

56:54 – 58:58
Dr. Sharon Stanphill: So, Dr. Dauphin have you guys begin preparing for the executive order? Or have you guys, do you have plans because this is a whole new thing? This is something that's it's like a gateway. Now the door's been opened by the President to say yes, we want you to look at your budgets and assure that tribes are being taken care of that's how all of this is being solved. Have you guys had the opportunity to start that process? We truly, truly need to be looking at the A-19 for legislation if that's what needs to be done so that these funds can come through.

And then I want to make a quick statement about Oregon tribes. You know, that didn't come easily. Tribe stood by for years and watched the counties in the state get funds for public health. And we kept trying to work with our counties and we kept being told, you know, if they want to share the data with you, they will, if they want to share the funds with you, they will. And we were the big, the biggest partners helping them until finally the tribe said no,

no more, we need our own funding. So, this didn't come easily. Not only did the state provide the path, the money to us pass through which we'd like to have our own, they gave us extra money. They gave us up and above money. They then asked us who do you want to work with, and we said our own health board. Great, you can use full contract with them. The state stepped side. They let us do our own thing. That's why we've been so successful. And whether it's public health money, emergency preparedness, diabetes. Every time the state steps aside, they see the tremendous work of nine tribes and an urban organization that changes the whole Northwest. So, I just want to really encourage you as you think about this executive order and you go to prepare your budgets for 2025/2026. The work that the tribes does helps the entire community, the entire state. And so, I just, I think it's got some bigger implications than just tribal nations. So, thank you.

59:02
Deputy Chief Bryan Warner: Yes, Miss Russell.

59:02
Ms. Kim Russell: Thank you Chief Warner, and I think this is probably a greater conversation within the TAC made with National Indian Health Board. I know that we will bring up the executive order and all the different TAC meetings that we have with the HHS. But have we created any aims or goals that we would like the HHS agencies to maybe work towards And I don't know if we've if we've done that, but you know because I sit on other TACs as well and I'm pretty certain we'll have the same conversation. So National Indian Health Board, have we done something like that, We have the order right, but have we kind of said this is what we'd like to see by this time, Have we done that collectively,

59:44 -59:52
Deputy Chief Bryan Warner: Not on this TAC, but I think that's the next order of business, you know as these comments and these questions are started to be brought up. So great point.

59:56 – 1:00:45
Dr. Les Dauphin: I would add also that this is a great opportunity as we are setting our goals because we must be aligned with HHS. And I think I want to thank you for the great presentation and clarifying that when we set forth budget request, there's this negotiation in the sort of back and forth between CDC and HHS. This is a great opportunity if we are setting goals at this level to do the same at the secretary's level. So, for any of you who are engaged on the STAC, and they are aligning and working on the executive orders and order and setting specific goals for us to make sure that ours is aligned there. So, I think we have a real opportunity with CDC's, TAC and the STAC, working together at this time. This is the time to do it. So, thank you.

1:00:46 -1:08:41
Deputy Chief Bryan Warner: Right. Anyone else that hasn't made a comment or a question yet, Well, I will say this, this TAC is making me very proud this morning to be the chair. We are lifting the level of discussion today and I think I hope that everyone can hear that and understand. I mean we we've got some meaningful robust conversation, but it's not that doesn't mean that this is our consultation process. I want to be mindful of that that that we continue that I love the talks about executive order, the mention of the CDC crosscut. I would hope that the CDC would continue and hopefully honor that responsibility to participate within that crosscut. That's something that is very important to this TAC and across Indian country. You know it's been mentioned here too about tribes and so, so long it's can they handle this? Well, there's a, it's not an experiment. It was something that we went through and there was coronavirus relief funds, there was American rescue plan funds. So we're coming out on the other side of that. I know our tribe, we've got $1.2 billion worth of capital projects right now to set us up for the next 7 generations to come. We have a joint venture that's been underway for some time that provides close to $120 million a year to operate our clinic in Tahlequah. And we and we've been able to operate that and those dollars. But as we build out this capacity, I just want to paint a picture for you, and I can do that within the Oklahoma setting. And I want to be inclusive because I know these things are going on all around and other tribal nations and other states. But a study was done in 2019 about an economic impact study of the tribes in the based in Oklahoma northward of $15.65 billion. That's 2019. Look at what we've continued to do today. Now the Cherokee Nation just this year alone over 6000 students are going to college that are receiving a scholarship from the Cherokee Nation. I know many other tribes do this $19.5 million. Now we have 11 close to 11-12 thousand employees across our government and our business arm. So these jobs or take we hope that we're educating our next workforce but also these individuals are going to work and other places. You look at the money that we put when we talk about our car tag money and the money that we put over $7,000,000 into 107 school districts within Northeast Oklahoma. The roads you know millions of dollars to go on these roads. The sewer and the water treatment plants facilities rebuilding a we're building a new hospital 127 bed hospital right beside our clinic. We're building a new clinic in Salina. I don't know if anybody knows where Salina is at but it's a great place to be those individuals there. But what is public health folks I'm trying to paint a picture I don't never want to hold harm to the messenger here. OK we understand that but I need you guys to advocate for us because we're advocating that you're doing a great job and what you do. But when I when I look out and I say, you know what, what is that story that I want you to want to tell because public health, it protects the individual, it protects the family, it protects the community, it protects that county, it protects that state, it protects that tribe. What I'm trying to paint you a picture of is our tribe believes in raising the tide and that tide will raise all ships in our area. Native, non-native beneficiary, non-beneficiary, however you want to define it. In in order for us to continue to do what we do and we we're not going to stop building this capacity. If it up to me, we're going to continue to build it. But we also have to have that help. We also have to have those operational dollars. And I know like I said I will not hold the messenger harmful in these situations. When we're talking about working with the state, I've seen times when us and the governor for the state of Oklahoma pass work very well. I've seen in the present where it's not so well. I'm hopeful

for a future even with that individual still in the office to make sure. And it was mentioned here you think about grant opportunities when we apply we have to consult the state but they do not have to consult the tribe. I think that that should be on equal ground when you come in there. They should if they want to apply for a CDC grant or any other governmental agency, they should have to come to the tribe. And I think $15.65 billion is a lot of reasons why. You know, and you look at we're, we're an employer of choice in our area. So was my brothers and sisters from the Muskogee, my brothers and sisters from the Chickasaw. I could name all the 39 federally recognized tribes, in that state. But you know the, I think on the back end of a lot of these things that we're spending this money responsibly, wise, that we've always been under the microscope. We've always been, people have been critical of what tribal nations can do with dollars. I'll tell you what tribal nations can do. They can help you. They can heal you. They can help you move down the road whether or not you're a member of our tribe or not. And you just ask the individuals that understand what that means. When we talk about, nobody wants to talk about wastewater infrastructure and water lines tribes do! And we're going into these places and nobody there's the county we're the first place, I know these other tribes have the same situation, we are the first ones that they call when they need help. Whether it's a sponsorship for a little girl showing a pig or playing in a sport or somebody going to Harvard or somebody doing great things or hey, what about the namesake of cancer? I'll give you another example. We crossed the state line and Mercy Hospital is building a cancer treatment center in Fort Smith, AR. We were willing to pony up $8 million to go towards that treatment center because we believe in that effort. Now who's going to get treated there? Anybody and everybody that is willing and able to be able to do this. And it's just one small portion of what we do. Because when you take; I would love to see the collective impact across the United States of America of all of our tribal nations and what we do, whether it's economic impact, whether it's public health, but we have to remember folks, now most of your life you're outside of that clinical setting, that healthcare setting, you're out there and you're in that public health space. So, we've got to continue in order to do what we do. We've got to protect people. We've got to protect our communities, and together. And what I'm doing, is I'm asking you to join in with us because we're here to join in with you. And this, It's not a fight, it's not a battle, it's just a way of life. You know what, you want to call it pragmatic. I say common sense. Common sense says invest in tribes. Tribes will invest in you as well and vice versa. So that's all I have to say. So, yes, Legislator Barker.

1:08:45 – 1:09:02
Legislator Connie Barker: Connie Barker, tribal legislator for the Chickasaw Nation. I just really have one comment. You know from our presentations yesterday; these are federal trust obligations. And so, I would like to see tribes be a first thought and not an afterthought. Thank you.

1:09:03- 1:10:00
Deputy Chief Bryan Warner: Thank you. Legislator Barker and I think folks we're getting there. And another thing to this TAC and those that are listening. We want this TAC, I'm a competitor, we want this TAC to be the best. We want this TAC to take the lead. Dr. Dauphin, she wants it, and she's been a champion for us. I've heard throughout that she is talking about tribes and for tribes and with tribes. But we need to continue. When we talk about elevating this office of OTASA, when we talk about having that director, those visits, these things must continue to happen. We have to have champions for tribes that may or may not be tribal members, because guess what? We're champions of people. We're champions of Gigayu, which means love. We are champions of love. And that is our language. And gosh, I could talk about language all day long because we know how valuable each of our languages are, but we're running, I've taken us right to time, Dr. Dauphin. So that is it.

1:10:04 – 1:10:07
Dr. Les Dauphin: Great Deputy Chief. Thank you, Deputy Chief.

1:10:10 – 1:10:37
Deputy Chief Bryan Warner: So, at this time, we'll be taking a brief break. So, and I'll say briefly, thank you, Miss Gallagher. I appreciate you so much. Thank you for being here. We'll take a brief break from 10:15 to 10:30. So we'll start back promptly at 10:30.
Now, one more thing. We have got the esteemed Dr. Dauphin here. We need to take another photo. OK, so let's mount up there on that stage and let's take a photo. So, we'll take a break, and we'll return at 10:30.

1:11:05
Deputy Chief Bryan Warner: Really quick, before we get started. Someone has left a phone up here, on Legislator Barker and we've got another one up there. So, if you're missing a phone, we've got them. We're taking photos right now, selfies.

1:11:19
Legislator Connie Barker: So, let's do it.

1:11:27 - 1:12:31
Deputy Chief Bryan Warner: It's like you don't want them. Yeah, if you're missing your phone, we've, we've got a couple of them in captivity.
All right. Well, welcome back. Now I'm pleased to introduce our esteemed presenters for the session on supporting tribal public health capacity in coronavirus preparedness and response grant assessment results. We are privileged to have the following individuals sharing their expertise and insights. First, we have Miss Jenkins, the Director of the Division of Jurisdictional Support for the Public Health Infrastructure Center, and Miss Lamia, Associate Director of For Evaluation in the Division of Jurisdictional Support, also for the Public Health Infrastructure Center. Ladies, welcome. And you have the floor.

1:12:34 - 1:17:31
Ms. Stacey Mattison Jenkins: Ok, great. Thank you. Deputy Principal Chief Warner and tribal Legislative Barker. I would like to start by saying that I was so grateful to participate in yesterday's meeting. Virtually, the presentations were excellent educational and enlightning, and I've participated in TAC meetings before, but I particularly enjoyed the discussions around tribal sovereignty. Yesterday. I learned a lot, so thank you for that.

I'm pleased to be here today to talk about the Supporting Tribal Public Health Capacity in Coronavirus Preparedness and Response Grant, also known as the OT 22,004 COVID-19 grant, for short. I'm grateful to be able to continue working with you while respecting tribal sovereignty to leverage the capacity, expertise and resources to achieve the greatest impact on health issues affecting American Indians and Alaska Natives. This remained at the forefront of our minds and the implementation of this particular grant. What you will hear and see in this presentation is that COVID-19 Tribal Capacity Grant Aided Tribes, Tribal Organizations and Tribal Consortia and their ability to deliver critical programs and foundational public health services in response to the pandemic while building public health infrastructure in Indian Country. Let's go to the next slide please.

During this presentation, I will provide a brief background on the grant and my colleague Ms. Tamara, the Associate Director for Evaluation in DJs Division of Jurisdictional Support. Ms. Tamara Lamia will present the grant assessment results overall and take a closer look at the results that support the building of tribal public health infrastructure and capacity. These results are based on review of close out reports submitted by the grant recipients. Next slide please.

We will take about 25 minutes to present the findings and have approximately 30 minutes for discussions and questions. Next slide, So, to set the stage, I'm going to go through again a brief background of the grant including its scope, size and strategies. Next slide. Oh, go back one more, sorry. Thanks, Ms. Tamara. So many of you know this, but as a reminder, this was a one-year grant that was awarded in spring, summer of 2020. The grant provided approximately 153 million in Federal Emergency funding to a total of 346 tribal recipients. These included tribal nations, tribal organizations, and tribal consortia. Through these entities the grant reached 495 tribes. It was a non-competitive grant that the recipients use funds for a wide range of COVID-19 emergency response needs across 8 strategy areas. The grant recipients were allowed to be reimbursed for COVID related costs that were incurred prior to and during the pandemic, excuse me, for the alteration and renovation of non-federally owned facilities, which was something that was novel to typical CDC grant programs. And we also recognize that there was a lot of COVID funding available during this time. Therefore, we were able to offer no cost extensions to allow our recipients additional time to use the funds. So over 300 of the grant recipients did receive no cost extensions up to June of 2023. Now we can go to the next slide. The grant supported public health activities across a set of strategies and Ms. Tamara is going to go into specific examples of activities related to each of these strategies. But as a reminder, they were emergency operations and coordination, health information technology, laboratory capacity, communications, countermeasures and mitigation, recovery activities and other preparedness and response activities. And so, for the purpose of this assessment, all of the activities that we looked at in that 8th area were aligned to the seven aforementioned strategies. That's as they best fit each area. So, I will turn it over to Ms. Tamara to get into the details.

1:17:36 – 1:35:47
Ms. Tamara Lamia: Thank you, Stacey. Good morning, committee members. Thanks for the opportunity to present today. As Stacey mentioned, I am Ms. Tamara Lamia. I'm the Associate Director for Evaluation in the Division of Jurisdictional Support and I am very, very happy to be able to present these findings to you all today. I think it's a great segue from this morning's conversations as well and look forward to your reactions and discussion. So there were two key purposes, and you can go to the next slide please. There are two key purposes for the assessment. First, the assessment is meant to demonstrate the results of CDC's investments in COVID-19 preparedness and response in tribal communities. And 2nd, it's intended to build evidence to see what works to improve public health capacity in Indian country. Next slide.

So, in addition to these purposes, the project was guided by a set of key questions which included how did the COVID-19 Tribal Capacity Grant support recipients in addressing the community's COVID-19 response needs and then how did the grant also support recipients in building basic public health infrastructure and foundational capabilities in Indian country? Next slide please. So before moving into the summary, we'd like to share a bit more information about the approach taken and the type of data that were included. The assessment reflects activities submitted in 272 recipient final performance reports and this is of the 346 awarded as Stacey mentioned. And this represents almost 80% of the funded recipients work. So final performance reports or closeout reports that were submitted by September 30th of 2023 were included in these analysis. So, this time frame represents achievements from the start of the grant, which again was around summer 2020 through the summer of 2023. So, among the 272 recipients for submitting reports included in the assessment, 223 were tribal nations, 27 tribal organizations and 22 were tribal consortia. And the analysis includes reports from recipients from all 12 Indian Health Service areas. And I did want to note that as we reviewed and summarized the data, we did look to see if there were any notable patterns or trends by these recipient types. And in general, we did not see any major differences. So, when you see their resource results reported out in the following slides, these represent nations, the organizations, and the consortia. So next slide.

So, our approach to the assessment included the following. We had a team of 10 staff members with public health and evaluation experience working on the project, and they started by doing a close read of each individual final

performance report, which is submitted in the form of a spreadsheet to understand what activities were completed and review the descriptions of what was accomplished. The data then was tagged, so all the results, achievements, deliverables and so on were allowed us then to group and tally common types of results being reported. And then we summarized that in aggregate to get an overall picture of the grant accomplishments. Next slide please. So, I'd like to emphasize a few contextual points and considerations related to the assessment. So first, the grant was designed to be uniquely flexible funding mechanism with more allowable expenses that is typical for a federal grant. Secondly, the reporting process was intended to be low burden in nature to minimize extra work. So, the project was, we approached this project then with these two priorities in mind. And so the methodology accounted for and included a large range of activities that recipients were using funds for and the work utilized reports that were already part of the regular biannual report submission process. So, although the starting point for the work as individual recipient reports, the overall analysis and summary focuses on aggregate results, those across the whole grant. And finally, it's important to highlight that the summary is quantitative in nature. So, it really does highlight the numbers less so the stories and we recognize there are more layers of meaning and narrative that are not captured in what we are showing today and that is a limitation. Next slide please. So, moving into our findings, I'm going to share a summary of grant, areas of focus and a few accomplishments. So next slide, so as shared earlier, the grant included different strategies in various areas of emergency preparedness and response and these are listed on the left hand side of this bar chart. So, recipients could choose to work their focus, their work on any number of these strategies. So, some recipients focus their work maybe in just one or two, and others spread their work across a greater number. So, this graph shows that it was most common for recipients to report results that fit within the countermeasures and mitigation strategy. And this strategy encompasses a lot of different types of work related to responding to and mitigating the impact of COVID-19 and communities. Other popular strategies are communications, emergency OPS and coordination and laboratory capacity. So, note here that the total number is 271 and for those that were closely listening and seeing the other ones, this is 1 less. And this is because one of the final reports included was not in these analysis as their report results did not align with how the coding protocol was set up. So also, I want to note that recipients again could work across multiple strategies. So, as you look at these totals for each strategy, they're not going to equal the total number of recipient reports. Ok. So next slide please.

So, beyond looking at results by each grant strategy, we explore the data in many ways and identified several cross-cutting trends that I will briefly highlight here, a few of which I'm going to go into greater detail in the following slides. So, the top area of accomplishment that we saw is in procurement of supplies, equipment and other infrastructure related products and assistance for the COVID-19 response. So, we saw 98% of recipients reporting some sort of result in this area. 74% of recipients reported having developed or implemented some type of programs or services related to COVID-19, 67% reported having conducted some sort of data analysis or assessment work to support the COVID-19 response and 64% hired or filled staff positions and were provided or received technical assistance. So next slide please.

So, diving deeper into the results, we sought to understand in what ways this grant may be supporting broader public health infrastructure and foundational capabilities in Indian Country. So next slide please. So, to understand the results from the grant, we are using a framework known as the Foundational Public Health Services Framework. So, what you see here on the screen, and it outlines the unique responsibilities of governmental public health and can be used to explain the vital role of public health in a thriving community. The bottom part of the graphic shows the foundational capabilities. These are focused on key infrastructure, capabilities and services that are seen as important for public health departments to have in order to fulfill their mission and serve their entire community. Note here that equity is not only a capability, but also is the underpinning for the entire framework. Next slide. Oh nope, sorry, please go back. Thank you. I want to go in a little bit detail on all of the areas and foundation of capabilities. So, the top part of the graphic describes the public health foundational areas, and these are more programmatic areas of work. So, these are critical to public health department functions, including everything from communicable disease control to access and linkage with clinical care. The foundational areas reflect the minimum level of services that should be available in all communities. So, to understand how the grant may have supported broader public health infrastructure and foundational capabilities in Indian Country, we manually cross-walked this framework with our COVID-19 Tribal Capacity Grant code book to analyze the recipient closeout reports. So, when appropriate, the code book was overlaid with the framework allowing for closer analysis. We then aggregated and visualized the data, which then could point us to how the COVID-19 tribal capacity grant work may be supporting various foundational capabilities and program areas. We saw that grant accomplishments have spanned the areas and capabilities with some activities more focused on direct delivery of programs and services in response to the pandemic, while others are more related to building or supporting key infrastructure capabilities. So, we're going to go ahead and review now the results for each of the capabilities in area present in the data.

Ok. So, we'll start with the foundational capabilities. So that's what was at the bottom of that graphic you just saw. And there are 8 foundational capabilities that are needed in public health infrastructure. And again, these are those cross-cutting skills and capacities needed to support basic public health protections programs and activities. And so, recipients reported deliverables that aligned with five. And those are the ones that are circled here on the screen. Of those 8 foundational capabilities of the five capabilities represented recipients most frequently reported results aligned with the organizational competencies. So, we'll look at each of these in closer detail. Next slide, please. So as mentioned, the recipients most frequently reported results with the organizational competencies and what's included in this are financial management contract and procurement services, including facilities and operations, information technology services and workforce development in human resources. So, 219 recipients reported results in this capability area. So again, a reminder as we go through and look at these for all of the data, the recipients are tribes, tribal consortia and tribal organizations and they could work in multiple areas and

complete a variety of activities within and across strategies. So, again, this data that you're going to see within each of these top five will add up to more than the total number of recipients reporting a result in these capabilities in area areas. So, digging into the organizational competencies, we can see that they fell into the areas of information technology services and workforce development. So, those results aligned with the IT services included communication, IT infrastructure supplies or services procured. And examples of these are things like video conferencing, laptops, phones, radios, help IT infrastructure supplies or services procured. Some examples of these are things like telehealth, online portals, remote patient monitoring devices, mobile telemedicine units. And then also Internet connectivity was established or expanded. So, this includes having stable broadband connection, Wi-Fi, and mobile coverage. So, the results aligned with workforce development included hiring or filling staff positions for mostly countermeasures and mitigation and emergency op and coordination roles. And these were with a wide variety of titles and roles within the communities. Next slide please. So, 201 recipients reported results in the assessment and surveillance foundational capability, and the top 2 results in this capability were conducting testing and processing test specimens for COVID-19. So, recipients also reported collecting, analyzing, and reporting on surveillance and EPI data, which includes developing models to anticipate disease progression, analyzing patterns and trends, and reporting out of these findings to leaders and others. They also did screening and tracking for surveillance purposes. So, this includes screening employees or clients coming in and out of workplace settings as well as travelers entering or leaving jurisdictions. They also procured and installed physical infrastructure or large equipment for lab capacity. So, this would be a construction or renovation of an existing space into a lab facility, establishing a testing site or procurement of a mobile unit to conduct COVID-19 testing. Next slide please. So, 166 recipients reported results in the communications foundational capability. So, the most reported activity under communications was conducting outreach and disseminating educational materials and messages to increase community knowledge and awareness of COVID-19. These materials included flyers, presentations, videos, and public service announcements. So, other activities under this area included deploying communication and media channels. So, this would be setting up websites, social media pages, putting in place e-mail, listservs, text messaging, tailoring, and disseminating communications for specific audiences and developing plans for communications as well as then communicate or delivering, developing at trainings and resources for communications. Next slide. So, 157 recipients reported results in the emergency preparedness and response foundational capability, and this included a wide range of activities focused on COVID-19 emergency ops and coordination. So, they developed plans, they established incidence management structures, implemented programs and protocols to support the health and safety of the public health workforce, also developed plans for recovery and procured it, installed physical infrastructure or large equipment for emergency ops and coordination. And some examples of this may be trailers, generators, construction, or renovation of a temporary or permanent facility. Next slide please.

