Tribal Consultation on CDC/ATSDR's Tribal Consultation Policy

July 2, 2021–September 7, 2021

The Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) hosted a tribal consultation on CDC/ATSDR's Tribal Consultation Policy on August 5, 2021, and accepted written comments until 5:00 pm (EDT) on September 7, 2021.

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Introduction

On August 5, 2021, CDC/ATSDR hosted a virtual government-to-government consultation with tribal leaders on ways to improve the CDC/ATSDR Tribal Consultation Policy. There were 179 participants, including tribal leaders, CDC/ATSDR senior leaders, and other tribal partners. Comments were accepted from July 2, 2021 to September 7, 2021, 5:00 pm (EDT). This consultation was held in response to the Presidential Memorandum on Tribal Consultation and Strengthening the Nation-to-Nation Relationships, which requires agencies to submit a detailed plan for tribal consultation. CDC/ATSDR is committed to working with federally recognized tribal governments on a government-to-government basis. CDC/ATSDR strongly supports and respects tribal sovereignty and self-determination for tribal governments in the United States and look forward to continuing to work with tribes to improve CDC/ATSDR's tribal consultation process. The current CDC/ATSDR Tribal Consultation Policy is available on CDC's Tribal Health website.

The Department of Health and Human Services (HHS) Tribal Consultation Policy states that tribes should receive at least 30 days' notice of a consultation and the details about the topic to be discussed. CDC issued a Federal Register Notice 34 days before the first consultation session and included the purpose and details of the meeting. A Dear Tribal Leader Letter was sent to tribal leaders 30 days before the consultation. Additionally, CDC/ATSDR shared information about the virtual consultation session and comment period with various tribal partners.

As the President's memorandum states, "History demonstrates that we best serve Native American people when Tribal governments are empowered to lead their communities, and when federal officials speak with and listen to Tribal leaders in formulating federal policy that affects Tribal Nations."

CDC/ATSDR sought tribal leader recommendations and feedback on how CDC/ATSDR can improve the agency's policies and practices to better engage with Indian Country through meaningful consultation.

Specifically, CDC/ATSDR sought tribal leader feedback on the following topics:

1. How do we strengthen our tribal consultation policy and process to ensure CDC/ATSDR is responsive and engaging with Indian Country in a meaningful way?
2. How do we improve communication and outreach regarding agency policy or program changes that impact tribal nations?
3. Are there specific areas where tribal officials would like more information or feel they are not getting adequate outreach to engage in a meaningful way?
4. How do we improve tribal consultations? Should we have sessions every year?

This report provides tribal leaders with a summary of recommendations and input received during the consultation period.

CDC received input from 12 federally recognized tribes and 4 tribal partners during the consultation period.

CDC has summarized tribal leaders' responses to the questions above and provided initial responses to the most frequent comments. The agency will use this information to continue to address how the agency's policies and practices around meaningful consultation can be improved.

Detailed Responses to Tribal Leaders' Summary of Recommendations Regarding CDC/ATSDR's Tribal Consultation Policy

This part addresses recommendations made by tribal leaders (or their designees) at the CDC/ATSDR Tribal Consultation on August 5, 2021, and during the written comment period ending September 7, 2021. CDC/ATSDR reviewed all comments and communications received and summarized recommendations under the following themes: 1) better coordination with tribes, the CDC/ATSDR Tribal Advisory Committee (TAC), and across HHS agencies; 2) accountability in reporting and follow up; 3) communication methods; 4) dear tribal leader letters; 5) CDC/ATSDR's tribal consultation process; 6) adequate preparation time; 7) meeting mechanism; 8) technical assistance; 9) prioritization of tribal public health infrastructure and capacity; and 10) tribal funding flexibility and transparency.

1) Better Coordination with Tribes, with the TAC, and Across HHS Agencies

Tribal leaders recommended that CDC/ATSDR better coordinate consultation activities. Comments were received concerning how and when the agency should engage tribal nations, the CDC/ATSDR TAC, and other HHS agencies to ensure timely and meaningful engagement is achieved.

Summary of Recommendations on Better Coordination with Tribes

Tribal leaders specifically identified a need for better coordination between CDC/ATSDR and tribal leaders. They emphasized that tribes should have access to regular engagement with top-level CDC/ATSDR leaders to ensure meaningful tribal consultation and that discussions should occur before decisions are made that may have significant impact on tribal nations. Tribal leaders requested that tribal consultation be planned to provide adequate time for tribal leaders to prepare; they recommended that as a new administration is elected and takes office, four years of tribal consultation be prescheduled. Tribal leaders also requested that the policy recognize that tribal nations have the right to initiate consultation.

Tribal leaders commented that it is vital for all CDC/ATSDR staff to be educated about meaningful consultation and about the reasons for consultation with tribal governments. Their comments emphasized the importance of considering tribal sovereignty and consultation rights at both national and regional levels to understand regional tribal governments' interests, needs, culture, and norms.

Response on Better Coordination with Tribes

CDC/ATSDR acknowledges tribal leaders' recommendations for better coordination with tribal nations and tribal leaders.

CDC/ATSDR recognizes the need for tribal leaders to have access to agency leaders and is committed to working with agency leaders to ensure they are available. To address this need, CDC/ATSDR will send early and frequent communications, invitations, and "save the date" reminders to tribal leaders and will ensure that such communications reiterate the government-to-government relationship that CDC/ATSDR has with tribal nations. CDC/ATSDR also recognizes the significance of building relationships at the staff level in addition to leadership-level relationships and will continue to improve coordination and communication between partners.

Summary of Recommendations on Better Coordination with the TAC

Tribal leaders specifically recommended better coordination between the CDC/ATSDR TAC and CDC/ATSDR. It was recommended that the agency fully utilize the expertise of TAC members. While the TAC does not supplant tribal consultation, engaging TAC early in policies, activities, or initiatives that

might have significant tribal impact can help ensure that proposed policies, activities, or initiatives are tribally informed. Tribal leaders emphasized that the TAC has information that is representative of various regions and will allow for tribally informed actions. Tribal leaders recommended that CDC/ATSDR engage the TAC to support planning and implementing consultation, and that the agency engage the TAC early for transparency in the policy-making process so any proposed policy can be tribally informed from the start. Tribal leaders said TAC members are the best conduit through which CDC/ATSDR can receive technical assistance that is tribally informed and representative of the various regions in the country. In addition, with any consultation, CDC/ATSDR should compile comments and recommendations raised, and the TAC should review and consider them. Tribal leaders commented that while the TAC is a valuable resource for collecting and collaborating with Indian Country, it is never a replacement for tribal consultation.

Response on Better Coordination with the TAC

CDC/ATSDR appreciates the recommendations from tribal leaders regarding the CDC/ATSDR TAC. CDC/ATSDR recognizes that the TAC does not supplant tribal consultation but agrees that the committee's expertise and regional knowledge could be used to help inform both CDC/ATSDR and tribal leaders on policies, issues, or concerns.

CDC/ATSDR will work with the CDC/ATSDR TAC to support tribal consultation by facilitating and bringing issues and concerns to CDC/ATSDR that may rise to the level of tribal consultation.

Summary of Recommendations on Better Coordination Across HHS Agencies

Tribal leaders specifically recommended better coordination around tribal consultation across agencies within HHS. CDC/ATSDR heard that there needs to be better coordination with other HHS agencies and offices, especially with the Indian Health Service (IHS), when there is mutual interest. CDC/ATSDR should streamline processes where possible and implement a standardized framework in coordination with HHS. Tribal leaders recommended that, where possible, joint HHS consultation should occur, as many issues cross multiple agencies.

Response on Better Coordination Across HHS Agencies

CDC/ATSDR appreciates the recommendations that HHS agencies increase coordination to support tribal consultation when mutual topics of interest are being addressed. CDC/ATSDR recognizes that tribal leaders are extremely busy and that collaborative consultation across HHS will help ensure tribal leaders are able to convey their recommendations on related matters to multiple HHS agencies at the same time.

Currently, CDC/ATSDR is involved in discussions with HHS to formalize multi-agency tribal consultations and to develop an HHS-wide calendar of all tribal-related consultation activities. There are also opportunities to work more closely with HHS Regional Offices on annual consultation meetings. These activities will help minimize overlap and decrease meetings for tribal leaders.

2) Accountability in Reporting and Follow Up

Summary of Recommendations on Accountability in Reporting and Follow Up

Tribal leaders commented on the need for accountability from all agencies, especially those responsible for helping address health disparities in Indian Country. Tribal leaders also recommended that the CDC/ATSDR Tribal Consultation Policy explicitly show 1) how tribal leaders' recommendations and the outcomes will be tracked, 2) how recommendations are being used to ensure that true and meaningful

consultation is acted upon, and 3) that the agency's actions are accountable and transparent. Information and feedback shared during consultation should be included in the final rulemaking to ensure the concerns and questions from tribal leaders are addressed. CDC heard that tribal leaders would like an update on the status of previous recommendations and that updates should be provided to the TAC, the CDC director and ATSDR administrator, and the HHS Secretary's Tribal Advisory Committee (STAC).

Response on Accountability in Reporting and Follow Up

CDC/ATSDR appreciates the recommendations on accountability and acknowledges the need for accountability in reporting and following up on tribal leader's recommendations. CDC/ATSDR will continue to prioritize providing updates to the CDC/ATSDR TAC and HHS STAC through regular TAC conference calls and quarterly STAC meetings. As CDC/ATSDR works through the recommendations from tribal leaders and collaborates with HHS on their Tribal Consultation Policy, CDC/ATSDR will update the CDC/ATSDR Tribal Consultation Policy to align with HHS's policy.

3) Use of All Relevant Channels of Communication and Standardizing Communication with Tribes

Summary of Recommendations on Use of All Relevant Channels of Communication and Standardizing Communication with Tribes

Tribal leaders specifically recommended that all relevant channels of communication be used to inform tribal leaders of upcoming tribal consultation. Tribal leaders expressed the need for CDC/ATSDR to maintain an up-to-date list of tribal leaders. They recommended that information be disseminated by as many relevant methods of communication as possible (e.g., social media, partner distribution of information, Dear Tribal Leader Letters, and both in-person and virtual sessions). Tribal leaders also recommended the use of listening sessions and other methods of information gathering prior to policy, activity, or initiative development to ensure tribal leaders' voices are heard. These pre-consultation sessions may help inform CDC/ATSDR decisions prior to consultation. Tribal leaders also recommended that the CDC/ATSDR point of contact (POC) be listed by name on all correspondence, on the Tribal Health website, etc. Tribal leaders recommended that each consultation session be transcribed and posted verbatim. Tribal leaders should have time to view consultation documents online and make corrections to both verbal and written testimonies.

Response on Use of All Relevant Channels of Communication and Standardizing Communication with Tribes

CDC/ATSDR acknowledges and understands the importance of standardizing the process for advertising and announcing tribal consultation. The agency will work to develop a process that standardizes consultation planning and CDC/ATSDR advertising of consultation to tribal leaders and incorporate this process into the consultation policy. CDC appreciates tribal leaders' input on the use of listening sessions to support early planning for important policies that impact Indian Country. CDC will take advantage of these listening sessions for this purpose in the future. Per tribal leaders' recommendations, CDC/ATSDR will also work to maintain an updated point of contact list to regularly communicate with tribal leaders and ensure that national organizations have a designated CDC/ATSDR point of contact to improve communication and coordination.

4) Advanced Notice of Consultations Via Dear Tribal Leader Letters

Summary of Recommendations on Advanced Notice of Consultations Via Dear Tribal Leader Letters

CDC/ATSDR heard from tribal leaders that Dear Tribal Leader Letters (DTLLs) to announce upcoming tribal consultation sessions need to be sent to all tribal leaders further in advance via multiple modes of transmission. CDC/ATSDR also heard that, following tribal consultation, tribal leaders should be informed of tribal leaders' summarized feedback as well as CDC's responses to feedback via a DTLL and by posting summaries on the CDC Tribal Health website. In addition, tribal leaders said that tribal recommendations and the agency's responses need to be communicated back to tribal leaders in a timely manner.

Response on Advanced Notice of Consultations Via Dear Tribal Leader Letters

CDC/ATSDR appreciates tribal leaders' emphasis on the importance of using DTLLs to communicate tribal consultation, both before consultations and after them to report on recommendations and follow-up concerns. CDC/ATSDR sent a DTLL by email on July 6, 2021, to inform tribal leaders about the August 5, 2021, consultation; however, the letter might not have been received by all tribal leaders. To improve this communication channel, CDC/ATSDR will ensure that DTLLs about important meetings be posted on the CDC/ATSDR website and advertised through CDC/ATSDR's and national partners' communication channels.

5) Increased Guidance on Consultation Procedures

Summary of Recommendations on Increased Guidance on Consultation Procedures

Tribal leaders recommended both regional and national listening sessions for tribal leaders for topics that might be discussed during tribal consultation sessions. They also recommended that during these tribal consultations, CDC/ATSDR review strategies; share background, data, and evidence that will help guide decision making; discuss existing and future policy development; and define priorities and goals.

Tribal leaders recommended that CDC/ATSDR consider ways that information obtained during consultations can be analyzed and presented and a timeline to do so. They also recommended that CDC share the tribal consultation report with other agencies working with tribal leaders on public health issues.

Furthermore, tribal leaders recommended that information for tribal leaders on how to seek tribal consultation be defined clearly and be made easily obtainable on CDC's Tribal Health webpage.

Response on Increased Guidance on Consultation Procedures

CDC/ATSDR will work to provide more awareness and guidance on how tribal leaders may seek consultation. During the consultation itself, CDC/ATSDR will furnish more background and details concerning the specific topic to provide more guidance for tribal testimony. Additionally, the agency will provide a formal report identifying recommendations and the agency's responses to those recommendations within 45 days after each consultation period has closed. CDC/ATSDR also acknowledges that certain meeting forums that work for some participants might not work for all. The agency will consider this in future consultation planning before determining a meeting mechanism and forum. In some instances, consultation may be more appropriate between CDC/ATSDR and an individual tribal nation. Once consultation occurs, a summary would be shared with that tribal nation.

6) Adequate Preparation Time for Upcoming Tribal Consultations

Summary of Recommendations on Adequate Preparation Time for Upcoming Tribal Consultations

Tribal leaders recommended that CDC/ATSDR provide timely notification of upcoming tribal consultations. Tribal leaders recommended that tribal consultation be announced with more than 30-days' notice to give tribal leaders adequate time for preparation, discussion, and concurrence within their tribe. Tribal leaders also noted that adequate preparation time gives them an opportunity to come together and generate ideas and solutions at tribal leader meetings internally and nationally and in TACs within relevant federal agencies. In addition, tribal leaders would like to be informed earlier in the process of any project, program, or policy that may have significant impact on tribal nations. It was recommended that CDC/ATSDR use additional ways to engage tribal nations early, including listening sessions in preparation for more formal consultation sessions.

Response on Adequate Preparation Time for Upcoming Tribal Consultations

CDC understands and acknowledges the importance of providing adequate time to prepare for tribal consultation sessions. CDC also acknowledges the importance of the government-to-government relationship and having leaders present to receive tribal leaders' concerns and feedback. To standardize and communicate this process, CDC/ATSDR will update its tribal consultation policy to account for the time needed to schedule consultation and identify who should participate. CDC/ATSDR recently updated the Federal Register Notice (FRN) timeline to specify that FRNs are to be posted for at least 60 days. It is anticipated that this extended timeframe will allow for adequate preparation time for tribal leaders. CDC/ATSDR also acknowledges that the timeline for preparation may sometimes need to be shorter, such as during emergency responses or for deadlines for decisions outside of the agency's control.

7) Meeting Mechanism and Increased Flexibility in Meeting Options

Summary of Recommendations on Meeting Mechanism and Increased Flexibility in Meeting Options

Tribal leaders specifically recommended that any future tribal consultations be held in person with the option for a virtual platform. This will allow all tribal leaders to be engaged in meetings without the need to travel and will allow for more robust participation.

Response on Meeting Mechanism and Increased Flexibility in Meeting Options

CDC appreciates tribal leaders' input on the best consultation meeting method and the importance of flexibility for meeting locations. CDC/ATSDR will work to ensure flexibility in meeting methods for future consultations.

8) Increased Proactivity in Providing Technical Assistance

Summary of Recommendations on Increased Proactivity in Providing Technical Assistance

Tribal leaders recommended that the CDC/ATSDR TAC provide technical assistance to tribal leaders and keep tribal leaders informed. Tribal leaders recommended that CDC/ATSDR seek input from tribal leaders prior to policy development and said the TAC could help inform CDC/ATSDR based on TAC information and input. Tribal leaders also emphasized the importance of resources to address priorities, such as direct set-asides in funding and broadband coverage. CDC heard that there needs to be communication between tribal leaders and CDC's Centers, Institute, and Offices (CIOs). Specifically, funding opportunities and public health leadership opportunities to strengthen tribal public health should be routinely shared with tribal leaders.

Response on Increased Proactivity in Providing Technical Assistance

CDC/ATSDR recognizes the TAC's important role in serving as subject matter experts and informing tribal leaders about CDC/ATSDR's public health activities.

CDC/ATSDR appreciates the input on health concern priorities and the importance of resources to address the priorities. CDC/ATSDR will look into future listening sessions to gather more details on these health priorities and how CDC/ATSDR can support Indian Country with those challenges. To ensure meaningful consultation for future sessions, CDC/ATSDR will gather guidance from tribal leaders through listening sessions early in the planning process as well as collaborate with national partners to communicate these opportunities.

9) Prioritization of Tribal Public Health Infrastructure and Capacity

Summary of Recommendations on Prioritization of Tribal Public Health Infrastructure and Capacity

Tribal leaders specifically recommended that CDC/ATSDR review tribal public health infrastructure and funding of systems. Tribal leaders also mentioned that during the pandemic, utilizing and implementing tribal-dedicated funding and respecting sovereignty was a true paradigm shift. Allocated funding allowed tribes to use their existing infrastructure to help distribute the COVID-19 vaccine in a meaningful way that saved lives. This also allowed tribal nations to adapt strategies to their current capacity and infrastructure. Tribal leaders asked that this example of tribally allocated funding be honored and considered after the COVID-19 pandemic.

Response on Prioritization of Tribal Public Health Infrastructure and Capacity

CDC/ATSDR acknowledges the importance of prioritizing public health infrastructure and capacity within Indian Country. The agency appreciates tribal leaders' input on this subject and is prioritizing tribal public health infrastructure through multiple CDC/ATSDR activities, such as CDC's National Center for Chronic Disease Prevention and Health Promotion's (NCCDPHP's) Healthy Tribes. NCCDPHP partners with AI/AN communities to promote health, prevent disease, and strengthen cultural connections to improve health and promote wellness. This occurs in four action areas: epidemiology and surveillance, environmental approaches, healthcare system interventions, and community programs linked to clinical services. In addition, CDC's Center for State, Tribal, Local, and Territorial Support's (CSTLTS's) Tribal Public Health Capacity Building and Quality Improvement cooperative agreement works to increase the capacity of Indian Country to identify, respond to, and mitigate public health threats, improving the health, safety, and well-being of AI/AN communities. While these cooperative agreements do address tribal public health infrastructure, CDC/ATSDR acknowledges the importance of increasing opportunities and continuing to listen to tribal leaders' concerns and recommendations concerning tribal public health infrastructure. During the 22nd Biannual CDC/ATSDR TAC Meeting, tribal public health infrastructure, data, and social determinants of health were discussed to determine ways forward and gather information from TAC members on important barriers for tribal nations on these issues. These conversations between the agency and tribal leaders will continue as CDC activities and programs evolve.