So, the last finding for the foundational capabilities represents results for community partnership development and 137 recipients reported results that align to this capability. And as you can see on the slide, recipients reported informally collaborating across many of the grant strategies, so in mitigation, emergency ops coordination for communications, for surveillance and epi and for lab capacity and testing purposes. So, now we're going to turn to the foundational areas within the framework. So next slide. All right. So, there are 5 foundational areas or public health programs in the framework. And these are the public health sort of topic specific programs and services aimed at improving the health of communities. And the foundational areas reflect the minimum level of service that should be available in all communities. So, the two areas where recipients reported results, communicable Disease Control as well as access and linkage with clinical care show us really not surprisingly that the grant funding has gone to support improvement for a wide range of mitigation, surveillance and preparedness and response programs. Next slide. So, looking at these two in closer detail, 257 recipients reported results in the communicable Disease Control foundational area and this includes again a wide range of activities. In this visual, we've listed the top five types of results in this area with procurement of supplies, equipment and infrastructure related products or assistance was the top area. So, most of these had to do with acquiring concrete goods, but in some cases also included procurement of services and activities. So, for this we see that procuring PPE or personal protective equipment such as gloves, face shields, goggles, gowns was the top result, as well as in procuring, cleaning and disinfecting supplies. This includes hand sanitizer, procuring or installing large equipment or infrastructure for countermeasures or mitigation. So, this would be converting a building to serve as a COVID-19 vaccination site or structural improvements to build ventilation and air circulation, procuring office and field operations. Supplies for countermeasures and mitigation included items to reduce COVID-19 transmission such as plexiglass barriers, automatic faucets and motion sensors or hand free doors and then supporting the COVID-19 vaccines as well. So, these are activities to support the distribution and delivery of COVID-19 vaccines. And note here though that this this does not include payment for vaccines nor clinical care as those were not allowable expenses for this grant. So next slide please. So, 127 recipients reported results in the access to and linkage with clinical care foundational area and this area includes activities focusing on coordinating healthcare services with a focus on COVID-19 treatment. So, under this area recipients reported a wide variety of activities, again with the top result being coordinating telehealth services. They also procured non COVID-19 healthcare supplies and that example includes equipment to improve the safety of dental or oral health services as well as surgical applies and apparel also procuring COVID-19 diagnostic and treatment supplies for healthcare or clinical settings. So, these are things like ventilators, oxygen supplies, supporting or facilitating access to COVID-19 healthcare services. So, these are things that took place to support the prevention, management, and treatment. So, looking at mobile medical units and then supporting or facilitating access to non-COVID-19 healthcare services. So, things that would help to maintain the continuity of care for the community during the pandemic, so supporting dental care or eye care for example. So, overall, as I walked through all of that with all of those numbers, we really do see that the COVID-19 tribal capacity grant has made a concrete difference in delivering programs and services in response to the pandemic as well as looking at building that public health infrastructure in Indian Country as we see with the alignment with the foundational public health services framework. So next slide please.

So, I'd like again to thank you for your time today and I'm going to turn it back to Deputy Principal Chief Warner and tribal Legislator Barker for any discussions or questions you have. And we do have some for consideration on the slide as well. So thank you very much.

1:35:49 – 1:36:24
Deputy Chief Bryan Warner: All right, well, thank you both. Great presentation, very appreciative. So, now I want to open up the floor to our TAC delegation for further questions regarding the assessment. So, just a reminder online you please use the raise hand function and we will open up the floor to our TAC delegation for any questions. Anybody online I might have a couple, just, never mind, Miss Russell, go ahead.

1:36:35 -1:36:54
Ms. Kim Russell: So, thank you for the report out on the assessment. I'm glad that you did do this assessment. So, what did of course you kind of shared with us what you learned from it. But being that you learned from it, what sorts of things can you do moving forward in this space? To continue some of this. I'd like to hear maybe your thoughts on that.

1:36:58 – 1:38:40
Ms. Stacey Mattison Jenkins: Well, yeah, I can certainly start and one thing I did want to remind people about this grant this in my mind. I'm proud to say that I was able to work on this grant from writing the NOFO to seeing it through. And so, it was such an honor for CDC to fund this many tribes ever directly. So, I do think that we made some progress in that area and so that kind of feeds into that question. I think that this can be done, us working together. I was taking notes and listening to the discussion earlier and I see that there are two, two primary areas that we could work on collectively. One is around the eligibility expansion for our grants and cooperative agreements and then also the direct funding line. And so that's something that I'd like to continue having discussions with all of you around like how we do that, you know from our different respective roles. So, we do know that this can be done. So those are I'm open to suggestions and ideas on how we can continue to get funding opportunities just like this one because I think this is one of the good things that did come out of COVID. We were able to provide funding, broader funding at a much faster rate. It usually takes us a year to write a grant or a cooperative agreement. We did this one in like, less than three months. So there are things that can be done when we're put in situations or facing public health emergencies and we all work together. So I'll stop there just to see if anyone else wants.

1:38:44
Deputy Chief Bryan Warner: Yes, Dr. Dauphin.

1:38:44 – 1:38:28
Dr. Les Dauphin: I'd just like to add that just for those who may not be aware, Ms. Stacey and Ms. Tamara represent the division in our center where the tribal cooperative agreement sits as well as the COVID supplemental tribal coax set. So, in terms of taking the recommendations that we're hearing here today, I think it would be great, I'm putting one of our directors on the spot for Ms. Stacey and her team to join our TAC meeting so we can come up with concrete actions that we can move forward. So, I'm inviting Ms. Stacey to attend an upcoming TAC meeting where we're talking about tactical things that we can do to address the recommendations that we're here today. And I know she'd be delighted to do that.

1:39:30 – 1:40:15
Ms. Stacey Mattison Jenkins: Yes, it would be my honor and I will be remiss if I didn't introduce two other faces. I would like for you all to get to know. And that's Teresa Dobb, she's in the back and Sonal Doshi, if you guys can stand up. Teresa is the branch chief, and they manage the preventive Health and services, Preventive Health Services block grant that you all may be familiar with. And also, the umbrella cooperative agreement that Dr. Dauphin gave an update on. And Sonal is the deputy branch chief. So, we all work collectively as a team on all three of these funding vehicles. We also manage the public health infrastructure grant. I'm sure you all are aware of that. So there's lots of opportunities for us to continue to collaborate.

1:40:25 – 1:40:48
Ms. Kim Russell: Thank you, Chief. So, you so you do have an infrastructure so continuing I just implore you to continue to build upon that infrastructure and let's not wait for another emergency like COVID to happen for us to be forced to do this. So, you all are at different point in the in the race. So, just please continue to take what you have and build upon it. Thank you.

1:40:52 – 1:40:53
Deputy Chief Bryan Warner: Yes. Second, Chief Del Beaver.

1:40:53 – 1:44:50
Second Chief Del Beaver: Thank you for the presentation, and I thank you for the assessment. I always like assessment to see how well we're doing. And so, it's and really; I think of all the bad things that the Coronavirus did to our communities. There were also some good things that I don't want to say it did direct communities, but it did there's some good things that it showcase that the tribes can do for our communities. And so, when we talk about response hands down, the tribes responded quickly, and we've responded with a lot of information from the CDC and I think this really showcases how well the tribes are in tune with the communities that we serve. And so and with this the grant money that we received I think goes around maybe like 1.4 million somewhere around there

we're able to buy you know tents, hospital beds, a text alert system those types of things. And so, we appreciate that. And so, I heard it just a minute ago that this has really set the foundation for what tribes can do. And so, I do appreciate what the CDC has done. And you know, I think that we need to start looking at this as more of a as a true government-to-government agreement. You know, we are sovereign nations. We take care of the people within our reservations, within our boundaries and it really doesn't matter to us if you're a citizen or not. When it comes to emergencies, we don't politicize things, whereas maybe the state does. And so, if you're if you need help, we tend to help you. We don't care if you're Democrat, Republican, independent doesn't matter to us. So, I think that those things, and the way we have our perspective is, this goes to show that whenever programs infrastructure is funded in Indian Country it really does get to the get to the people that need it the most and it's not it's not locked up in bureaucracy it's not mismanaged. You know we run tight budgets and I dare to say we want a better budget than the state that we're in right now and so we have we are well ran and especially in our health systems and so I do appreciate that really what this did it showcased not just my nation but all nations of what we can do. And so, and I heard, and I like I said I heard it before this is just a steppingstone. This is the foundational block of what we can do as tribes even during that.

On the FEMA side, our chief has issued a lot of state of emergencies within our reservation, whereas the state might not. And so last year FEMA, we issued a state of emergency within our reservation. FEMA gave us money and we were able to and there was actually some municipalities able to get money from us because the state didn't and the state wouldn't And so we were able to act as that government entity whereas where the a local municipality that needed that help we were able to help and so whenever you know we don't want, we don't ask the state for anything and we don't want to ask the state for anything and we shouldn't have to ask the state for anything. We are a sovereign nation and so that's the way we see it and that's the way it's going to be does that you know we wholeheartedly feel it's a government-to-government relationship and so we appreciate that. Thank you.

1:44:52 – 1:45:02
Deputy Chief Bryan Warner: Thank you, Second Chief. Anyone else? Well, I'll take it, oh, go ahead, Miss Frias.

1:45:05 – 1:46:32
Councilwoman Herminia Frias: Well, thank you for your presentation and thank you for presenting this data. I really do appreciate it. And I know that you mentioned that, you know, this is all the empirical data, but it doesn't include the stories. So, I don't know if there will be an opportunity to share those stories because those stories are really important, and I think that having the opportunity to go back and talk about those stories and share those stories are important. So, I think that, that we should do that.
The other thing that I wanted to mention is that with the, you know, I agree with Dr. Dauphin's inviting you to come to the next TAC and really have a discussion about how do we get this funding flowing. Because one of the things that has come up is, you know, with the grants and also cooperative agreements has kind of been used interchangeably. And they're very different. Yeah, they're very different. And when it comes to actually administering these funds, they're very different. So, we want to make sure that what it is that we're doing; it whether it's a grant, it's cooperative agreement or with that the opportunity is there that we can create direct funding, we are creating those opportunities. So just want to make that that statement. Thank you.

1:46:33 – 1:47:04
Ms. Stacey Mattison Jenkins: I totally agree with you about that. And one of the reasons we chose the grant mechanism versus cooperative agreement for this because there's more flexibilities with grants. But I wholeheartedly agree with you on figuring out a way that we can, let this set the stage for future funding that that's broader. Because like I said, I was I was grateful to see that we were able to do it. So, I know that it can be done, but we definitely need additional funding to really, really make an impact.

1:47:15
Deputy Chief Bryan Warner: Miss Sanchez, yes.

1:47:15 – 1:47:41
Council Member Teresa Sanchez: Thank you for this presentation. I just have a comment that it's very refreshing to see a non-competitive grant and go out to so many tribes and work so well. It's always my frustration that they're always competitive and this just proves how well they work when they're non-competitive and the money is there. It was it's very refreshing to see these results. So thank you.

1:47:42 – 1:47:49
Deputy Chief Bryan Warner: Thank you. Anyone else? Legislative, Barker, anything. Ok, well, I yes, go ahead, Ms. Russell.

1:47:53 – 1:49:44
Ms. Kim Russell: Thank you, Chief. So, your work with tribes is unique. You know, I think this is a blueprint across not only CDC, but, you know, other departments within the HHS, other agencies. Can you maybe speak to some of the conversations you had with tribes since you were able to work with so many outside of what you could fund, and what were they? And I'm trying to get more at the social indicators of health, and maybe what is that conversation you're having here internally and working with other agencies within the HHS and even outside of the DS. And so just to kind of kind of try to get have you where I'm in this space. So, our issue with our tribe is housing. Right, when we were going through COVID, we wanted to we want where the message was isolate. It was very, very difficult to isolate our members because we lived in multi-generational homes. It's not unheard of to have 15 members or more in a one-bedroom home. That's not unheard of, for my nation. And so we wanted them to

isolate, was a very difficult. My mom caught COVID. It was very difficult for us to do that. We had all of our kids had to take time off of work. It was very difficult, but we were able to do it because we had stable jobs. But that's not the issue. That's not the norm for most of the people from my nation. But access to safe housing was a huge issue. And then also just wanted to speak to food insecurity, on my nation. I think that's probably the one thing that I address almost every week is food insecurity on my nation. And so, I'm just curious about, you know, the work that you did with tribes. What were some of the things that you could not fund that was being requested? And I'm going to assume it's outside of your scope. And what conversations are you having with like HUD or with USDA or these other departments around that?

1:49:54 – 1:52:22
Ms. Stacey Mattison Jenkins: Great questions, thank you. And for this particular grant, I do remember we worked directly with IHS and the Bureau of Indian Affairs. But you know we were rushing to get the funding out, so we didn't have you know, broader government, broader conversations with HUD and others like that. That's something that we definitely need to do a better job at doing. But for this particular grant, some of the things that we try to build in that aren't in typical grants, were you know as I mentioned, the being able to use the funds for renovations or you know construction like we typically don't do that. So that was one of the things we tried to build in, also put in a mechanism where the recipients could get reimbursed for any cost that they incurred prior to getting the grant that were related to COVID of course and during that time. So that also included, like dealing with some of the food insecurity issues. You know, a lot of our grants, you can't buy food per-se, but this one, you could buy food. You know, you could reimburse people. I think that there was one of the recipients that had police officers and almost everyone in their community helping provide public health services. So, they were able to pay for some of those salaries just to kind of help and so, so the point that you made about telling the stories, getting into the granular details about some of those stories is something that we're working on. And so, we'd love to hear ideas from you on how we can share that, you know, out beyond our at TAC and beyond with the recipient so others can learn from that. So that kind of speaks to some of it. But as we move forward, I do think working across government can kind of help leverage all of the different parts because since we're so siloed, but all of us fundamentally have, you know, the same shared interest in improving the health of people across our country. So, we do need to do a better job of working across the different government agencies as well. So, hope that, may not be a satisfactory answer, but it's what happened. Thank you.

1:52:22
Deputy Chief Bryan Warner: Well, I just that sorry, Miss Danforth.

1:52:22 - 1:53:35
Ms. Deborah Danforth: Again, just echoing what everyone else has said is thank you for the presentation and I'm just going to share one of the stories because we were a recipient, my tribe was a recipient of this grant. And one of the stories that I think is important is that you know with the funds that were issued to us as part of this grant, we were able to set up remote work for all of our behavioral health program, all of our medical offices, our dental office and our optical office within a span of two weeks' time because we were able to purchase the equipment in our IT department, worked day and night to get those remote working for all of the staff that needed to do that. So, I just wanted to share that. And the other thing I wanted to share is that with some of the funds, we were able to utilize that with some other funding that we had to purchase a large generator that would facilitate our whole health facility. My staff weren't real happy because now the generator keeps them working for eight hours instead of letting them go home after the first 45. So, I just wanted to share that with you. So thank you.

1:53:36 – 1:53:37
Ms. Stacey Mattison Jenkins: So, congratulations. That's awesome.

1:53:39 – 1:55:50
Deputy Chief Bryan Warner: That's a great consequence to have though. Yeah, I didn't. That's not all the record is that. Yeah. No, no, thank you all. Great, great conversation. Some stuff that was brought up in some of our talkers earlier and I heard something about federal reimbursement. Perhaps, you know when we're starting to think about strategy, maybe a guidance document, I know it's pertaining just this grant, but maybe if there's other areas where there's federal reimbursement, how do we guide a tribe or an entity through that process that could become cumbersome times. You know proper preparation prevents poor performance right. So, strategy, all of these opportunities, health IT strategy emergency operations center. Yesterday we were we got to see what the CDC had. Not all of us need anything like that, although it would be cool you know. But Dr. Gann from Cherokee Nation was with us and he's like, you know, this would be something great to have. And you know what, I know a lot of other tribes looking at that. But I think on a lot of this, when you look at assessment, what type of strategies can we develop out of this to help to mitigate any circumstances with stumbling blocks early on when anxiety is the highest? Because our ultimate job of these things is to lower that anxiety so that learning and capacity goes up. They're both inversely proportional to one another. So great. And thank you, Miss Danforth for sharing those met needs, those met goals that that's the thing that resonates those stories and everything. So, both of you, great job, very appreciative of the presentation. Let's give them a round of applause, please. All right. Well, that takes us to a good time here. Looks like we're going to have a little bit of extra time for a networking lunch. Before we break, though, I want to ask Capt. Damion Killsback if he has any information or anything he would like to add to the group. I know I'm throwing this right at you. Yeah.

1:55:54 – 1:57:06
Capt. Damion Killsback: Oh, I think we have the same setup for lunch today as we did yesterday. But I do want to echo deputy principal chiefs the comments about the discussion we had earlier. I want to thank Stacey and her

team for the work they've done, very, very impactful work across Indian country. But you know there's a lot of good things that have come up that came out of COVID and it was a very generational, I think pandemic that impacts a lot of folks and it really shouldn't take a pandemic for us to like to get to be able to help one another. And to Principal Warner, Principal Chief Warner's point about that all our tribal communities, we're not just comprised of tribal members, we have people from different tribal nations representing on our on our homelands and also non-natives as well. So, they also are benefit. They'd benefit when we support our tribes, and we work together with our federal agency. So that's the spirit of cooperation. We have one common goal for all U.S. citizens as well, not just the citizens of our individual tribe. So thank you for, for those comments earlier, Deputy Principal Chief.

1:57:11
Deputy Chief Bryan Warner: Yeah, thank you, Dr. Dauphin, any comments before we break?

1:57:14 – 1:57:45
Dr. Les Dauphin: I just think this was a really great discussion, the budget discussion leading very nicely into the assessment of the grant program. So, thank you for your comments. We are noting everything. So, in addition to recording the meeting, we also have note takers and we are committed to following up on the recommendations and the outcomes from this meeting. So, this engagement means a lot to us. We take it very seriously and we appreciate it. A very good first start of the second day. So thank you, Deputy Principal, Chief and Legislator Barker. I'm not going to take any more time because it's lunchtime and it's good to have more time for lunch. So. I'll turn it back over to you to let us.

1:57:57 – 1:58:31
Deputy Chief Bryan Warner: Thank you both and also too, just a reminder, we have lunch outside. This is the point where when we come back from lunch, the meeting is going to get a whole lot better, Ok. Because Legislator Barker is going to be in the lead. We're taking off on a plane. But in Cherokee Nation, we say, we, I love you. That goes out to each and every one of you, thank you for your time, your talent, your dedication to your tribal nation and to this TAC. We are elevating this TAC each and every day, each and every second. And also, agiosi. I'm hungry, so let's go eat.

RECORDING STOPPED

RECORDING STARTS

0:00 - 0:22
Legislator Connie Barker: I hope you had a good lunch, had time to network with your friends and colleagues. One more time: I would like to mention that there is a lost telephone, and I cannot believe someone's not panicking over losing their phone all morning. But if you cannot find your phone, Anne Marie has a spare phone over here that was left. I think we were taking pictures is that is that…

0:22 - 0:29
Dr. Les Dauphin: I think that's my phone.

0:30 - 0:31
Legislator Connie Barker: Ok.

0:31- 0:32
Dr. Les Dauphin: I knew it was in safe hands.

0:32- 0:38
Legislator Connie Barker: Ok, the lost and found has been a question has been answered. Dr. Dauphin's phone. Ok, no more of that.

0:38-0:39
Dr. Les Dauphin: I didn't miss it at all.

0:50-1:30
Legislator Connie Barker: Ok, thank you everyone. So, and we're waiting on Dr. Killsback. We'll go ahead and start without him so we can stay on schedule then. Ok. So, without further delay, we will now proceed to our next presentation on exploring avenues to enhance American Indian/Alaska Native information sharing. We are honored to have two distinguished speakers joining us for this topic. Dr. Daskalakis, Director of the National Center for Immunization and Respiratory Disease at the CDC. and Dr. Wharton, Associate Director of the Vacancy of the Vaccine Policy, and Executive Secretary of the Advisory Committee on Immunization Practices. So welcome.

1:32-15:18
Dr. Demetre Daskalakis: Great. Thank you so much. Thank you so much for having us. I was able to be here for most of the morning until I got pulled in a couple of directions and just, I'm so grateful for the invitation and also so grateful to spend time sort of hearing from you and really interacting. So, I'm excited for the next part, where I actually get to talk to you as opposed to just listen, which is great. And then I'm looking forward to sort of your insights and again, really so happy to be here and we all love Les. Thanks, Les. Amazing. So next slide, please.

So, what we're going to do today is really, I'm going to start and I'm going to then pass the baton over to Dr. Melinda Wharton. I'm going to be talking a bit about NCIRD, the National Center for Immunization and Respiratory Diseases, and then Dr. Wharton will then take a deeper dive into ACIP, and you'll learn all about that in a moment. Next slide please.

So, a big overview of what we're going to do. Again, a little background on NCIRD as well as sharing our priorities which I hope you will see your community in and would love to sort of get your perspective and feedback on that as well. We'll then move to Dr. Wharton, who is going to talk about the ACIP policy formulation process as well as recent developments related to American Indian/Alaska Native recommendations as well as discussions with you about better info sharing. So that what is the lay of the land of how we're going to sort of run this section? Next slide please.

And so, I'll start as promised talking about NCIRD. And so first we'll take the aerial view of what it, what is the National Center for Immunization and Respiratory Diseases by really looking at its mission. And so, the mission is the prevention of disease, disability and death through immunization and control of respiratory and related diseases. Challenges include that we are we have a both a domestic and a pretty significant global footprint really interacting closely with our colleagues in the Global Health Center and then also accommodating all populations at risk for vaccine preventable diseases. And really thinking about this you know from the entire lifespan view, so from newborn all the way to nursing home and beyond. So, we will always point you toward a very robust website. So, you can take a look at our website at NCIRD for more details and a deeper dive next slide please.

So, in terms of the how we actually implement this mission, we're going to go over some of our core strategies. So, we work to provide leadership and expertise and service in lab and EPI sciences and an immunization program delivery. So, I'll stop for one second there and just say NCIRD has a couple of different characters in terms of how it works. So we are, we support vaccination programs throughout the country through health departments. We also support guidance around vaccination, but then also really are responsible for monitoring many of these diseases as well as pushing the envelope on the science, both epidemiologic and laboratory. We conduct focused and applied research specifically on prevention and control and that really ranges from diagnostics all the way to exciting new vaccine platforms that could change the way that vaccines are administered in the US and beyond. We then have a very clear process of taking not only our research findings but other research findings quickly into public health policies and practice. And I think Melinda will give more of a flavor around that when she talks about ECIP. We are also a service organization and provide diagnostic and reference laboratory services to some partners. Part of the work that we do is to conduct surveillance. Surveillance is a strange word. So, what we do is monitor what's happening with the diseases that are within our center and then also focus on research. That again, goes from very operational research all the way to the most basic of basic science. We not only do sort of the work here, but also through collaboration with our partners, respond to disease outbreaks and we do this both domestically and abroad. And I'll say recently I got to travel to Asia and sort of see the team in action responding to avian influenza in Cambodia. And so really a broad view. And so, in the US that often means providing really significant technical assistance to local health departments so they're able to deliver on outbreak response and occasionally also if they need additional resources ensures that public health decisions are made objectively and based upon the highest scientific data. We'll deeper dive into that with ACIP. Also, we are responsible for having some of the world's experts and by having world's experts in immunization and respiratory diseases, we provide technical expertise, education, and training not only to domestic but also international partners. So again, that scope is pretty wide. Next slide please.

But it doesn't end there. We, we provide leadership to internal and external partners for establishing and maintaining immunizations. We develop, implement, and evaluate domestic and international public health policies. And so again, you're going to hear about ACIP. Even where we don't necessarily touch global, sometimes what we say and do through our collaborations and through our policy development ends up influencing what happens around the world. We also are responsible for communicating information so that we can increase awareness, knowledge and understanding of both public health issues regarding our areas internationally and domestically. And embedded in that is also communication to not only improve confidence in one or two vaccines, but to improve confidence in vaccination, which is like one of the key missions of NCIRD. We obviously work within a wonderful organization and as you probably heard like we're really taking a "One-CDC" strategy. So, we really work to align our focus with what the larger priorities are of the director as well as the whole agency. Though we're not alone in this, we are also a really significant part of the synchronization of CDC's pandemic preparedness and response. So that that really scopes from strategy to actual response. So really important that we're a part of that discussion and that's another one CDC moment that we work across the agency and then also we implement, coordinate, and evaluate programs across our center and CDC. So, you'll, you'll hear a little bit about BFC as an example, vaccines for children, which is a massive program that really supports prevention in in over 50% of children. And there's a very specific component that I think is important to the American Indian/Alaska Native population which we'll go into. So really a great, a great program that we implement, coordinate, and also evaluate. Next slide please.

So now going a little bit closer to what are our more short to medium term priorities. I'll start with a really important one that I think is really instructive for all organizations that have been through the pandemic. We're taking a step back and we're looking at our own organizational health, thinking about ways that we can modernize our structure and the way that we operate, but also identifying ways that our organization can work as a thriving organization rather than one that is only responding to challenge and trauma. And so, I think we're taking a lot of work into that space, and that actually then permeates into all of our other priorities. Not surprisingly, September, October, November, December, January, February, and March happen every year. And so, we are working to

establish a really clear readiness structure that is for the routine respiratory season, realizing that every routine respiratory season often has things that happen within it that are not routine. So also having space for those wild cards that when we are hit with things that we don't expect. But really, how can we make this really routine and as transparent as possible in terms of what the expectations are on the third mission? Really plugs into everything I've said before, which is that we're really here to establish equitable access to vaccine in the US and the importance of that is not just in children, but across the lifespan. But we are also very specifically focused on children and adults around the issue of catch-up vaccination. And so, what I mean by that is all vaccines took a hit after COVID-19 emerged. And so, we have some work to do to catch up. And so as well documented in the news, we're seeing sort of outbreaks and cases of measles around the country that's really driven by unvaccinated folks. So really important for us to sort of work on the catch up. Next slide please.

So thinking about equity, one of our very important populations that we focus on are pregnant people and we're looking at how we can improve the platforms that we have to look at maternal or vaccinations in pregnant people not only to assess the safety which we already have some robust systems but also outcomes both in the pregnant person as well as their newborn. So really exciting given that we have a lot of products that are that exist and a couple that are in the pipeline, they really focus on vaccinating the pregnant person so that we can prevent them, we can, we can protect the newborn. And then finally and this is like a a lot of a sort of acronyms. So, I'm not going to read all of the acronyms, but working across the US government so that we can help accelerate diagnostics. So how can we get tests that people need, whether it's in the public health arena or the clinical arena? How can we be a part of the pipeline so we can move them faster and improve people's awareness from the clinical perspective as well as public health? Next slide, please.

So, am I going to read every single box. No, I'm not. I'm so this is, this is our organizational chart for NCIRD. And I just really wanted to highlight that we have 5 divisions. I'll also highlight that four of the divisions have an overt global component as well as domestic. So, our divisions are influenza division. So that division is really important globally, not only domestically because we do the lab work and have the connectivity in the world to be able to help with strain selection for the flu vaccine. So, the work that we do in at this campus that connects to the entire world actually is important in how we figure out what the next, the next vaccine is going to be that we have the division of viral diseases. So that division covers a lot of diseases that you're well aware of. I will focus, I will say measles is one of them that we cover but also polio and a lot of other infections that are urgent, emergent, or re-emergent. Division of Bacterial Diseases: lots of work again both domestically and globally thinking about pneumococcus as one example. So, one of the bacteria that causes pneumonia and other invasive diseases, meningococcus, so like one of the bacteria that causes meningitis, these are all in that wheelhouse. And introducing our newest division, which is CORVID: coronaviruses and other respiratory viruses' division. So, this division focuses on COVID as well as other viruses, RSV respiratory syncytial virus as an example. But really also in a very similar frame to influenza division is really helping to make sure that we make that the right global selection for COVID vaccinations so that we're ready to go for us for our next update of that vaccine. The last division is the immunization services division, which houses the vaccines for children as well as a lot of other really important work around surveillance and vaccine implementation. And they do not have a global footprint. They're very domestic, but what they do, people watch and has domestic and has global influence as well. Next slide please.

And just a couple of highlights in terms of programs that I wanted to highlight for us here is our immunization gateway. So, this is one of our programs that really helps improve the way data flows so that we are better able to really track as well as let people access their own data around immunization coverage. I wanted to highlight that we specifically have contracts in place to provide technical assistance to IHS to onboard, this very important gateway and really well it will be really important in improving preventative services and health and in AI/AN populations. And then also this is what I said I was I was going to highlight at the end is that our Vaccines for Children Program. it, it doesn't just cover COVID-19 and flu. It covers all of the recommended vaccines for the Advisory Committee on Immunization Practices, ACIP. you'll hear a lot more about that in a moment. But one of the important things to remember is that VFC also covers all AI/AN children who are under the age of 19. They're all eligible and are able to access vaccine at no charge. I think I now hand it over to Melinda: Dr. Wharton.

15:22-26:42
Dr. Melinda Wharton: Next slide please. Thank you, Demetre. Next slide. So, I have the, the privilege of serving as Executive Secretary of the Advisory Committee on Immunization Practices, which is a federal advisory committee that provides advice to the Director of the CDC on the most effective means to prevent vaccine preventable diseases in the United States. So, the committee makes recommendations on vaccines and some related products like immune globulins and that would include the long-acting monoclonal antibody that was licensed last summer, Nirsevimab. and of course, most of the products that ACIP makes recommendations for are FDA licensed products. But when the circumstances warrant it, like during the pandemic, ACAP also can make recommendations for unlicensed vaccines, vaccines that are available under EU wave, for example. Can we get back to the slide, go back, back a few more. I think that's it. Ok, forward 10. No, here we go. Ok, so for the products that ACIP considers, they provide guidance to the agency on who should get it, under what circumstances it should be used. And they consider a number of factors in making these recommendations. That includes the epidemiology of the disease; how much disease there is; is there enough disease that it's worth having a large program for prevention? How well does the vaccine work? What's the effectiveness? Duration of protection; vaccine safety; the quality of the evidence reviewed; economic analysis and implementation issues: Do the characteristics of the product actually allow it to be used in an immunization program? Next.

Traditionally, the committee has met 3 times a year. Those used to be two-day meetings. Recently we've had a number of three-day meetings. Our meeting that's next week will be two days. I'm pretty sure the one in June will be 3 days, just because there's a lot of things the committee has to talk about and make decisions on. But the during the COVID pandemic, there were many more frequent and extra meetings to address both COVID vaccine issues as well as other issues that required addressing outside the normal 3 meetings a year. We did have a couple of extra meetings last summer for one for COVID and two for RSV prevention products. One notable thing about our committee is that the meetings are open to the public. We webcast them so anyone in the world can watch them. And for meetings that are making really big decisions, there may be 10s of thousands of people from all of the world watching. And certainly, for individuals who are interested, it's easy enough to go on to the ACAP web page and watch the meeting while it's occurring. Or if you want to watch it later, the videos are posted on YouTube during the live meeting. We do have oral public comment, which is scheduled at every meeting at which votes are taken, and there has been increased public interest in providing public comment over the last few years. We also received written public comment through a published docket on regulations.gov And again, individuals and organizations who want to weigh in on issues coming to the committee can submit that written public comment to the committee through regulations.gov. The information about the committee is on is available on the web and you can see the link there. And again, when our meetings are occurring, you can actually watch the meeting on that web page or on the ACIP website. Next.

The committee under our charter, we can have up to 20 voting members. We're not quite there at the moment, but the committee should have a consumer representative and then other members with expertise in specific disciplines like Pediatrics, public health. Immunology, nursing, different disciplines. We aim for four year overlapping terms. So, there's not too much, too much turnover in any given year. And we screen for conflicts of interest and at the beginning of a term annually and at every meeting. And notably, although I guess there's a couple of CDC employees in that photograph there, ACIP is independent of CDC and voting members are not CDC employees. They're members of a federal advisory committee.

Next, we do have ex officio members who represent other government agencies and offices, and this helps bring the perspective across the government from FDA and CMS, Indian Health Service, NIH, HERSA and the Office of the Assistant Secretary of Health. The members of these organizations participate in work groups and participate in the meetings next. Also, there's a larger group of organizations that participate as liaison organizations and these are organizations with broad involvement in immunization who have a designated representative who brings the perspective of their organization to the ACIP's deliberations. And we expect that these organizational representatives will keep their organization and their organization's membership apprised about ACIP's deliberations and recommendations. Many of them do serve on work groups and participate in and they should all be participating in every ACIP meeting. Also, some organizations sign on to our updated immunization schedules every year. Next.

The, although we have these very intense public meetings, which you know kind of will look like the meeting you all are having right now, there's a lot of work that goes on behind the scenes in our ACIP work groups that that that isn't visible. These subcommittees provide an opportunity to provide in depth review of the information available and really pull it together in a in a comprehensible way for the committee so that in a session of an hour or two they can actually get a very good view, a very good summary of a whole lot of work that was done by the work group and CDC organizes those work groups and manages their work. And notably the work groups don’t make recommendations to CDC, only the whole committee can do that. Next.

Now there's a couple of things that have happened recently that may be of particular interest to you. In August 2023, ACIP recommended Nirsevimab, which is a long-acting monoclonal antibody product for prevention of severe respiratory syncytial virus. And that was recommended for all infants during their first RSP season and for infants 8 to 19 months of age who were at increased risk of severe RSV during their second RSV season. And among the infants who fell into that group at increased risk were American Indian or Alaskan Native children. So, there was a recommendation that was that that recommendation for use in the second year of life included those children. The need for tribal engagement on this was not really recognized until very late in the process and we clearly should have done it sooner. It was it was done kind of at the last minute. We appreciate the help of OTASA in in allowing us to do that. I'll be it in a sort of abbreviated and rapid way, but with a more recent question. We did have a listening session back in January that included a more than 60 participants who asked good questions about use of the vaccine, about adding to the existing preferential recommendation for one specific Hib vaccine product, whether that preferential recommendation should be extended to a combination, a combination product that includes that Hib vaccine product. There's a because American Indian and Alaskan Native infants are at risk at an earlier age than some other children, this one product is has been preferred because it provides protection earlier and now there's evidence that the combination vaccine can also provide that protection earlier. And so ACIP will be discussing this and making a decision on it and the information and feedback we got during the listening session will help inform that discussion for the committee. Next.

Oh, and here's what I just said. So in in January, we did have a listening session in conjunction with OTASA. There were there were representatives from tribes, tribal serving organizations and IHS and there were again active participation, engagement questions about the policy change. And this discussion will be incorporated into the subsequent presentations before the committee next. So, we're we we're actually would I'd really much like to hear from you about how we can do a better job of sharing information and getting input on the on the committee proceedings. It is not frequent. There are specific recommendations that are specific for the American Indian/Alaska Native population, but it does happen occasionally. And I gave you 2 examples. But of course, the recommendations to the committee impact everybody in the country. And there's a variety of ways that we

interact with individuals and organizations. I gave you examples of some of them, but we'd really welcome any thoughts, questions, feedback, or questions from you right now. So, thank you very much.

26:46-27:30
Legislator Connie Barker: Thank you Dr. Daskalakis and Dr. Wharton for your insightful presentation. Now I'd like to invite all TAC members to share any further questions or comments regarding the exploring avenues to enhance American Indian/Alaska Native information sharing presentation. The floor is open for discussion. TAC members attending the meeting virtually, please use the Raise Your Hand feature or place questions in the chat box when you speak. Please remember to state your name twice in the area you represent to ensure accurate note taking. So, I'll turn the floor over to TAC members for questions or comments. Yeah, Ms. Freeman,

27:30-27:53
Councilwoman Carrie Freeman: Carrie Freeman, Tribal At-Large member. So, have you changed your process on getting tribal engagement earlier? As you stated you know you, you realize that it should have happened a little earlier moving forward with anything that emerges in the future, like is that part of your process and planning now?

27:55-28:21
Dr. Melinda Wharton: Yes, thank you. Thank you for asking that question. Actually, the team from OTASA will be talking to our ACIP work leads on Monday and providing the background on the you know sort of why, why this needs to be done and we need to build it into our process. And certainly, we will be alert to this issue in the future and collaborate with OTASA on the specific processes that that they use going forward.

28:32-28:57
Legislator Connie Barker: And I have a question that may not quite be related back to the Vaccines for Children. It may not be related to American Indian and Alaska Native children, but it may affect them. And this may not even be a question you can answer. But what is the CDC doing about immunizations for immigrant children who are coming into the United States who maybe have not had immunizations yet? How are we protecting our Native American/Alaska Native children from diseases that may be brought in from immigrant children?

29:02-30:11
Dr. Demetre Daskalakis: So I'll start in terms of sort of the eligibility requirements for vaccines for children. So really the eligibility really focuses on like their insurance status, what insurance product they have and their age. So that means that that they that this resource is available and is used sort of with sort of recent immigrants when it comes up. So that's an important sort of component of this in terms of the work that happens on the sort of VFC side, the global effort of VFC is to improve coverage of all of the ACIP recommended vaccines in populations. And again, there's that special specific focus on American Indian/Alaska Native populations. And so, a lot of the work that looks like it's just about building, and they'll come sort of providing vaccine is actually then backed by a lot of additional work to improve confidence and access just beyond here's the vaccine. But also, with provider education and connectivity to make sure that we are improving coverage across the lifespan and very specifically in kids through the VFC program.

30:11-30:12
Legislator Connie Barker: Thank you.

30:12-30:13
Dr. Demetre Daskalakis: Thanks.

30:18-31:12
Dr. Les Dauphin: Thank you both for a great presentation. I would like to ask a question that's kind of focused on the structure of the organization and how different parts work together. I'm thinking specifically Dr. Daskalakis on how we are engaging tribes and our plans for potential listening sessions or at some later point tribal consultation. Could we go back to the slide that has your org structure? It was a few slides; it was earlier in your presentation. Who's controlling the slides? Ok. If you could go back to the structure in the center, I thought I noticed you have you have the, let me see influenza division, you have COVID and then there's a respiratory division of viral diseases and then there's the immunization and did you remember all of them.

31:12-32:38
Dr. Demetre Daskalakis: You're good, you're supposed to have 5. So, it's that was pretty impressive. So, the five are flu, COVID, DBD, this is why you had the thing that's bacterial diseases and DVD which sound alike but they're different. And so, we have those programs that really you know I would say focus on some of the science and some of the policy and some of the sort of specific work for the organisms that that they sort of own in their world. And then the immunization services division, they're kind of our like operational component that really touches the sort of the front line. And so, you know very often there are issues that may sort of touch the American Indian/Alaska Native population that sort of live within one of the divisions like let's say we are we just hit one now. So Haemophilus Influenza as an example that lives in our bacterial in our division of bacterial diseases, but the implementation and some of the additional work moves into the immunization services division which interacts really closely with ACIP that really sets policy. So, it's all of the parts though it looks like there are that it is both wide horizontally and tall vertically. There's a lot of cross linking in terms of how the actual sausage is made, like how we move from like ideas and science into actual policy and implementation. Did that answer the question?

32:39-33:14

Dr. Les Dauphin: It does. I was thinking specifically about some of our touch points, the touch points between NCIRD and OTASA. And there may be many areas across the center where we can work on things together to engage our TAC or even expand that engagement. And so, we can talk offline. But I thought it was important to share with this group to highlight that this is, this is a center that touches on very quiet of a broad spectrum of activities that we would be engaging on and can do so through OTASA, and they have a coordinated approach for doing so.

33:14-33:19
Dr. Demetre Daskalakis: So, try our best and we do, we'd love to knock on your door for it for help. So, thank you.

33:22-33:24
Legislator Connie Barker: Ms. Frias, did you have a question?

33:24-35:21
Councilwoman Herminia Frias: Oh. Yes, thank you for your presentation. Herminia Frias, delegate at large and also Council member for Pasqua Yaqui Tribe in Southern Arizona, in Arizona. I just want to refer to the Vaccine for Children and what you commented on catching up and what some of the issues around anti-vaxers and some of the disinformation that's out there and how we can go on giving factual information and ensure that people are getting the right information. So, you know how we can do that in it in our tribal communities because we also face that. You know a lot of times we think that we actually have a pretty good rate I think when it comes to vaccine rates and in our tribal communities. But we're starting to see that you know we're starting to see a difference now you know with that anti-vaxers and also it also effects our employment because you know people that decide not to vaccinate, you know, maybe people that are working with us, it affects people that even in you know, people that you know we're just starting our childcare center. But tribes that have childcare centers, you know that children that are not vaccinated, we have a head start. You know how it affects our school systems, how it affects, you know. So, this is a real issue of ensuring that our children are vaccinated and especially some of the children that you know previously were vaccinated but now some of the parents are choosing not to vaccinate because they're getting information that is not factual.

35:21-36:48
Dr. Demetre Daskalakis: So, thank you so much for your question and I feel like this is the stuff that keeps us up at the at night. So, I'll start by saying that first I'll say sort of as a sort of CDC representative like there is so much work happening on the agency level, not just within our center about sort of addressing this and disinformation. So, I think it's a really important sort of piece of work that really helps us going forward because I think it is important to say out loud, we're going to have a rough time. And I think it's because you know, I think people are thinking of vaccines and vaccination in a way they never have before. Components of this have been politicized components. Components of it have been fraught with missing disinformation. So, the work that we do at the agency is critical. And then also diving deeper into the work that we do within NCRD, not only to think about the missing disinformation, but how to just build up general confidence. So, when we think about our ISD, our immunization services division as well as or other core divisions, a lot of the work that we're doing is really figuring out how we can provide materials and information that is actionable and usable by our partners. And so, you know, we would love to keep this dialogue going because I think that one of the ways that we can fight mis- and disinformation: is to saturate the system with good information. And we would love to be your source of that good information. And thank you.

36:49-37:06
Councilwoman Herminia Frias: Yeah. And I. And I think part of that, what's important to have is, especially with our tribal communities, is to have a, the leadership and people trusted people in the community that can support that, that they're hearing from people, trusted people in the community that are saying it's ok, yeah.

37:09-38:55
Dr. Demetre Daskalakis: So, I think we've seen that. We saw that play out in COVID, I think over and over again. And I think part of the work is to really make sure that we identify folks who are trusted partners and trusted communicators. And then really, I think the really important part is that again and the more you can help us, the more we can do is sort of identify who is the trusted source of information. And again, I'm going to say it's us in terms of the expertise as well as information that really supports vaccinations. So, any opportunity that we have, any sort of partners that we can connect with and provide really good information to be able to sort of support this effort because I want to go back and say it is going to be an uphill battle, especially when and not to sort of go too long on this. When the difference between like having a good amount of protection in the community to not having enough, sometimes it's like one or two percentage points in coverage. Like it's not like oh, it's 20% now and it was 80%. It's like if we if we lose a little bit of ground, we're going to see measles outbreaks, we're going to see you know, more of the things that we don't see very often. And so, we'll, I'll double click on what you said and agree. And it's not just about the materials but also about who's delivering it because there are definitely circumstances where I may be a great messenger and definitely circumstances where I'm not the person that people want to listen to. And it's really important for us to know that and really not sort of use people as tools but to bring them into the story. Because I think you know and I know especially for my interactions with tribal communities, there is such a community of making sure that there is support for the health of the community. It's such a core value that that I think your partnership and partnership with your leaders is critical in what we do. So, thank you.

39:00-39:03

Legislator Connie Barker: Yes, Ms. Russell?

39:05-40:46
Ms. Kim Russell: Thank you, Ms. Barker. My question is around what sort of strategies or work you're doing to improve vaccine confidence within American Indian populations? Do you have any sorts of tribal specific campaigns that you're considering putting together? Of course, with tribal input for my community, we're--at least with the COVID vaccine--We're recognizing of course in the beginning a lot of us were taking the vaccines, but over time, and I'm certain it's other populations, it's really decreasing into a very significant amount. And the Vaccines for Children that you brought up, we're having a Welcome Home Baby event in April and we're kind of we're copying another tribe. I can't remember what tribe, but our first lady of our nation saw what they were doing, and she just had a baby as well. So really trying to bring a focus to maternal and child health within our tribe. And so, I'm this is kind of really current for me but the other one would be the maybe a campaign not only vaccine confidence, but you know the catch up on vaccine you know what sorts of materials could you put together? Of course, with tribal input because for my community, it's going to be you know these materials that we need for us. We're very rural. Internet is not a primary way that we do communicate that way, but it's going to be the written you know materials that we need to put it out there. The other way that we communicate for my nation is a large largely on radio as well. So that's my question. And in regard to improving vaccine confidence and any sorts of tribal specific campaigns.

40:48-42:46
Dr. Demetre Daskalakis: Great. No, thank you. So, and thank you for the question. So, I'll start by talking about sort of a new piece of work that we're moving on, which I think is really exciting. And I think you've already heard about a product called Nirsevimab, which is a monoclonal antibody, which is an immunization. So, it's not a traditional vaccine where we give a shot and you know the then the, the person's body then responds and creates protection. It's providing an antibody that just pretty much is protective from the moment that that child gets the vaccine. So, we have this new, this new immunization called Nirsevimab. it protects against respiratory syncytial virus and we're going to, we're actually launching some very specific engagement in tribal communities so that we can see how between that product in the new maternal RSV vaccination, how we can improve uptake, given also the high burden and high morbidity of disease. So, this is a space to watch. So, watch this space we're at with us as we move forward. I'll say also your concern about young, new, young families is also one of the core priorities at CDC. And this sort of work specifically with American Indian/Alaska Natives falls within that broader CDC priority. Just sort of demonstrating the sort of fact that you know we plug into the bigger picture of what folks are interested in and what's prioritized at the agency. So, we can do better and more in terms of getting our materials sort of reviewed and also give get the feedback to make sure that they're responsive to what the needs are and look forward to more conversations to be able to do that better. Because I think you know part of the confidence issue is providing good information but also in a way that's digestible to the populations that we're trying to reach. So, a little bit of watch this space, a little bit of exciting news in terms of RSV, the RSV program and then more to come. Thank you. I hear you on the radio that's really important. Thank you.

42:46-42:51
Legislator Connie Barker: Anyone else?

43:00- 43:29
Ms. Joanne Odenkirchen: Joanne Odenkirchen. and one of our national partners at NIHB actually did receive funding for vaccine confidence. That funding goes through the end of July. So, it is possible that you could reach out to them for some of that that those materials as well. In addition, NIHB is also putting on some vaccine clinics. So, you might want to reach out to them to see if it's also possible to get involved in some of those activities as well. So, I just wanted to make sure that the TEC was aware of that. Thank you.

43:30-43:31
Dr. Demetre Daskalakis: Thanks.

43:32-43:41
Legislator Connie Barker: Thank you for those comments and thank you NIHB. Anyone else? Ok. If not, thank you both again for your presentation. Very informative.

43:42-43:43
Dr. Demetre Daskalakis: Thank you for having us.

43:43-43:44
Dr. Les Dauphin: Great. Thank you.

43:54-44:18
Legislator Connie Barker: So I think we are ok. We're a little bit ahead of schedule and so we're going to take about a 10-minute break. We'll start our next presentation in exactly 1:30. Yeah.

44:33-45:06
Legislator Connie Barker: Oh ok. Here we, here we go. Ok, our next presenter. So, thank you for coming back from break. So, we'll go ahead and get started. I am, we are now delighted to introduce our next presenter, Dr. Muthuswamy, Public Health Analyst in the Program Implementation Branch, Division of Diabetes Translation. She'll be sharing valuable insights with us on CDC's National Diabetes Prevention Program. So, let's give them our

full attention as we delve into this information presentation. Where is that presenter? I should be sitting at the other day.

45:10-45:11
Ms. Kavitha Muthuswamy: Hi everyone. Can you hear me, ok?

45:14-45:15
Dr. Les Dauphin: We can. Thank you.

45:15-1:26:57
Ms. Kavitha Muthuswamy: Thank you. My name is Ms. Kavitha Muthuswamy, and I'm a public health analyst with the Division of Diabetes Translation in the CDC's National Center for Chronic Disease Prevention and Health Promotion. And I'm joined today by my colleague Beth Ely, who's a senior analyst with the National Diabetes Prevention Program. And first and foremost, good afternoon, honorable committee members and colleagues. I apologize for not being with you in person and as I had planned and I thank you for the privilege of presenting to the honorable committee members, CDC colleagues and participants during our time together today. During this hour, we'll provide a brief overview of the National Diabetes Prevention Program also referenced to the national DPP. And then we'll move to the 2024 update to the CDC Diabetes Prevention Recognition Program standards and operating procedures or the DPRP standards for short. As you know, at CDC, we have a lot of acronyms, and we'll also share current activities to meet the needs of native communities and implementing the national DPP lifestyle change programs. And I don't know if the slides are up. Actually, we can go back to the title slide. Thank you. So, before we start, I wanted to thank Dr. Killsback, Ms. Coleman, and CDC colleagues and also the TEC team for making this virtual presentation smooth. I really appreciate that. But most importantly, I would really like to express our deepest gratitude to all of our tribal partners who we've had the privilege to work with and their commitment to their communities, their candid feedback and expert guidance. This is really the engine for our work. Next slide.