10) Tribal Funding Flexibility and Transparency

Summary of Recommendations on Tribal Funding Flexibility and Transparency

Tribal leaders recommended that CDC provide critical funding and services to AI/AN people in furtherance of the government-to-government relationship. CDC should support tribal models of health and healing that may not fit Western standards, and funding opportunities should recognize the value and applicability of cultural and traditional practices. Tribal leaders also recommended that CDC work

closely with tribes to obtain a better understanding of tribal public health needs and allow for tribal public health funding flexibility. Tribal leaders encouraged the use of interagency transfers with federal agencies like IHS, as well as use of Indian Self Determination Education Assistance Act Self-Governance agreements to streamline distribution of funds. Tribal leaders specifically recommended that a crosswalk be provided to tribal leaders that shows budget allocations and processes, outlining allocations to tribes, states, and other jurisdictions, as well as who has made those budget decisions for the previous 3 years and current fiscal year. Tribal leaders requested information on COVID-19 funding. Tribal leaders posed specific questions on how much COVID-19 funding has gone from CDC/ATSDR to IHS and how much has been distributed to tribes, Tribal Epidemiology Centers (TECs), and other tribal evaluation, research, and programming needs. Tribal leaders also requested information about plans for the upcoming fiscal year. Tribal leaders recommended a 5 percent set aside for tribal funding and that CDC should move away from competitive grant-making practices. Instead, CDC should provide recurring, consistent funding to tribes as public health authorities on the same basis as states. Tribal leaders recommended information be provided on the $2.25 billion provided to public health agencies, of which none was provided to tribal public health. Tribal leaders asked if there is a similar notice of funding opportunity for tribes and suggested that $800 million was appropriated for data modernization. Tribal leaders said there was a need for consultation so that CDC/ATSDR understands how funding impacts public health infrastructure for tribes and TECs. Tribal leaders recommended direct funding for tribal public health capacity on a recurring basis and requested information on how funding opportunities match with tribal priorities obtained during consultation. Tribal leaders also recommended support for technical assistance for health priority issues.

Response on Tribal Funding Flexibility and Transparency

CDC/ATSDR appreciates tribal leaders' concerns about continuing direct investments for tribal communities and acknowledges the importance of these funding opportunities. CDC/ATSDR provides regular updates on budget, when available, to the CDC/ATSDR TAC during conference calls and biannual TAC meetings. To be transparent and provide awareness of funded activities, CDC/ATSDR posts funding profiles, information about CDC/ATSDR COVID-19 funding, and other budget resources (e.g., grant writing resources) on CDC's Tribal Health website and through the CDC Grant Funding Profiles site. Regarding the request for direct set-asides for tribal nations from each CDC CIO, CDC cannot commit to this recommendation. CDC has many budget lines, most diseases are risk-factor-based, and Congressional appropriations contain many directives on how the funding must be spent. In many cases, CDC does not receive enough funding for a particular public health issue, activity, or program to fund all jurisdictions; therefore, many of CDC's funding opportunities are competitive. Additionally, CDC's funding opportunities must be directly tied to CDC's underlying statutory authorities and programmatic intent. CDC strives to maximize its funding opportunities, to the extent allowable under federal law, as much as possible. As permitted by CDC legal authorities and in alignment with programmatic intent, direct funding to tribal nations for tribal public health has increased in recent years. CDC now has five premier programs that were informed by tribal input, including direct funding to tribes, tribal-only eligibility, incorporation of tribal cultural and wellness practices, and provision of funding to tribes and tribal-serving organizations to address COVID-19 through a noncompetitive grant (see CDC's Tribal-Specific Cooperative Agreements and Grants). Setting aside 5 percent of every CIO budget for tribal nations may have the challenge of disproportionate distribution among tribal nations because of the disparate status and variations of tribal health infrastructure across Indian Country. CDC looks forward to working with the CDC/ATSDR TAC and tribal leaders and organizations to build on this progress.

Next Steps

For next steps, CDC will work to incorporate the recommendations and input into the existing CDC/ATSDR Tribal Consultation Policy. After the comments have been incorporated, CDC/ATSDR will conduct an internal review followed by a close review by the CDC/ATSDR TAC, which will act as subject matter experts as suggested by tribal leaders during this consultation period. Once the internal review and review by the TAC are complete, CDC/ATSDR will send a Dear Tribal Leader Letter with the updated consultation policy for additional feedback and approval from tribal leaders.

Appendix A: Consultation: Written, Oral, and Other

CDC/ATSDR's Tribal Consultation on CDC/ATSDR Tribal Consultation Policy
August 5, 2021
Consultation Transcript (Oral Testimony)

Dr. Nathaniel Smith: Good afternoon, I'm honored to speak with you today. My name is Nate Smith. I'm the CDC Deputy Director for Public Health Service and Implementation Science. CDC would like to first acknowledge the Muskogee Nation and the Cherokee Nation, whose tribal lands we are on.

I want to start off by reaffirming our government-to-government relationship. CDC is committed to working with tribal governments on a government-to-government basis and we strongly support and respect the sovereignty and self-determination of tribal governments in the United States. To further affirm this commitment, President Biden signed a new Presidential memorandum on January 26 of this year that re-commits the Federal Government to respect tribal sovereignty and strengthen the nation-to-nation relationship between the United States and tribal nations. This presidential memorandum requires CDC/ATSDR to submit a detailed plan for implementation of the executive order. This executive order charges agencies to engage in regular meaningful and robust consultation with tribal officials when developing federal policies that have implications for tribal governments entities. We're here this afternoon to honor this executive order and engage in consultation about the CDC/ATSDR Tribal Consultation Policy and how it can be improved to meet the needs of tribal nations this feedback will be used to edit the current CDC/ATSDR Tribal Consultation Policy. Thank you for this opportunity to speak with you and hear your guidance, I look forward to hearing your input, as well as any recommendations or concerns that you may have regarding the CDC/ATSDR Tribal Consultation Policy.

I'll now turn the meeting over to Deputy Principal Chief Bryan Warner, who is also the CDC/ATSDR Tribal Advisory Committee co-chair. He'll provide some opening remarks and then open this meeting in prayer.

Bryan Warner: Thank you, Dr. Smith. Well, good afternoon or good morning, depending on where you're joining us from. My name is Bryan Warner. I'm the Deputy Principal Chief of the Cherokee Nation, and, like Dr. Smith mentioned, I am, well, I was the co-chair now and the chair as of about an hour so, for the CDC/ATSDR Tribal Advisory Committee. It is always my pleasure to welcome you to the CDC/ATSDR tribal consultation on the current CDC/ATSDR Tribal Consultation Policy.

I would like to open this meeting with the prayer. First, I would like to ask if there's anyone that would like to volunteer to lead us in prayer. Okay, then, I will stand to task. If you will, bow with me, please. Your heavenly Father Lord, we come to you again, Lord, so thankful for this time of fellowship so thankful and blessed. To be in your presence, Lord, we just ask that you fill our vessels with the fruit of your spirit. Lord, give us an extra measure of wisdom, give us an extra measure of patience, Lord, as we go through this task of figuring out a way to better do things and follow your will. Lord we ask for guidance, we ask for protection in Jesus' name, we pray. Amen.

Okay, well, thank you again for the opportunity to co facilitate this meeting, I will now turn the meeting over to Dr. José Montero, director of the Center for State, tribal, Local, and Territorial Support, also

known as CSTLTS, to review logistics for the consultation and background on the CDC/ATSDR consultation. Let's see, Dr. Montero.

Dr. José Montero: Thank you very much, Deputy Chief Warner. So, a quick overview of CDC/ATSDR's Tribal Consultation Policy. As Dr. Smith touched on earlier, this consultation is being held to honor Executive Order 13 175 and to be consistent with the presidential memorandum on tribal consultation and strengthening the nation-to-nation relationships. As I stated previously, CDC/ATSDR is committed to working in partnership with tribal nations with the Tribal Advisory Committee, or TAC.

The TAC, the CDC/ATSDR TAC, advisees us in the planning and coordination of tribal consultation sessions and ensures that the CDC/ATSDR activities and policies that impact Indian country are brought to the attention of tribal leaders.

As the presidential memorandum states, history demonstrates that we best serve Native American people when tribal governments are empowered to lead their communities and when federal officials speak with and listen to tribal leaders in formulating federal policy that affects tribal nations and Alaska Native villagers.

This consultation session, according to the current CDC/ATSDR tribal consultation policy, will be held between Indian tribes represented by the tribal president, tribal chair, tribal governor, or an elected or appointed tribal leader or their authorized representatives and the CDC/ATSDR administrative designees. Those are Dr. Nate Smith and myself.

We are prepared to listen and hear from tribal leaders of federally recognized tribal nations who have joined us for this meeting. The order of feedback will run as follows: first tribal president/chairperson governor. Then, we moved into tribal vice presidents, vice chairpersons, or lieutenant governors, then elected or appointed tribal officials, and, finally, any designated tribal official.

For the record, when you begin to speak, please announce your name, title, and tribal nation you are representing. For those who would also like to send written remarks, please send us your initial comments and recommendations no later than 5 pm Eastern Time on September 7, 2021.You may send your comments or emails to our inbox tribalsupport@cdc.gov. Finally, this Zoom meeting is being recorded for record keeping purposes only. If you do not wish to be recorded, you can disconnect now.

I would like now to turn the meeting back to Deputy Principal Chief Bryan Warner, who'll facilitate the discussion.

Bryan Warner: Thank you, Dr. Montero for that overview and information about the logistics now. I will start the discussion portion of the meeting. So, as you see on the slides, CDC/ATSDR is asking for specific input on for guiding questions regarding the current CDC/ATSDR Tribal Consultation Policy. They are as follows:

- How do we strengthen our travel consultation policy and process to ensure the CDC/ATSDR is responsive in engaging with Indian country in a meaningful way?
- How do we improve communication and outreach regarding agency policy or program changes that impact tribal nations?

- Are there specific areas where tribal officials would like more information or feel they are not getting adequate outreach to engage in a meaningful way?
- And finally, how do we improve tribal consultations. Should we have sessions every year?

We will take comments on each question one, at a time.

I would like to invite the tribal elected leaders in the audience to share their comments provide recommendations on the first question. If you would like to speak, we ask that you raise your hand using the feature in Zoom. If you are on the phone, please press star six to unmute, and you can give your testimony. We request that you start by sharing your name title and tribal nation you're representing. Once you are unmuted, we also invite you to turn your camera on if you would like, so that we can see you as you ask your question or give the comments. To assist those joining us over the phone, I will read the question aloud on each one.

So, tribal elected leaders and designated tribal officials, first question again, how do we strengthen our Tribal Consultation Policy and process to ensure CDC/ATSDR is responsive and engaging with Indian country in a meaningful way?

I will open up the floor. Looks like we have Dr. Aaron Payment. Mr. Payment, you are, you have the floor, sir. Good to see you.

Dr. Aaron Payment: Can you hear me?

Bryan Warner: Yes, sir, loud and clear.

Dr. Aaron Payment: All right, if you don't mind if I could do, I actually have an amalgamation of the responses and do my testimony that way.

Bryan Warner: Dr. Montero?

Dr. José Montero: We can try to break it down, certainly, you can . . . do you want to comment on all of those. If there are specific things based on how the discussion goes, I will recommend you come back with each one of the questions later on.

Dr. Aaron Payment: You'll have to rotate back to me because I'm going to have to go back and segment out my responses. I'm sorry. I'm not sure if you heard me. I'm going to have to go and break my testimony into separate responses, then, thank you.

Bryan Warner: Yes, Sir, thank you.

Dr. José Montero: Kari, process question. Can we accept the whole testimony at once or do we need to break it?

Karen "Kari" Hearod: I think it's fine to accept the whole testimony at once and then we can, in our summary, break it down.

Dr. José Montero: Yes, Dr. Payment, please come back.

Dr. Aaron Payment: I'm sorry. I don't mean to be difficult.

Dr. José Montero: No, we're trying to make this easier, and sending you back to break it down it seems as a hassle, so please, you can then come back and tell us, I don't know what the order we have.

Dr. Aaron Payment: Okay, all right, I appreciate that, especially because I think in a very holistic and traditional way, so my testimony will answer all of the questions throughout my testimony, so I appreciate that. Thank you.

Dr. Aaron Payment, Chairperson of the Sault Ste. Marie Tribe of Chippewa Indians, we are the largest tribe East of the Mississippi. I'm thankful for the CDC for taking this affirmative step to enhance the CDCs Tribal Consultation Policy and I look forward to working with the Agency to create a policy that respects and reaffirms tribal sovereignty.

But first to underscore the critical nature of our collaboration, let me share a few stark statistics. American Indian/Alaska Native health outcomes of either remain stagnant or become worse in recent years. As tribal communities continue to encounter higher rates of poverty, lower rates of health care coverage and less socioeconomic mobility than the general population. As US civil rights Commission addresses so effectively in this chapter in Chapter two of the Broken Promises Report tribal communities are already at substantial health risks, since the efforts of the Federal Government to uphold the trust and treating responsibility for tribal health has been so ineffective. On average, American Indian/Alaska natives born today have a life expectancy, that is five and a half years, less than the national average with some rural are geographically isolated tribal communities experiencing even lower life expectancy. In South Dakota, in 2014, the median age at death for whites was 81 compared to 58 for American Indians. This is about a quarter of a century difference for American Indians in life expectancy. Further, according to the CDC in 2017 at 800 deaths per 100,000 people American Indian/Alaska Natives have the second highest age adjusted mortality rate of any population. In addition to the highest uninsured rates, highest infant mortality rates, highest prevalence of diabetes, significantly higher suicide, and death rates; um, Hep C and also type two diabetes, chronic liver disease, and cirrhosis deaths. Further, while overall cancer rates for whites declined from 1990 to 2009, they rose significantly for American Indian/Alaska natives and so I'm going to leave the rest of these statistics for my written testimony, and I'll get right into the responses to the consultation.

So, strengthening government to government relations, tribal consultation is considered a necessary part of the federal treaty and trust responsibility. As President Biden stated in his presidential memorandum on consultation "my administration is committed to honoring tribal sovereignty and including tribal voices and policy deliberation that affects tribal communities. The Federal Government has much to learn from tribal nations and effective communication is fundamental to a constructive relationship." President Biden also called on agencies to engage in regular meaningful and robust consultation with tribal officials in the development of federal policies that have tribal implications. We are eager to provide the government-to-government relationship between tribal nations and the Federal Government. While we recognize that federal agencies regularly conduct consultation, the notion that the consultation requirements are achieved by merely scheduling a time and sending personnel to hear concerns is neither substantive nor respectful of true government to government relationship.

So, one request is prior to consultation engagement, it must allow for the heads of tribal governments to come together, share concerns, generate ideas and solutions, negotiate their roles and

responsibilities, and agree on a course of action. Federal agency should provide frequent opportunities for agency leaders and tribal leaders to engage in this manner.

Respect for sovereignty, for tribal nations, should drive and frame every interaction between tribes in the federal government. The Agency should ensure that all agency officials and employees are educated on tribal sovereignty and the importance of the federal Indian trust responsibility; we call that “Indian 101.”

For consultation to be meaningful and robust tribal leaders should have regular engagement with top level political leadership, tribal consultation meets the president's criteria only when the top-level political leadership is available to tribal leaders before policy decisions are made. CDC should ensure that tribal leaders have regular opportunities to meet with the CDC top level political leadership.

So, in improving accountability, as leaders of sovereign nations we anticipate and will rely upon accountability from all the agencies and specifically those that are responsible for helping to address the health disparities plaguing our communities.

We acknowledged that Section G and E of the CDC consultation policy provide for performance measures and accountability and evaluation reporting. However, these sections lack any clear substance and only point to the corresponding section in the HHS Tribal Consultation Policy. This is not go far enough in mandating a thorough review of the tribal consultation and does not provide a mechanism for tribal leaders to track how the Agency is using their recommendations. True and meaningful consultation requires affirmative efforts from the Agency to demonstrate that our concerns are being heard, considered, and adopted.

So, I would like to request, to facilitate accountabilities, agencies should at minimum issue a dear tribal leader letter after tribal consultation that details what was discussed, what tribal leaders requested, and follow up actions in response to those suggestions. This communication should invite critique and reflectively allow for modification to ensure that the tribes input was understood.

Other mechanisms should explore and utilize to allow for improved communication and accountability, in addition to a follow up letter, for example, having federal agency partner report out in every meeting about prior recommendations would lead to an increased accountability and improved transparency This in turn would solidify the value and genuine commitment to substance to follow up.

A report of all consultation activity TAC activity should be provided to the CDC TAC, the CDC director, and the HHS Secretary’s Tribal Advisory Committee, and the HHS Secretary. This report should also be published on the CDC website and distributed via a dear tribal leader letter. Far too often tribal leaders make suggestions but are never heard back from. We are left to wonder whether our time and effort is valued and our suggestions received understood and considered. Meaningful consultation is not possible without meaningful consideration, communication, implementation, and follow up. It should be required that the CDC address why certain suggestions were not implemented as part of the consultation. In any follow up mechanism used, the CDC should/must include a way for tribal leaders to inquire further of why their request or proposal was not incorporated or to suggest alternative approaches that may be mutually beneficial.

We also urge the Agency to survey tribal leaders to attend consultations to see if they were effective and how they can be improved upon in the future. Assessment of the efficacy of any effort can be a valuable tool to build buy-in, respect, ownership, and commitment.

Tribal leaders have the right to invoke consultation whenever we desire, however many tribal leaders do not know of this right, and if they do, there is no clear method for requesting or to initiate formal consultation. The CDC consultation policy should prescribe a method for contacting the Agency and any timelines for response from the Agency. Providing tribal leaders with prescribed steps on how to initiate a tribal consultation and make clear this policy will go a long ways towards facilitating accountability.

Next let's address informed tribal decision making. I understand that some situations call for quick decision making, but rapid consultation should be avoided at all costs, except in the most urgent situations like the covid19 crisis. Crisis planning does not typically produce good results for Indian country, rushing through a consultation exercise does not give tribal leaders enough time to research and prepare to discuss the issue at hand. Lack of adequate preparation time often results in consultations that feel like they are relegated to a check the box exercise, and not just simply learn from Indian country our concerns. Tribal leaders are leaders of sovereign nations and cannot be expected to be at the ready for a consultation on the short notice.

In addition to preparation time, it also takes a lot of time for notices of these meetings to get to tribal leaders who are then expected to drop everything to quickly prepare with little or no prep. Tribes needed a degree of predictability regarding tribal consultations to operationalize preparation and have a mechanism to ensure that we have ample time to prepare. There is currently no prescribed timeline in the consultation policy, we believe that a uniform requirement will allow for both the degree of predictability and adequate time for tribal leaders to prepare. I urge the Agency to adopt a policy of requiring at least 30 days for consultation with limited exceptions for emergency items. The CDC is urged to move towards a consultation policy that encourages informed tribal decision making by giving tribal leaders ample time to prepare.