First, we wanted to start by honoring the deep history of diabetes prevention programs across tribes and tribal communities and American Indian and Alaska Native populations. The invaluable contributions of native communities and the success of the Indian Health Service Special Diabetes Program for Indians have been the foundation in shared history with the CDC national DPP. As you can see, here are some of the examples of that history and that work. Next slide please.

We just wanted to share a really a brief overview of the shared timeline as you can see like in 1997 and I'm sure this is really familiar to many of you, but just a quick overview. In 1997, the balanced budget amendment establishing the SDPI, the Special Diabetes for Indians and in 2002 the landmark DPP study confirming that type 2 diabetes can be prevented. In 2004, we saw the SDPIDP was authorized by Congress, followed by, you know years later in 2010, Congressional authorization of the national DPP at CDC. In 2012, just two years later, the CDC Diabetes Prevention Recognition Program or also the DPRP was launched. And just very briefly over, you know the last 10 years we've had the Good Health and Wellness in Indian Country cooperative agreement working with tribes which the Division of Diabetes Translation shares in as well as the pilot program from the top town nation of Oklahoma to expand access to the national DPP lifestyle change program. You know across different tribes that they that they served in 2021 and 2022, CDC expanded the preliminary status in the DPRP that we talked about to SDPI programs to include SDPI programs who have participated in SDPI and who currently do, and we'll talk about that a little bit later. And so currently we have a total of 73 CDC recognized tribal programs. I also wanted to just our overview, our work in the Division of Diabetes Translation is really driven by and committed to our federal trust responsibility in serving tribal communities. We're committed to listening and learning and using that to direct our work. We've heard from part partners the need for support that fits tribal communities and tribal programs. As all of us here today really know, a goal of health equity isn't just to offer more of the same thing to everyone, but rather the right things so everyone can achieve wellness. And that's our goal. For the work that we're going to review today and our work together. Next slide. Thank you.

We'll go just have a brief overview of the National Diabetes Prevention Program. It's a partnership of public and private organizations working collectively to build a nationwide delivery system for an evidence-based lifestyle change program for adults with high risk for type 2 diabetes to prevent or delay the onset. The National DPP Lifestyle Change Program is founded on the science of the Diabetes Prevention Program, DPP, the research, study and subsequent translation studies which showed that making modest behavior changes helped people with pre-diabetes lose 5 to 7% of their body weight and reduce their risk of developing type 2 diabetes by 58%. Next slide.

At a population level, the national DPP has four overarching strategic goals: Increasing the supply of quality programs across the US, increasing awareness and demand for the program among adults at increased risk for diabetes, increasing referrals from healthcare providers even though a referral is not required for the program. We know that it helps increase participant enrollment and an increase for the public and private health benefit coverage for the program to ensure long term sustainability of the program All of these are really critical, and our work has to occur in all four areas. And for us in in the division, we recognize that you know, we also need to work in partnership with the programs that are already working, not just SDPI but other programs that are working in tribal, you know, communities to prevent diabetes. But the, you know, tribes are not unfamiliar with this and have been doing this incredible work for decades. And working with those programs is really key. And we'll cover in this presentation our ongoing activities to tailor these goals for tribal communities and programs. Next slide. Thank you.

The CDC Diabetes Prevention Recognition Program or the DPRP, as we stated earlier, it plays a key role in ensuring quality across the many diverse organizations that are delivering the program across the country. The DPRP awards 3 levels of recognition pending preliminary and full, and this is awarded to program delivery organizations that are able to meet the National Quality Standards. And these standards are updated every three years. Both to stay in alignment with the science of Type 2 diabetes prevention and to respond to the lessons learned from the field and through the analysis of program data. The DPRP plays an important function in collecting and analyzing the data across the organizations offering the program. Each program gets each organization gets feedback on their data and whether they are on course to achieve recognition and the support that they need. If they're not, we really are committed to offering technical assistance to identify the problem areas and troubleshoot challenges in the program delivery. We also maintain an online registry of all the programs in the US that's really maintained in in real time. So, you know people can go and find a program near them, you know that they can CDC recognized program near them to attend or take, you know participate in a lifestyle change program and it can also serve as a as a referral base. And again, this is really we tried to update this in real time. Thank you. Next slide.

There are many benefits to having recognition and these include quality, which is linked to national quality standards, which we'll discuss here in a minute and outcomes proven to prevent or delay the onset of Type 2 diabetes data. It enables CDC to monitor progress individually and by program and across the nation, and, therefore, provide tailored technical assistance and support. And also, to really inform the work that we're doing in our team to you know help meet the needs of programs that are serving tribes or American Indian, Alaska Native participants. Sustainability and reimbursement is also a big and evolving aspect to this. You know many private and public peers are reimbursing for the program and are requiring CDC recognition because of those set standards. And this is something that you know we're really trying to expand and especially in in trying to you know delve deeper into those systems. As you know for tribes, for tribes and also urban organization, urban Indian organizations and how those reimbursement mechanisms work, support the recognized programs, have access to technical assistance, training, and resources that's on our customer support center. Marketing also is you know we be being a recognized program is an effective marketing tool to encourage referrals as well. Next slide.

As mentioned, the DPRP assures the quality of recognized organizations. And to ensure quality and impact, CDC sets the standards for organizations that wish to offer the National DPP Lifestyle Change program. These standards, you know, the Diabetes Prevention Recognition Program standards and operative procedures or the DPRP standards for short. Again, another acronym. As we mentioned before, they're updated every three years. They're informed by the latest evidence regarding the science of diabetes prevention, DPRP data and feedback from partners. And you know this is really the important part that we really want to emphasize today. And it has to go through formal Office of Management and Budget OMB posting to allow for public comment. Next slide.

We wanted to highlight one of the main topics we wanted to discuss today were the key updates to the 2024 standard. So, we're in this three-year, you know the next three-year cycle of updates and so we wanted to discuss that with the committee members and colleagues here today. So, some of the highlights and key updates to the 2024 standards, you know to kind of synthesize that for our presentation today from organizations, The organization's zip code is used to fast-track organizations to preliminary status. As we mentioned before, it was preliminary, pending in or pending preliminary in full recognition. So fast tracking organizations to the preliminary recognition status for organizations that are serving populations in areas of the of the country that are identified as having a high social vulnerability based on the social vulnerability index. But for tribal programs, there's you know again we had talked about the expansion of recognition status for SDPI programs. So, in 2021 and then it was amended again in 2022, in response to requests from tribal leaders and acknowledging the expertise of SDPI programs and the success of SDPI programs, This CDC expansion included any SDPI affiliated program interested in implementing the national DPP program to automatically be granted preliminary recognition. So, skipping over the pending recognition when they applied for application to the to the DPRP, the recognition program and also any SDPI affiliated program currently under pending status during that time when that provision was you know that expansion provision was finalized would were automatically advanced to preliminary status. And just as reference the preliminary recognition status enables organizations to more quickly apply to become Medicare diabetes prevention program suppliers and DPP suppliers. And you know we hope that this and other payment sources can again go back to promoting long term sustainability that that we had mentioned earlier. Oh, actually, if we could go back to the previous slide. Thank you.

Additionally, from the organization, an optional field for social needs is going to be for a social needs assessment: information on participants and that'll be included in this version of the DPRP standards data. Elements related to health-related social needs are included so that we can really all better understand the relationship between these needs and participant outcomes in the national DPP lifestyle change program and identify ways to support participants and accessing and participating in the program. So again, this is an optional element in in the standards. But it's also something that you know we're working in other ways and with our partners and our program and activities that we'll discuss later to assess and incorporate as we tailor this program to meet the needs of programs delivering this in tribal communities or serving American Indian and Alaskan participants. For participants, collecting the ZIP code is going to provide a more precise understanding of the geographic landscape of national DPP participation and it allows for a deeper understanding of geographic areas of disparity to formulate program materials and provide technical assistance to organizations delivering the programs in these areas. Collecting disability status will is going to involve a six-item variable as recommended by the Office of Management and Budget and will allow CDC to analyze participant data from a functional perspective to determine disparities between disabled and non-disabled population changes to race at race, ethnicity collection

consists of two additional options with an existing variable. So, the revision is going to allow CDC to align with OMB and health equity best practices guidance that recommends collecting additional race ethnicity information from participants to create a more to create more accurate reports and a better understanding of populations being served. The new variables include Middle Eastern or North Africans, but there's also a write in option which I think is really pertinent to you know what we're talking about today. And it's so the intake form will have a write in option. And this is a particular note for Native participants because it allows for participants to self-identify as American Indian and Alaska Native even if they're not enrolled in a federally recognized tribe. And you know we recognize and know that this is incredibly important. So, we're glad that that's there and we wanted to include that And the delivery mode we're redefining combination programs which allows for a better understanding at CDC of you know at a program level of organizations approach to combination delivery you know and distinguishing between live delivery and online delivery. Where we are now with the standards, the 2024 standards or the updates and standards were posted on the Federal Register in December. and at the same time, we a Dear Tribal Leader letter was sent to tribal leaders and many of you here were probably received that letter and a copy is also on the CDC website. That comment period is complete and we're currently in the process of synthesizing the comments and will repost on the Federal Register for another 30 days. And at this time, the proposed release date for the final standards, 2024 update to the standards is in early May. And we plan on actively disseminating this to tribal programs and beyond. And one of the asks if you will, you know of our presentation today and ongoing into the future is how we can best disseminate, you know, you know those standards and really do our best to help programs implement those standards, whatever is needed as far as technical assistance, friends and support. Next slide.

Next, we wanted to present our newly initiated work. By new, I mean over the last few years to you know one or two years to culturally adopt the CDC PreventT2 curriculum for American Indian and Alaska Native participants. As a quick note, the CDC Prevent T2 curriculum is the primary national DPP curriculum and not a separate program. And the curriculum was launched in 2016 and follows the year long lifestyle change program and it builds on the evidence base for relationships between diet, physical activity, and health. An updated curriculum was released in 2021 and some of the modifications included a focus on Whole Foods, engaging coaching practices and storytelling, A tailored approach for cohorts, graphics, and other tailoring to allow for cultural representation. The curriculum has 16 core modules and some of the examples are listed here and there are also six reinforcement modules to be selected from ten options which together fulfill the 22-week cohort over 12 months. Next slide.

So parallel to these updates to the Prevent T2 curriculum: In general, we've had we've long been hearing, and this is surely not unfamiliar to committee members. We've been hearing from partners and tribal leaders about the really critical need for an adopted curriculum for American Indian and Alaska Native participants to really make not just the curriculum but the program overall relevant you know for Native communities. So that was that was a really, we really took that very seriously. But it's also a daunting task you know, and we're committed to a deeper and respectful tailoring that aligns with what's supported by the science of the curriculum. And as we started this work it was really important to establish a few key understandings. We cannot create a one-size-fits-all that doesn't honor the diversity among tribes and cultures. But we do want to create something that captures shared cultural strengths and values and important issues and topics with room for more tailoring and you know at a deeper community and tribal level. And we know that it's not for CDC to do this work of cultural tailoring on our own and our wish is to be respectful and to center on the real experience of native participants. So, we were committed and still remain committed to making this a co-created product and seeking guidance at every step for a curriculum that's relatable and also honoring you know an honest history and current experience. And this is and this you know value and mindset and just kind of you know approach has been something that's really guided us for our future work too that we'll go over today. So, to begin determining the elements that needed tailoring in the spring of 2022, we convened a group of eight partners representing 5 areas and they were a combination of tribal programs, area health boards and tribal serving organizations from California, Great Plains, Great Lakes, Navajo Nation, Portland, and others. And a big thank you to everyone. We're incredibly grateful for this candid feedback in helping to start this work. And the convening partners where they were invited based on their experience with the national DPP, including serving as program coordinators or lifestyle coaches, some of established national DPP lifestyle change program, their understanding of the Prevent T2 curriculum and adopting, you know, their previous work and trying to adapt the curricula. You know, I mean, have they tried to do this before because they saw it as a need. And we also wanted to include folks who had expressed a desire for a culturally relevant curriculum and also people and this is really important who chose not to implement the national DPP lifestyle change program due to lack of cultural tailoring. And as we said, the candor of why things don't work is really incredibly important as we direct our work. So, we used that a phased approach to identify elements of the prevent each of curriculum that should be adopted to really create a more engaging and culturally relevant content. And the phases were gathering information on the previous curriculum, adaptations, and research, developing key questions for partners, conducting the interviews to refine the questions, and then conducting the convening with these partners to discuss how to the Prevent T2 curriculum. And from this really came a value based and cross cutting themes. And they really thankfully and probably predictably really strongly aligned with feedback that we've heard over the years from partners and our own qualitative analysis of tribal programs implementing the National TPP lifestyle change program. And the feedback in the session provided areas of opportunity for each one of these themes and you can see here the supporting evidence and quick wins and long-term recommendations associated with each area embedding American Indian, Alaska Native cultural preferences: you know considering relevance, visual example, addressing food deserts, commodity foods, traditional foods and representing urban and rural tribal environments, strengthening lifestyle coaches. So, and we'll talk about this how this is kind of fed into our current other current work establishing the ability for lifestyle coaches, recognizing their importance in in cohorts and really bringing everyone together and establishing the relationship between participants with participants in the cohort and engaging techniques and best practices. What really emerged also was instituting a whole family

approach and including community and family, considering pre-diabetes and diabetes, the impact among youth, which is a which is a big issue, and addressing the stigma of pre- diabetes and diabetes in communities and connecting to resources. And this is really big because eligible participants currently in the national DPP Lifestyle Change program, you know it's for 18 and older, but that is for you know counting the eligible participants to be reported for recognition. But the class overall and the cohorts overall, we really want it to be inclusive of the entire family, which we know is such an important, you know, aspect and cultural value of in native communities having the intergenerational family tie. And also, we saw a few programs who are instituting an approach like this already, and they had incredible retention as well. And last was incorporating formatting and delivery changes, which is you know kind of flexibility in delivering the curriculum considering you know just sustainable weight loss and incorporating teachings on mental, spiritual, physical health aspects of the curriculum. Next slide please.

In the next phase in the beginning in you know which goes from 2022 and ongoing, we're working with a curriculum developer and also a native owned agency to take these themes and apply it to the Prevent T2 curriculum and we conducted 3 sessions. So, we went from this panel where we got the, the, the four themes into taking that and going into finer detail of reviewing each module. And we conducted 3 sessions of expert panels to review the curriculum for nutrition, physical activity and behavior change in the modules in context of you know the relevance of cultural adaptation. And again, we had 13 long time coaches and coordinators each having over a decade of experience working in diabetes prevention in tribal communities, not just national DPP lifestyle change program. And we wanted to include all programs really working in diabetes for prevention in native communities. And their diversity was really represented by geographic location, professional background, and varying stages of implementing that prevent T2 curriculum. Again, it ranged from implementing it to knowing about it, but not implementing it because you know of different cultural adaptation, you know barriers. So, we organized the expert panelists and assigned each person to a core topic based on their expertise. And the experts were provided guidance that outlined which modules to review as well as areas to consider providing direct feedback. And they were asked to review the curriculum through a lens of cultural relevancy and also based on their experience, next slide.

And from these incredibly informative sessions, you know they were really wonderful. We heard some key themes. One was really top of list was time constraints. Panelists voiced that the pace of the Prevent T2 curriculum felt sometimes rushed and you know there often wasn't time to cover all of the material in one session and just really you know navigating virtual content during in in person classes such as playing videos sometimes takes a lot of time away from the group and especially if Internet access is limited. And just also recognizing the need for that you know peer support and discussion and the stories that that everyone has to share. So, the participants also stressed the importance of allowing program participants the time to share and bond, develop trust in the group which really predicts success. And you know participants, you know their experience with participants really liking to discuss their challenges and getting group support. And again, these are things that really add to the group. And so, with time that's needed for that kind of discussion, it felt like the overall time of the class was kind of short. They also we also heard the need for you know coaching training and facilitating skills and new coaches needing better training and facilitation skills on how to navigate really tough conversations. And participants agreed that it was that it really takes a good lifestyle coach to redirect the conversation to allow participants to discuss how they feel about the topic. And having a coach with a lot of passion really matters and technology barriers, which I think you know, comes as no surprise to any of us. And the curriculum as it was, they felt, relied heavily on Internet connectivity and web links, which can kind of be confusing to navigate when there's limited Internet access. Next slide. Thank you.

Additional challenges that we that we saw some of the recommendations were adapting the photos, names, and stories, giving the option to add community specific cultural foods, physical activity examples and stories and adapting physical activities to be more relevant to native communities like safety and then also rural areas with limited access to gyms. You know if there's a reference to that and adapting nutrition centered lessons to be mindful of barriers to accessing nutrition nutritious foods. Next slide.

We also saw just the need to focus on strengths, adapting examples to meeting people where they are and using judgment free language, being mindful of the impacts of historical trauma and the current lived experience of native people. And this is a really, really important issue and topic and something that we are committed to incorporating whether in the curriculum or also guides and prompts for coaches to be trained to deliver that or to access that depending on their assessment of their particular cohort. To move beyond just changing pictures, names, and recipes. You know, inviting coaches to supplement the modules with community specific foods, stories, activities, differentiating between commercial tobacco and sacred tobacco and changing the layout to be, you know, more printer friendly. Next slide.

And just to speak you know to just next steps the team has begun to adopt the modules for field testing and selective active cohorts and these insights have also been applied to the adaptation of another resource CDC resource called New Beginnings. The discussion, the discussion guide and We've begun the process of identifying testimonial stories and really developing an overall look and feel with images, color palette, font as well as like the deeper content that that we talked about. And this feedbacks really informed and aligned with other current work that you know that that we'll go over. So, on this slide we heard from partners also and again this probably comes as no surprise. The need to use images and content relevant to American Indian and Alaska Native people. And the Division of Diabetes translation worked with a native owned media firm to photograph images across three geographic regions depicting regional cultural diversity across tribes. And we plan to use these images in our content and the and our curriculum and really beyond the intention with the design curriculum framework and adaptations, they're really the first in demonstrating the shared intention of building a connectedness among the

program with you know Native programs and communities and serving American Indian and Alaska Native people. Next slide.

So, we're in early stages of additional work to meet the needs of tribal programs. And again, as we mentioned we've seen our work really evolve from you know what we've done a few years ago with these talks with partners and these convenings and what we've learned into really finding out what the deeper needs are and that's really helped to shape and push our work and we'll continue to do so. So, some of the other programs you know and work that we have ongoing is building on a pilot program that we mentioned led by Choctaw Nation of Oklahoma. We're working with area heath boards; you know 3 area health boards right now in a shared and Co created road map of how to support and establishing and sustaining diabetes prevention networks with you know area tribes. And so, we want we're really working with these health boards to hear their needs, their unique strengths and capacity and the needs of their tribal partners who are delivering the program. And this really has the potential to provide support and assistance to tribal programs who are doing this incredible work. You know they're changing the trajectory of health for their participants. You know we hear that from the coaches for delivering this program. They're really making a difference and they have incredible motivating stories of participants really engaging and implementing these changes not just for themselves but for their families and community. But they just need to strengthen numbers and also the support to gain that recognition you know and some technical assistance. So, you know our work and our mission is to how we can work with area health boards to help. We're also working with training entities to expand the small but mighty existing group of master trainers and also to expand the number of lifestyle coaches and who delivered to travel programs. And we hope to include the culturally relevant recommendations into these trainings. And in the future create a network of ongoing support to help mitigate the impact of staff turnover and the reality that everyone working in tribes you know wears 20 hats or more you know so. And the staff turnover is something that we've heard a lot of. And last, we conducted a needs assessment with current CDC recognized programs for technical assistance and support to build their capacity to establish and sustain the national DPP lifestyle intervention. And this needs assessment will be shaped into recommendations and then an ongoing strategic plan for our division and everything you know, kind of all of our work moving forward. Next slide please.

So in summary, these are some of the things that we shared, the shared history between SDPI and the national DPP, an overview of the national DPP and the Diabetes Prevention Recognition program, DPRP, updates to the 2024 standards, an overview of the cultural tailoring of the curriculum and also other you know programs, you know activities that we're working on to help to tailor our programs. And again with that definition of HealthEquity, how do we not just deliver more of the same but also deliver what's needed and first and foremost always really trying to access what people need and talking to our partners and going from there. Next slide.

We are incredibly grateful for your valuable time and guidance, and you know specifically we'd love to hear from the honorable committee members on recommendation on soliciting input from the national DPP and delivery organizations serving tribes about their challenges and successes as well as recommendations to strengthen partnerships or other efforts. You know anything that that you can suggest. Next slide please.

And in closing, I would like to again express my, our deep gratitude for the privilege of sharing the work of CDC's Division of Diabetes translations work today. And as stated earlier, we're really committed to serving communities and diabetes prevention and honoring the federal trust responsibility. And we want the guidance, your guidance to shape our ongoing work. And as always, your candor is deeply appreciated and very welcome. So would that thank you and we can open it up for questions and comments, I think.

1:26:57-1:27:51
Legislator Connie Barker: Thank you, Ms. Muthuswamy and for your presentation. TAC members, I'll welcome your feedback. If you have additional questions or comments regarding CDC's National Diabetes Prevention Program, we encourage you to share those thoughts. The floor is yours and we look forward to your valuable contribution. Is there anyone on the line that has a comment, a question, be sure and raise your hand. Do you a little hand sign if you want to comment? Ok. Anyone here at the table have any questions or comments? Ok, Sharon.

1:27:51-1:34:46
Dr. Sharon Stanphill: Sharon Stanphill, Rep at large. Well, that was a great presentation. Thank you. I commend you on the work your office is done, your commitment to tribal nations, love the marketing materials and the work you've done. The work you've done with the tribes you have some, you know your those we love. We love your picture on the one of the slides as well. It's great to see you again and talk not that part, but the 12 Tribal Nations and Urban. I saw Nara up there. You got some real experts helping you and you should be proud of your accomplishments. We do appreciate the every few years, I think it's every three years now that you go back and you look at your metrics, your requirements and the things that will make the program sustainable for the country. We do appreciate that and there's still work to do. Always there is work to do but just want to thank you for all that you've done for Indian Country and if I could make a few comments.

The first, is has to do with the SDPI. The reason the SDPI has been so successful is because the tribes have been allowed to do it their way. And we found that out real early and it the funding was a contingent on whether or not the tribes we're all doing it the same. If the data added up, we really knew that in order to make this program successful and it's a quarter of a century if you can believe it over 25 years now that SDPI has really become the most effective public health department public health program in the nation. We know childhood immunizations and, in your program, obviously you stated its number one in the nation as well. But the SDPI was done by the

tribes. We were the leaders of doing it and we and we learned a lot of lessons that we've shared, and we probably shared those with you. One of the things I really want to point out is that the key to this whole program is the lifestyle coach. And so, I appreciate the trainings that you're going to be starting up and I understand that they'll be a hopefully we'll have consultation, and we can talk about some funding perhaps to each area so we can have a master trainer that will be able to work with our tribes so that we can have strong lifestyle coaches in our communities. But I want to touch on just a few things, and one is the preliminary status that the tribes were grandfathered into. whereas that's been great, you've noticed that don't not even 25% of the tribes that have SDPI are in this program. And one of the reasons I think is because of the difficulty in the data. Yes, you're aware the all the requirements of the cohorts, how big the groups have to be. We have some very small tribes. So, if you have to maintain a certain number of people to come for six months and they can't miss or you got to make it up, you need a pretty decent sized staff. You need your coaches to be trained, you need to be able to do a lot of the things that you're incorporating now. And so, from 2019 to 2021, great strides have been made.

However, really what should happen and true partnership and acknowledging the work of the SDPI is that these nations should be grandfathered into full recognition. And they're one of the reasons for that isn't just the respect of these programs and the and the honoring of the work that's been done here. It it's also for the fact we can't get paid. I know in Oregon we can be paid at the preliminary status, but I don't know if across the country all of these nations and programs can be paid for this work. And so, in order to run programs, let's face it, you have to be able to have funding. Everybody needs to be able to have a staff person to run this.

So, I did my homework before I came to this meeting and I spoke with some tribes in the Northwest and one of the most successful programs is Nara Northwest, Nara our urban site. They had to, during COVID due to the obviously the negative impact of COVID, they had to go to a complete tele situation. Whereas a lot of tribes had to shut down their programs and in doing this they had to use a lot of funds to be able to get iPads and all the things you need to do to be able to keep up this program. The lifestyle coaches had to transition do things entirely different. They begged and borrowed from other programs just to be able to have staff to be able to help because a lifestyle coach has to hold the hand sometimes of the participant and their family for a very long time to for these lifestyle changes. These are mental health issues, these are social determinants of health issues, food issues. This is a very, very intensive program that lasts a year. So, the NARA was able to make this transition, but in doing so, because they don't even have one full time person, they had to piece it together. They gave me an example of just the data. They said that for 31 participants over the course of six months, they had to a spreadsheet was 520 twenty rows. It was 31 or 28 columns deep and it took them hours upon hours upon hours with errors being kicked back from the spreadsheet. So, they ended up purchasing a program that would help them because they know data is important. We all know data is important. So, I think when we really get into the nitty gritty of how this program works, we need to we need to eliminate as many barriers as we can. Data get more lifestyle coaches into the tribes. Let the tribes run their program as you as you're showing. You know, incorporate traditional foods and events that we do. And a lifestyle change isn't about going to an event, it's about what you do all the time in your life. It's connecting spiritually. It's all of these things.
So, I just want to in closing say that really appreciate the work you guys have done, but we need to take a much deeper look. And I know you said May is the date that the new recommendations are going into effect, but we need another consultation. When you look at cohort size, we need to look at whether the data, it can't just be what we're already submitting for SDPI anyway and how to eliminate some of these barriers, especially with the status so that these tribes can be paid for this program. So, I want to thank you again and thank you for hearing my comments and just really encourage you to keep working with us because this, this program is changing lives as SDPI is proven to change lives. So, thank you.

1:34:47-1:36:59
Ms. Kavitha Muthuswamy: Thank you. If I could just say something, I know we're running out of time and I want to hear everyone's, but I really deeply want to thank you Dr. Stanphill for your comments today. And also, it's nice to see you again and Ms. Barker also, like we saw each other at TLDC and it's just so wonderful to continue this work. And this is exactly what we want to hear, and we are incredibly grateful and privileged to have your candid feedback and partnership in this and a lot of things that you discussed today. You know the need for master trainers and lifestyle coaches, you know we're really trying to address but also stronger commitment to letting the tailoring of these programs really fit what communities and programs need and taking that as a uniform of success from the incredible success of the SDPI programs and incorporating traditional foods, the whole family approach, the events. But you know the data submission also is something that you know we're really you know taking another look at and as far extending as far as extending the full recognition, you know I hear that and definitely we will take that back.

But I'd love to ask you and I know my colleague Beth Ely would love to ask you a question as well. So, I'm going to turn it over to her. But I'd love to ask and maybe if it's not on today's call because we only have a few minutes. But you know if we can work together like it, you know if we can contact to you and NARA like you know in the in the future because we have so many points of feedback and all the projects that we're going in. But we really want to have these focused discussions of the incredible work that tribes in Oregon have done. I was a project officer in juick for Yellow Hawk and others. And so, you know in in extending full recognition, how can we also are getting your feedback and everyone else's feedback, how can we really help support the sustainability of full recognition? And the reimbursement piece is definitely a part of it that needs to be tackled and, but we'd love to continue that discussion and thank you so much. and if it's ok with the facilitators like, can I turn it over to Beth to ask a question or can, should we take other question.

1:36:59-1:37:04

Legislator Connie Barker: I are there any other questions at the at the table?

1:37:04-1:27:06
Ms. Kavitha Muthuswamy: I should probably ask.

1:37:07-1:37:10
Legislator Connie Barker: Ok, if not yes, go ahead.

1:37:12- 1:37:13
Ms. Kavitha Muthuswamy: Beth you gonna.

1:37:13-1:38:26
Ms. Beth Ely: Yeah. Hi. Thanks. Hi Sharon, that was that was really great for us to hear. I work you know with the data components. So, when you talk about the data submission that's you know that's me and I guess, and we probably don't have enough time now. I'd love to actually talk with you though at some point about because you did acknowledge the importance of data what would make the process easier, I think and again not something to get into now because there's not time, but I would really love to hear from you and hear what you think that could look like. The only other thing I want to say, and I don't know how much consolation this is, I don't believe Kavita mentioned this is with the new standards we are proposing indefinite recognition. So once an organization achieves full recognition, they've got it forever. And we're doing that because we feel that if you achieve that full recognition, you've met the requirements, you've checked that box off, we know you can do this and now let's take the pressure off of you so you have it permanently and all we ask is that you continue to run your program the way you need to run it. So hopefully that at least will help relieve a little bit of the pressure.

1:38:29-1:39:08
Ms. Kavitha Muthuswamy: And on this last slide and hopefully obviously this you know everyone has the slides and we'll have the recordings that's my e-mail there and also the our websites and also you know we have a customer service center that you know that's really incredible. So please you know anyone in in the committee today or others or you may know like you know please send us those comments and feedback because we really, we really do want to engage. This is just one part of how we're trying to reach out and connect. This is incredible. Thank you. Anyone else?

1:39:08-1:39:13
Legislator Connie Barker: Any other questions or comments? Ok, go ahead.

1:39:13-1:40:32
Dr. Sharon Stanphill: This is Sharon Stanphill. I could make another comment. I think if we could work with CMS that we would be able to, it's just Medicaid, but at least we could have one, one pair right be able to recognize everybody who is impending status now. Again, I want to emphasize only 25% of our tribes that have SDPI even are attempting this. I think once folks once COVID hit and things it was difficult for folks to keep tribes to keep up with the data. So therefore, they just dropped out of the recognition process. I know of several tribes that did that. So, I think we're trying to move the needle. The other direction is to get folks to want tribes to want to be recognized and yes that's a great quality. We're into quality of our programs, we're into data, we're into all of that, but we really want to make sure that we don't have more barriers in doing that. So that that's why I think working with CMS is 11 aspects, love to talk about the data, love to talk about the some of the systems that the tribes have. Adopted to be able to make this data more streamline and make it easier on themselves. But to think it would take a whole week to do that kind of data entry. That's just a lot of work. So, thank you.

1:40:32-1:40:55
Ms. Kavitha Muthuswamy: And thanks for mentioning that even if tribes you know tribal programs aren't pursuing CDC recognition, they're still doing amazing work in preventing diabetes, you know and how do we of them to want to pursue the recognition, pursue recognition for this and participate in this program. Thank you for that.

1:40:58-1:41:49
Legislator Connie Barker: Ok, thank you, Ms. Muthuswamy. And thank you for the wonderful presentation. So, we are going to be moving on. We actually have another break from 2:30 to 2:45 but let me just mention this right quick. You were given these sheets of paper for TAC meeting suggestions. So, if you would, fill that out and there is a suggestion box out the door I think on the table out here and if you would put that in that box during break, then that would help maybe plan the next meeting, you know, agenda items. So, we'd appreciate it if you do that. Thank you. And we will reconvene back at 2:45 and that will be at that time we'll be hearing a presentation on from the office Smoking and Health engagements, current and future initiatives. So, we will be right back.

BREAK. RECORDING ENDED

RECORDING STARTS
0:00 – 0:08
Dr. Les Dauphin: Back wonderful. It's our team. It's our team. Thank you.

0:10- 0:40
Legislator Connie Barker: Ok, So welcome back. We're delighted to introduce our next presenters Dr. Collins, Deputy Associate Director of Health Equity in the Office on Smoking and Health, and Ms. Villaluz, Health Equity Manager for the American Indian Cancer Foundation. They'll be sharing valuable insights with us on Office on Smoking and Health engagements, current, and future initiatives. Please give them our full attention as we delve into this informative presentation. And you have the floor.

0:43-5:21
Dr. Kevin Collins: Thank you. Thank you. Let me start again like everyone else and thanking the Tribal Advisory Committee for having us here. It's an honor to be here and present to you and we look forward to hearing from you further. Not just today, but also going forward in the future. So, we really value this experience. Just want to spend a little bit of time talking to you all about some of our current and future initiatives as we roll forward, trying to achieve our vision of a world free of the harmful effects of commercial tobacco.
My name again is Kevin Collins. I want to talk a little bit to set the ground, give us some context, and then I'm going to turn things over to my esteemed colleague Ms. Coco Villaluz, who will introduce herself in a little bit further detail than that. As we move on to set the stage though, I think it's best that we start by giving a couple of contextual things. The first one being the looking at the difference between traditional versus commercial tobacco. CDC recognizes that some American Indians use traditional tobacco for ceremonial, religious medicinal purposes. However, commercial tobacco is manufactured by companies for recreational use and cigarettes, smokeless tobacco, tight tobacco, cigars, hookahs, and other tobacco products. Commercial tobacco is highly addictive and contains harmful chemicals. So, want to kind of set the stage. There's also just to give a little bit of background, again the context of things we're addressing. We're in the process in the Office of Smoking and Health of as we say it's CDC baking equity into everything that we do. So, I think it's also important that we pause and reflect on the definition of health equity, which is, it means that all people have a fair and just opportunity to be as healthy as possible. So, with that sort of as the underpinning, the foundation of where we start, I hope that's where you see where we're coming from. Our Office on Smoking and Health seeks to advance health equity by identifying and eliminating commercial tobacco product related inequities and disparities. We've developed a health equity strategic plan that is shaped by key informant interviews. Did more than 2000 inputs from people on in developing that plan. We had listening sessions, conferences in a systematic literature review and environmental scans and formal comments from the public. The plan and I think I probably need to advance now to the next slide.

The plan has six key priorities that address interventions. As you can see, they consist of a full spectrum of tobacco products, science, partnerships, capacity, and infrastructure, and increasing the identification and understanding of related to tobacco and tobacco-use harms. Those are the key components of our strategic plan. And as we continue our work, we are implementing interventions that help us achieve these priority areas. While we're going to, let me also just say before I turn it over to my esteemed colleague, while you may hear us talk about the benefits and acknowledging certain policy interventions, we need to, for the record, state very clearly that we do not endorse, support, or promote any particular legislative action at any level. So, with that, I'd like to stop and turn it over to my esteemed colleague Ms. Coco Villaluz.

5:22-22:27
Ms. Coco Villaluz: Thank you, Kevin. We ought to have a stay half a day. Chazemi tawa maki maki API tobeko Akwa and mati hinck na chamorro na nacola. It is such an honor to be here with all you in this circle and on the ancestral homelands of Muscogee.
I, like Kevin said, I'm Ms. Coco Villaluz, and it's such an honor. I've been working with Kevin for about 20 years now in the field of commercial tobacco control as well as traditional tobacco. And really, we're talking about this journey and honoring, right, the uniqueness that exists within Indian Country. And so, I just want to first state that you know for many American Indians, we use tobacco traditionally, ceremonially. We also acknowledge that not everybody uses it in that way. But our hope is that people join us to honor the original intention and the gift from Creator that it is to keep it sacred. It is a healing medicine. It's a gift. And you know, it's held in the utmost regard. And so just always wanting to make that distinction when we're talking. And so, you know, we encourage all of you to join us in keeping it sacred and honoring it and reclaiming it. And so that really kind of sets the stage for some of the work that we've been doing. You know, we work on, you know, with the tribes in many different capacities, and I work for the American Indian Cancer Foundation on all thing's traditional tobacco, right. We want to do things where you know, like Delight said yesterday, the indigenous ways of knowing we're using our culturally based teachings and protocols and solutions to be able to create change. You know, and also, it's really important to acknowledge the American Indian Religious Freedom Act that didn't happen until 1978, which is not that long ago. I'm not going to age anybody, but I'm like that was two years before I was born. So that's not that long ago where we were not able to hold our medicine, hold our medicines, carry our medicines. Like in my bag I have traditional tobacco and at one point that was illegal. So, we have a lot of catching up to do and reclaiming and restoring. But our tribal communities are doing that. One of the initiatives that I worked on as a consultant with the Office on Smoking and Health was conducting an environmental scan, and I went through all of the federally recognized tribes using key terms to see what kind of policies were implemented. And this was done during the height of COVID. And we found that 177 tribes have commercial tobacco policies. But at the core of a lot of those policies are you know, making sure that we're honoring our medicines or just honoring our cultural life ways. With COVID-19 we've seen a surge of smoke free casino policies because that's protecting. So, you know that that silver lining,

that bittersweet moment of seeing more of our citizens and tribal members protected by these, you know, these policies. Also, Oh yes, we can in advance a slide.

If it was up to me, we would have a lot of pictures, but we're keeping it, leaving it low-key, but it was really important. And then also we conducted key informant interviews with subject matter and cultural experts from across the country to just help guide us you know, thinking about what best practices look like in tribal communities. And again, you know even the term best practices, promising practices, it came back to making sure that we're thriving and, you know, ensuring a legacy for our seven generations. We also have to acknowledge, right, colonization: Unjust, discriminatory practices that, you know, we're still living in those contextual times. Yesterday when the gentleman that was sitting here, he was talking about you know, Ishi, who was in the museum just last month. My children and I, we were part of repatriation and bringing our ancestors home back to Fort Peck and reburying them because they were held in museums. And at the core of that was making sure that we were using our medicines and our cultural teachings to offer that. So, when we talk about you know, historical trauma, those are still impacting our communities today and how that has to deal with tobacco, knowing that we have such high rates of disease and disparities. We know that one in four American Indian/Alaska Native community members smoked commercial tobacco, but in some community there's upwards to 60%. So, to me that's a public health emergency. And so how do we address those? And I'm really trying to figure out how we do this in a positive way using the generational wisdom and knowledge in so many of our communities. We see you know, cultural practitioners being held in the almost regard and, you know, going there and, you know, so it's kind of like that walking in both worlds. And so that's just really important as we acknowledge, you know thinking about where we're always, you know talking about funding. Sometimes it's like the oppression Olympics or it's like oh, I'm number one in this thing. But how do we turn that that, you know, that paradigm and be number one in thriving where we're healthy? We have all of these teachings. So, it's just, you know, knowing that. And I also want to state too, you know, we're not here to shame anybody. We know good people are addicted to tobacco. We have to understand all of those underlying issues. And so, some of the great activities that are happening within the Office on Smoking on Health is that the national and state tobacco control programs, CDC provides funding to help support 50 states, the District of Columbia, eight US territories and freely associated states as well as 26 tribal organizations. And right now, there's a community disparities requirement that calls for recipients to partner with populations experiencing commercial tobacco-related disparities. And eight states chose to focus on American Indian and Alaska Native populations and those states include Alaska, Arizona, Montana, North Dakota, Oregon, South Dakota, Utah, and Wisconsin. So, you know as mentioned yesterday too, right, like all of the United States is Indian Country and thinking about how we partner with all of our tribal nations, our community members, knowing that we have of a large population residing in
the urban areas as well. Another initiative that is happening is Rocky Mount Tribal Leaders Council, which is based in Montana, Wyoming, is one of the nine national native networks funded by CDC's five-year cooperative agreement to help achieve equity in commercial tobacco prevention and control as well as to reduce cancer-related disparities. Rocky Mount Tribal Leaders Council will work on addressing social determinants of health as well as mass reach health communication on behalf of American Indian/ Alaska Native communities. So, I'm really excited cause that's in in my home state. You know just seeing all of the great work that they do, it's really positive and knowing at the core of a lot of their work too is the traditional tobacco. And I always sound like the broken record because I don't think we can acknowledge enough of, you know, our traditional tobacco. Even saying it and calling it out. I think within the past five to ten years you're seeing that distinction of commercial tobacco versus traditional tobacco. So, to us, that's a huge win. And even, right, the word tobacco, that's another colonized word. In so many of our communities we've been gathering and collecting those different translations where some is known as mountain smoke.
I think in Navajo Nation, you know, some is like the head sacred offering. So even that reclaiming that language and some of the work is so imperative. Another initiative that we have is the Our Breath is Sacred: A Three Fires, Menthol, and Flavored Tobacco Reduction Project that is housed within the Inter-tribal Council of Michigan. They're one of the 8 organizations funded by CDC's new five-year cooperative agreement to reduce the burden of menthol and other flavored commercial tobacco products in communities hardest hit by the tobacco epidemic. And so, what they'll be doing is focusing on building capacity to help reduce tobacco product use and initiation as well as improve cessation among American Indian/Alaska Native citizens in MI. Another amazing--you guys have probably all seen--is the Tips for Former Smokers. CDC launched the first ever federally funded national tobacco education campaign back in March of 2012. And this campaign was really to focus on, you know, people who had real life, serious impacts from smoking. And so there were ads that featured now who are two ancestors, Michael P, who is a Klickitat tribal member, as well as Nathan M, who's an Oglala Lakota member. And now and I think fresh off the press because of last week, there's a new ad featuring Tammy W, who is a member of the Little Traverse band of Ottawa Indians. And so, these will be shared through multiple channels, media, print radio. You'll see all of those. And you know, I really encourage you all to check them out and see Tammy's story. Tammy, you know, she was, she'll tell you herself, she was kind of that vision of perfect health. She was a marathon runner, you know, and nobody would have ever expected that those commercial tobacco related from smoking would have impacted her in that way. So, she really shares a powerful story. So, I encourage you all to check out the TIPS campaign. More initiatives is that we have the American Indian commercial tobacco program, the Quit Line, and that's operated through National Jewish Health. This Quit Line offers American Indians access to free, culturally tailored commercial tobacco cessation services, including calls with the dedicated native coach. There have been some states who have worked to make sure they are creating a very specific curriculum.
We're working with these quit lines for them to understand you know, what it is like to work with tribal communities, understanding the uniqueness between traditional tobacco and commercial tobacco, even understanding all of the little nuances, you know, and building and creating those trusting relationships to be able to, you know, quit using commercial tobacco. So that exists and, and you know, there's a toll-free number to call.

Something that is also new and hot off the press as of December is a smoke free native texting program. This new free evidence-based text messaging program offers a culturally aligned digital resources to help American Indian/Alaska Natives, you know, quit using commercial tobacco. And that this is something we're really proud of because we worked alongside the National Cancer Institute, Indian Health Services, University of Minnesota and then the American Indian Cancer Foundation where we tailored all of the different messages and try to put more of a positive spin. You know, talking about like generations, saying 'you belong here.' So, we're not shaming smokers, because, like, people who smoke or use commercial tobacco--we all know, right-- It's hard and people who want to quit and making that journey. So, we're trying to put that spin on it and honoring it in a good way. So that just launched. We'll be also having a webinar on it next Tuesday and talking about that process. Another great resource is tobacco where you live. It is a Native community's best practice user guide and this brief really provides information to help develop strong relationships with Native communities, leaders and members and communicating the harms of commercial tobacco as well as the respect for traditional tobacco. And I just want to acknowledge all of these initiatives are done with some incredible people in this room and the tribal partners. You know, when you work in tobacco, it's like tobacco connects everybody. You know, once you're in that circle, you're in it even though you may go anywhere else. And I think that's the beautiful thing because that is such a powerful medicine. So just acknowledging all of the people that put so much time and effort, you know, into this work.
And some of the work that we've been doing too with the American Indian Cancer Foundation is working with tribal communities to be able to do what works best around traditional tobacco. So, we're seeing some of the first-ever tribal tribally led own seed banks. They're reclaiming their traditional seeds and their medicines and so that that's really huge. We're seeing communities growing greenhouses in their medicines, sweetgrass, sage tobacco. And so that is such a, you know, a transition to help create policy change, help create educational change--and in a good way. And you know, thinking about where we are in 2024, it's hard to believe it's almost March and beyond. Some of the other initiatives that we're thinking about is menthol tobacco products including how and to whom they're market to and sold. We know that we're at a significant risk to public health--the menthol products--because, you know, menthol makes it less harsh. We probably have all these stories... I don't know about you guys, I love Vicks. You know, it's just that that smoother taste and so really it enhances the effects of nicotine on the brain, can make tobacco products more addictive and can make it harder to quit smoking. So really, I think this is a time too for tribes--you know using what Deputy Chief Werner said-- 'opportunity for tribes to look at how, you know, we can do things such as prohibiting the sale of menthol and other flavored tobacco products to save lives, especially like our communities who we know are greatly impacted and really shifting that norm. Another really exciting thing-- and maybe you guys could all come--is we're holding a national tribal tobacco conference in June 27th and 28th at the University of Minnesota in Minneapolis. And this is really kind of you know, we know all the facts and figures, and we're encouraging all of our tribal partners to come and share what the work that they've been doing in their communities. Talking about some of the work that we've highlighted here: You know, hearing one of the grantees that we're working with based in Utah, they are putting a greenhouse right in the center of Salt Lake in a parking lot that they share with the Mexican consulate. But like it's generated so much information. So, they'll be sharing some of those highlights. But just thinking of innovative ways.
We also seen tribal communities, you know, make their own canoes, or even purchase canoes to be able to harvest their medicines along the riverbank. So, thinking about these kinds of out-of-the-box strategies that may seem out-of-the-box for us, but are culturally based to really create that change in the communities. And so those are some of the things looking forward. But you know, through all of this, through all of the work that we've been doing for over the past 20 years, some of the lessons that we've learned from the environmental scan, from our key informant interviews, from all of our different partners, was at the core, was respecting and understanding tribal sovereignty. We've heard this time and time again that not one-size-fits-all. And you know, even within our tribal communities, I have protocols and teachings of how to use our tobacco. And the next family has their own protocols. Recognizing culture and tradition are at the core of tribes. Knowing that, you know, for us in our community, I have to go talk to the Elders. When I was working on policies for our tribal nation, I literally knocked on 5000 doors to make sure that I was getting input from our communities to see how we could create change. We even looked on how to translate 'keep tobacco sacred' in our language. And so that took time and investment. Another recommendation was to listen to indigenous voices for solutions and strategies. Like, our tribal communities know, know what needs to do. You know, we got it going on. So, you know, how do we do that? Because at the end of the day, right, we're all working towards healthy. We want to see thriving. We want to see, you know, 7 generations. And so, everything that we're doing right now is going to impact. And so, you know, just continuing to carry that, we cannot stress enough about collaborating and partnering with tribal nations and communities from beginning to the end of the processes, ensuring that they're at that part of the table. And I'm like including in the circle, right, making sure that there's feedback loops and some of our work with like creating a specific American Indian quit line. We made sure to send it and e-mail social media all the different ways. And now there's cool ways like TikTok right, to get the information out to the communities to be able to provide us their thoughts and feedback on any initiatives that we were doing. Continuing to engage with tribal partners on initiatives, funding programs and other work, especially within the Office on Smoking and Health. Another one is ensuring that representative staff or American Indian/Alaska Native liaisons positions are in place when working with tribal communities. This one I cannot stress enough. We've heard about data: data modernization ensuring that data use agreements exist when conducting research with American Indian/Alaska native communities. Another initiative that we have at the American Indian Cancer Foundation is the Tribal Tobacco Use Prevalence Project that from beginning to end when we were working with the tribes to own their own data around traditional tobacco, commercial tobacco use, those agreements were in place. And we would only ask if we can get their number to put into the statewide aggregate. But the tribes owned all of their own information, and we would only know their specific tribal number if they chose to give it to us. So that was something that was really important and, you know, cannot be emphasized enough as well. And as well as understanding policy terminology comes in a variety of accepted terms. Understanding can be seen not always in a good light because of all of the things that have been shared. But we're trying to shift that. And talking about when working in communities, policy also

means writing for the way that we want to live, and we want to live in a good way. So, these take on many different terms and so that was really important for us in our environmental scan. So, I think just with that, that we're going to turn it over to you all and part of the insight. So, I think we'll go on to the next slide.