So, communication methods, there are no requirements or standards around how the Agency should communicate tribal consultation to tribal leaders. Currently the policy states that the CDC will initiate consultation regarding the event through communication methods as outlined in the HHS Tribal Consultation Policy. However, section 8A of the HHS department policy on, Tribal consultation merely provides a non-exhaustive list of communication methods that the Agency can choose from. We urge that the agency to adopt a uniform requirement of sending a dear tribal leader letter to every, for every consultation, and mandate that the letter include all pertinent information in advance, so that we can be prepared.

So expanded consultation participation methods, many tribes are small and do not have the resources to pay for travel for their leadership to participate in consultations. As we've learned through the pandemic it's possible and effective for consultations to be conducted remotely for tribal leaders to be engaged in that format. The ability to participate remotely expands the number of tribal leaders who may participate, which helps to ensure that the Agency is hearing from a broad cross section of tribal leaders from across the country. We request that the agency permanently expand the methods, through which tribal leaders could participate in tribal consultation. While the Agency should resume in person consultations when it's safe to do so, they must also ensure continue to provide an option for tribal leaders to participate remotely and virtually as we're doing today.

So tribal technical assistance and I'm just about done, the CDC engages tribal leaders from the start. If we engage from the start, it should make for a more fruitful consultation process. The CDC should not wait until we have a formulated policy or regulation before asking for feedback from Indian country.

The CDC tribal advisory committee can be as an essential tool in the consultation process, but not as a substitute for consultation. We urge the Agency to begin engaging the TAC early in the policy and regulatory making process, so any proposed policy can be tribally informed from the start.

Tribal advisories or TAC should be used by the Agency when formulating policy because TACs are the best conduit through which the CDC can receive technical assistance that is tribally informed and representative of the various regions in the country.

We also urge federal agencies to consider expanding the use of listening sessions during early stages of policy development to hear directly from tribal leaders.

Tribal organizations such as the National Indian Health Board and the National Congress of American Indians are routinely consulted by tribal leaders in preparation for TAC meetings and tribal consultations and so we're asking to more formally institute that and provide for funding that for that continuation.

Finally, my written testimony is much lengthier and fully articulated pragmatic steps, covering a more holistic comprehensive adaptive and reflexive approach to ensure substantive input and participation from tribes in the federal outreach that impacts tribal nation and the lives of our respective tribal citizens. In my written testimony I include an appendix which details a reflexive conceptual framework to give a visual representation of when the process of policy formulation or decision making occurs, whether it's conceived by the Federal agencies or requested by tribes, then provide for a preliminary draft to be explored through listening sessions, formal consultation, with supplemental guidance from tribal advisories, confirmed or refined through reflective review and consent tribes, and finally, as drafted as policy or action planning with assessment and evaluation to follow.

So that was what I have to share with you today. I look forward to submitting my written testimony for you and I will wait around for any questions if you have after others testify, thank you.

Bryan Warner: Thank you, Dr. Payment, much appreciated. So, Captain, do we have anyone else that has raised their hand?

Karen "Kari" Hearod: I am scrolling through.

Bryan Warner: Okay, we have Verne Boerner.

Karen "Kari" Hearod: Yes, and, also, Nate Tyler had his hand up a little bit earlier.

Verne Boerner: And I will defer to Nate Tyler if he had his hand up before me.

Nate Tyler: Yeah, I'd like to allow Vice Chairwoman Marilyn Scott from the Upper Skagit Indian Tribe to go in front of me.

Marilyn Scott: Oh, this is Marilyn Scott, can you hear me.

Bryan Warner: It's fair.

Marilyn Scott: Thank you so much for the opportunity to provide comments on the CDC consultation policy. My name is Marilyn Scott and I'm Tribal Vice Chair of Upper Skagit Indian Tribe in Washington state and I just want to provide some comments on the questions that were presented before the tribes to provide comment on and I support all of the comments that Dr. Payment that has already shared with the Agency. And wanted to just share some recommendations, in addition to some of the things that was already discussed around not having enough notice time and making sure that there's the opportunity for tribes to be prepared for consultation, and on what issues and concerns and topics that the Agency has that want the tribes to comment and consult on.

But one of the things I think is so important for us as tribes, with the Agency, is to have the Agency consider developing sections within the policy that would establish objectives formalizing the CDC policy and seeking consultation and participation of tribes in the development of policies, program, and research activity that impact tribes. The agency's responsibility does involve research activities and when research is done within tribal communities or if data is being submitted by tribes it's expected each tribe has its own policies and program policies that direct how that data and research is handled within our tribal community. So, I'm hoping that the Agency will consider establishing specific objectives that could be met within the policy. And also, just having a minimum set of requirements and expectation, with respect to consultation and participation with the administration within and the management policies within CDC.

I would also like to see that there is an established communication channel with tribes and tribal organizations to increase the knowledge and understanding of the CDC programs and funding opportunities and priorities.

Thank you so much, and we will be submitting from the Portland area and the tribes within the Portland area written comments for the policy.

Bryan Warner: Thank you, Ms. Scott. Okay, captain, who did we have next? Is Mr. Tyler?

Nate Tyler: Okay, Nate Tyler, Makah Tribe, Makah Tribe Council, Portland area representative. So, I appreciate the opportunity to provide recommendations on improving the consultation policy through the CDC.

Northwest tribes look forward to working with the CDC closely to improve government-to-government relationship and in fulfillment of trust and treaty obligations. As we returned to meet in person, we asked that the CDC continues to include a virtual meeting option for travel consultation and TAC meetings. We've seen participation increased significantly with the option for us to participate and vote virtually.

We are concerned, however of how the CDC has announced this important tribal consultation on their consultation policy. To my knowledge CDC announced this consultation through the Federal Register, and not through dear tribal leader letter that was widely distributed amongst the tribes. The current Tribal Consultation Policy requires agencies to use all appropriate methods to provide official

notification, including mailing, broadcast, email, Federal Register, and other outlets. We recommend that any tribal consultation official notification to be complete through a dear tribal leader letter that is widely broadcast through the TAC listserv and any other travel listserv CDC maintains. All these letters should be posted on the CDC tribal web page, any CDC associated social media streams, and tribal partner agency.

Coordination includes the Indian Health Service and other HHS divisions.

And on behalf of the Makah Tribe, we're going to also submit our written testimony. And we fully support what the Chairman had stated leading off on this consultation; so, appreciate the time, thank you.

Bryan Warner: Thank you.

Karen "Kari" Hearod: Sir, I believe, next is Mrs. Boerner, or Ms. Boerner.

Verne Boerner: Sorry, I'm trying to unmute and get my video started.

Bryan Warner: There you are.

Verne Boerner: [speaking in indigenous language] Good morning, it is good to be here with you. My Inupiat name is Qaanaaq I am enrolled tribal Member with the Native Village of Kiana. I am the President and CEO for the Alaska Native Health Board. My English name is Verne Boerner. I am honored to join you all here today. I would like to thank you, Dr. Montero and deputy, Deputy Chief Warner for hosting today's tribal consultation. I'd also like to extend my thank you to the leadership at CDC and our brother and sister tribes across Alaska and the lower 48.

We are thankful for Executive Order 13175; the Alaska Native Health Board was established in 1968 as the unified voice for Alaska native tribes on health. In Alaska we have 229 federally recognized tribes. That is 40% of all tribes in the United States. We are dispersed over 660,000 square miles and where 80% of our communities are off of the road system and depend solely on air and or boat to gain access to the communities. Those communities are in effect islands with some of our communities need into fly distances equaling those flying from California to Kansas to see a general family practitioner or physician.

Given these extreme conditions, the 229 tribes have taken innovative approaches that truly should and must be recognized by the Federal Government as a successful model. The Alaska tribes, those 229, have done something quite unique in the United States, they banded together to create the Alaska tribal health compact, a single compact negotiated with the Federal Government for healthcare services meeting the federal trust responsibility. With that they have been able to create a true system of care. That we commonly and proudly refer to as the Alaska tribal health system that system provides care the hub and spoke model across the entire state and includes referral patterns, data sharing, and resource sharing overall.

As I share, ANHB has been created to be the voice of, the united voice of the Alaska tribal health system, we do not speak on all issues, but we do raise those concerns that tribes have come together

and highlighted as their unified positions. We do not supplant tribal sovereignty, we raise it up and we celebrate it and we encourage input from the local levels on, to the region's into the state levels.

With 229 tribes coordination has been the core aspect of being able to develop and create the Alaska tribal health system. And some of the recent interactions with regards to how do we strengthen Tribal Consultation Policy and process to ensure CDC/ATSDR responsiveness engaging with Indian Country in a meaningful way you must look towards those systems that tribes across the nation and across the areas have created in order to communicate with the Federal Government. We need to be informed of of the meetings that are being brought forward to us, the consultation evens but also included with the materials that, that are presented to the TAC. We need that, that transparency with the tribal health organizations across the nation. And limiting the TAC to the input to the single individual on the TAC, in Alaska's case, would silence the other remaining 228 tribes in Alaska. And a recent example of the challenges that we had faced, due to term expirations, Alaska did not receive the proposed or the, the Charter, where CDC was seeking input on any updates or changes to the Charter for the TAC because we did not have an active individual. Not because that person wasn't nominated, but because the process had not gone through just yet. And therefor for the initial release of that to provide input on a fundamental document Alaska did not have that opportunity to do so.

Individuals do not necessarily, do not have the capacity that particularly in Alaska to help with the information dissemination and we depend on statewide organization, such as the Alaska Native Health Board, the Alaska native tribal health consortium to help disseminate information and these entities, need to be involved with the communication and efforts in order to improve engagement with regards to tribal consultation overall.

So, with regards to communication outreach, we need to ensure that these organizations have a point of contact with CDC so that we are able to share those; we agree with the statements that have been put forward with regards to issuing dear tribal leader letters and I'm looking at the next questions here.

I just wanted to highlight and one other area where utilization of the infrastructure and capacity that tribes across the nation have built over many decades. In looking at the vaccination efforts for the COVID-19 pandemic, utilizing and implementing the sovereign nations or tribal allocations was a true paradigm shift and allowing, allowing tribes to utilize their existing structures, their existing infrastructure, to help get out the vaccine and a meaningful and lifesaving manner, we advocate that; that capacity structure and those communication lines be honored and included, not just in pandemic response, but in all areas and aspects of health promotion, disease prevention, surveillance and research.

And with that I'd like to say thank you again. And I do hope that Dr. Montero and Deputy Chief Warner, you consider joining us when it is safe to tribal again up in Alaska; Dr. Montero I know that you've been up here, but we would definitely like to welcome you back. Thank you.

Bryan Warner: Thank you, ma'am, and great comments and very well received, but well taken, so thank you. And I would love to come up and visit anytime.

Next up, I believe we have Jennifer Webster. Is that correct, Captain?

Karen "Kari" Hearod: That's correct, sir.

Bryan Warner: Okay, Jennifer, you're up.

Jennifer Webster: Good afternoon, can you hear me?

Bryan Warner: Yes, ma'am, okay.

Jennifer Webster: [speaking in indigenous language] My name is Jennifer Webster. Good afternoon, I'm a Council member from Oneida Nation in Wisconsin. We are located just outside of Green Bay with about 17,000 members worldwide and about 5000 Members on or near the reservation here.

Thank you for this opportunity to share our needs with you today. With the new Director of OTASA there's an opportunity to bring about positive change and build and strengthen the relationship between CDC and tribal nations. With the COVID crisis and the new variant, it's critical that CDC engages with tribes, maintains a strong relationship in order to work towards addressing the current public health challenge.

CDC's track record and working with tribes demonstrates the need for improvement. As quoted in a recent 2021 publication from the former director TAC members have raised concerns on how CDC engages with tribes and request process improvements, such as the need to provide input earlier in project formulation and the need to reach out to tribes for feedback. Tribes need the option of consulting on current large projects, new initiatives, and policies because there's been a lack of transparency and how decisions get made.

Tribal leaders have consistently requested that dear tribal leader letters be sent out rather than announcements through the Federal Register, and I think everybody's mentioned that already. It appears that CDC engages in box checking regarding consultation, in other words the lowest form of effort is taken so that the Center can claim that consultation occurred. There also needs, there also needs to be, need to build and maintain trust, repair past relationships between CDC and tribal nations.

So, our specific ask, we request or report on the status of the tracker tribal leaders request and how CDC has responded. We would like this to be presented to the TAC and have a report also sent to STAC.

We request that CDC create a crosswalk table that shows budget allocations and processes; table with CDC appropriations and line item; how much has gone to tribes; and if states are expected to work with tribes, the distribution, of how much actually went to tribes; how does internal applications align with tribal priorities and request through consultation - including details such as when the tribal leaders provide consultation on the issues, the programs, and the project; which mechanism formula - cooperative agreement or contract. Given that tribes have requested the formula funding, programming evaluation and research; topic areas of funding, such as COVID, opioids, diabetes, childhood adversity - how and who made the decisions and include the three most recent years and the upcoming fiscal year.

For COVID funding, include relevant funding that has gone the IHS, either directly or through an agreement with CDC which might otherwise have gone to CDC or other governments; what are the plans for tribal spending for the upcoming fiscal year or fiscal year 2020 budget, how much how much goes to the tribes, TECs, and other tribal evaluation, research, and programming.

We see a major increase in opioid and community violence dollars, we would like to see that at least 5% is set aside for times, regardless of if it's an allocation within the legislation.

Request opportunities consult on recent activities and have dear tribal leaders' letters go out.

The CDC Center for State Tribal Local and Territorial Support has awarded funding, $2.25 billion, to public health agencies none the tribal public health. So, we're not sure if there was a similar notice of funding opportunities for tribes. $800 million was appropriate for data modernization, need for consultation, and how this impacts public health infrastructure for tribes and TECs.

So, with that we'd like to thank you and we will also submit our writing as well to the CDC. Thank you.

Bryan Warner: Thank you, ma'am, very good. Looks like we have Mr. Daniel Preston.

Daniel Preston: Okay, let me start my thing here. I thank you; my name is Daniel I'm a Councilmember of the Tohono O'odham Legislative Council, and I represent the San Xavier District. And so I guess my comments encompass 1-4, not specifically, but you know I echo the same, or we echo the same sentiments the comments as Chairman Payment and the rest of the tribal leadership that that had spoke.

We are 35,000 in population, we also have a high prevalence of diabetes and the majority of our communities, our rural. And access of services are limited due to access of care, and so we have to work within the bounds with what we have.

And, just to be aware that on Tohono O'odham Nation government has a process and this process involves the executive office and the departments to offer comment and recommendations.

And then goes to the, the legislative committee oversight, the respective oversight then on to the Legislative Council to ratify through resolution and is a joint effort. I'm sure there are other tribal nations that have their own process but, sufficient time to respond is recommend it from any federal agency in regards to tribal consultation. This resolution also requires determine signature after the passage of legislative resolution, just as Mr. Payment has mentioned that ample time as needed. I also agree that the dear tribal leader letter is a, it is a official outreach to tribal nations and that seems to work a little bit. And I understand that it's good that this administration is advocating for that executive order. And then also part of our process is the Chairman of Tohono O'odham Nation is the official spokesperson of the Tohono O'odham Nation whether he designate somebody but, and again I know all tribal nations are very busy, especially during this pandemic time and also yourselves at the federal level are very busy, so I think that coordination needs to be better coordinated, so we can be able to voice our thoughts our recommendations and our comments, I do have my fellow my colleague Councilwoman, Vivian one Sanders on the line; I'm not sure if she would like to add to any of my comments that I made here, if that is allowable at this time.

Vivian Saunders: Not at this time, thank you, very much appreciate Councilman Preston's comments, thank you.

Daniel Preston: Okay, thank you very much for listening to us and having this virtual meeting. That's it. Thank you.

Bryan Warner: Thank you, Mr. Preston, much appreciate it. And next we have Dr. Jill Jim.

Dr. Jill Jim: Ah yes, good afternoon, I'm Dr. Jill Jim. I'm the authorized representative for Navajo Nation; I speak on behalf of on President Nez and Vice President Lizer, they're not available to attend today. So, I just want to reiterate some of the comments that we provide it to the Department of Health and Human Services.

And regards to the same questions I think one thing that we wanted to just kind of be consistent about is just because of the various tribal consultation policies that were asked for to kinda streamline some of these expectation across all the agencies under DHHS and so basically to strengthen our tribal consultation policies to engage in a meaningful way, that the division meaning the CDC must be transparent and accountable.

There are several parts of the current policy again that require reporting on the outcome of consultation and by sometimes we don't always see that happening so would be good for CDC to summarize the type of comments they receive and explain how to adopt policy with amended or to address these concerns. Um, as well so along these lines, and also [inaudible] to listen to the tribal concerns, but they must be incorporated into the final product.

For in, I think there's some examples that we had for Indian Health Services but I think that the CDC similarly this looking at incorporating our recommendations and into any sort of policies that are being decided on. And then additionally consultation must not be an afterthought so engaging in a meaningful way is often not possible when it's when it's reduced to soliciting input after the fact, so in order for there to be true, respect for the government-to-government relationship tribes must be at the seat. And to have a seat at the table, this means tribes must be included agency decisions that have significant impacts for tribes. So, I just wanted to just express some of those comments that we have provided for to the Department of Health and Human Services in regards to that same question, thank you very much.

Bryan Warner: Dr. Jim, Thank you. Okay, before moving on to the next question, Captain, I just want to do a little bit looking around and make sure that we've gotten everyone's comments.

Karen "Kari" Hearod: I see no more raised hands.

Bryan Warner: Okay, well, I want to thank you for those comments on question one, and I, you know, just sitting here listening and thinking back, ample time to prepare a Dear Tribal Leader Letter; you know, using other outlets, besides the ones, I think it starts to help summarize, but we will wait for Dr. Montero to do that momentarily.

Now I'd like to open up the floor on comments on the **second question**, which reads, how do we improve communication and outreach regarding agency policy or program changes that impact tribal nations? Again, how do we improve communication and outreach regarding agency policy or program changes that impact tribal nations?

And we will open the floor to that question, so, show of hands and we'll get started.

Dr. José Montero: Mr. Chairman, quick comment, I know that many of you already answered all four questions. When we look at the notes and do our assessment and analysis, we will break it down, so we can put it in the right sections. Don't feel that you have to tell us again, but if you want to add something specific that came to your mind after you leave your initial testimony, please feel free to do so. All that input is point valuable. Thank you, Sir.

Bryan Warner: Thank you. Any show of hands? Well, I can kick us off real quick, well, Dr. Jill, it is, I will defer to you, ma'am. You have the floor.

Dr. Jill Jim: Thank you once again to CDC and other leaders on the call. I just wanted to just re-emphasize that in regards to just the improving communication and outreach regarding policy or program decisions, and one thing that we're recommending is that some type of consultations or policies or team does require only a little preparation, but others requires significant amount of time to adequately research the issues and prepare to give a formal informed advice. Ideally, we should, this should be brought up in the process of the beginning, as soon as the agency begins to consider any policy changes or program changes in and long before any proposals are solidified so that way we can begin researching the issues at the same time as the federal agency and to be better prepared to provide input and effectively engage in the Tribal Consultation Policy or process. So, agencies should allow for discussion and feedback through appropriate tribal leaders committees and advisory meetings such as this group so, that would just be in regards to having an effective communication process, and that would just end my brief comment regarding improving communication. Thank you.

Bryan Warner: Thank you. All right, Boerner.