22:28- 23:04
Dr. Kevin Collins: Next slide, please. We again we saw this as an opportunity to be interactive to hear from you. As much as we wanted to present and update you with some of the things that are going on in our Office, we wanted to get some feedback from you. We were presumptuous and putting a couple of questions up there that did to maybe get you to think about, but if you have other questions or other ideas, we'd much prefer to hear whatever you have. And so, with that, we'll pause and listen.

23:07- 23:52
Legislator Connie Barker: Do we have anyone from the TAC, either on the phone or at the table, who would like to have a comment or question? And I think we have three questions actually on the on the screen here. So, for those of you on the phone, if you can, on the, Yeah, on your phones if you can see it. Number 1: what information do tribal leaders need concerning menthol- and flavor- related policies? Number 2: What is the best way to partner with Native American/Alaska native communities to understand the impact of the Tips from Former Smokers campaign? Number 3: Are there other topics related to commercial tobacco prevention that tribal leaders would like to see OSH address? So those are the three questions. Yes. Sanchez.

23:53-24:16
Councilmember Terresa Sanchez: Hi, I'm Teresa Sanchez Morongo, Band of Mission Indians. I'm just wondering does this campaign also include vaping, the vaping tobacco pens. And how does that fit into this program-- if it does? Because it's such a it's a huge problem in our especially with our youth.

24:18-24:48
Dr. Kevin Collins: So, they start asking questions and you turn your microphone off. [Laughter] I believe it does. I can double check that to be perfectly for sure. But we agree vaping is a tremendous problem across the country and not only with youth but with adults now and so it is a tremendous issue. So, I, I we we'll definitely take a look at that.

24:52- 24:54
Legislator Connie Barker: Yes, Ms. Freeman.

24:55-25:29
Councilwoman Carrie Freeman: Carrie Freeman, tribal member at-large. I guess my question is, is does your program collaborate with other CDC programs to merge activities that are all related to tobacco cessation, diabetes program, cardiovascular health, those types of things? Because you know everybody's busy and if, they, I'm in the diabetes program, and I'm in tobacco cessation, and I'm in this... when a lot of times you can merge the activities that are in each of those, and it's still beneficial.

25:30-26:56
Dr. Kevin Collins: Yes, great question and thank you. Yes, we do. First off, we are part of our National Center for Chronic Disease Prevention and Health Promotion. As you saw earlier today in the budget presentation, there is a 12+ million-dollar initiative called Good Health and Wellness that comes out of the Chronic Disease Center that we participate and that includes the other divisions within the Center. So that gets at, you know, diabetes, heart disease, and cancer, and some of the others that that are all within our Chronic Disease Center. In addition to that, we, you heard us mention that we have the National Network Initiative, and that is a joint initiative that we do with Cancer. And so that is jointly funded with both tobacco and cancer funds. So those awardees address both they address tobacco and broader cancer issues as well. And then just by nature of being within the National Center for Chronic Disease Prevention, we are constantly in collaboration and communication with one another too. It's looking for opportunities to build on one another's programmatic efforts. Yes.

26:56-27:05
Legislator Connie Barker: Any other questions or comments? Okay, Ms. Russell.

27:06-28:54
Ms. Kim Russell: Thank you for recognizing. Thank you. I'm happy to report my Nation and it was really kind of ushered in with COVID and being that COVID is a respiratory, you know disease. So, it was just kind of like the prime opportunity for our coalition to pass to have our council pass the smoke free policy. I'm so happy that it also was extended to our tribal casinos. So really happy that's happening, and we're and we're working with that particular coalition to now tax vaping products. Fortunately, smoking commercial tobacco isn't a really big issue for our nation, but we're seeing the uptake of vaping products for our young, young members. So, my question was around what sort of maybe assistance or technical assistance that you can provide to tribes so that they can connect the systems, maybe IHS. So, there are 6 or 8 facilities in hospitals to nicotine replacement therapy options when somebody wants to quit smoking. Is there a policy or a model that you could share in that regard? The reason why I bring this up is because I used to do tobacco cessation, and a lot of the times the people came to me when it was really too late for them to cease tobacco use. But they brought their partners, and we were able to connect them to nicotine replacement therapy with a really great success rate. When you have the behavioral modification and then also the, the nicotine replacement therapy combined, you know the chances of quitting are a

lot greater. So, anything you can share in regard to those two systems coming together, whether it's a program or a policy that can be shared with other tribes.

28:56-31:38
Dr. Kevin Collins: Yes, one of the things that I think in the previous question we were asking about the TIPS campaign, and I wasn't really sure if the TIPS campaign addressed vaping directly. But I should have also said that in addition to the TIPS Campaign, we have all we've maintained and continue to build on our media communications Resource Center that we house. And that has hundreds if not thousands of communication vehicles that are already developed that some of them are television ads, radio ads, print ads and they are some of them address very specific population groups. So, we may have some for American Indian, we got some that that target African American or rural areas of what have you. Many of them have already been evaluated and so we can show you the evaluation results so that you can see the effect, the effectiveness of the various programs when they were developed. And it serves on as a collaborative piece that we are constantly updating it because we're developing new ads, the States and locals are developing new, and they submit theirs into the MCRC.
So, there are literally hundreds of not thousands of resources there that folks can come into. And many times, if you can get it for free, if we could give it to you for free or the state that developed it could let you use it for free, they will. Sometimes there may be a small talent fee associated with it, but that's all you pay. You're not paying this research development and you know all this other cost. So that's a tremendous resource that's available today that's been available that we really encourage people to do take advantage of. And another resource that we've mentioned is the National Networks. You mentioned behavioral health. One of the advances that we've made with the National Networks over the years is that for the first time now one of our national networks is a Behavioral Health Network. And so, we are looking forward to them helping us to develop new partners and new resources that will address those issues as well.

31:40- 31:44
Legislator Connie Barker: Ms. Frias, you have a comment?

31:46- 35:10
Councilwoman Herminia Frias: Yeah, thank you for your presentation. Really, really do appreciate it, both of you. The your question number 3 about other topics related to commercial tobacco. One of the things that I wanted to bring up is I've been a proponent also about, you know, for commercial free tobacco in our in our casino. And prior to the pandemic, I had proposed it and wasn't very popular, but you know, pandemic happened, and I was like, oh, okay, now we're talking. you know, and so its people understand it. But one of the reasons not just for, for the for patrons that were going there, but was also for the employees. It was really about, you know, all of the employees that are working there. And you know, a lot of those employees are our own tribal citizens and that they're working there sometimes more than 8 hours a day, full time. And we've seen an increase in asthma. We've seen, you know, we have seen statistics, we, you know what is happening and so there that you know, we know what's what happened. We, we have statistics of secondhand smoke, you know, and we can talk about our ventilation system, we can talk about how great all these things are, but it's not as great as not having smoking indoors, right. And at this point everywhere else at least in in our area in Arizona, there's there are no smoking indoors in restaurants and everything else. But our casinos have it. And so now our casinos, you know, we don't have it there, but we you know, have designated areas. But still, I think about the employees, and I think about the long-term impact of our employees, and you know. so, so my so back to your question is going back and thinking about coordinating with the Institute of Occupational Health and Safety and talking to them you know within CDC and having those conversations about how do we go back and think about our employees and the different industries, you know, our casino industries and different types of businesses that our tribes and our nation's operate? And how important it is to talk to tribal leaders like myself to really influence and really have that conversation about these long term effects and what it really does to us because a lot of times we don't think about that and we just think about well you know it's revenue and we're doing this and that but it's not it really is the health of our community and we really do need to think about the long term ramifications of our health and our healing. It's us and it's everybody else who works there. So, I just wanted to bring that up and to think about, you know, coordinating with, you know, Occupational Health and Safety and how that would work.

35:11- 35:14
Dr. Kevin Collins: Thank you for that. And do you want to have that? I have two.

35:14- 36:16
Ms. Coco Villaluz: Yeah. I was going to say we really love that. Two tribes that we worked with in Minnesota with those same concerns within their employees actually did clean indoor air quality studies where we worked with their casino to be able to put you know the different types of monitoring machines. I don't know all the terminology, but we put it within their casino, within their hotel. And that information was brought then back to the tribal leaders to eventually pass commercial tobacco free policies because they've seen the importance of protecting their not only their employees but also their patrons. You know, in addition to different types of surveys. One thing I'm just going to put this out there, I don't know who's going to fund it. We haven't seen anybody bite on it. But we're like can we like have tribes try going smoke free for or the casinos going smoke free and if there is any, you know, revenue loss that they would be able to be compensated. I know that's kind of a wish of it. but you know but yeah that we I could send you some paperwork on that on one of the studies that we did about on the cause. One of the tribes let us publish on it because it just shows the benefits to their tribal members.

36:17- 37:58
Dr. Kevin Collins: So, the other thing that I was going to add to that is I think your point is very well made. It is a tremendous issue that is affecting the health of employees is an employee safety issue in addition to doing great customer service, a disservice by allowing smoking in an indoor place. What we've learned is sometimes the messenger is as important as the message. And so, I could walk in all day long and be seen as the public health guy, the smoking nut or whatever. And it goes in and out the next ear. You know, whereas having folks from the gaming industry, there are a group of people in that industry now who have gone smoke free and seen the benefits in real dollars. It's less wear and tear on your carpet. It's less wear and tear on your curtains. It's less burn marks in the bathrooms, in your, in your hotels. It is, you know, there are a number of people who refuse to go to casinos because of the smoke. So, in real language that they understand, their colleagues are talking to them saying hey, we went smoke-free and we're seeing the benefits and that seems to have more power than the public health guy walking in saying your ventilation system don't do it. So yes.

37:58-38:00
Legislator Connie Barker: Yes, Ms. Russell.

38:02- 38:56
Ms. Kim Russell: So, I mean you have this conference that's coming up, right. I hope you reached out to I think it's the Black Hills Center for America and Need Help. Right. They were. So, they can tell you their efforts to for our nation to go smoke free, including our casinos. And it wasn't overnight, but I think it took them almost a decade to do this and they were sharing with me all the different things that was happening within the with the casino workers and everything. And but they got it done. So, it can happen. And I'm so grateful that my tribe did that. I'm so happy. But my other question was around when you talk about tobacco, that also includes smokeless tobacco, right. I think I know more at least in my community more chewers and then smokers. So, it would and so your campaign materials would also include that, right.

38:56- 39:22
Dr. Kevin Collins: Yes, it does. And again, one of the benefits of just being within the Chronic Disease Center, one of our sister divisions is the Division of Oral Health. And so, we partner a lot with them and messaging around smokeless tobacco and oral cancers and all of that. So, yes, to answer your question.

39:22 – 40:25
Ms. Kim Russell: I'm really happy that thank you for recognizing that you're working with that Division of Oral health because that's another huge issue for my nation is oral health. And there's a lot of oral health policy that we were a part of. And at least in our state, our Medicaid program does not. We don't have a very robust dental benefit for Medicaid in my state of Arizona, and we've been trying to expand that, but it's really difficult. So that's another, in my opinion, a public health emergency is all the oral health disease that we have within our whole population, but especially our kids and they have the benefit, right. So, I'm, I'm happy that you're working with them. I think it may be a larger conversation at least. You know from my community we have high early childhood carry rates and it's just off the chart again. You know if we really, really were to look at it, we could deem it a public health emergency. But anyway, just thank you for the presentation, how we, how you're all kind of wrapping around in in different ways.

40:27-40:28
Legislator Connie Barker: Ms. Stanphill.

40:33-43:10
Dr. Sharon Stanphill: Thank you for your presentation. Sharon Stanphill, Rep at large, here on the TEC from the NW. And first of all, I want to thank you very much for the handout. It's lovely and all the good information you provided is right there for us. So, thank you very much for that. And I wanted to I'm going to read my question because it comes from a conversation or information from both Rocky Mountain Tribal Epi Center as well as the NW Portland area. So, it's real short and the IT: the gist of it is that we need some technical assistance from the CDC for our TEC and according to our understanding this is about national tobacco networks. The TA requests, and apparently requests are limited to those who can make a request through the CDC's award management platform AMP. And if, for instance, if the Good Health and Wellness Center in Indian Country grantees don't use AMP website, they won't be able to request technical assistance, apparently. And they'll need to go through one of the seven tribe or tribal organization programs or perhaps one of the 50 states. So, the example they gave me to share with you is for the Northwest Tribal Epi Center: The request for support from Rocky Mountain Tribal Epi Center for the WE program (Good Health and Wellness) would need to be submitted to someone at the Northwest Tribal Comprehensive Cancer Control Project at the Northwest Portland Air Indian Health Board. And then they would have to submit it on this website for the CDC staff to review it, to triage it, to get back with the Rocky Mountain TEC. Two additional programs involved for requests that could otherwise come directly from Good Health and Wellness straight to Rocky Mountain. So, the quote request is 'Can the CDC, can your Office, clarify the process to make sure we're understanding it right?' And then the second part of that is, is there a way to streamline these technical assistance requests? Thank you. Oh, and lastly, under #1 there, I think having consultation with tribes concerning menthol, menthol- and flavor- related policies would be a great respect to our tribes, especially for those that are still in the process of realizing that commercial tobacco is not healthy of course. But that would be a great place to start be consultation I think for #1. Thank you.

43:12 – 43:18

Dr. Kevin Collins: Thank you for your question and please allow us to go back and investigate and get your response.

43:20 – 43:33
Legislator Connie Barker: OK. Anyone else? And we need to move on to our next presenters. OK. I want to take this time to thank you Dr. Collins and thank you, Miss Villaluz for your presentation. Great information and great conversation at the table. So, thank you very much.

43:34-43:35
Dr. Kevin Collins: Thank you.

43:41 – 44:22
Legislator Connie Barker: We are delighted to welcome our next presenters, Commander Hymer, Senior Injury Prevention Specialist in the National Center for Injury Prevention and Control Program Implementation and Evaluation Branch, Behavioral Self Behavioral Scientist and evaluator in the Division of Injury Prevention and Ms. Willocks, Behavioral Scientist, and evaluator in the Division of Injury Prevention. Today they are present on the Division of Injury Prevention funding for tribes, updates and plans for future funding. We encourage everyone to give their full attention as we delve into the information presentation. Let's make the most of the opportunity to further explore opportunities for funding the tribes related to injury prevention. So welcome. Thank you.

44:24 – 54:43
Commander Jason Hymer: Thank you. And it's an honor to be here with you all this afternoon. I was thinking I; I think the last time that I attended a TAC meeting in person was all the way back in 2019 before the pandemic. So, it's really great to be here with you all. I'm going to talk a little bit about some of the work that's happening in our division and then transition over to Ms. Stacey to talk about some of our evaluation work. So, if you can move on to the next slide. The vast majority of our tribal overdose prevention work in the Injury Center is administered by the Division of Injury Prevention's newly formed Tribal Support Team. And so, before I share about our work, I want to share a little bit about our team. Our tribal Support team was formed and stood up on August 1st of 2023. So, we're just about six months old right now. And I think for us that was really a significant milestone. Prior to August 1st of last year, our, our tribal overdose work was administered by the state local tribal support team, which was a great team, but focused you know both on states and tribes. So, it's been really great to have a team dedicated to advancing injury and overdose work across our division and really across our entire Center. You know with that we also have a new team lead. So Michon Mabry, she's back in the corner there. If you can wave me, Michon is our new team lead for the tribal support team, and she is fantastic. The other thing I want to before I jump into our values here is talk about when I say our team, you know that's not just the tribal support team. So, we also work very closely with our evaluation team which is a sister team in our branch. You know Ms. Stacey is here with me today, but we really do work closely with our colleagues on the evaluation team and while on paper we really are two different teams with our tribal overdose work, we do operate as one team. So, you know, Ms. Stacey and our other colleagues from the evaluation team are really embedded and integrated in the work that we're doing, and we really do operate as one team**.** And our joke is kind of you know, when if you ask Ms. Stacey and I or I to come and talk, you really, you're going to end up with both of us, like today. And that's because our work is so intertwined. So, our team is really committed to empowering tribal communities to develop and shape the programs that affect them and encourage community ownership and participation. And so, our approach is respecting and integrating tribal cultures and indigenous knowledge into our work. We listen, learn, and adapt to the unique needs of each of the tribal communities that we serve. So, we fully understand that a one-size fits all approach really doesn't work with tribal overdose prevention. And I think that we accomplished that really by operating, you know, kind of by some core values that are listed here on the slide. We promote meaningful collaboration with our tribal partners and respect tribal sovereignty and also recognizing tribes and tribal epicenters as public health authorities. And you know, we've consistently heard that you know from our tribal partners from the TAC that culture is prevention. And so, we support the inclusion of indigenous knowledge and reclamation of culture and the prevention of overdose and are really intentional about providing that space for these activities in our funding that goes out to tribal communities. Next slide please.
So, we are funding overdose prevention initiatives through three kind of kind of categories of supplements to three different cooperative agreements. The first of those is the Tribal Epidemiology Center Public Health Infrastructure or (TECPHI) cooperative agreement for the overdose supplement. And so, this project is intended to improve overdose data for American Indian and Alaska Native people by working with Tribal Epi Centers to improve data and surveillance activities related to both fatal and nonfatal overdose and also providing training and or technical assistance to tribes in their areas on overdose data epidemiology and surveillance. In addition to that, TECs do you have the ability to explore data and surveillance related to the primary prevention or protective factors of overdose during this funding cycle? The Tribal Overdose Prevention Program is a supplement to the Public Health Infrastructure Centers new Strengthening Public Health Systems and Services in Indian Country Umbrella Cooperative Agreement. And so, this program is designed for tribal communities to heal from the overdose epidemic by developing a comprehensive and culturally based approach to preventing overdose. And so, activities for this program include community based and cultural interventions to enhance protective factors against overdose, to improve overdose data and surveillance at the local level, health systems and public safety partnerships and interventions, and then other innovative community-based strategies that may not fit under one of those other buckets. We do also fund 3 supplements that address overdose prevention through public health infrastructures, strengthening public health systems and services through National Partnerships Cooperative agreement.
So, we are working with the National Network of Public Health Institutes and through them with the Seven Directions Indigenous Public Health Institutes to provide training and technical assistance to tribes and tribal

serving organizations on overdose prevention. So, over the life of this project, they've developed several products including two environmental scans and a report on promising practices for overdose prevention throughout Indian Country and Alaska. They've also developed a diversity toolkit that provides tailored resources for supporting tribal and urban Indian community members who might also be members of LGBTQ two-spirit communities, youth, Elders, and veterans. And they've also led the development of the Indigenous Evaluation Toolkit and are providing training and technical assistance to Injury Center funded overdose, suicide, alcohol, impaired driving, and older adult falls prevention recipients. We're also funding the National Indian Health Board to implement an overdose prevention track at one or more national conferences each year. And we're also working with the National Council on Urban Indian Health on a one-year project to learn more about the current landscape of overdose prevention and urban American Indian and Alaska Native communities. And we hope that this project will help to identify some current overdose prevention initiatives in urban communities, identify specific needs that urban Indian organizations have related to preventing overdose and also identifying unique protective factors within urban communities related to preventing overdose.
And the next slide is just a list of our currently funded partners. I know that that's a little bit hard to read, but with our tribal overdose prevention program, we are funding 16 total partners, 6 tribal nations and 10 tribal serving organizations. We're also funding 8 of, sorry, funding 10 of the 12 Tribal Epidemiology Centers through the TECPHI supplement and those partners that have the * listed there on the slide or partners that are receiving funding under both of those funding streams during this funding cycle. Next slide, please. So, in addition to overdose prevention projects, the Applied Sciences Branch in the Division of Injury Prevention is also funding 3 tribal initiatives. The purpose of the Tribal Suicide Prevention Program is to identify, implement, evaluate, and improve holistic community-based interventions that increase protective factors and reduce risk factors for suicide in a culturally centered way. The purpose of the Tribal Alcohol Impaired Driving Prevention Program is to reduce injury and death related to alcohol impaired driving and AIAN populations by implementing interventions using evidence-based strategies and indigenous approaches. And the Elder Falls Prevention Project is intended to improve capacity within tribal communities to develop, implement and evaluate evidence based clinical and community links fall prevention strategies. The ultimate goal of that project is to incorporate clinical fall prevention as a routine part of clinical care for tribal Elders and also applied tribally driven community strategies to support that clinical implementation. One upcoming project that's not listed on this slide from the Division of Violence Prevention, also in the Injury Center, is that in 2024, CDC will be funding up to 10 tribal sexual assault coalitions to implement and evaluate evidence-informed and indigenous knowledge- informed strategies that address sexual violence and indigenous determinants of health across Indian Country. So, this will be a four-year grant that will begin in June of 2024 and the maximum funding amount for those funded coalitions will be $90,000 per year. Required activities include building infrastructure for sexual violence prevention, working with state health departments to develop or enhance the state or territorial action plan, implementing community and societal level sexual violence prevention strategies that promote health equity, and using data to inform prevention strategies. So, this project has been published. I don't have any additional information, but if you do have questions or would like any more information, we can link you to our colleagues in the Division of Violence Prevention. And with that I'll turn it over to Ms. Stacey to talk about indigenous evaluation.

54:44- 1:13:16
Ms. Stacey Willocks: Thank you. It's good to be back. This is my third TAC meeting in a row talking about indigenous evaluation. And so hopefully with each time you're, you're getting a good idea about our progress and Jason was joking that if you invite one of us to speak, we both need to show up. And the other joke that we tell in the beginning is that he's the program and money guy, and I'm the scientist evaluation person. And so, between us together, you get one solid public health professional. And so that's hopefully what you're getting from us today. And so, for this section of our talk, I'll share a little bit about background context. We were able to present to the TAC at both meetings last year on the development and plans for the indigenous evaluation approach. And so, we're back again to tell you how that's going. So, provide a little bit of context. I know that there are new folks with us on the TAC and also in the room and on the telephone. And so, I'll provide a bit of background on that, a very little bit of background because our focus today is really to learn from you all. But if you'd like more information, wave me down after, drop a note in the chat, we can get you my e-mail address, address, and this is my favorite thing to talk about. So, you should hit me up for a conversation. If I don't, if I don't give you the information you need today. And then I'll also provide a progress update after we talk a little bit about context. And we're in a very different place with Indigenous evaluation than we were last February when I was in this room, sort of letting people know what was, what was going on. And so even though we are, you know, advanced a whole year from there, it still also feels very much like we're in the beginning. And so, I think you'll probably pick up on that as part of the talk as well. And through that, we'll talk about progress at two different levels. And so, it's not just the progress that's happening in Indian Country on the ground with our tribal partners and tribal organizations in the way that they are implementing indigenous evaluation, but there's also stuff that has to happen internally as well where we sit in the division of injury prevention, and we'll talk about sort of our progress with that as well. And we will take a look ahead about what's to come because we were talking earlier today about that five-year funding cycle and we're almost three or one. So, we've still got some time ahead of us. And may I please have the next slide. Thank you.
And so, for those who may have not heard us discuss DIP Division of Injury Prevention's indigenous evaluation work before, we're moving away from requiring sort of CDC centric Western approaches for both injury prevention programming and also evaluation science. And we're doing this for two reasons. We're doing this for out of respect for indigenous knowledge and we're doing this out of respect for tribal sovereignty. And so, I would like to brag a tiny bit that we started this work before the guidance came down from the Biden administration on building indigenous knowledge into federal programming and projects and also the tribal self-determination executive order that came down a couple of months back. That's something that we've been and pretty focused on even before that came down. And so, we wanted to brag a little bit about it. We're not going to like, you know, break arms

patting ourselves on the back because there's still so much work to do. But we did want to note that. and we also wanted to know that Dr. Stanphill and also Ms. Russell, you had each asked earlier today about how this is happening sort of at an agency level, how are we leading into this guidance, how are we, how are we operationalizing that executive order. And I just want you all to know that we are not representing the agency in that we're talking about this little pocket of people's nested very deeply and sort of that's where that's coming from. So, not representative.

So, we heard yesterday from this group about the ways tribe know their history, circumstances, and needs best. And someone brilliantly reminded us yesterday that tribes and CDC agree on the outcome. We do. Everybody who's in this room, everybody who's on the telephone. We all agree that we want American Indian/Alaska Native people to be healthier and safer. We agree on that. That is a monumental starting point. But going about that looks a little bit different. It looks a lot different from the way that we work through state health departments and local health departments. And I also want to note in providing a bit of context is that we have a deep and valued partnership with the team at the Seven Directions Indigenous Public Health Institute at UW in in Seattle. And we are almost six years in work to working with the team at Seven Directions and they're about six years into working with our overdose prevention partners and that means a lot. There's a lot of learning, mutual learning that's taken place sort of among and between US. And so, I wanted to provide that bit of context and we've got their name on the slide because they really deserve the credit. So again, we're not going to be too busy patting ourselves on the back when we know we have really been led, not only from our partners at Seven Directions, but also our partners who are funded to do this work at the local level. So, at the request of our partners at the local level, Seven Directions developed an indigenous evaluation framework for tribal overdose prevention. And then they developed a tool kit for community based tribal partners to use and grounding their approach within unique history, context, values, knowledge and needs and building their programs and evaluations from there. And so again, this is a departure. I've been working in public health a long time, and this isn't the CDC vetted evidence-based package that needs to be implemented and tracked using the set metrics at all. It's the opposite. It's building on indigenous knowledge. It's leaning into sovereignty and building public health approaches up from there and we've expanded that through the funding that Jason outlined. It's not just focused on overdose now, it’s now crossing tribal suicide prevention, elder adult falls, alcohol-impaired driving and so forth. So, I shared a good bit about that tool kit. It was released February of last year. So, it's been in the field for a year. And this this range of funding that we shared with you earlier, this is the first time that this has been formally offered to tribal partners in the field. And so, those, Seven Directions has done a great job disseminating it through their networks. So OTASA has helped us. We've had a big dissemination push, and we've reported back to you on that. This is really our first effort to roll it into funding to tribes. And so, we're really happy about that, and it's the first time. So, it's experimental, and we're learning a lot, and so we're really happy to sort of keep you looped in and to report on that. Their original design was focused on overdose. They right now are also developing a version of the tool kit for suicide prevention. And they're also working on developing some different more usable formats. So, things that fillable forms for worksheets and things like that, that we hope will be more practical to folks who are doing the work. And so instead of striving for a fidelity to a Western model that CDC is requiring, our partners are now able to operate with fidelity to their own communities, to their own values according to their own needs. And may I have the next slide, please?

And so, the update. And so, for those of you who have not seen Seven Directions' Toolkit, there's a QR code there for you. You can also find it on their website. They've got a whole bunch of great resources on their website. Or you can ping us in the chat and we'll get it to you. And one of the important things about this toolkit, and you know we got this from Seventh Directions, is that it's optional. So that's something else that's new in this round of funding is that we're not requiring any specific model or tool kit. So, we understand the variation that's coming in from Indian Country. We have tribes that are highly sophisticated and well entrenched with a clean well-oiled machine to pump out Western evaluation and if that is what that tribe wants, we are here for that, and we'll provide them evaluation support as they need it. We also have heard from tribes that they really want to lean into a more indigenous approach, and they would really like some tools. And so, this is offered for tribes to take what is used of use to them, but it will not be required because again that would lean into programmatic and evaluation sovereignty and so it's an offer not a requirement. So, what have our partners been up to across this program? All the programs that Jason outlined for us, they're on a similar timeline. And so, if you on the slide we've got, you know, the quarter from the last quarter of 2023, that is when our partners across the programs were, you know hiring staff, meeting TA providers from CDC and, you know, really kicking off the their first year. They're also reworking their work plans. They had a real skinny minute to apply for that funding. And now they have their first year to really dig in and rework their work plans and if they would like to, they can build that indigenous approach into what they're doing, and that may not have been in their original design, and that's totally fine. So, Seven Directions held there, the first training for the sort of blended cohort of tribal partners in January and we got a lot of really good feedback from our partners on that. And that TA opportunity serves as sort of a part one. And so, we've got coming up next month, we're super excited. Our partners are coming to Atlanta for a few days.

And so, we're going to convene everybody and meet everybody in person for the first time. And there's going to be a full day of indigenous evaluation capacity building. And during that day, we will have, we'll have a tribe present that has really done this operationally in a clear and experienced way to sort of share because it is a shift in, in the way that we work with our partners. And so, we have a tribe in mind that could, you know, lead others through that process. And then we've got some workshop sessions as well that will build upon what Seven Directions has started. And then we'll have ongoing TA. We'll have monthly calls with us: my evaluation officer colleague, Brittany Carter in the in the back. We also have our team of technical monitors on the travel support team for the opioid work. And so that technical assistance will be ongoing as well. And may I have the next slide, please? Great, Thank you.

And so now we'll talk about what's happening on the inside. And so, you know, it's a major culture change, right? I mean, to most people who are involved in this, this feels different. This is like a different kind of relationship with

CDC. This is a different kind of opportunity and some of our partners are a little bit like 'What? You're not telling us what to track?' So, we're definitely having those moments, and it's a culture change, and not everybody understands that yet. And so even internally within CDC we're doing a lot of sharing of information and trying to sort of sort of help people along. And so, it's not as though we can you know simply offer an indigenous evaluation tool kit and call it done. We have successful successfully made this transition. It's actually just the very beginning. And if we were to disseminate this tool kit to our partners and not look internally at our own processes, at our own requirements, we're setting ourselves up to require something that actually could violate tribal sovereignty, that could actually, you know, violate data sovereignty. And so, we're really having to do the hard work internally as well. And so, we're, we're shepherding our sort of internal cultural change as we do this work too. And the first really opportunity to do that was in building the work plans for the supplements that were just published for all of those folks who just got funded. And it was a learning process. Different units within the division had different depth of understanding of indigenous approaches. And you know, we're a, we're a body of Western trained scientists. And so, it's a process. But that's one of the big things that we're doing, is we're working on capacity buildings within our own ranks to understand this process to align ourselves with sovereignty and indigenous knowledge. We're also learning from current tribal partners about indigenous evaluation uptake and implementation from year to year. So, we're highly engaged having monthly calls looking forward to having visits with them on site visits and also bringing them to Atlanta. And we are using that learning as we design future funding opportunities as well. And hopefully we're increasing our responsiveness to tribal input as a as a as a as a value of the tribal team and the evaluation team as we work with tribes. And part of that is coming here and being accountable to all of you, letting you know what's going on or asking for the correction if we, if you, see one that we need to make, and developing TA tools and supports with tribal partners. All of this came out of requests from our partners. This wasn't something that we dreamed up on our own. This came, this was a response to requests for technical assistance and training on indigenous evaluation approaches. And then the bottom line is lofty because it really is a shift from the way CDC tends to do things, and that's developing presentations and publishing papers with and not about our tribal partners to advance tribal injury prevention at the federal and tribal levels. That's something we're real guilty of is having teams of people inside CDC publish articles without any tribal input at all. And that's something that has been a very hot topic since we have been here just yesterday. And so that's something that-- just for our programming at least--that is a goal for us to keep that from happening and to really build meaningful partnerships where those collaborations happen organically and not as they tend to. And let me have, I think, my last slide, thank you.
And so, this is just ongoing. So, we are sort of 3/4 of the year through year one. I'm looking ahead to year two. We will continue with our monthly calls. We will continue with our site visits, peer-to-peer engagements with our recipients. And we are really watching this process closely because we're hoping to learn because it is new and it is different and we still are feeling, it's feeling baby steps to us still. So, we are really counting on tribal partners' feedback. We're building that into our connections with them on monthly calls. Also, when we have folks here next month, we're going to get to see work plan revisions at the end of year one, so we can see what was proposed for initial funding. And then we're going to see through this process of technical assistance and engagement, how has the work changed? Have they been able to build more of the cultural values into the work? Are they exploring metrics that are actually more culturally relevant? And so, we're going to. It's a question we don't know. So, we're happy to sort of learn from that process and we will also we're engaging our partners in a conversation in March about performance measures. Again, something that tends to be standard issued from CDC: Here's your spreadsheet, fill it out, get us back. We've heard overwhelmingly that when we do that, we often burden our partners with data collection of elements that don't have external validity. So, they're not important to the people who generate those reports. And so, we've heard that, and we were starting a conversation in in Atlanta next month. We would like to know from our partners, you know, is there a way? Yes. CDC needs to understand what's going on. Yes. And we want to go to bat. We want to make the case for the programs and make the case to build and grow. And to do that, we need information, but we don't want to be requiring information from a community that may not have the capacity to pull it together at that time. We don't want people gathering information that actually doesn't measure what's important. And so, we're starting that conversation and we'll let you know how that goes. It's, it's emergence again, a learning opportunity and we will having, you know, just our internal engagement sort of within CDC as well within the division of injury prevention as we all sort of learn how this, this process can move forward. And so, with that it's back to Jason.

1:13:19- 1:16:29
Commander Jason Hymer: Thank you, Ms. Stacey. Next slide please. So, you know, as exciting as it is to kind of talk about, you know, some of the work we're doing and share with you some of the work that we're doing. And again, we're only six months into these new kind of funding, you know, these projects and funding cycle. We really are thinking already thinking about what the future of injury prevention and overdose prevention looks like in in tribal communities as this kind of process and ideas evolve. We do plan to conduct, you know, both listening sessions and official tribal consultation at the appropriate time, although we don't know exactly when that's going to happen yet. And so, as we're kind of thinking about the future, if you could go to the next slide, please.
I think it's really important for us to acknowledge some of the barriers that, you know, tribal nations and tribal organizations face kind of related to I think, both applying and receiving federal funding. And I was really happy to hear Dr. Cohen acknowledge and talk about some of those barriers yesterday during her talk. I think what's listed on the slide here is kind of just based on our experience over the years working with tribes and tribal organizations. It's, you know, what we've learned from interacting and engaging with attack over the years. So, you know, this isn't intended to be an all-inclusive, you know, sort of list of barriers that tribes and tribal organizations face related to federal funding. And they're also not specific, of course, to the Injury Center. I think these apply across not just the agency, but, you know, really to all federal agencies that provide funding to tribes. And then if I'm being totally honest, Ms. Stacey and I really aren't in a place to make major changes like to some of these barriers that are listed here. But I think in the spirit of trying to be a good partner, we really do want to learn more about these barriers.

We want to try to hopefully overcome some of those barriers where we have a little bit of control. And of course, we want to be an advocate for you all, you know, within the agency and trying to overcome some of these larger barriers. And so, you know, we've heard how burdensome that the federal, you know, application, you know, funding process can be. You know, we've heard about how limits to overhead or indirect cost can really be a barrier to tribes and tribal organizations. How, you know, some tribes or tribal orgs have, you know, limited time or personnel capacity for program planning, for evaluation planning. We've heard lots about the burden of reporting and that is something that we have tried to change a little bit at least internally, which I think Ms. Stacey also mentioned. And so, this is, I think a great segue into the real reason why we're here, which you know there is a question listed here which is are there any other barriers that we're missing. But we really are here to kind of learn from you all about not just barriers, but if we could transition to the next slide, just some other questions about how we move forward in our injury prevention and overdose prevention funding for tribes.

1:16:30 – 1:18:16
Ms. Stacey Willocks: And so, we, sorry, we're breaking all the rules about the number of words on a slide, but y'all have these list of questions in your packets. And so, we just wanted you to sort of be ready. There's a list of questions here. As Jason said, we would love to learn more about the barriers. If there are barriers, we're not tracking to applying for CDC funding, we'd love to know that. Any recommendations you have for reducing those barriers? We'd like to know what types of questions we should be asking to learn more about preventing injury and overdose in tribal communities. What advice do you have for conducting successful listening sessions and tribal consultation? You know, we know that this is elemental to beginning anything new and you know, we're looking for advice in this process as well. We'd like to know if you have any initial thoughts or suggestions for next steps in the injury and overdose prevention portfolio. You've seen the body of it today. And so, if there are additional things that you'd like to suggest, we are absolutely here for that. And then we know that in the past in TAC meetings there have been questions about mechanism for the way that we fund our injury prevention work. And so, we'd love to know your thoughts on the tribal umbrella versus an injury specific cooperative agreement that funds tribes directly. We'd really like to know you're thinking on these things. And so, I think what we'll do now is stop talking, turn off the mics, we've got folks taking notes and we would love to hear some discussion and ideas that you have. Thank you.

1:18:17 –1:18:55
Legislator Connie Barker: Thank you, Commander Hymer and Ms. Willocks for delivering a insightful presentation on Division of Injury Prevention funding for tribes, updates and plans for future funding. I invite all tech members to provide their feedback. Your input is highly valued, so please feel free to share your questions or comments. Be sure to if you're virtual, be sure to raise your hand. And if you're at present, be sure to speak into your microphone. Give your name in the area that you represent so the floor is open for discussion. Yes. Ms. Frias.

1:18:55 – 1:20:40
Councilwoman Herminia Frias: Hello, thank you for your presentation. I have a question about the difference between you're the Division of Injury prevention and the Injury Center because I was trying to find your information on the CDC website. So, I was trying to find the evaluation and then I was trying to find your information, but I can't find it. And what I can find is the injury center. So, is it the same or is it different? Because you talked and I go a little bit further because it's very narrow: the information that you talked about with the overdose, and with you know, some of the things that with the overdose and with the, you know, some of the, some of the, things that are funded under with the overdose, and also with the alcohol-impaired driving prevention, and the Elder falls. So those are very narrow. But when I look at the, the Injury Center, those are the types of programs that that I was interested in looking at: also, you know with the particularly with the driving impaired, driving in general with young drivers and Elders, and also with bicycle safety and transportation, and a lot more things. So, it's trying to connect with the injury center and what you're talking about here. So, can you help me out with that?

1:20:41-1:21:21
Commander Jason Hymer: I'll try my best. So, the Division of Injury Prevention is one of three divisions under what we call the National Center for Injury Prevention or in shorthand we say injury Center. There is a tribal specific page. I honestly, right now, I know there's a little bit of transition with our website. We can make sure that you have the links, at least the links that are currently available for our programs, knowing that that will look a little bit different in the future, but we can make sure that you get access to those. So, the Division of Injury Prevention is one of the three divisions in the Injury Center. So, there's also a Division of Overdose Prevention and the Division of Violence Prevention. And those 3 divisions make up the entire Injury Center.

1:21:23 - 1:21:37
Councilwoman Herminia Frias: OK and so you'll give us that information. So do you coordinate with the Injury Center or...? that makes up... I'm still confused. All right. Maybe I'm just tired.

1:21:37 – 1:21:46
Commander Jason Hymer: No, no. It's been a long couple of days. No. So we are under the umbrella of the injury center, right?

1:21:46 -1:21:46
Councilwoman Hermina Frias: OK. Thank you.

1:21:47-1:21:48
Commander Jason Hymer: You're welcome.

1:21:48 -1:21:49
Councilwoman Hermina Frias: The standing evaluation.

1:21:49 –1:22:30
Ms. Stacey Willocks: Yeah, and I just wanted to add about the evaluation. So, you will not find it on CDC's website and that's purposefully done. And so that the Indigenous evaluation tool kit sits on Seven Directions, Indigenous Public Health Institute's website as their intellectual property. And we did that for two reasons. #1, it's their intellectual property. And #2, we feel that it may have more legitimacy living on an Indigenous Public Health Institute website and it may increase people (tribes) accessing it. And so that's where that is. And again, we can get that link out to you as well.

1:22:31-1:22:32
Councilwoman Hermina Frias: OK, thank you.

1:22:32-1:22:33
Ms. Stacey Willocks: You're welcome.

1:22:35 – 1:25:07
Dr. Sharon Stanphill: OK, Thank you for your presentation. Sharon Stanphill, Rep at-large. I can tell you're both very passionate about the work you do and just as tribes are and the work that you share with us today about overdose suicide prevention. You can imagine that for us this is injury prevention is right at the top of our needs and our tribes' goals are for our people. And so, I just want to thank you for the work you do and #1 bullet there you have is how to reduce the barriers to funding tribes. I I noticed that 5 tribes were funded in that first group that you showed us and a lot of TECs, health boards, councils who I'm assuming tribes are getting services through. But there were only 5 tribes that were actually funded, and I just want to restate as I did yesterday that the executive order of the President maybe I said it today was been a long day. We need to have funding that's more accessible and flexible. This is a really this is like some and for some tribes this is the number one health need they have a need is injury prevention. And when you look at suicides, and you look at the epidemic that we're in right now and while we're focusing our attention so much in this, we're losing our children. We're losing all across the spectrum tribal members who are in pain who have some real needs to be met. So. So this work we need to make sure we have accessible flexible funding that needs to come through our compacts and contracts. If that's how a tribe chooses to receive it. We recommend no grants. You know, we just recommend the funds would come directly to us. I know that's going to be a logistic nightmare probably for you, but that process doesn't work for us. And so I just want to really, if you're really going to think about reducing barriers, I would say that that's where you need to start: is with that executive order working with the CDC, and your, and in your system on how to respond directly to removing these hurdles of grants so we can receive funding for this valuable work, and all the work that you folks have been doing. Thank you.

1:25:12-1:25:13
Legislator Connie Barker: Ms. Russell.

1:25:13 – 1:30:06
Ms. Kim Russell: Thank you, Ms. Barker. And thank you, Dr. Stanphill for kind of segue-ing the conversation for me. Ms. Kim Russell, Director for the Navajo Department of Health, Navajo Nation. So, I just confirmed with my Epi director and for the ages of 10 to 59 for my community, unintentional injuries is the leading cause of death. Leading cause of death. I don't believe we have any funding from CDC, although we are doing, you know, different things to address it. But again, for my nation, for the ages of 10 to 59, the leading cause of death is unintentional injuries. I'm going to go back and see how do, how does that breakdown? But just being a part of my community, I know largely it's going to be motor vehicle accidents. Of course, some of them resulting in a traumatic brain injury, suicide, and one that I was kind of just recently informed of that I really didn't think about until it's like, yeah, that makes sense: But we have community members that freeze to death during the winter and that, that that that was interesting to me. I didn't know that, but it was because I had a staff member who worked for state government, and she would go through the through the death certificates because I always saw freezing to death as a cause of death for Navajo. So, and you know, Dr. Dauphin, I'm glad you're here, and I think some of these issues that we talked about really requires a multi-pronged approach to address some of these things, right? You know, one of my, my, my fears is really being in a car accident for my whole family because it's just so common for that. And I notice of course the tribal alcohol- impaired driving prevention program, $125,000: One recipient, right? I also want to indicate talk about how there's other things in regard to at least on my nation: we're very rural; we lack a lot of infrastructure. I mean just from the house that I live in, tribal housing that I live into my road. I was like because that is filled with potholes. Filled with potholes. And every morning I'm like, 'Oh my God, when are they going to fix these potholes?' Right. But it helped me get my frustration out. So, I saw that as a positive but that's just commonplace for my nation, is to have pothole ridden roads which become very unsafe, a lot of unpaved roads. Another thing that really gets me upset when I go home is that our roads are not marked. They're very faded. So, when you drive through a 5-lane highway like in my community right across from a high school, those how those roads are not marked. So, when you're going through the nighttime, they're nonexistent. So, I guess my point being is, you know: Where, how do we approach this with other departments within federal government? You know, I mean I'm not part of our transportation department, but gosh you know that the things that I wish: we could maintain our roads; I wish we could have access to healthy foods. Those are the two. Oh, and access to housing.

But that's not within the kind of housing or the health realm. right? But we understand that these three overarching big areas of really promoting and creating a healthy community. That's what you need to really impact the work that we're going to do. So, you know, I, I take that approach with the work that I do. I try to work as closely as I can with my other directors of my nation; our Department of Transportation; Housing. Just, you know, the whole lot. But again, going back to injury prevention, I know that you know what the CDC, what you can do is here. But we're really having to kind of go out and you know, work with other sectors of government to really address some of these things because you know, until we can get our roads paved and safe where it's going to still be, you know, what is it called, not injury prevention. But the other term that came out, I can't, I can't remember the term, but it's like reducing the risk or reduce the harm reduction, right. But that's kind of what we're doing right now anyway. Just wanted to mention, you know, those statistics that we have for our nation that the leading cause of death for my people from the ages of 10, the age of 10 to 59, is unintentional injuries.

1:30:06- 1:31:11
Dr. Les Dauphin: There wasn't a question, but I do want to make a comment because I one of the things that is coming out of this is the need for us to be thinking a little bit more broadly about how we work in the interagency space and particularly outside of HHS. That's not an approach. I can say quite frankly that we have, at least in our center have, spent a lot of time doing. We have pockets that work with, for example, our division of partnership support works with the Department of Interior and some activities. But I haven't seen a really focused effort on as you put it, a multi-pronged approach that involves the interagency outside of HHS and I think this is something we really need to bring back. So, I appreciate the comments. We're having some really great discussion here today and thank you to our presenters. We want to be respectful tonight, right. We have gone over for this, and we want to stay on schedule. So, we're going to thank you for your presentations, and if we have any comments or feedback additional that we want to provide to this group, we'll certainly make sure we get them back to the to the group. Does that sound good? OK, all right.

1:31:13 – 1:31:51
Legislator Connie Barker: OK. Thank you once again for a great presentation. OK. Our next presenter is going to be Dr. West. Dr. West is...OK, OK. Dr. West health scientists, Infectious Disease Readiness, and Innovation, and the National Center for Emerging and Zoonotic Infectious Disease. We'll be sharing valuable insights on building wastewater surveillance and tribal communities and strengthen public health, public health. Let's give her our full attention as we delve into this important topic.

1:31:53 – 1:32:02
Dr. Rachel West: Good afternoon, everyone, and thank you so much to the committee for the opportunity to present to you today. I'm really excited to speak with all of you about wastewater surveillance this afternoon.

1:32:02 – 1:32:09
Dr. Les Dauphin: I'm sorry, I'm going to ask you to move just so we're having difficulty hearing. Maybe if you move the microphone just a little bit. I want to make sure that folks can hear you.

1:32:09 – 1:32:10
Dr. Rachel West: Is this a little better?

1:32:11
Dr. Les Dauphin: A little.

1:32:12 – 1:32:13
Dr. Rachel West: OK. Maybe just try to project.

1:32:14 – 1:32:16
Dr. Les Dauphin: Yeah. OK. Thank you. Appreciate that.

1:32:27- 1:52:36
Dr. Rachel West: So, I'm, I want to also introduce my branch Chief, Nicole Fehrenbach. And we work in the Rapid Response Research and Surveillance branch. And today I will be discussing our efforts so far. And I'm really eager to learn from all the committee members on ways to build further wastewater surveillance with tribal communities in the future. Next slide please.
So first I want to go over the foundations of wastewater surveillance for those of you who aren't quite as familiar with it. For those of you who are, it's just a little bit of a refresher. Next slide please.
So, wastewater surveillance has been going on for decades, but in the domestic US, it's a rather new system. And when I speak about wastewater surveillance, what I'm really referring to is testing influent untreated wastewater for markers of disease, typically pathogens to best understand disease transmission within a community. And so very simply put, we're looking at this influent untreated water to look at those markers so we can get data in a timely way so that the communities can act quickly to prevent disease spread. Next slide please.