Verne Boerner: Thank you, can you hear me?

Bryan Warner: Yes, well.

Verne Boerner: I think the only thing that I would like to add to this in considering what programs have a direct impact on tribes and tribal health organizations. I would just like to encourage the agencies to keep an open are flexible or broad mind and considering this. We already know that Alaska Natives and American Indians suffer some of the highest disparities in the nation, and not all programs have or are listed as with tribal set asides. So, the tribes or tribal health board brings an issue to CDC we recommend, ah we request, that the agency be responsive to those requests for consultation, when we identify that our programs are being directly impacted by a change, a programmatic change.

Bryan Warner: Thank you. Anyone else?

Well, I'll give it a shot. I am Bryan Warner Deputy Chief of the Cherokee Nation. And in regards to question two, I believe the CDC should maintain an accurate and updated email list of tribal leaders and tribal contacts, for every federally recognized tribes in the nation with various national and regional tribal organizations, and tribal epidemiology centers to ensure that information is properly disseminated with ample time for tribes prepare and submit written or oral comments. The past year and a half has shown us how underserved and unprepared public health infrastructure in Indian country is. Any updates from CDC regarding policy changes or consultation are vital to ensure the health and well-being of all Native American and Alaska natives and that we as Indian country are following the most up to date policies and procedures to keep our Community safe.

CDC should share with tribal leaders any public leadership opportunities to strengthen tribal public health and share the importance of tribal public health to those national organizations who look to the CDC for guidance, such as the NACCHO, ASTHO, and NNPHI. CDC should also work with the TAC to address the barriers that the TAC members are experiencing regarding fully utilizing technical assistance from their tribes in these discussions. That the complexity of public health issues aren't able to be addressed by one technical advisor to cover all 21 CIOs and their process and the TAC member must end the process that the TAC member must go through to allow their Technical Assistant representative to speak to be simplified by looking at other HHS TACs address the issue.

We also note that, while the TAC is a valuable resource for collecting and collaborating with Indian country it is never a replacement for travel consultation, thank you.

Any others? Captain, do you see any other hands?

Karen "Kari" Hearod: I don't see any other hands. I wonder if we should ask if anyone is on their phone if they would like to make a comment at star six to unmute. Also, after that I believe Lauri Hayward has her hand up now as well.

Lauri Hayward: Hello, can you hear me?

Bryan Warner: Yes, ma'am. You've got the floor.

Lauri Hayward: Yes, I was just my name is Lauri Hayward I'm from northeastern California, Pit River Nation. I am the Board of Director, Pit River Health Services, chair lady. I just want to echo out that I hear your comments regarding TAC. Here in California, we have over you know we have 110 federally recognized tribes and then looking at Alaska, and we don't there's not enough TAC members to meet all the needs or to represent our areas our regions, because in the other ones there's more. And then there's not enough to be able to voice what it is that we want represented at the tables or through Consultations.

So, I just wanted to echo, make that comment and echo that behind the person that had just previously spoke. Excuse me but I'm in traffic, and so, for that I also wanted to just tell you all that, thank you for these webinars and these times. I know it's been you know the past couple years have been really, a lot of work, just to go into all this, so I just wanted to express that. And as far as the broadband, yes, we live in a rural area and snow is pretty in the winter and it's very hard to get in and out, over the mountain and things like that, but we also you know, could use assistance in Tele health and all those other things that require broadband and so forth. So, I just wanted to say thank you, I appreciate you all and be safe.

Bryan Warner: Thank you, anyone on the phone that would like to make a comment on question two, please hit star six and you will unmute and we will give you the floor.

Okay, all right, well, thank you for those comments on question to I will now prepared open up the floor for comments on the third question, which reads, "Are there specific areas where tribal officials would like more information or feel they're not getting adequate outreach to engage in a meaningful way?"

And, and, before we open this up, I will say that on the TAC, we've had a subcommittee that's been working quite some time, for I call it a playbook, but it's a resource guide on all the CIOs; and we've also had a recent funding profile that was sent to us for FY 2020. So these, hopefully, these are some of the things that will help with the outreach, give you an idea who these folks are maybe to forge a relationship where we can get some of that meaningful robust consultation moving down the road so with that I open the floor to question three.

Anyone? Reminder, on the phone, star six to unmute, and we will give you your time.

Nate Tyler: I'd like to add a few more things. Nate Tyler, Makah Tribe, Makah Tribe Council, Washington State. As a representative of the Portland area, we, I know we have a number of reps on the on the call here. A couple other things I'd like to add, is for the CDC to compile comments and recommendations raised here and regional consultations for the TAC to review and consider. Coordinate with the Indian Health Service and HHS deviations on issues of mutual concern and anything that does affect us one way or another. And to charge and hold responsible all levels of management within CDC and its institutes and centers for implementation of this policy.

And like I stated, Makah tribe will submit written testimony appreciate it.

Bryan Warner: Thank you, Mr. Tyler, much appreciate it. Any more for question number three?

Bryan Warner: Okay, well, thank you for those comments on question three. I'll now open up the floor for comments on the fourth question, which reads, "How do we improve tribal consultations? And it's kind of a two-parter. Should we have sessions every year? So how do we improve tribal consultations, and should we have sessions every year?

Okay, Ms. Marilyn Scott, you have the floor.

Marilyn Scott: Yes, thank you so much. I'm sorry, my video is not connecting up. My connection is not very well, so sorry I'm not able to put my video up.

I wanted to just add additional comments with regards to the importance of having a working group possibly of the tribal advisory committee that would be responsible for reviewing comments and recommendations to the consultation policy and possibly assist the administration in drafting consultation policy to present to the tribes through the consultation as part of the consultation coordinating with some of the other divisions, because each division has consultation policies, but in some cases that works better for tribes if we have collaboration and consultation jointly between divisions of the Agency.

I know that we have our regional consultation with HHS happens annually, but at the same time, some of the issues that we tribes need to consult with crosses over between divisions within HHS and, and at times it works better, if we have joint consultation sessions, possibly with CDC and Indian Health Service as a, as an example at times especially now, with the pandemic sometimes issues that we have crossover between the Indian Health Service and CDC so we're trying to address some of the policies for the public health and how we're establishing jurisdictions and policies within Indian country within our communities, because we serve not only our tribal members and other natives but also other citizens that live within the borders of our reservation. So, I think it's important that we have consultation between the agencies in some cases like that. And I submit this comment with the recommendation

that we also possibly consider having the Agency established better coordination between the tribal Advisory Committee and tribal governments, in addition to the consultation. And I thank you again, [speaking in indigenous language].

Bryan Warner: Thank you, Ms. Scott. Anyone else on question four? Star six to unmute if you're on the phone.

Okay, well, I will. I am Bryan Warner, the Deputy Chief of the Cherokee Nation. I will be brief, but I believe the CDC must conduct regular meaningful consultation whenever considering any rule or decision making, that will affect Indian country. Consultation should not happen on a strict timeline rather it should occur anytime CDC develops policies that have an impact on tribal communities. Additionally, CDC must incorporate the information and feedback shared during consultation into the final rulemaking to ensure the concerns and questions from tribal leaders are addressed, although.

And do I have anybody on the phone that would like to unmute?

For the final question, I will say this has been a very good listening session. I'd like to thank all the individuals that have spoken up on behalf of not only their tribe, but the entirety of Indian Country, which is very important as we all move together. So, if I have no further comments on the question, I will return the floor back to Dr. Montero so that he may use this time to summarize testimony heard during this meeting.

José Montero: Okay, let me see if I was able to unmute myself.

Bryan Warner: You are good sir.

Dr. José Montero: Okay, thank you. Thank you, everybody. For those of you on the call, before I on into summarize, and I want to highlight, we have many members of CDC's senior leadership team present. There have been many more present at different times of the testimony. As I said earlier, we had Dia Taylor, our Chief Operating Officer, we have Les Dauphin, who is our Director for CSELS [inaudible], Dr. Karen Remley, who is the Director for the National Center for Developmental Disabilities and Birth Defects, we have Dr. Hacker from the National Center for Chronic Diseases. We have Dr. Pat Breysse from the National Center for Environmental Health. Those are the ones that I can just see. I may be missing some or missed some who made it during the session. So you know that in addition to Dr. Nate Smith and myself, there are several other senior leaders here listening to this consultation session.

So, I am going to follow Chairman Payment's example. I am not going to go try to summarize what I heard question by question but trying to do it in a global systematic way. So, I heard that we need to improve the way that we plan and communicate for these sessions, that it has to be a multi-lever approach for the way that we invite, make notice, and include the tribal communities on this, that we should have Dear Tribal Leader Letters that are part of that communication Process. That as we review and think about our own policy, we need to make sure that we have mechanisms for collecting the feedback and providing clear reports to the general tribal community to, annual, or whatever the appropriate frequency of Dear Tribal Leader Letters is. At the same time that we do that, and include that, with our Tribal Advisory Committee, I heard the suggestion to have, within the Tribal Advisory Committee, a subgroup that looks at these issues, that looks at the recommendations, and that receives those different reports.

Everything has to have proper time. There are different levels of complexity in the different topics that are addressed by the consultation process; some of them require way longer time of prep.

So, the tribal leaders have the time to be briefed on the implications and come to CDC with proper recommendations and prepare in a way that they feel confident on that.

CDC leadership should be present to hear tribal testimony. Actually, that's part of what I highlighted, the leadership that we have present today.

I heard that we should ask the tribes of what topics as well because there may be topics that are impacted by things that we didn't anticipate, so it's not just unidirectional from CDC but looking at what the tribes have to tell us. There should be a standardized way to follow up on items and recommendations.

I heard that we should have some interaction and streamlining through HHS policies because there are different approaches to consultation policies. At the same time, I heard that we should have, or should consider, different OPS, sorry that's a technical term within HHS, different divisions or groups within HHS having joined consultation sessions, depending on the topic.

I hope that I didn't miss any of the big, big, big components. People are quite satisfied with the virtual options and hope that after we come back to times of live meetings, we maintain the virtual option that has facilitated and increased participation for tribes and tribal members.

Mr. Chairman, I think that that's what I have in my notes. You know I went to medical school; my handwriting is not that good. I cannot read some of my sketchy notes here, so I promise that we will get back and get a more clear summary of this after we get the written testimonials.

Bryan Warner: Thank you, Dr. Montero. I want to thank you and Captain Hearod for being here. And Dr. Smith, thank you, sir, for being here and listening, and thank you to all the tribal leaders and tribal members across Indian Country. It's very imperative that we do our due diligence. There is talent that has been put in each and every one of us, that is specific to us, and thanks be to God for that talent, but it's our own diligence will what see that talent through, and of course the many blessings of our Father.

Again, I want to thank you for giving me this opportunity. I too, as Dr. Montero, I have much chicken scratch, so sometimes or I forget or can't read my own writing, so I think it's just a sign of somebody that's trying to listen and get everything down. And do the right thing, and that's the option there, that's the only option that we have, is do the right thing for Indian Country. And I believe that wholeheartedly, that everybody that's here that's commented on the chat or in person has that their heart put in the right spot. And I, and I feel a lot of balance with this group between logic and emotion. So, in order to, we've come to the end, so I want to close this out, but I offer everybody, I want to start this prayer, and then I'm going to go into the Lord's Prayer. So, if you want to join me, in the spirit of being together, we will join in prayer now.

Your heavenly Father, Lord, we thank you for this time this precious time that you give each and every one of us lord. Thank you for all the blessings, thank you for the extra measure of mercy and grace that that we do not deserve it, yet it's that extra measure that we can give to our brothers and sisters that help us let your light shine through us Lord. Lord, I thank you for the day that you put before us. I pray that you help us have safe traveling graces as we go home. Put a hedge of protection around our families, Lord, and thank you for the prayer that you give each of us our father who art in heaven. Hallowed be thy name thy

name. Give us this day our daily bread and forgive us our trespasses as we forgive those who trespass against us. And lead us not into temptation but deliver us from evil. For thine is the kingdom and the power and the glory forever. Amen.

I want to again have one more chance to turn this over to Dr. Nathaniel Smith if for any parting comments, sir.

Dr. Nathaniel Smith: Thank you very much. I want to thank all who spoke with wisdom and clarity and also thank all those who were listening carefully and work together to help improve the tribal consultation process. I heard also clearly the need for accountability in this process, and a continual assessment of the effectiveness of the tribal consultation process. So, thanks to all who spoke, all who listened, and those who will do the hard work, as we move ahead. This consultation session is now officially adjourned. Thank you very much.

Unknown Speaker: Thank you.

Dr. José Montero: Thank you, sir. Thank you, everybody, thank you

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CDC/ATSDR Tribal Testimony Chat Comments:

Daniel Preston: Just to be aware, the Tohono O'odham Nation government has a process. This process involves the Executive Office and the Departments to offer comment and recommendations and then goes to the oversight Legislative Committee then onto the Legislative Council to ratify through resolution and is a joint effort. I'm sure there are other tribal Nations that have their own process but sufficient time to respond is recommended from any federal agency in regards to tribal consultation. Thank you.

Daniel Preston: This resolution also requires the Chairman's signature after the passage of a legislative resolution. Just as Mr. Payment has mentioned that "ample" time is needed.

Melanie Fourkiller: On behalf of Choctaw Nation -- We agree with the statements made by other Tribes regarding proactive and participatory Consultation with Tribal governments, as well as direct communication to Tribal Leadership via DTLL on consultation activities. Federal register notices, as is the practice with public stakeholders, is not sufficient to engage in Tribal Consultation. Consultation requires a mutual dialogue and deliberative process that is not achieved through Federal Register notice and comment. Additionally, Tribal Consultation requires honoring the government-to-government relationship between the U.S. and Tribal Nations, which means moving away from a competitive grant making practice to rather providing recurring, consistent funding to Tribes as Public Health Authorities on the same basis as states. The urgency for addressing this has been made very clear during the public health emergency - to directly fund Tribal Public Health capacity on a recurring basis. Thank you for the listening session.

Jennifer Webster: Oneida also supports having technical advisors and subject matter experts available and easily accessed during meetings.

Testimony provided by:

Aaron Payment, EdD, EdS, Med, MPA - Tribal Chairperson, Sault Ste. Marie Tribe of Chippewa Indians

Marilyn Scott - Tribal Vice Chairwoman Upper Skagit Indian Tribe; Upper Skagit Indian Tribe

Nate Tyler - Council Member Makah Tribal Council; Makah Tribe

Verne Boerner, MPH - President/CEO Alaska Native Health Board; Alaska Native Health Board; Native Village of Kiana

Jennifer Webster - Councilwomen Oneida Nation Legislative Operating Committee; Oneida Nation

Daniel Preston - Legislator San Xavier District, Tohono O'odham Nation; Tohono O'odham Nation

Jill Jim, DrPH - Executive Director of the Navajo Department of Health, Authorized Representative, Navajo Nation

Lauri Hayward - Board Chairperson, BOD for Pit River Health Services Inc.; Pit River Tribe

Melanie Fourkiller - Authorized Representative**,** Choctaw Nation

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CDC/ATSDR's Tribal Consultation on CDC/ATSDR Tribal Consultation Policy
August 5 – September 7, 2021
Written Testimony

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Testimony for Consultation Between The Tribal Nations and Centers for Disease Control and Prevention / Agency for Toxic Substances and Disease Registry

Regarding
CDC/ATSDR Tribal Consultation Policy and Process

(Tribalsupport@cdc.gov)

August 5, 2021

BiiWaagajiig, n'dizhnikaaz. Kina Baawaa'ting Anishinaabek Omaa go nda Onji-kida. **My name is Aaron Payment.** As the elected Chairperson of the Sault Ste. Marie Tribe of Chippewa Indians ("the Tribe"), I am submitting testimony on behalf of my Tribal Nation. This Testimony is in response to the Centers for Disease Control and Prevention (CDC)/Agency for Toxic Substances and Disease Registry (ATSDR) request for comment regarding how it can improve its Tribal consultation policy and the public health issues impacting Tribal nations.

Over the course of a Century, sovereign Tribal Nations and the United States signed over 350 Treaties requiring the federal government to assume specific, enduring, and legally enforceable fiduciary obligations to the Tribes. The terms codified in those Treaties – including for provisions of quality and comprehensive health resources and services – have been reaffirmed by the United States Constitution, Supreme Court decisions, federal legislation and regulations, and even presidential executive orders. These federal promises – which exist in perpetuity - collectively form the basis for what we now refer to as the federal treaty and trust responsibility. During permanent reauthorization of the Indian Health Care Improvement Act, Congress declared within the law that, "…*it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians . . . to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy*.[1]

The United States owes a special duty of care to Tribal Nations, which animates and shapes every aspect of the federal government's trust responsibility to Tribes. Rooted in treaties and authorized by the United States Constitution, the federal government's unique responsibilities to Tribal Nations have been repeatedly re-affirmed by the Supreme Court, legislation, executive orders and regulations.[1] In 1977, the Senate report of the American Indian Policy Review Commission stated that, "[t]he purpose behind the trust doctrine is and always has been to ensure the survival and welfare of Indian tribes and people."

This trust responsibility is highlighted recently in the Department of Health and Human Services (HHS) Strategic Plan FY 2018–2022:

Importantly, the Federal Government has a unique legal and political government to-government relationship with Tribal governments and a special obligation to provide services for American Indians and Alaska Natives based on these individuals'

relationship to Tribal governments.[1]

The trust responsibility establishes a clear relationship between Tribes and the federal government.[2] The Constitution's Indian Commerce Clause, Treaty Clause and Supremacy clause, among others, provide the legal authority and foundation for distinct health policy and regulatory decision making by the United States when carrying out its unique trust responsibility to provide for the health and welfare of AI/ANs.

The federal government's work with Tribal nations and tribal people ***must*** be informed by this responsibility. **Tribal Consultation is the primary means through which this relationship is respected and is a necessary part of that relationship.** Tribal consultation was affirmed by Executive Order in 2000 and through Presidential Memoranda in 1994, 2004, 2009, and most recently by President Biden in 2021.

The Centers for Disease Control and Prevention is one of the federal entities charged the federal trust responsibility of addressing the health disparities among AI/AN Tribal Nations and Peoples; however, every branch and agency of the federal government is required to honor and uphold the trust obligations for health and public health to sovereign Tribal Nations and Peoples. These trust obligations are owed to AI/AN peoples and do not have an expiration date.

AI/AN health outcomes have either remained stagnant or become worse in recent years as Tribal communities continue to encounter higher rates of poverty, lower rates of healthcare coverage, and less socioeconomic mobility than the general population. As the US Civil Rights Commission addresses so effectively in Chapter 2 of its 2018 Broken Promises Report, Tribal communities are already at substantial health risk, since the efforts of the federal government to uphold its trust responsibility for Tribal health care has been so ineffective.[3] On average, AI/ANs born today have a life expectancy that is 5.5 years less than the national average, with some Tribal communities experiencing even lower life expectancy.[4] For example, in South Dakota in 2014, median age at death for Whites was 81, compared to 58 for American Indians.[5] This is nearly a life expectancy age disparity of a ¼ of a century.