Now what that really comes down to is an individual's contribution to a sewer line. And that's where all of this starts. It begins in our communities and once the individual flushes their toilet, that enters the sewer system and that becomes our untreated influence at a centralized treatment plant or other sampling point. That untreated influence is then taken, and this is by our amazing partners at utilities who have been with us throughout the history of the national wastewater surveillance system. And they take these samples that are then sent to a lab. That lab can then process those untreated samples to concentrate the marker and extract the markers of those

pathogens. Typically, that's genomic material, usually DNA or RNA, and then that can be amplified and detected. All of that gives us that raw data that we receive, analyze, and visualize. And all of this, on average, from the time that someone flushes their toilet to the time we have data in hand, is about 7 days. So that goes to inform metrics about disease transmission in the community so that it can best inform public health decisions in a really timely way. Next slide, please.

So, this timeliness is one of the opportunities that wastewater surveillance presents. But there are many other opportunities that we've found throughout the history of wastewater surveillance in the US. And one of those is that the single sample can collect, infection status information on hundreds to millions of community members. As long as someone is contributing to that sewer line, which is a term we call a sewer shed, that's the community that's contributing. If they're in that community, then we can capture that infection status. And again, that's with a single sample. So, this is a really nice literal and figurative bang for your buck. We, it helps us to better understand disease trends in a community and this is independent of healthcare seeking behavior. So, whether or not someone is able to seek healthcare or maybe they don't know that they're sick, their symptoms are mild, we're able to still capture those markers of infection and not only can we capture the infection status of multiple individuals, but also within a single sample, we can look for multiple disease targets. And this is because wastewater is such a rich sample, but that also offers a flexibility for our communities if they have priorities and disease trends that they want to monitor. Now of course there are limitations to this system. We're not able to include septic systems or decentralized wastewater treatment facilities. And now this has a special implication for more rural or remote communities that tend to rely on these systems. Wastewater surveillance also can't be used to clear a community. So, a negative result doesn't necessarily mean that there's absolutely no disease transmission. It just means that perhaps this is below the limit of detection in that in that sample. What it can tell us though is about transmission levels. And over time, we can understand what those negative results mean and perhaps it can indicate very, very low disease transmission. And finally, for every pathogen that must that can be monitored within wastewater surveillance, we do need data to understand the best metrics to express that data and to translate it to public health action. So, in other words, for every pathogen we're looking at, we need data to make better data in the future. Next slide, please.

All of these opportunities with these limitations have still resulted in a system that allows us to inform timely public health action. And we found throughout the COVID-19 pandemic and other outbreaks that wastewater data can provide information on rising levels of infection in a community Days before this can be detected by other metrics, such as hospitalizations. And those days of advance notice for our communities have resulted in COVID-19 public health interventions, vaccination campaigns, better allocation of resources to the communities that most need them, particularly when testing access might be limited or metrics might be changing. In addition, it helps to better inform communication surrounding new variants and their spread. And this has been valuable for many of our communities with COVID-19 to better understand really what's going on in their community and how this might impact clinical outcomes with Mpox. We've also been monitoring for that, and detections have similarly been used to understand the emergence and sometimes a re-emergence of Mpox within a community. Particularly for our communities' interactions with clinicians, this has been very important to notify them early to look for the symptoms that are associated with Mpox and also to communicate with community members about these detections. Next slide please.

So, all of this to say: wastewater surveillance is particularly valuable because it offers an additional perspective on community health. Wastewater samples capture this community level data to understand changes in disease transmission regardless of an individual's ability to seek healthcare. In addition, the wastewater sample itself is a flexible testing matrix. You can look for multiple different pathogens or targets according to community public health needs. And finally, it provides timely data that can be used to enhance public health action in all of our different communities. That has been one of the most valuable aspects of wastewater surveillance: is that timeliness. Next slide please.

So now I'd like to go a bit into the National Wastewater Surveillance System infrastructure, which is the program that I work in. Next slide please.

So, the National Wastewater Surveillance System, or NWSS for short, was born out of the COVID-19 pandemic in 2020. And since that time, we've grown to over 1500 sites and throughout the US, its territories, and tribal lands. And the image here shows our sampling sites. Those in coral are those that are testing and contributing data for SARS-CoV-2, and those in teal are SARS-CoV-2 and Mpox. These are sites for which we're receiving data, and our secure data portal called DECIPHER. And from that portal we're able to share data publicly on our dashboards. All of these sites are the majority of them are led by our jurisdiction-led programs. So, a state or other jurisdiction creates their own wastewater surveillance infrastructure and leads the development of that system in their community. But we also have up to 400 sites at any given time that are participating in a testing contract, and this provides twice weekly sampling and testing at the participating sites. This is particularly useful for sites that may not be eligible for a more traditional funding mechanism. I say traditional we're a very young system, particularly when in reference to other surveillance systems within CDC. But we're really grateful for all of our participants and we're still eager to learn more and better ways of developing. And through that we have our four centers of excellence in California, Colorado, Houston, and Wisconsin, which provide regional guidance to our jurisdictions, but also guidance back to us of successes and obstacles so that we can better adapt. Next slide please.

Another way that we're looking to grow as a program is through expanding the pathogens that we're looking for in wastewater. As I mentioned, it's a very flexible testing matrix and in 2023, we first began to prioritize testing for influenza and respiratory syncytial virus, or RSV, as the as we were hitting a respiratory virus season and wanted to

prepare our sites as much as we could. We're also evaluating new targets and assays. And in 2023, we worked on enhanced data visualization so that the data that we were sharing publicly made sense and was accessible to the public. This was after really extensive feedback from our public partners that we really appreciated. And now this year, we're really working to focus on validation, piloting and roll out of new targets. So, this is what we'd like to refer to as our expanded core panel. And so, in addition to SARS- CoV-2, Mpox, and those respiratory viruses, we're also looking at additional targets such as West Nile virus, norovirus, and antibiotic resistance genes. Hopefully later this year, after careful validation and piloting with our centers of excellence, we'll be able to roll that out system wide to all of our partners so that they may also look for those targets depending on their community's needs.
Next slide, please.

Throughout the history of news, our engagement with tribal communities has really evolved. Primarily we want to best serve tribal communities by learning about each community's unique needs and capacity for wastewater surveillance and through that work developing government to government relationships so that we can get them the data that they need and support them as much as we can. We've had two primary mechanisms of doing that so far and the first was the news testing contract that I mentioned earlier. This provided twice weekly testing, and, at first in 2021, it really focused on SARS-CoV-2, and this provided real time data directly back to the tribes. One thing that we prioritize when working with tribes is that the data goes directly to that contributing community, not to neighboring jurisdictions without the tribes' explicit consent. They also have access to our secure data portal which provides that data in real time. As soon as we have the data, it goes through quality checks and within minutes it's available through the contract and any work with news. We also offer engagement with the news community and that includes our communities of practice which are led with health departments, labs, and utilities to just collaboratively learn and share successes and also learn updates from news. In 2022, we were really excited to start work with the 1803- Cooperative Agreement with the Office of Tribal Affairs and Strategic Alliances, and we had a single recipient that year who was working on education and communication campaigns. And in 2023, we expanded that now to five recipients who are working on really diverse projects, from those education campaigns to directly supporting their utilities. Our colleagues at the Turtle Mountain Band are working to directly support their utilities who have walked through feet of snow to get twice weekly samples for years and that work with began before we were able to start supporting that tribe. And we're just so grateful to be able to support that work now in 2022 and 2023. We also expanded those targets within the testing contract and now in 2024 that contract is still ongoing and we're looking forward to working with more tribal communities in the future. Next slide please.

So, through all of those relationships and mechanisms that we've been using, we, there are a lot of different factors that that contribute to the success of these systems and some of those are infrastructure and logistics. So, what is the available infrastructure in a community? What are their data needs? What are their data protection needs importantly and what communication styles are preferred? Who should we have at the table from the very beginning--from utilities to tribal leadership? Who should we include and regularly include as well as tribal community members? But at the core of all this work is to earn and maintain trust, and how we do that is informed by each community's history and their current needs. And so that relationship building and respect for sovereignty is really just the foundation upon which we want to build any new relationship with tribes. So far throughout the history of news, we've really worked to go directly to a tribe, usually reaching out to their utility or their health services department so that we can then learn who their trusted partners are. And then based on that know how to leverage any networks that may exist. But also respect those boundaries that they've shared with us so that we can best understand who to share data with, who should have access to the data, and who should have input on this surveillance system. Along those lines are data protections. We know that data sovereignty is incredibly important for tribal communities, and so we really work with each community to understand their boundaries and comfort, and how we can best support them through our existing data protections? And if we don't have an existing data protection, how we might be able to support a new one? Through all of this, we have ongoing conversations with communities. We want to learn successes and challenges in real time so that we can best support them and make sure that their data is timely and effective for their community. Next slide please.

So now I'd like to focus a bit more on our future work to better support tribal communities' public health with wastewater surveillance. Next slide please.
So, I mentioned earlier some opportunities and limitations of wastewater surveillance as a field, but in tribal communities, I wanted to further contextualize this. So, we still find that the opportunity for community level surveillance is incredible and that you can capture many individuals with a single sample and you can also capture multiple pathogens in that single sample. Along those lines, we're very open to creative sampling and testing methods. We grew out of the COVID-19 pandemic. We're used to creativity alongside our science, and we want to work with communities to understand what works best for them, whether that's a sampling type or frequency or a testing system. We want to meet them exactly where they are using all of those methods. We want to help support translating wastewater data into public health action. Many of the committee members have shared that tribal communities know their communities best, particularly tribal leaders, the tribal health services and our utility partners are invested in public health. And so how do we get all of them at the table so that we can translate these wastewater data into public health action, so that we can effectively serve their communities? Now there are of course challenges. Current funding mechanisms. That's something that we've heard a lot about, and I've really valued the input so far in the past two days. But our current funding mechanisms are fairly limited, and we want to learn more about preferred funding mechanisms for tribes. We also acknowledge that they're hard to reach communities that are served primarily by septic systems or those decentralized systems. And we can still work creatively to find alternates if a community still wants to participate in wastewater surveillance. But that is a challenge for us that we want to acknowledge. That goes hand in hand with resource considerations, and that goes

from everything from money to time of the utility workers to staff that are available to analyze these data. We want to be respectful of the capacity of the community and not just impose a system, but really learn how we can best integrate into existing systems and build up those that are already working well. Outreach and relationship building is somewhere where we'd really like to learn more about how to reach tribes directly and build those relationships and make ourselves accessible to tribes so that they know who to reach out to. About wastewater surveillance: if they're already doing it or if they're interested, how we can best reach out to them? And then finally, but very importantly, data use and data protections. What can we do from the CDC side to protect the data to the extent that we are able to? How can we be transparent about those opportunities and how can we work with tribes to build up data protections that work for them? Next slide please.

So, all of this informs our future efforts. One item that we'd really like to learn more about is ongoing wastewater surveillance efforts. News is one effort in wastewater surveillance through the country, but we know that tribes have ongoing wastewater surveillance systems that they've been working on for years. We'd love to learn more about them, about their successes, about how they've creatively built those, and also their challenges. We also want to identify new mechanisms of support for wastewater surveillance in tribal communities. That's primarily funding, but also technical support. How can we make that best available to these communities? And then to continue to improve our internal processes so that they work well for tribes? If there are barriers to entry, we want to know about them. If it's our data platform, if it's our communication or even the language we use around wastewater surveillance, how can we use the incredible knowledge of our tribal partners to better improve our processes? And finally, to prioritize and integrate ethics into wastewater surveillance practices? We're a fairly young surveillance system, but that gives us an amazing opportunity to put ethics at every element of our surveillance system early on, and that will be iterative. We know that over time, technology can change, science can change, and priorities can change. So how do we make this a living ethical framework that we can base our work on? And how can our tribal partners help inform that? Next slide please.

So today, I really value the chance to learn from all of you, and these are our goals for learning from you. And I realized these are several questions. I'm very open to any other questions that you might have, but particularly we'd like to focus on ways to encourage participation by tribes in wastewater surveillance. That might not necessarily be with news, but if it is, is that's wonderful how we can seek partnerships with tribes, particularly around technical challenges, and find solutions in more remote environments? How do we communicate wastewater surveillance findings best and how do we translate this into public health action? And then particularly considerations around data protection and sharing considerations. We know that this will likely be different with each community, but if there are best practices that we are not already doing, we want to learn about those and finally to learn about news targets and priority pathogens for monitoring and wastewater surveillance. Wastewater surveillance is a really rich sample, and we are able to look for many different targets and markers of disease, but we want that also to be informed by our communities. So, beyond that expanded core panel, what would be most useful? Are there natural disaster panels that would be of interest? Are there panels that would focus on climate change that would be of interest and diseases that are associated with that? So, all of this to say, I will, I hope to learn more from all of you and thank you so much again for the opportunity to present to you today.

1:52:39 –1:53:02
Legislator Connie Barker: Thank you, Dr. West. Thank you for delivering such an insightful presentation on building wastewater surveillance with tribal communities to strengthen public health. So, I will open the floor for discussion of questions from all the TAC members. Yes, Ms. Freeman.

1:53:03- 1:55:24
Councilwoman Carrie Freeman: Thank you, Ms. Barker. Carrie Freeman, tribal at-large member. I've had the opportunity to get to sit with Dr. Rachel the past couple of days for lunch and I posed a very interesting question. And based on your fantastic all this information that you've given us, there's a very interesting idea that we floated during lunch today about the implications of monitoring for other things other than pathogens, specifically increasing opioid use in communities and especially communities that take ownership of their own wastewater surveillance. We had conversations about ethical implications and potentially using or having punitive types of situations happening if it's on a broader scale. In this TAC committee, we've talked a lot about data use specifically. So, if the tribe is able to monitor specifically for increasing opioid use in their communities, they own that data. They don't necessarily have to share it. So, it wouldn't be put out into a broader audience for punitive types of issues, but I feel like it could impact counteractive measures on community outreach if you're noticing spikes in usage in your community, potentially heading off overdoses in a community, expansion of counteractive measures like Narcan, increasing education for communities. So would your department or program be able to work with tribes on, you know, training, technical assistance in, you know, starting these types of surveillance in their communities? Thank you.

1:55:26 – 1:57:32
Dr. Rachel West: Thank you for that question. And that's something even beyond illicit substances, but any disease that might have stigma associated, being mindful of that when designing the testing program and designing the data sharing. So short answer to your question: yes, we would absolutely be happy to work with tribes in a way that they're comfortable so that they are leading their wastewater surveillance in their community for priority markers such as opioids or emerging illicit substances. So that is somewhere where I would want to bring in our colleagues from the Division of Overdose Prevention who have been really valuable partners so far, because the science of opioid and wastewater surveillance has a long history. But we still want to understand what the most valuable metrics would be for that. So if we're getting that data in for a community, and we're getting it in in a timely way, which would be so valuable, what exactly are the metrics that are most valuable in that public held-

action and allocation of resources, even in justification for need of more resources to show in real time what's happening in a community? and What metrics potentially might not be so helpful? And metrics that maybe you don't need to spend as much time on? So that's something that we understand. that, and we want to learn more about how illicit substance abuse and overdoses are impacting tribal communities because it is a public health issue and it's an opportunity for wastewater surveillance to provide support. But we do want to do that in a mindful way so that the data are used for public health good and not for stigma as best as we can. And a lot of that is--is probably learned, not probably-- definitely learning from tribal communities in who should be at the table? who should be getting that data? how should it be shared with the community? and how do we get community feedback on that as well?

1:57:40- 1:57:43
Legislator Connie Barker: Was there anyone else? Okay, Dr. Dauphin.

1:57:45 – 1:58:32
Dr. Les Dauphin: Yeah. I just want to thank you. I thought your presentation was fantastic. I really enjoyed learning about what you have in place for wastewater surveillance and years ago I had some work in the laboratory where we worked with large water samples and tried to concentrate them, and it was really challenging. So, it's amazing to see what can be done. Now my question is about data use agreements. You mentioned that right now that the groups that you work with, you're able to collect the data, you do quality check, and then within a few minutes you provide that data pretty much in real time to the recipients. If I heard you correctly say, you do not share it unless you've been given permission from the tribes to share that data with others. Is that right?

1:58:33 – 1:58:34
Dr. Rachel West: Yes, that's correct.

1:58:34- 1:59:03
Dr. Les Dauphin: So, you've set up a model that we'd like to see carried out across other surveillance systems. I'm really interested in how you set up the data use agreements and maybe perhaps we can talk about you know with ESIT. how you did that because others are interested in doing the same and you seem to have been able to do that successfully. So, it'd be great to be able to share sort of your model with others across the agency and maybe you've already done that. This is just the first I'm hearing of it. So, thank you.

1:59:03 – 2:01:09
Ms. Nicole Fehrenbach: Well, thank you for that comment. Dr. Dauphin, one of the one of the things that I coming from a background at the agency where I actually started in informatics back in 2005. One of the one of the challenges that CDC has faced is the ability to share data back. And the amazing thing that the wastewater surveillance team did almost I think without realizing it because they hadn't been burdened by some of the history that the agency has that they set up in their decipher system immediately from the get-go. That states, tribes, counties, cities that were submitting data have their own space where the information comes in is analyzed and provided back in a in a summarized form so that they can do also their own analytics as well as get information essentially real time. And then from all the jurisdictions and participants that we have those data use agreements that we are allowed to publish that information. We then visualize that and in an aggregated way. And of course, protect. Whatever a jurisdiction only has a few cases or something that we are, we are very mindful of making sure that we are not exposing a jurisdiction to some information that they may not be comfortable having reported out. And so that's particularly true for our tribal partners who are engaged with us in this and how they have chosen to enable us to share data or to not share data. But they still have access to all the information with the additional technical assistance that CDC can provide. and it's all behind multiple firewalls so that it is protected and it's, it's a wonderful model, and we would love to be able to share it more broadly. It does take a bit of doing on the back end, you know when you open the hood so to speak that there is a, there is an investment that has to be made in the technical resources that are that can enable that to happen. But once you have those pipelines set up and those algorithms built, it can work relatively well with minimal, you know, ongoing maintenance and quality oversight. Thank you.

2:01:11- 2:01:13
Dr. Les Dauphin: Thank you. Really great presentation. I appreciate it.

2:01:15 -2:01:17
Legislator Connie Barker: Dr. Stanphill.

2:01:17 – 2:01:26
Dr. Sharon Stanphill: Sharon Stanphill, Rep at-large. Thank you for the presentation. Do you work with a lot of tribes? I mean do you have a lot of tribal partners?

2:01:28 – 2:01:14
Dr. Rachel West: So, I'm proud to say that we work with five contract sites that serve tribal communities and we have 5 recipients now through the cooperative agreement. And I realize that hearing from some of my colleagues and other divisions, that may seem like a small number, but I will say I am incredibly grateful to each and every community for that. But that is something that we are mindful of that of our many sites, there are only 5 contributing data into that data platform that represent tribal communities, and that is a big gap. So that is one thing that we're working to improve upon is how do we encourage participation in a way that's also respectful of their boundaries? And so, yes, that's the number.

2:02:16 – 2:02:21
Dr. Sharon Stanphill: Sounds like you're off to a good start. Thank you very much. Appreciate your information.

2:02:24- 2:02:35
Legislator Connie Barker: OK. If there's nothing else, I'm going to turn the meeting over to Dr. Dauphin. She's going to give us a summary of our TAC meeting.

2:02:35 – 0:04:43
Dr. Les Dauphin: Really great. Thank you. Appreciate it. Well, I think we've had a successful two days. We are about to close out another successful TAC meeting. So, I want to start by just thanking all of our TAC members and technical advisors, your technical advisors who support you for your thoughtful questions, comments, and recommendations. And I want to thank all of the presenters for really doing a fantastic job of not only presenting the information, but addressing questions and engaging in discussion and posing questions for us to consider as we move forward. I want to thank OTASA for all of the hard work they did in coordinating this meeting. Can we please give them? We have a fantastic team who worked really, really put in tireless efforts to help make this a success. I really thank our OTASA team and all the staff across our center who support these engagements and thanking our facilities and AV staff too. So just thanks to everyone. We opened the discussion today with looking at an overview of our budget and then we ended with wastewater surveillance. So, we've had a variety of topics here today. We think we are working to make each meeting better and better. And so, we appreciate our engagement with our TAC, and we want to continue to engage you through our monthly meetings with the co-chairs, through our monthly meetings with the with the TAC to hear from you how we can make the most use of your time and really begin to put in some tactical measures to address some of the things we've learned. I think we're at a point now where we can set some clear goals and work together to try to accomplish them. So, I feel we're in a really good place. I look forward to our next meeting and our next conversation. Look forward to seeing everyone in Oregon this summer. So, our next meeting we are moving back to Indian Country and looking forward to that. And I want to give all of you thanks and wish you safe travels and I think I will turn it back over to Legislative Barker to close us out.

2:04:44 – 2:04:46
Legislator Connie Barker: OK. Dr. Killsback, did you have anything you want to say?

2:04:47- 2:06:17
Capt. Damion Killsback: Yeah. Thank you, Legislature Barker. So, I just want to make sure as a reminder in your logistics e-mail, we provide an update CIO guide. The resource offers comprehensive information about CIO providing all the TAC members with electronic access to essential details that OTASA team can maintain. It includes the center directors' names, contact information, points of contact or organizational chart link example, priority areas, technical assistance services, budget updates, health equity initiatives, health equity data collection efforts and endeavors to enhance travel data infrastructure. We have received feedback from our TAC Chair and Co-chair indicating that would be beneficial to have this information available on the FTP site where all uploaded meeting materials are located.
Please note that we will consistently update the guide and share these updates with you via FTP site. To accommodate members who prefer printed copies, we have some copies available for TAC delegates who would like one. Please approach me or a member of the OTASA team if you'd like to be interested in receiving a printed copy. It is essential to remember this information is readily available on the FTP site and will be regularly maintained there. Thank you. And lastly please drop your name tags off at the at the main at the at the table out front because our we so we can use them for future meetings. Thank you.

2:06:18- 2:08:19
Legislator Connie Barker: Thank you. Thank you, Capt. Damion Killsback. Everybody's a doctor around here. But anyway, sorry about that. I just want to remind everyone about our conference calls, and we voted today on when our conference calls would be. I believe it was on the 4th Thursday from this is Eastern Time from 4:00 to 5:30 Eastern Time. So now they're going to be 90 minutes. So just remind all TAC members that if we don't have a quorum on those calls, sometimes we can't vote on important business that we need to take care of. So, I just want to thank everyone for the for the dedication. You know, it's not easy leaving home for a couple days and coming to these meetings, but it is well worth it because we take so much information back to our tribes. But not only that, we give so much information to the CDC. And so that is our goal is to be able to be great partners with them and to share information. What they give, we take, what we give, they take. And so, we want to appreciate Dr. Dauphin and her team for everything they've done for us to be able to have this wonderful meeting, look forward to meeting in Oregon and look forward to our calls. So safe travels for everyone going back. And I'm going to ask at this time, do we have a volunteer to close us out in prayer? Okay, if not then I'll do it.

So, if you'll just bow your heads, Father God, we just want to give thanks for this day Lord, and all the information that you shared with tribes, Father. And just all the information that we'll be able to take back, Father, as we travel home. We just ask that you watch over us and take us back to our families where we've been missing. Father, we just want to thank the CDC and everyone here who has opened our hearts and minds to the information. Just be with us, Father, as we continue to work hard for our tribal citizens knowing, Father, that everything we do here on earth is to give. Glory to you now, Father. God, just be with us as we as we go home. These things we ask in your Son's name. Amen.

OK, we're adjourned.