According to the CDC, in 2017, at 800.3 deaths per 100,000 people, AI/ANs had the second highest age-adjusted mortality rate of any population.[6] In addition, AI/ANs have the highest uninsured rates (25.4%); higher rates of infant mortality (1.6 times the rate for Whites)[7]; higher prevalence of diabetes (7.3 times the rate for Whites); and significantly higher rates of suicide deaths (50% higher). AI/ANs also have the highest Hepatitis C mortality rates nationwide, as well as the highest rates of type II diabetes, chronic liver disease and cirrhosis deaths. Further, while overall cancer rates for Whites declined from 1990 to 2009, they rose significantly for American Indians and Alaska Natives.

At the core of the federal trust responsibility to Tribal Nations is the fact that the federal government is supposed to ensure the health and welfare of Native peoples. The COVID-19 pandemic has given the federal government an opportunity to uphold its obligation in a way that is perhaps unparalleled in modern American history. However, Tribes are increasingly confronted with systemic barriers that impede their ability to receive

[1] Introduction, "Cross-Agency Collaborations", https://www.hhs.gov/about/strategic-plan/introduction/index.html
[2] *See*, Worcester v. Georgia, 31 U.S. 515 (1832) (Supreme Court explicitly outlined that the relationship between the federal government and the Tribes is a relationship between sovereign nations and that the states are essentially third party actors).
[3] U.S. Commission on Civil Rights, *Broken Promises: Continuing Federal Funding Shortfall for Native Americans* (2018), https://www.usccr.gov/pubs/2018/12-20-Broken-Promises.pdf.
[4] Id., 65.
[5]South Dakota Department of Health. Mortality Overview. Retrieved from https://doh.sd.gov/Statistics/2012Vital/Mortality.pdf
[6] Kochanek KD, Murphy SL, Xu JQ, Arias E. Deaths: Final data for 2017. National Vital Statistics Reports; vol 68 no 9. Hyattsville, MD: National Center for Health Statistics. 2019.
[7] Centers for Disease Control and Prevention. Infant, neonatal, post-neonatal, fetal, and perinatal mortality rates, by detailed race and Hispanic origin of mother: United States, selected years 1983–2014.

help from the federal government and this is slowing or even outright denying access to aid. One such barrier is the federal Indian health care delivery system is designed to address just a fraction of the needs of a tribe. For my tribe, only one third (15,000) of our population reside in our purchase and referred service area. This means the remaining two thirds (30,000) go without any Indian Health Care services through our Tribe. This is true for most tribes ~ that only a fraction of our population derives health care through Indian Health Services. For those who do reside in our service area, the federal government covered less than 50% of our identified need.

As sovereign governments, Tribal Nations have the same inherent responsibilities as state and territorial governments to protect and promote the public's health. Tribes were largely left behind during the nation's development of its public health infrastructure and systems continue to be chronically underfunded. As a result, many Tribal public health systems remain far behind those of most state, territorial, and even city and county public health entities in terms of their capacity. This includes core services, such as disease surveillance and reporting; emergency preparedness and response; public health law and policy development; and public health service delivery. Additionally, HHS must commit the resources and CDC must continue its meaningful and sustainable direct investments into Tribal communities for public health if we are ever to close the gap in the disparities of lower health status, and lower life expectancy of AI/AN Peoples compared to the general population.

It is critical that the agency keep these striking health disparities in mind when considering the CDC/ATSDR Tribal Consultation Policy and how it can be used as a tool to strengthen the government-to-government relationship and help facilitate meaningful progress towards the goal of eliminating AI/AN health disparities.

CDC/ATSDR TRIBAL CONSULTATION POLICY

CDC/ATSDR must update their Tribal Consultation policy to increase accountability, acknowledge and honor a Tribe's right to call for Tribal Consultation, and provide opportunities for meaningful engagement in policies that impact AI/AN nations during the policy development process. First, Tribal leaders ***need*** to know that the agency is hearing them and that their recommendations are accepted and implemented to the greatest extent possible. To that end, we want to ensure that the agency respects the government-to-government relationship. The current consultation policy does not provide a reflexive mechanism for Tribal leaders to verify whether the agency considered their feedback, making it difficult to hold the agency accountable for the consultation results. We also urge CDC/ATSDR to facilitate accountability with other agencies, particularly when the actions of those agencies impact its policies. Meaningful consultation is also tricky when the agency fails to give tribal leaders adequate time to prepare, and the agency is not providing support to the organizations on which they rely for technical assistance with consultation preparation and participation. Due to the COVID-19 pandemic, many agencies have recently come to rely on rapid consultations, which Tribal leaders do not find helpful as a regular course of action. **For meaningful consultation to occur, Tribal leaders must have adequate time to prepare.**

The Sault Ste. Marie Tribe of Chippewa Indians looks forward to working with CDC/ATSDR to respect and affirm our Tribal sovereignty, and we believe that the steps outlined in this testimony will be beneficial as CDC/ATSDR is considering ways to make their consultation policy more responsive to the government-to-government relationship.

Strengthening the Government-to-Government Relationship

Tribal Consultation is considered a necessary part of the federal Indian trust responsibility. As President Biden stated in Section 1 of the Presidential Memorandum on Tribal Consultation, "[m]y Administration is committed to honoring Tribal sovereignty and including Tribal voices in policy deliberation that affects Tribal communities. The Federal Government has much to learn from Tribal Nations and effective communication is

fundamental to a constructive relationship."[8] He also called on agencies to engage in "**regular**, **meaningful**, and **robust** consultation with Tribal officials in the development of Federal policies that have Tribal implications."[9]

Tribal leaders seek to improve the government-to-government relationship between Tribal Nations and the federal government. While we recognize that federal agencies regularly conduct consultation, we reject the notion that the consultation requirements are achieved by merely scheduling a time and sending personnel to hear concerns. Proper consultation and government-to-government engagement exceed that limited scope. The engagement must allow the heads of governments to come together, share concerns, generate ideas and solutions, negotiate their roles and responsibilities, and agree on a course of action. Consultation policy requires recognizing a Tribal Chairperson to speak first among Tribal representatives – yet no parallel construct exists for the federal government. That needs to change. Comparable heads of State from the federal government must meet with heads of State of Tribal governments. Tribal consultation, as a tool for intergovernmental relations, must include the concept of ***consent*** to be meaningful, respectful, and ultimately successful.

The Sault Ste. Marie Tribe of Chippewa Indians recommends HHS **recognize a cogent and uniform definition of "Tribal Consultation"** to be used throughout the Department. The absence of such a uniform definition creates confusion throughout the CDC/ATSDR and the tribes. Additionally, the uniform definition should incorporate the principles of free, prior, and informed consent (FPIC) that is consistent with the **United Nations Declaration of the Rights of Indigenous Peoples (UNDRIP) which has been affirmed by the United States.**

The Tribe also strongly recommends that the Department of Health and Human Services adopt a uniform consultation framework throughout the Department, with individual services, bureaus, and offices adding to it to reflect their mission areas. Meaningful consultation must include consent to actions that impact Tribal resources and people. Moreover, the framework must consist of a dispute resolution mechanism (short of achieving consensus) based on international diplomacy standards. If HHS cannot uniformly adopt this standard, the CDC/ATSDR should adopt a consultation framework that includes Tribal consent and a dispute resolution mechanism (short of achieving consensus) based on international diplomacy standards.

The CDC/ATSDR and its service to AI/AN people are critical parts of how the United States government honors and respectfully implements its trust and treaty obligations to help eliminate the many health disparities faced by Tribal nations and ensure access to essential health and public health services. The CDC/ATSDR is a direct representative of the United States government, and it provides critical funding and services to AI/AN people in furtherance of the trust responsibility. **It is imperative that the CDC/ATSDR is mindful of this relationship and frames their interactions with Tribal nations. CDC/ATSDR cannot be effective if the concerns of Tribal leaders do not inform their policies.**

<u>The "Substantial Direct Effects" That Should Trigger Consultation.</u>

Any federal action, including legislative, promulgated rulemaking, executive, or administrative policy directions, budget formulation, or any other efforts **that impact Tribes or may impact how Tribes govern their citizens, should be subject to consultation.** Quantifying "when" the agency should initiate engagement is complicated, but just as federal "notice and comment" has been established for most actions of the federal government, so too should the opportunity be afforded for Tribal leaders to weigh in and effectuate outcomes that impact their governments and their very lives of their respective citizens.

[8] *See* "Memorandum on Tribal Consultation and Strengthening Nation-to-Nation Relationships," https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/26/memorandum-on-tribal-consultation-and-strengthening-nation-to-nation-relationships/, January 26, 2021.
[9] Id.

The Sault Ste. Marie Tribe of Chippewa Indians also recommends that all agencies recognize Tribal governments as having the right to initiate a consultation with the CDC/ATSDR on any significant level of government action or generally to set the direction for some new policy initiative not yet contemplated by the federal government. **Consultation is a much broader thing than what the agency currently practices. Consultation should be considered a perpetual activity that is inclusive of every stage of decision-making.**

The CDC Tribal Advisory Committee (TAC) can be an essential tool in the consultation process. But note, consulting with a TAC is not a substitute for Tribal consultation. TACs should be utilized by CDC/ATSDR when they are formulating policies, because TACs are the best conduit through which CDC/ATSDR can receive technical assistance that is Tribally informed and representative of the various regions. CDC/ATSDR currently has a very active advisory committee that the agency can utilize to inform the different policy areas that their programs touch. We urge CDC/ATSDR to begin engaging the TAC early in the policy and regulatory making process so any proposed policies can be Tribally informed from the start. Further, the CDC Tribal Advisory, as well as, all tribal advisory under HHS, should have a vehicle for reporting up to the HHS Secretary Tribal Advisory and for the substance of their work be considered at the White House Counsel level in order to ensure cogent Federal Indian Policy.

We also implore the CDC/ATSDR to consider expanding the usage of listening sessions during these early stages of policy development to hear directly from Tribal leaders. During the Clinton Administration, the federal government used regular "listening sessions" as an essential communication tool with Tribes. Listening sessions are a preemptive step to formulate ideas and proposals for consultation. Listening sessions enhance understanding between the federal government and the Tribal governments and identify where strategic issues exist. Consultations put forward proposals to which Tribes can respond. And so, in addition to consultation on matters as they arise, the Sault Ste. Marie Tribe of Chippewa Indians recommends regular listening sessions at the national and regional levels.

In addition to meeting with Tribal governments on specific issues that arise, the Sault Ste. Marie Tribe of Chippewa Indians recommends the CDC/ATSDR meet with Tribal leaders every four years, at the start of each Presidential term, for Sectoral and Thematic Priority Listening Sessions. We recommend that, within these sessions, the CDC/ATSDR review broad sectoral and thematic strategies; share background, data, evidence, or narrative that will help guide decision making; discuss existing and future policy development; and define priorities and goals.

The Tribe also recommends regional bi-annual leadership listening sessions. These meetings would gather Regional Directors and Tribal leadership at regional levels and, within the strategic framework established at the national level, allow them to:

1. Define broad mutual goals (identify alignments and areas, not in alignment);
2. Share background, data, evidence, and narrative that will help guide decision-making; and
3. Discuss "big picture" ideas (on all sides) reflecting areas of work and the limits of allocation of resources.

The bi-annual leadership meetings would be an opportunity to have an honest discussion of capacity, focusing on efficiency and effectiveness throughout the system. We believe the regional bi-annual leadership listening sessions will make a significant difference. A method of support could improve the chances of regional meeting success. That support system may include training, incentives, newly defined metrics, and opportunities for acknowledgment for innovative work. It would also be helpful to have dedicated positions for Tribal experts.

If CDC/ATSDR engages Tribal leaders from the start, it should make for a more fruitful consultation process. CDC/ATSDR should not wait until they have formulated a policy or regulation before asking for Indian Country's feedback.

Informed Tribal Decision Making

We urge CDC/ATSDR to move towards a consultation model that encourages informed Tribal decision-making by giving Tribal leaders ample time to prepare so the consultation can be engaging and meaningful for both sides. Although some situations call for quick decision-making, the agency should avoid **rapid consultations in all but the most urgent situations, as was the case throughout the COVID-19 crisis**. A rushed effort does not produce superior results for Indian Country. We believe that such consultations do not give Tribal leaders enough time to research and discuss the issue at hand. The lack of preparation time often results in consultations that feel like they exist to allow federal agencies to "check a box" and not learn about Indian Country's concerns. Tribal leaders are leaders of sovereign nations; therefore, the agency should not unilaterally expect them to be ready for a consultation on short notice. While one might argue that a rapid consultation meets a minimum technical threshold to be called a "Tribal Consultation," such meetings are often respectful and do not allow for informed and meaningful discussions with Indian Country.

Further, we urge CDC/ATSDR to adopt a uniform notice requirement that ensures that every federally recognized Tribe is able participate in Tribal consultations. It often takes time for notice of these meetings to arrive at the desk of Tribal leaders, who the agency then expects to turn their attention towards getting ready for the meeting with little time to prepare. Tribal leaders should have some degree of predictability regarding Tribal consultations to operationalize preparation and have a mechanism to ensure that they have ample time to prepare. We are also concerned that Tribal leaders may not receive the invitation on time and cannot attend or have time to prepare. As heads of state of sovereign nations, tribal leaders often have competing priorities. It is unrealistic to expect them to be ready on short notice. **We urge the agency to adopt a policy requiring at least a 30-day notice for consultation, with limited exceptions for emergency items.** There is currently no prescribed timeline in the policy. We believe that a uniform requirement will allow for a degree of predictability and adequate time for Tribal leaders to prepare. Additionally, the agency should establish **a four-year schedule for national and regional listening sessions within** the first quarter of each Presidential term**. Sixty days before any listening session, a Dear Tribal Leader Letter (DTLL) should be issued, as a reminder, of the upcoming event.**

There are also no requirements around *how* the agency should communicate Tribal consultations to Tribal leaders. Currently, the policy states that the "CDC will initiate consultation regarding the event through communication methods as outlined in the HHS Tribal Consultation Policy." Section 8(A) of the HHS Department Policy on Tribal Consultation merely provides an open list of communication methods. A uniform means of reaching Tribal leaders is essential. Thus, we urge the agency to adopt a uniform requirement that consultation and listening session notices be published concurrently in the following manner:

1. The agency should publish all notices in a regular section of the Federal Register dedicated to Tribal consultation and listening session notices;
2. Notices should be published on the Indian Health Service (IHS) Tribal consultation and listening sessions' webpage;
3. Notices should be published on the White House Council on Native American Affairs consultation and listening sessions' webpage;
4. The agency should publish all notices via DTLL (to be sent electronically and via U.S. post); and
5. Notices should be published and sent for distribution to the National Congress of American Indians, the National Indian Health Board, and other inter-tribal organizations recommended by Tribal governments.

If any of these sites and web pages do not exist, they need to be established and maintained.

The agency must also expand the methods through which Tribal leaders can participate in Tribal consultations. As we learned during the COVID-19 pandemic, it is possible for agencies to conduct consultations remotely and for Tribal leaders to be engaged in that format. While the agency should resume in-person consultations, they must ensure that Tribal leaders can continue to participate remotely. Many Tribes are small and do not have the resources to pay for travel for their leadership to participate in consultations. The ability to participate remotely expands the number of Tribal leaders who can participate, which helps to ensure that the agency is hearing from a broad cross-section of Tribal leaders.

Improving Accountability

Tribal leaders require accountability from the agency responsible for providing health care to their citizens as leaders of sovereign nations. **Tribal leaders need affirmative efforts demonstrating that their concerns are being heard, considered, and adopted.**

During consultations, the CDC/ATSDR will receive a large volume of input from tribal leaders. To effectively respond the CDC/ATSDR's must:

1. Accurately record and verify all input;
2. Perform analysis and identify themes;
3. Provide a report on the results and how Tribal input has informed the CDC/ATSDR response to tribal issues;
4. Record the position of Tribes regarding the CDC/ATSDR policy recommendations;
5. Utilize the reports to inform budget formulations, committees work, and other inter-agency work.

To accurately record input **from tribal leaders, each consultation session should be translated to text and posted verbatim**. No interpretation or distillation should occur at this stage unless as an annotation. The agency should sort statements by consultation event date and tribal nation input. To verify input, **Tribes should have a week to view online and reflexively make corrections (if necessary) to both the verbal (translated to text) and submitted written testimonies.**

To identify themes and perform analysis, **the agency should establish and publish a protocol for how they will interpret the raw data to categorize comments and suggestions.** The CDC/ATSDR should adopt a methodology similar to what the Council of Energy Resource Tribes uses (CERT's Tribal Input Methodology.) Then **CDC/ATSDR staff should work to perform a mixed methods approach beginning with qualitative analysis and draft categories of like suggestions.** This process organically leads to the formation of categories that lend themselves to quantitative summaries and categories for
action planning. Qualitative research software like Nvivo[10] may increase efficiency in the process.

The CDC should publish the consultation analysis with both speech-to-text and the written comments. **Within two weeks of its publication, Tribal governments should be able to provide comments regarding CDC/ATSDR analysis to ensure the original intent of the suggestion is maintained. In situations in which the agency needs clarification, the CDC/ATSDR should seeks clarification from those who provided the input.**

To report on how tribal input has informed the CDC/ATSDR' response to tribal issues within a month of consultation, the CDC should provide a follow-up written analysis explaining how it will use Tribal input to address each topic addressed in consultation along with impact analysis on how it expects the "consultation informed" policies to perform.

[10] Richards, Lyn. Using NVivo in Qualitative Research. London & Los Angeles, Sage, 1999. ISBN 0-7619-6525-4.

The agency should publish a record of Tribal support and opposition to Indian Health Service policy decisions. In situations in which consultation sessions do not end in "consent," the dispute resolution mechanism (to be based on international diplomacy standards) should be engaged. To utilize the reports and records of support and opposition, they should all be invoked during budget formulation, tribal advisory committee work, and play a key role in across agency work performed by the White House Council for Native American Affairs for inter-agency project management with goals and objectives, milestones and measurables and assessment including at least an annual report during the White House Tribal Leaders Summit.

Education & Training

The CDC/ATSDR must educate (initially and continuously) all its vital policy staff members about the meaning of consultation and the reason for consultation with Tribal governments. Just like any organizational education objectives, understanding the basis and basics of tribal sovereignty and Tribal consultation is critical. Without an organized curriculum with rubrics of targeted understanding and ongoing assessment to ensure continued learning, this knowledge cannot be otherwise acquired or retained if not utilized regularly. The United South and Eastern Tribes (USET) noted that education should be like what the US does with its foreign Ambassadors: Ambassadors are fully briefed on the culture, top issues, and history of their nation. In the same way, US federal representatives should be "briefed"/given ongoing education regarding the Tribal Nations they are working with. The Sault Ste. Marie Tribe recommends national level representatives be regularly and consistently educated on Tribal sovereignty, consultation rights, and the reason for consulting with Tribes; at the regional level, education must include the region's Tribal governments' interests, needs, cultures, and histories.

Tribal Technical Assistance

Tribal organizations, such as the National Indian Health Board and the National Congress for American Indians, are routinely consulted by Tribal leaders in preparation for TAC meetings and Tribal consultations. However, there is little support for this work. **We urge the agency to financially support the work of National, Regional, and Inter-Tribal organizations, who are vital in ensuring that Tribal leaders have access to the subject matter expertise that helps them prepare to offer meaningful feedback to the agency.** We believe that this technical assistance is vital to full and meaningful consultation.

Reflexive Tribal Consultation Conceptual Framework

The above has been distilled into a ***Reflexive Tribal Consultation Conceptual Framework*** (see **Appendix A**) to depict the steps for meaningful Consultation with tribes that respects tribal sovereignty, invites integration of tribal input at all stages including necessary validity checks on content and is steeped in UNDRIP concept of FPIC ~ Free Prior Informed Consent to truly respect tribal sovereignty in shared decision making. This proposed method borrows from general American Indian consensus building that creates ownership and buy-in of the outcome. Sequential yet cyclical steps are further articulated in Appendix A on page 13.

TRIBAL PUBLIC HEALTH CAPACITY & INFRASTRUCTURE

The COVID-19 pandemic brought with it a disproportionate impact on AI/AN people and illuminated many of the disparities Tribes experience, particularly in the public health arena. These have contributed to disproportionately poorer COVID-19-related health outcomes experienced by AI/ANs. It has never been more important to increase the resources flowing to Indian Country. Now is the time to adjust the funding and policy landscapes to better support Tribal public health infrastructure, the societal realities Tribes experience associated with poverty, remoteness, and lack of investment into Tribal public health systems.
According to the latest data from the CDC, American Indian and Alaska Native (AI/AN) people are 1.7 times (70%) more likely to be diagnosed with COVID-19[11], 3.4 times (340%) more likely to require hospitalization[12] and 2.4 times (240%) more likely to die from COVID-19-related infection when compared to non-Hispanic white people[13]. However, these disparities in COVID-19-related death rates are not evenly shared across all AI/AN age groups. Young AI/ANs are experiencing the largest disparities. Among AI/ANs aged 20-29 years, 30-39 years, and 40-49 years, the COVID-19-related mortality rates are 10.5, 11.6, and 8.2 times, respectively, higher when compared to their white counterparts[14].

AI/ANs continue to face significant chronic health disparities, especially for conditions like diabetes and respiratory illnesses, which increase the risk of a poor COVID-19 health outcome, including death. These disparities will continue to go unaddressed without a bold and substantive IHS budget. A weak budget would leave Indian Country more vulnerable to COVID-19 outbreaks. It is imperative to prioritize Tribal public health infrastructure and capacity for Tribes to see meaningful decreases in these disparities. **NIHB fully supports the Biden Administration's call for increased health and public health equity.**

Unfortunately, because of high rates of misclassification and under-sampling of AI/AN populations in federal, state, and local public health disease surveillance systems, available data likely significantly underrepresents the impact of COVID-19 in Indian Country. To be clear, misclassification of AI/ANs on disease surveillance systems is not unique to COVID-19, however, the issue has taken a new level of urgency given the unprecedented devastation of this pandemic on underserved communities. Multiple states with large AI/AN populations including but not limited to Minnesota, Michigan, New York, and California continue to report thousands of COVID-19 cases without any information on patient race/ethnicity or categorizing cases as "other" on demographic forms. In California, for instance, the state noted they lack race/ethnicity data for nearly 30% of reported cases. Multiple studies demonstrate that surveillance systems frequently misclassify AI/ANs or omit them from surveillance systems entirely. These issues continue exacerbate health disparities including those from COVID-19.

The CDC must work with state and local health departments, community-based organizations (CBOs), Federally Qualified Health Centers (FQHCs), IHS facilities, Tribally-run health facilities, and Tribal Epidemiology Centers (TECs) **to ensure that complete and accurate data is captured and shared with Tribes** so they can effectively respond and recover from COVID-19, and other similar public health

[11] Data reported by state and territorial jurisdictions (accessed 03/10/2021). Numbers are ratios of age-adjusted rates standardized to the 2019 US intercensal population estimate. Calculations use only the 53% of case reports that have race and ethnicity data available; this can result in inaccurate estimates of the relative risk among groups.
[12] COVID-NET (https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covid-net/purpose-methods.html, accessed March 1, 2020, through February 27, 2021). Numbers are ratios of age-adjusted rates standardized to the 2019 US standard COVID-NET catchment population.
[13] NCHS provisional death counts (https://data.cdc.gov/NCHS/Deaths-involving-coronavirus-disease-2019-COVID-19/ks3g-spdg, data through March 6, 2021). Numbers are ratios of age-adjusted rates standardized to the 2019 US intercensal population estimate.
[14] Arrazola J, Masiello MM, Joshi S, et al. *COVID-19 Mortality Among American Indian and Alaska Native Persons — 14 States*, January–June 2020. MMWR Morb Mortal Wkly Rep 2020; 69:1853–1856. DOI: http://dx.doi.org/10.15585/mmwr.mm6949a3

emergencies. Timely and accurate data play a vital role in public health decision-making, and would allow for better, data-driven Tribal public health policy, which would better protect Tribal members.

Expand and Strengthen the Government-to-Government / Expand Self-Governance.

The Tribes and CDC established the CDC TAC in 2005 to improve the government-to-government relationship. The TAC serves as an advisory body to CDC on policies, programs, and funding opportunities that impact Tribes but does not supplant formal Tribal consultation. Meaningful and robust Tribal consultation must continue. Tribal leaders know best how to care for their people; therefore, it benefits the CDC to implement and incorporate Tribal leader recommendations into every aspect of the CDC that impacts AI/ANs. Tribes and the TAC have repeatedly called upon the federal government to expand self-determination and self-governance authority across all of HHS. In the interim, the CDC should work closely with Tribes to obtain a complete understanding of the current public health needs and allow for maximum flexibility in the administration of funded Tribal public health programs.

Remove Barriers that Inhibit Adoption of Traditional Practices

Recognizing Tribal sovereignty means recognizing the sovereign right of Tribal nations to utilize traditional practices to provide for the health and public health of their people. Traditional medicine is central to many Tribal cultures and is effective at treating and preventing many chronic health issues facing AI/AN people. **Tribal Nations continue to experience many barriers when implementing or incorporating traditional and cultural practices as grant activities because it is not supported by CDC even though such practices have been supporting Tribal health and wellness for time immemorial.** The CDC could and should support Tribal models of health and healing that may not fit well into standard Western approaches by including language in their funding opportunity announcements that recognize the value and applicability of cultural and traditional practices as viable Tribal grantee activities.

New CDC-Wide Requirement

The Consolidated Appropriations Act of 2021 directed each Center, Institute, and Office (CIO) within the CDC to create written guidelines to integrate Tribal public health priorities and needs across the entire agency. These written guidelines are to be developed in consultation with the CDC TAC and will establish best practices around the delivery of Tribal technical assistance, as well as the consideration of cultural and traditional Tribal public health practices. Because the CDC is required to work with the TAC to develop these guidelines, the Tribes are afforded an unprecedented opportunity to create a new, more inclusive path forward for working with CDC. **However, consultation with the CDC TAC does not supplant Tribal consultation. NIHB requests that the agency engages in meaningful and robust Tribal consultation throughout the development process.**

Create Set-Aside Funding for Tribes Throughout the CDC and Invest in Tribal Public Health Systems

Tribes interact with the CDC on a regular basis and there should be funding dedicated to ensuring that the agencies can meet unique Tribal needs. Unfortunately, the status quo often prevents the fulfillment of Tribal needs. For example, CDC frequently distributes funding via competitive grants and conducts programming aimed at strengthening Tribal public health infrastructure and systems, but these methods of funding do not allow for equitable funding across all Tribal public health systems.

Dedicated funding for Tribes and Tribal organizations is the most effective way to ensure that adequate resources are reaching Indian Country, while also furthering the fulfillment of the federal government's trust responsibility for health. With Good Health and Wellness in Indian Country (GHWIC) as a potential model, CDC should consult with Tribes to design and fund Tribal public health infrastructure and capacity development initiative in Indian Country with the flexibility to permit Tribes to tailor programs to their unique community priorities. The CDC must commit to these direct Tribal investments that support Tribes in addressing public health development and other issues. **There should be a minimum of 5% set-aside for Tribes across all CDC Centers, Institutes, and Offices (CIOs) to meaningfully begin to build equitable Tribal public health systems, compared to states and local health departments**. This funding

will help integrate Tribal public health needs and priorities across the entire CDC and all CDC programs. For those CDC CIOs that do not send funding out as grants, **at least 5% of funding resources for internal activities should be directed and dedicated to Tribal support**.

Ensure Tribal Access to Data and Support Tribal Data Sovereignty

Recent federal scientific initiatives throughs the National Institutes of Health (NIH) and the Food and Drug Administration (FDA), have sought Tribal leaders' endorsement of their projects in Indian Country. While Tribal advocates support the development of scientific initiatives to prevent and cure diseases, Tribes are sovereign nations and are the ultimate stewards and owners of the data collected on their Tribal citizens.

The CDC must work collaboratively with Tribes to ensure that Tribes have access to their Tribal data. Understanding and honoring Tribal data sovereignty must be the cornerstone of all CDC Tribal data collection efforts. Doing so will improve overall public health data reporting and provide the most accurate information for developing budget and public health priorities, while allowing Tribal leaders and administrators the most accurate data in determining resource allocation and program development and evaluation.

Structural challenges in data reporting only serve to render invisible the disparate impact of COVID-19 in Indian Country. For example, TECs continue to face significant barriers in exercising their statutory public health authorities by facing major hurdles in accessing federal and state public health surveillance systems, including for COVID-19, which often has incomplete or inaccurate race/ethnicity data. In addition, not every state, city and county jurisdiction include AI/AN as a distinct demographic on health assessment and surveillance forms, often lumping them under "other." These race/ethnicity data gaps contribute to ongoing underestimates that only further obscure the true burden of COVID-19 and other diseases for AI/ANs. Furthermore, Tribes often experience significant barriers in accessing the patchwork of state infectious disease tracking and reporting systems. This must be corrected to allow the Tribes access to their own data in a timely manner.

While available data demonstrates higher rates of health disparities among AI/ANs in a variety of health conditions, **estimates of disease prevalence and incidence for AI/ANs are likely to be underestimates due to high rates of racial misclassification and undercounting of AI/AN populations in state and federal surveillance systems**. A comprehensive plan to address the gaps in data collection across these surveillance systems is drastically needed to improve the information readily available to Tribal leaders to better inform their public health policies and programs.

Promote and Sustain Environmental Health Improvements in Indian Country

The health of the environment directly impacts public health in Indian Country. Contaminated drinking water, harmful air pollutants, destruction of natural habitats, climate change, extreme weather, and exposure to toxic heavy metals are issues that Tribal communities struggle to prevent, often with little or no support from the federal government. Twenty-five percent of the nation's 1,300 Superfund sites are in or near Indian Country, even though Indian County is, tragically, only approximately 2.3% of the national land area. **Lack of access to clean water, pollution, and insufficient sanitation infrastructures impact the physical and mental health as well as emotional and spiritual wellness for AI/AN communities and individuals.** Without proper access to clean water and adequate sanitation infrastructure it is hard – if not impossible – for Tribal citizens to be healthy and for Tribes to adhere to CDC recommendations and guidelines for COVID-19 mitigation and control, which further propagates COVID-19 infections across Indian Country. The CDC must establish Tribal sanitation and clean water infrastructure as a public health priority.

Prioritize Indian Country in the Ending the HIV Epidemic: A Plan for America

The rate of HIV infection among AI/ANs in 2016 was 10.2 per 100,000 – the fourth highest among other racial/ethnic groups. Furthermore, the frequency of HIV diagnoses among AI/AN persons continues to rise. The current national plan does not address the unique prevention and care realities of Indian Country. There

must be specific language to discuss American Indians and Alaska Natives as a population that is statistically at higher risk for acquiring or passing away from HIV or viral hepatitis. The CDC should continue to engage with Tribes through formal consultation to incorporate Tribes in all the federal government's HIV response activities, including how best to capture AI/AN data in an accurate and respectful manner.

Linkage to care has been proven to be one of the most effective and simple interventions that can be undertaken with a person newly diagnosed with HIV or a person that has fallen out of care. However, only a handful of providers across the entire I/T/U healthcare system are trained to provide HIV specialty care for American Indians and Alaska Natives. Therefore, many AI/ANs are required to rely upon referral care to providers outsides the Indian health system, and outside of their own communities – often traveling hours to make appointments. These providers, while technically knowledgeable, may not have experience or the cultural knowledge to provide comprehensive, competent care to AI/AN people living with HIV. The lack of local providers, distance to HIV specialists, and absence of culturally competency serve as deterrents for many AI/AN seeking ongoing care and monitoring. HHS and the CDC should, as integral components of its national HIV response, direct funding to support Tribal-specific training, technical and capacity building assistance, and materials dissemination.

CONCLUSION

To fulfill the federal Indian trust responsibility and to address social determinants of health and poor health status for AI/ANs the CDC/ATSDR must update their Tribal Consultation policy to increase accountability, acknowledge and honor the Tribe's right to call for Tribal consultation, and provide opportunities for meaningful engagement in policies that impact Tribal nations during the policy development process.

Thank you for your attention to the Biden Administration Memo and efforts to address its Tribal consultation policy. Rededication to government-to-government relationship presents an opportunity to improve the processes that maintain and strengthen these sacred relationships. Given the status of Tribes as pre-existing sovereigns and their unique position in the American legal framework, Tribal consultation must be robust and meaningful. There must be accountability from CDC/ATSDR. Thank you again for taking this first step and giving my tribe the opportunity to comment. We look forward to an ongoing dialogue on how to make Tribal consultation more respectful and responsive to the needs of Tribes.

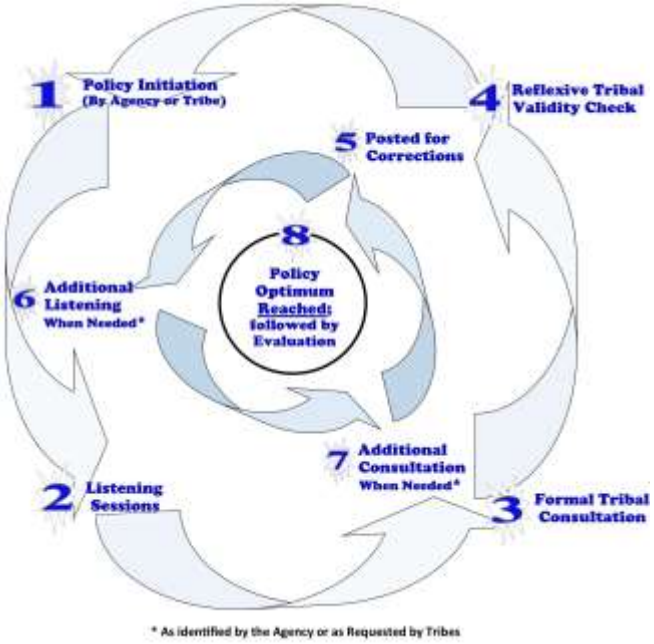
Respectfully,

Dr. Aaron A. Payment, Chairperson

Acknowledgement:

This policy position paper in for the form of consultation testimony was crafted in collaboration between the Sault Tribe of Chippewa Indians, the National Indian Health Board and the National Congress of American Indians for which Dr. Payment serves as 1st Vice President. Dr. Payment also serves as a Member of the HHS Secretary Tribal Advisory, NIH Tribal Advisory, SAMSHA Tribal Advisory and President of the Midwest Alliance of Sovereign Tribes and the United Tribes of MI.

APPENDIX A
REFLEXIVE TRIBAL CONSULTATION CONCEPTUAL FRAMEWORK



Understandably, the concept of Consultation can represent a "chicken and egg" challenge with the question ~ at what point is it appropriate to engage Tribal Consultation? In order to avoid a paternalistic approach of presenting pre-conceived outcomes, policy initiation should occur as soon as a problem or challenge (issue) arises or when requested by tribe(s). This conceptual framework is intended to be reflexive throughout like a feedback loop and to be a guide rather than a regimented series of steps. While sequential, steps should allow for reflexively returning to an earlier stage if tribal agreement on substance or consensus is not reached. This makes for a more deliberative process, but will likely build trust and buy-in by tribal governments.

Step 1:	Once an issue presents itself, either the federal government or tribal representative initiates a request to begin Tribal Consultation;
Step 2:	To flesh out and to gain an exhaustive understanding of the issue, listening sessions should be held. Notice should go to tribal leaders but expect administrative representatives and subject experts to participate; Some level of agreement should be sought to determine if Consultation is necessary. Tribes should play the key role in making this determination;
Step 3:	Formal notice of Consultation (no less than 30-day notice) with the Tribal Leaders should occur with the highest-ranking agency official possible. National and Regional Native Organization should be engaged to assist in preparing tribes for a full scope of understanding of the policy issue and possible solutions;
Step 4 & 5:	The full unedited or unfiltered results should be posted along a "notice and comment" approach. This step should allow for tribes to correct, make revisions, or provide addendums to provide a validity check and ensure substantive agreement;
Step 6 & 7:	If substantive disagreement exists, to gain clarity, or if requested by tribes, these steps allow for fuller integration of the tribal perspective(s). If needed, this may necessitate cycling back to Step 1 on the area(s) in need of clarification or consensus.
Step 8:	Policy or *Pareto* Optimum is a state so as to make any one individual or preference criterion better off without making at least one individual or preference criterion worse off. This is an idealized state and may not be reached but true and meaningful Consultation with tribes warrants a process that invites and integrates the very individuals for whom a proposed solution is intended to benefit.

National Indian Health Board

August 25, 2021

The Honorable Rochelle Walensky, MD, MPH
Director
Centers for Disease Control and Prevention
Agency for Toxic Substances and Disease Registry
1600 Clifton Road NE
Atlanta, GA 30329–4027

Re: CDC/ATSDR Tribal Consultation Policy

Dear Dr. Walensky:

On behalf of the National Indian Health Board (NIHB),[1] we are responding to your call for Tribal Consultation regarding the Centers for Disease Control and Prevention (CDC)/Agency for Toxic Substances and Disease Registry (ATSDR) Tribal consultation policy. We applaud CDC/ATSDR for taking this step towards reaffirming and strengthening the Government-to-Government relationship that exists between Tribal Nations and the Federal Government. CDC/ATSDR has a central role in fulfilling the United States' federal Indian trust responsibility. Therefore, the agency must have a policy that ensures that Tribal Consultation is meaningful, thorough, and consistent with the other operating divisions throughout HHS.

CDC/ATSDR must update their Tribal Consultation policy to increase accountability, acknowledge and honor the Tribe's right to call for Tribal Consultation, and provide meaningful engagement in policies that impact American Indian and Alaska Native (AI/AN) Nations during the policy development process. First, Tribal leaders need to know that the agency is hearing them and that their recommendations are accepted and implemented to the greatest extent possible. To that end, we want to ensure that the agency respects the government-to-government relationship. The current consultation policy does not provide a mechanism for Tribal leaders to verify whether the agency considered their feedback, making it difficult to hold the agency accountable for the consultation results. **We ask that, at minimum, the CDC/ATSDR issue a Dear Tribal Leader Letter (DTLL) 30 days after every consultation that outlines what participants discussed, enumerates Tribal recommendations and requests, and reports what the federal government is doing with that information and input.** We also urge CDC/ATSDR to facilitate accountability with other agencies, particularly when the actions of those agencies impact its policies. Meaningful consultation is similarly compromised when the agency fails to give Tribal leaders adequate time

[1] Established in 1972, the National Indian Health Board (NIHB) is an inter-Tribal organization that advocates on behalf of Tribal governments to provide quality health care to all American Indians and Alaska Natives (AI/ANs). A Board of Directors, consisting of a representative from each of the twelve Indian Health Service (IHS) Areas, governs NIHB. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas with no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. NIHB advocates for all tribes, whether they operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continues to rely on IHS for delivery of some, or most, of their health care.

to prepare. Additionally, the agency is not providing support to the organizations that Tribal leaders rely on for technical assistance with consultation preparation and participation.[2] Due to the COVID-19 pandemic, many agencies have recently come to rely on rapid consultations, which Tribal leaders do not find helpful as a regular course of action. **For meaningful consultation to occur, Tribal leaders must have adequate time to prepare.**

Tribal leaders look forward to working with CDC/ATSDR in ways that respect and affirm their Tribal sovereignty. We believe that the steps outlined in this letter will be beneficial as CDC/ATSDR is considering ways to make their consultation policy more responsive to the government-to-government relationship.

CDC/ATSDR and the Federal Trust Responsibility

Beginning with first contact and ending with the decision by the United States to cease Tribal treaty making in 1871, the United States and its predecessor European sovereigns and sovereign Tribal Nations signed over 350 Treaties requiring the federal government to assume specific, enduring, and legally enforceable fiduciary obligations to the Tribes. The terms codified in those Treaties – including for provisions of quality and comprehensive health resources and services – have been reaffirmed by the United States Constitution, Supreme Court decisions, federal legislation and regulations, and even presidential executive orders. These federal promises – which exist in perpetuity - collectively form the basis for what we now refer to as the federal trust responsibility. During permanent reauthorization of the Indian Health Care Improvement Act, Congress declared that "*…it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians . . . to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy*."[3]

This trust responsibility, was highlighted recently in the Department of Health and Human Services (HHS) Strategic Plan FY 2018–2022:

> Importantly, the Federal Government has a unique legal and political government to- government relationship with Tribal governments and a special obligation to provide services for American Indians and Alaska Natives based on these individuals' relationship to Tribal governments.[4]

The trust responsibility establishes a clear relationship between Tribes and the federal government.

This responsibility must inform the federal government's work with Tribal nations and Tribal people. **Tribal consultation is the primary means of respecting and being a necessary part of that relationship.** The executive branch affirmed Tribal Consultation by Executive Order in 2000 and through Presidential Memoranda in 1994, 2004, 2009, and most recently by President Biden in 2021.

CDC/ATSDR is one of the federal entities charged with addressing health disparities among AI/AN Tribal Nations and Peoples. However, every branch and agency of the federal government

[2] *See* discussion *infra* "Tribal Technical Assistance"
[3] 25 U.S.C. § 1602
[4] Introduction, "Cross-Agency Collaborations", https://www.hhs.gov/about/strategic-plan/introduction/index.html

must honor and uphold the trust obligations for health and public health to sovereign Tribal Nations and Peoples. These trust obligations are owed to AI/AN people and do not have an expiration date.

AI/AN health outcomes have either remained stagnant or become worse in recent years as Tribal communities continue to encounter higher poverty rates, lower rates of healthcare coverage, and less socioeconomic mobility than the general population. As the US Civil Rights Commission addresses so effectively in Chapter 2 of its 2018 Broken Promises Report, Tribal communities are at substantial health risk since the efforts of the federal government to uphold its trust responsibility for Tribal health care have been so ineffective.[5] On average, AI/ANs born today have a life expectancy of 5.5 years less than the national average, with some Tribal communities experiencing even lower life expectancy.[6] For example, in South Dakota in 2014, whites' median age at death was 81, compared to 58 for American Indians.[7]

According to the CDC, in 2019 AI/ANs had the second highest age-adjusted mortality rate of any population of 767.3 deaths per 100,000 people.[8] In addition, AI/ANs have the highest uninsured rates for adults aged 18-64 (32.9%) and children under the age of 18 (16.7%)[9]; higher rates of infant mortality (2.7 times the rate for whites)[10]; higher prevalence of diabetes (2.3 times the rate for whites)[11]; and significantly higher rates of suicide deaths (20% higher than non-Hispanic white)[12]. AI/ANs also have the highest Hepatitis C mortality rates nationwide[13], and the highest rates of type II diabetes, chronic liver disease, and cirrhosis deaths.

The core of the federal trust responsibility to Tribal Nations is that the federal government is supposed to ensure the health and welfare of AI/AN peoples. The COVID-19 pandemic has given the federal government an opportunity to uphold its obligation in a way that is perhaps unparalleled in modern American history. However, systemic barriers are increasingly impeding Tribes' ability to receive help from the federal government—slowing or even outright denying access to aid.[14]

As sovereign governments, Tribal Nations have the same inherent responsibilities as state and territorial governments to protect and promote the public's health. Tribes were left behind by the federal government during the nation's development of its public health infrastructure and systems continue to be chronically underfunded. As a result, the capacity of many Tribal public health

[5] U.S. Commission on Civil Rights, *Broken Promises: Continuing Federal Funding Shortfall for Native Americans* (2018), https://www.usccr.gov/pubs/2018/12-20-Broken-Promises.pdf.
[6] Id., 65.
[7] South Dakota Department of Health. *Mortality Overview*. Retrieved from https://doh.sd.gov/Statistics/2012Vital/Mortality.pdf
[8] CDC National Center for Health Statistics. Underlying Cause of Death 1999-2019 on CDC WONDER Online Database, released 2021.
[9] National Center for Health Statistics. *Percentage of angina for adults aged 18 and over, United States, 2019*. National Health Interview Survey. Generated interactively: Aug 12 2021 from https://wwwn.cdc.gov/NHISDataQueryTool/SHS_2019_ADULT3/index.html
[10] CDC 2020. *Infant Mortality Statistics from the 2018 Period Linked Birth/Infant Death Data Set*. National Vital Statistics Reports. Table 2. https://www.cdc.gov/nchs/data/nvsr/nvsr69/NVSR-69-7-508.pdf
[11] CDC 2021. *Summary Health Statistics: National Health Interview Survey: 2018*. Table A-4a. http://www.cdc.gov/nchs/nhis/shs/tables.htm
[12] CDC 2021. National Vital Statistics Report, Vol. 69, No. 13. Table 10. https://www.cdc.gov/nchs/data/nvsr/nvsr69/nvsr69-13-508.pdf
[13] CDC 2020. *Viral Hepatitis Surveillance — United States, 2018*. Table 3.7. https://www.cdc.gov/hepatitis/statistics/2018surveillance/pdfs/2018HepSurveillanceRpt.pdf
[14] CDC 2021. *National Vital Statistics Report*, Vol. 69, No. 13. Table 10.

systems remains far behind most state, territorial, city, and county public health entities. Many Tribal public health systems lack core services, such as disease surveillance and reporting, emergency preparedness and response, public health law and policy development, and public health service delivery. To address the chronic health disparities and lower life expectancy of AI/AN peoples, HHS must commit the resources, and CDC/ATSDR must continue its meaningful and sustainable direct investments into Tribal communities for public health.

The agency must keep these striking health disparities in mind when considering the CDC/ATSDR Tribal Consultation Policy. This policy can strengthen the government-to-government relationship and help facilitate meaningful progress towards the goal of eliminating AI/AN health disparities.

Strengthening the Government-to-Government Relationship

Tribal Consultation is considered a necessary part of the federal trust responsibility. As President Biden stated in Section 1 of the Presidential Memorandum on Tribal Consultation, "*[m]y Administration is committed to honoring Tribal sovereignty and including Tribal voices in policy deliberation that affects Tribal communities. The Federal Government has much to learn from Tribal Nations, and effective communication is fundamental to a constructive relationship*."[15] He also called on agencies to engage in "***regular, meaningful, and robust consultation with Tribal officials in the development of Federal policies that have Tribal implications***."[16]

Tribal leaders seek to improve the government-to-government relationship between Tribal Nations and the federal government. While we recognize that federal agencies regularly conduct consultation, we reject the notion that the consultation requirements are achieved by merely scheduling a time and sending personnel to hear concerns. Proper consultation and government-to-government engagement exceeds that limited scope. The engagement must allow for the heads of governments to come together, share concerns, generate ideas and solutions, negotiate their roles and responsibilities, and agree on a course of action. Consultation policy requires recognizing a Tribal Chairperson to be first to speak among Tribal representatives – yet no parallel construct exists for the federal government. That needs to change. Comparable heads of State from the federal government must meet with heads of State from Tribal governments.

Moreover, we recommend that HHS recognize a uniform definition of "Tribal Consultation" to be used through the Department. The absence of such a uniform definition creates confusion throughout the various HHS departments, such as CDC/ATSDR, and the Tribes. Additionally, Tribal consultation as a tool for intergovernmental relations must include the principles of free, prior, and informed ***consent (FPIC)*** if it is to be meaningful, respectful, and ultimately successful. Therefore, the uniform definition should incorporate the principles of FPIC that is consistent with the **United Nations Declaration of the Rights of Indigenous Peoples (UNDRIP) that was affirmed by the United States.[17]**

[15] *See* "Memorandum on Tribal Consultation and Strengthening Nation-to-Nation Relationships," https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/26/memorandum-on-tribal-consultation-and-strengthening-nation-to-nation-relationships/, January 26, 2021.
[16] Id.
[17] https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html

The CDC/ATSDR plays a critical role in how the United States government honors its trust and treaty obligations. The government has tasked the agency to help eliminate the many health disparities faced by Tribal nations and ensure access to essential health and public health services. The CDC/ATSDR is a direct representative of the United States government, and it provides critical funding and services to AI/AN people in furtherance of the trust responsibility. **The CDC/ATSDR must be mindful of this relationship, and the agency should ensure that respect for the sovereignty of Tribal Nations frames every interaction.** CDC/ATSDR cannot be effective if the concerns of Tribal leaders do not inform their policies.

Improving Accountability

Tribal leaders require accountability from all agencies tasked with addressing the health disparities plaguing Tribal communities. **The agency and its Tribal Consultation Policy must assure Tribal leaders that any federal action that impacts Tribes or may impact how Tribes govern their citizens are subject to consultation.** These actions include, but are not limited to program development, promulgated rulemaking, executive or administrative policy directions, budget formulation, or any other efforts by the agency that has the potential to impact Tribes or Tribal citizens. We acknowledge that quantifying "when" the agency should initiate engagement can be complicated. However, just as federal "notice and comment" has been established for most federal government actions, so too should the opportunity be afforded for Tribal leaders to weigh in and effectuate outcomes that impact their governments.

CDC/ATSDR Tribal Consultation policy should make it clear to Tribal leaders that they have a right to ask for consultation whenever they desire. The policy should prescribe a method of contacting the agency and any timelines for a response from the agency. Providing Tribal leaders with prescribed steps on initiating a Tribal consultation and making that clear in their policy will go a long way towards facilitating accountability.

Tribal leaders require affirmative actions demonstrating that their concerns are being heard, considered, and adopted. We acknowledge that Sections 3(G) and 3(E) of the CDC/ATSDR Tribal Consultation Policy provides “Performance Measures and Accountability” and “Evaluation and Reporting” guidance. However, these sections lack any actual substance and only point to the corresponding section of the HHS Tribal Consultation Policy. The current policy does not go far enough in mandating a thorough review of the consultations with Tribal leaders and does not provide a mechanism for Tribal leaders to track how the agency uses their recommendations. To facilitate accountability, CDC/ATSDR should, at minimum, issue a DTLL after every Tribal consultation that details what participants discussed, what Tribal leaders requested, and follow-up actions in response to those suggestions.

Other mechanisms should be explored and utilized that will allow improved communication and accountability in addition to a follow-up letter. For example, having federal agency partners report out in every meeting about prior recommendations could increase accountability and improve transparency. Similarly, the agency should provide a written report of all consultation and CDC/ATSDR Tribal Advisory Committee (TAC) activity to the CDC TAC, CDC/ATSDR Director, Secretary of HHS, and the Secretary's Tribal Advisory Committee. This report should also be published on the CDC website and distributed via a DTLL.

Further, **the Tribal Consultation Policy should require that CDC/ATSDR address why the agency did not implement certain suggestions**. In any follow-up mechanism used, the agency must include a way for Tribal leaders to inquire further about why their request or proposal was not incorporated or to suggest alternative approaches that may be mutually beneficial. Far too often, Tribal leaders make suggestions but never hear back. Instead, they are left to wonder if their request was received, understood, and considered. This often leads to a decrease in Tribal leader participation. Therefore, we urge the agency to survey Tribal leaders who attend the consultation to see if they were effective and how the agency can improve future Tribal Consultations. Additionally, the agency should track participation to ensure that there is sufficient representation and input. **Meaningful consultation is not possible without meaningful consideration, communication, implementation, and follow-up.**

Informed Tribal Decision Making

We urge CDC/ATSDR to move towards a consultation model that encourages informed Tribal decision-making by giving Tribal leaders ample time to prepare so the consultation can be engaging and meaningful for both sides. Although some situations call for quick decision-making, the agency must still honor the trust responsibility and consult with Tribes. These inherent Tribal rights must stand even during national emergencies. Additionally, rapid consultations should only be used in all but the most urgent situations, such as the case throughout the COVID-19 crisis. A rushed effort does not produce superior results for Indian Country. We believe that such consultations do not give Tribal leaders enough time to research and discuss the issue at hand. The lack of preparation time often results in consultations that feel like they exist to allow CDC/ATSDR to "check a box" and not learn about Indian Country's concerns. Tribal leaders are leaders of sovereign nations; therefore, the agency should not expect them to be ready for a consultation on short notice. While one might argue that a rapid consultation meets a minimum technical threshold to be called a "Tribal Consultation," such meetings do not allow for informed and meaningful discussions with Indian Country.

Further, we urge CDC/ATSDR to adopt a uniform notice requirement that ensures that every federally recognized Tribe can participate in Tribal consultations. It often takes time for notice of these meetings to arrive at the desk of Tribal leaders, who the agency then expects to turn their attention towards getting ready for the meeting with little time to prepare. Tribal leaders should have some degree of predictability regarding Tribal consultations to operationalize preparation and have a mechanism to ensure that they have ample time to prepare. We are also concerned that Tribal leaders may not receive the invitation on time and cannot attend or have time to prepare. Tribal leaders are leaders of sovereign nations and often have competing priorities. It is unrealistic to expect them to be ready on short notice. **We urge the agency to adopt a policy requiring at least a 30-day notice for consultation, with limited exceptions for emergency items.** There is currently no prescribed timeline in the policy. We believe that a uniform requirement will allow for a degree of predictability and adequate time for Tribal leaders to prepare.

On Thursday, August 5, 2021, CDC/ATSDR held a formal Tribal Consultation on the agency's Tribal Consultation Policy. **To our knowledge, there was no DTLL issued for this consultation**

and notice only appeared in the Federal Register on July 2nd, 2021. This is unacceptable and is a failure by the agency to provide adequate, informed, and timely notice to Tribal leaders. Unfortunately, this is not the first time the agency has failed to provide proper notice. Currently, there are no requirements in the agency's Tribal Consolation Policy around *how* the agency should communicate Tribal consultations to Tribal leaders. The policy states that the "CDC will initiate consultation regarding the event through communication methods as outlined in the HHS Tribal Consultation Policy." Section 8(A) of the HHS Department Policy on Tribal Consultation merely provides an open list of communication methods. There needs to be a uniform means of reaching Tribal leaders. **We urge the agency to, at minimum, adopt a uniform requirement to send a DTLL for every consultation and mandate that the letter include any pertinent information (such as a Federal Register notice).**

The agency must also expand the methods through which Tribal leaders can participate in Tribal consultations. As we learned during the COVID-19 pandemic, it is possible for the agency to conduct Tribal Consultations remotely and for Tribal leaders to be engaged in that format. While the agency should resume in-person consultations, they must continue to ensure that Tribal leaders can participate remotely. Many Tribes are small and do not have the resources to pay for travel for their leadership to participate in consultations. The ability to participate remotely expands the number of Tribal leaders who can participate, which helps to ensure that the agency is hearing from a broad cross-section of Tribal leaders.

We also urge the agency to consider expanding the usage of listening sessions during these early stages of policy development to hear directly from Tribal leaders. If CDC/ATSDR engages Tribal leaders from the start, it should make for a more fruitful consultation process. The agency should not wait until they have formulated a policy or regulation before asking for feedback from Indian Country.

Tribal Technical Assistance

The CDC/ATSDR Tribal Advisory Committee (TAC) and Tribal technical assistance from National, Regional, and Inter-Tribal organizations can be essential tools in the consultation process. But note, discussions with a TAC are not a substitute for Tribal consultation. TACs should be utilized by CDC/ATSDR when they are formulating policies because TACs are the best conduit through which CDC/ATSDR can receive technical assistance that is Tribally informed and representative of the various regions. CDC/ATSDR currently has a very active advisory committee that the agency can utilize to inform the different policy areas that their programs touch. We urge CDC/ATSDR to begin engaging the TAC early in the policy and regulatory making process so any proposed policies can be Tribally informed from the start, prior to initiating formal consultation. Additionally, we request that the agency support the TAC's desires for the Tribal Public Health Work Group, a vital means for technical assistance and expert guidance for the TAC.

To have meaningful consultation with the CDC/ATSDR TAC, the agency must prioritize completing the CDC/ATSDR TAC charter revision process and prioritize the TAC's input on all changes to the charter. **We support the TAC's request that the CDC/ATSDR responds to the proposed charter edits by October 15, 2021.** We also ask that any revisions or edits

CDC/ATSDR makes be marked and that the agency provide detailed explanations for any changes they rejected.

We recognize that only the primary TAC delegates can speak during official TAC meetings to maintain compliance with the statutory exemption to the Federal Advisory Committee Management Final Rule (FACA) found in the Unfunded Mandates Reform Act (UMRA). During the meetings, the TAC member must yield their seat to allow authorized representatives, technical advisors, or guests to talk. This requirement is contrary to traditional Tribal ways and customs, which allow for interactions where everyone involved can contribute equally to the discussion. We encourage the CDC/ATSDR to consider how these restrictions impact the quality of conversations. We implore the agency to explore meeting formats that conform with the UMRA while allowing for the least burden and inconvenience.

We also have concerns about support for technical assistance for Tribal leaders from Tribal organizations. Tribal organizations, such as NIHB, are routinely consulted by Tribal leaders in preparation for TAC meetings and Tribal consultations. However, there is little support for this work. **We urge CDC/ATSDR to support the work of Tribal organizations, who are vital in ensuring that Tribal leaders have access to the subject matter expertise that helps them prepare to offer meaningful feedback to the agency.** We believe that this technical assistance is vital to full and meaningful consultation.

Conclusion

Thank you for your attention to the Biden Administration Memo and efforts to address its Tribal consultation policy. Rededication to government-to-government relationship presents an opportunity to improve the processes that maintain and strengthen these sacred relationships. Given the status of Tribes as pre-existing sovereigns and their unique position in the American legal framework, Tribal consultation must be robust and meaningful. There must be accountability from CDC/ATSDR. Thank you again for taking this first step, and we look forward to an ongoing dialogue on how to make Tribal consultation more respectful and responsive to the needs of Tribes.

Sincerely,

Stacy A. Bohlen
CEO
National Indian Health Board

Oneida Nation
Oneida Business Committee
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September 1, 2021

Sent electronically to Tribalsupport@cdc.gov

Capt. Karen Hearod, MSW, LCSW
Office of Tribal Affairs and Strategic Alliances
Center for State, Tribal, Local, and Territorial Support
Centers for Disease Control
1600 Clifton Road NE, Mailstop V18-4
Atlanta, GA 30329-4027

RE: CDC/ATSDR Tribal Consultation Session

Dear Capt. Hearod,

On behalf of the Oneida Nation (the "Nation"), I submit the following comments for the 2021 CDC/ATSDR Tribal Consultation. I thank the CDC for providing Councilwoman Jennifer Webster an opportunity to provide testimony on behalf of the Nation during the virtual consultation Below you will find some information about our Nation and our full written testimony.

ONEIDA NATION BACKGROUND

The Nation is a Title V Self-Governance Tribe with approximately 17,359 citizens. Our reservation was established in 1838 and covers nearly 65,400 acres located within the boundaries of Brown and Outagamie Counties in Northeast Wisconsin. About 7,832 enrolled members live within the two counties, 57% of which live on Oneida Reservation land. We have 2,130 or 12.3% of enrolled members that reside within Southeast Wisconsin.

The governing body of our Nation is the General Tribal Council who elect and authorize the Oneida Business Committee to oversee Tribal operations. The Oneida Business Committee consists of a Chairperson, Vice Chairperson, Secretary, Treasurer, and five council members, each elected to concurrent three-year terms.

The purpose of our inherent right to self-governance is to protect the health, safety, and welfare of our members while protecting our culture, revitalizing our language, and restoring the environment to improve the quality of life for the community.

We are committed to maintaining our language and culture. The rich traditions, culture and language are incorporated into the very fabric of the Nation. For nearly 200 years, we have lived

in Wisconsin. We have built a community that is proud and dedicated to a good mind, a good heart, and a strong fire.

The Nation is located within the Bemidji Area and we have had a Compact and Funding Agreement with the US Department of Health and Human Services since 1997. Our Comprehensive Health Division serves over 14,000 patients and supplies a number of services including, but not limited to, ambulatory medical services, family health services, mental health, substance abuse, internal medicine, laboratory services, nurse services (population based), purchased/referred care, respiratory services, telehealth and tele behavioral health services, medicine services, community health representatives, public health nursing, long term care services, pharmaceutical services, public health, and more.

FUNDING

As you know, the IHS and tribal healthcare systems are chronically underfunded. We appreciate the recent one-time investments through CARES Act & the American Rescue Plan Act. Now more than ever, it is important that tribal nations receive funding as quickly and efficiently as possible to adequately respond to the pandemic. With this in mind, the Nation makes the following recommendations regarding funding:

Grants vs. Formula-Based Funding

The Nation believes that the CDC should move away from grants and competitive funding and move to a recurring formula-based funding. As of this week, there 1,101 funding opportunities listed on Grants.gov website that are open to tribal governments. No tribe can apply for and administer all of these grants.

The Nation believes Indian Self Determination Education Assistance Act (ISDEAA) Self-Governance agreements should be used to disburse CDC funding to Tribal Nations. This will allow Tribes to develop long-term plans to meet the needs of their communities rather than spend valuable time and resources on applying for, administering, and reporting on grants. The CDC should develop program formulas in consultation with Tribal Nations and identify all sources of funding that Tribal Nations are eligible for to remove the bureaucracy and streamline the process for distributing funds to the intended recipient.

Limit Reporting Requirements & Maximize Flexibility

CDC should also streamline reporting requirements and maximize funding flexibility for tribes. While the Nation is appreciative of new funding opportunities provided by Congress and CDC, the process to apply for, track and manage funding streams from multiple HHS agencies is burdensome. This is especially true during the COVID-19 pandemic, when many tribes have been forced to place support staff on furlough or layoff status.

Even non-competitive funding opportunities, such as Supporting Tribal Public Health Capacity in Coronavirus Preparedness and Response grant (RFA-OT20-2004), required significant staff time to prepare. Furthermore, as circumstances and needs changed over the course of the pandemic, we had to submit budget modifications and requests for extensions in order to best utilize the funds, taking even more staff time away from other duties. Compare this to funding provided through the IHS, which allows maximum flexibility.

Inter-Agency Transfers to IHS

It is the responsibility of HHS to ensure that federal funds, such as CARES Act and American Rescue Plan Act funds, reach tribes quickly and efficiently. For future funding, the Nation encourages CDC to streamline the process by negotiating inter-agency transfers with the IHS for distribution of funds to tribes through IHS Self Governance funding agreements.

Agencies like CDC have limited experience working with tribes in comparison to the established relationship with the IHS. The IHS has over 26 years of experience working with tribes and has long established mechanisms in place to ensure funds get out to the tribes in an effective manner. Distributing HHS funds through existing IHS funding agreements is the most efficient way to deliver these needed resources to tribes with the least administrative burden.

TRIBAL CONSULTATION & COMMUNICATION

With the COVID crisis and new variant, it is critical that CDC engages tribes and maintains a strong relationship in order to work toward addressing this significant public health challenge. The CDC's track record on working with tribes demonstrates a need for improvement. As quoted in a recent journal publication: "TAC members have raised concerns with how CDC engages the tribes, and requested process improvements, such as the need to provide input earlier in project formulation and the need to reach out to all tribes for feedback." *(Clelland article 2021 – former Director of Office of Tribal Affairs and Strategic Alliances, Center for State, Tribal, Local, and Territorial Support)*

Communication Methods

We request that Dear Tribal Leader Letters be sent out rather than announcements through the Federal Register for tribal consultation and funding opportunities. We recommend that you reach out to IHS staff and HHS IEA Tribal Affairs staff for examples of best practices for sharing Dear Tribal Leader Letters and announcements so that they reach a wide audience. We also recommend you share your announcements with tribal organizations like NIHB, the Self-Governance Communication and Education Tribal Consortium, and others who can spread the word to tribal leaders. These federal agencies and tribal organizations have existing email lists that may be helpful. In addition, after consultations are held, it is imperative that the CDC send up a follow up Dear Tribal Leader Letter to the tribes, tribal organizations, including urban health programs, summarizing the findings of the consultation, what responses were received, what responses were

implemented and not implemented and the justification as to why or why not those suggestions were implemented.

Tribal Consultation

In order to ensure that the CDC honors tribal sovereignty, government-to-government relationships, and fulfills its trust responsibility, we recommend that the CDC:

- Establish staff-level and leadership-level relationships with Tribes. Relationships between Federal and Tribal officials can provide a foundation for effective communication and a meaningful understanding of a Tribe's concerns.
- "Substantial Direct Effects" should trigger consultation. Tribes should have the opportunity to say whether an action requires consultation and agencies should be aware that Tribes may be affected not just by on-reservation actions, but also by funding and personnel decisions related to Federal Indian programs and off-reservation actions.
- "Consultation" must be a two-way dialogue and opportunity for joint decision-making on a nation-to-nation level that is more than a procedural or "check the box" exercise.

Information-Sharing

The Nation requests the following information:

- A report on the status of the tracker of tribal leader requests and how CDC has responded. We would like this to be presented to the TAC and have a report sent to the STAC.
- We request that CDC create a crosswalk table that shows budget allocations and processes:
    - Table with CDC appropriation and line item;
    - How much has gone to tribes and if states were expected to work with tribes for distribution;
    - How does internal allocation align with tribal priorities and requests through consultation, including details such as when did tribal leaders provided consultation on the issue/project/program;
    - Which mechanism (formula, co-operative agreement, contract - given that tribes have requested formula funding);
    - Programming, evaluation, and research;
    - Topic area of funding such as COVID, opioids, diabetes, childhood adversity;
    - How and who made the decisions;
    - Include 3 most recent years and upcoming fiscal year.
- What are the plans for tribal spending for upcoming FY?
    - For FY 2022 Budget how much will go to tribes, TECs, and other tribal evaluation, research, and programming?
    - Do funding opportunities include tribal set asides, particularly for opioid and community violence programs?
- Request opportunity to consult on recent activities and have Dear Tribal Leader Letters go out
- CDC's Center for State, Tribal, Local, and Territorial Support (CSTLTS) has awarded funding $2.25 billion to public health agencies. How much of this funding was provided to tribal public health agencies?

- $800 million was appropriated for data modernization. Need for consultation and how this impacts public health infrastructure for tribes and TECs.

CONCLUSION

Please accept these comments with our sincere request to work together with the Centers for Disease Control in the spirit of partnership and shared interest. I thank you for this opportunity to provide comments and recommendations and look forward to the CDC's consideration of our recommendations. Please contact Candice E. Skenandore, Self-Governance Coordinator, at (920) 615-9702 or cskena10@oneidanation.org if you have any questions or to discuss the comments.

Sincerely,

Tehassi tasi Hill,
Oneida Nation Chairman

NPAIHB

Member Tribes of the Northwest Portland Area Indian Health Board:

Burns Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
Colville Tribe
Coos, Siuslaw & Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Klallam Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshoni Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

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SUBMITTED VIA: tribalsupport@cdc.gov

September 7, 2021

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

RE: NPAIHB Testimony – CDC/ATSDR Tribal Consultation Policy

Dear Dr. Montero:

On behalf of the Northwest Portland Area Indian Health Board (NPAIHB), we submit testimony on the Centers for Disease Control and Prevention (CDC)/Agency for Toxic Substances and Disease Registry (ATSDR) Tribal Consultation Policy pursuant to 86 Fed. Reg. 35298 (July 2, 2021). Established in 1972, NPAIHB is a tribal organization under the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638, advocating on behalf of the 43 federally recognized Indian Tribes in Idaho, Oregon, and Washington on specific healthcare issues. NPAIHB operates a variety of important health programs on behalf of its member tribes, including the Northwest Tribal Epidemiology Center.

On August 5, 2021, the Office of Tribal Affairs and Strategic Alliances (OTASA) within the Center for State, Tribal, Local, and Territorial Support convened for the Tribal Consultation to receive input and guidance on improving the current CDC/ATSDR Tribal Consultation Policy in partnership with American Indian and Alaska Native (AI/AN) Nations, including those represented in the Portland Area. On behalf of Northwest Tribes, we share our gratitude to you, Captain Hearod, CDC OTASA staff and others who supported this consultation.

We also appreciate the opportunity to provide our written testimony to the CDC/ATSDR on the Tribal Consultation Policy.

I. NPAIHB's Recommendations

1. Objectives Section

We recommend that CDC/ATSDR add an objectives section with the following language:

The objectives of the CDC/ATSDR Tribal Consultation Policy are to:

- Honor self-governance and self-determination of Indian Tribes.
- Ensure consultation with Indian Tribes on proposed, new, and existing policies, programs, research activities/projects, and research and funding priorities that impact Indian Tribes;
- Establish a minimum set of requirements and expectations with respect to consultation and participation of CDC leadership;
- Identify critical events for which Tribal consultation and participation will be required for the CDC and its Institutes and Centers;
- Establish improved communication channels with Indian Tribes and Indian organizations, and the Tribal Advisory Committee (TAC) to increase knowledge and understanding of CDC programs, funding opportunities, and priorities;
- Ensure compilation of comments and recommendations raised during regional consultations for the TAC to review and consider;
- Coordinate with the Indian Health Service and other HHS divisions on issues of mutual concern; and
- Charge and hold responsible all levels of management within CDC and its Institutes and Centers for implementation of this policy.

2. <u>Tribal Consultation Process (Section 3D)</u>

CDC only announced this consultation on the CDC/ATSDR Tribal Consultation Policy through the Federal Register (FR) and not through a Dear Tribal Leader Letter (DTLL). Most tribes do not regularly check the FR so notice is often delayed to Tribal Nations when a DTLL is not circulated. The current CDC/ATSDR Tribal Consultation Policy, Section 3(D), states that "CDC will adhere to the consultation process as outlined in Section 8 of the HHS Tribal Consultation Policy." The HHS Tribal Consultation Policy, Section 8(A)(1), states that HHS frequently uses a DTLL format to notify Indian Tribes of consultation activities and that Divisions work with the Principal Advisor for Tribal Affairs, IOS/IEA, for technical assistance on the proper format and protocols. We do not know if CDC worked with Tribal Affairs on this consultation. In addition, Section 8(A)(2), states that the consultation shall be communicated to affected Tribes "using all appropriate methods including, mailing, broadcast e-mail, FR, and other outlets." It further notes that the FR is the most formal type of notice.

We request that the CDC/ATSDR Tribal Consultation Policy incorporate Section 8 from the HHS Tribal Consultation Policy into the CDC/ATSDR Tribal Consultation Policy, and that these additional requests be included:

- **Any tribal consultation official notification always include a DTLL, not just the FR, that is widely broadcast to the TAC listserv and any other tribal listserv CDC maintains.**

- **Any Areas who are not represented on the TAC at the time of notification be included in any outreach made via Area officials, Tribal Leaders, Tribal Nation officials, Area Health Boards, and Regional and National Tribal Organizations.**
- **All copies of DTLLs should be posted on the CDC Tribal webpage, and any CDC associated social media streams.**
- **CDC/ATSDR will work with Principal Advisor, Tribal Affairs, IOS/IEA, on any consultation notice to ensure broad dissemination.**

3. **Section 3E – Evaluation and Reporting**

Section 3E of the CDC/ATSDR Tribal Consultation Policy states that CDC will measure the level of satisfaction of Indian Tribes on an annual basis as outlined in Sections 12 and 13 of the HHS Tribal Consultation Policy.

We request that CDC/ATSDR:

- **Comply with the requirements of sections 12 and 13 of the HHS Tribal Consultation Policy.**
- **Include language that requires CDC/ATSDR to provide Tribes with copies of all reports and evaluations of consultation activities so that Tribes can provide more informed feedback on consultation activities.**

II. Review of Proposed Changes to Policy

We request that CDC convene a workgroup of the TAC charged with reviewing comments and recommendations to the Policy and to prepare a draft CDC consultation policy to be presented to the Tribes through consultation. Any revisions to HHS and IHS tribal consultation policies should be included in the CDC policy to ensure that all agencies are using consistent tribal consultative practices.

III. Conclusion

We reiterate to CDC/ATSDR and all Centers, Institutes, and Offices (CIOs) to utilize all pathways to announce consultation and ensure widespread awareness of and engagement by Tribal Leaders; that these also be timely and consistent to be considerate of Tribal Leader's schedules and planning needed to be prepared. We further urge the CDC/ATSDR to implement these requests in consistent and ongoing consultation with Tribal Nations.

We look forward to working with CDC closely to improve the government-to-government relationship and in fulfillment of trust and treaty obligations. Please contact Candice Jimenez, NPAIHB Health Policy Specialist, if you have any questions at 503-926-4179 or via email at cjimenez@npaihb.org.

Sincerely,

Nickolaus D. Lewis
Chair, Northwest Portland Area Indian Health Board
Councilman, Lummi Indian Business Council

cc: Rochelle Walensky, Director, CDC/ATSDR, director@cdc.gov
Captain Karen Hearod, Director, OTASA, CSTLTS, Rqj0@cdc.gov
Jenna Myer, Deputy Director, OTASA, CSTLTS, kuy2@cdc.gov

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Transmitted Electronically
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September 7, 2021

Captain Karen Hearod, MSW, LCSW
Director, Office of Tribal Affairs and Strategic Alliances
Center for State, Tribal, Local, and Territorial Support
Centers for Disease Control and Prevention
160 Clifton Rd. NW, Mailstop V18-4
Atlanta, GA 30329-4027

Dear Director Hearod,

On behalf of the United South and Eastern Tribes Sovereignty Protection Fund (USET SPF), we submit these comments in response to the Tribal consultation held on August 5, 2021 by the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) on strengthening its Tribal Consultation Policy. USET SPF is encouraged that CDC/ATSDR is adhering to President Biden's Memorandum issued on January 26, 2021 to reaffirm the Administration's commitment to uphold and implement the directives of Executive Order 13175, "Consultation and Coordination with Indian Tribal Governments" (E.O. 13175). President Biden's January 26th Memorandum emphasized the Administration's commitment to respect Tribal Nation sovereignty and self-governance, while acknowledging that honoring the federal government's trust and treaty obligations to Tribal Nations is vital due to current crises related to health, the economy, social justice, and climate change. We remain concerned with some of CDC/ASTDR's existing protocols for consultation, communication, and outreach to Tribal Nations, including during the COVID-19 pandemic. USET SPF urges CDC/ATSDR to meaningfully adopt and implement Tribal guidance received during this consultation in fulfillment of trust and treaty obligations, and to generally improve its Tribal consultation practices.

USET SPF is a non-profit, inter-tribal organization advocating on behalf of thirty-three (33) federally recognized Tribal Nations from the Northeastern Woodlands to the Everglades and across the Gulf of Mexico.[1] USET SPF is dedicated to promoting, protecting, and advancing the inherent sovereign rights and authorities of Tribal Nations and in assisting its membership in dealing effectively with public policy issues.

[1] USET SPF member Tribal Nations include: Alabama-Coushatta Tribe of Texas (TX), Aroostook Band of Micmac Indians (ME), Catawba Indian Nation (SC), Cayuga Nation (NY), Chickahominy Indian Tribe (VA), Chickahominy Indian Tribe–Eastern Division (VA), Chitimacha Tribe of Louisiana (LA), Coushatta Tribe of Louisiana (LA), Eastern Band of Cherokee Indians (NC), Houlton Band of Maliseet Indians (ME), Jena Band of Choctaw Indians (LA), Mashantucket Pequot Indian Tribe (CT), Mashpee Wampanoag Tribe (MA), Miccosukee Tribe of Indians of Florida (FL), Mississippi Band of Choctaw Indians (MS), Mohegan Tribe of Indians of Connecticut (CT), Monacan Indian Nation (VA), Nansemond Indian Nation (VA), Narragansett Indian Tribe (RI), Oneida Indian Nation (NY), Pamunkey Indian Tribe (VA), Passamaquoddy Tribe at Indian Township (ME), Passamaquoddy Tribe at Pleasant Point (ME), Penobscot Indian Nation (ME), Poarch Band of Creek Indians (AL), Rappahannock Tribe (VA), Saint Regis Mohawk Tribe (NY), Seminole Tribe of Florida (FL), Seneca Nation of Indians (NY), Shinnecock Indian Nation (NY), Tunica-Biloxi Tribe of Louisiana (LA), Upper Mattaponi Indian Tribe (VA) and the Wampanoag Tribe of Gay Head (Aquinnah) (MA).

USET SPF welcomes the opportunity to provide recommendations on how CDC/ATSDR can improve its consultation and coordination efforts with Tribal Nations. We see the value in the spirit of the January 26th Executive Memorandum, which is to recommit and refocus federal agencies to engaging in meaningful Tribal consultation. However, these actions alone are not sufficient to address systemic failures in the various consultation processes across the federal government. Broadly, the U.S. must work to reform the Tribal consultation process—to "build back better," in a way that truly modernizes our relationship with the federal government. Tribal Nations continue to experience inconsistencies in consultation policies, the violation of consultation policies, and mere notification of federal action as opposed to a solicitation of input. Letters are not consultation. Teleconferences are not consultation. Providing the opportunity for Tribal Nations to offer guidance and then failing to honor that guidance is not consultation.

While each executive department and its agencies must reevaluate its protocols and procedures for Tribal consultation, communication, and engagement, there must be a broader reconciliation across the federal government to provide certainty, consistency, and accountability in this process. The federal government must work to standardize and provide a uniform foundation to its Tribal consultation methods to provide certainty to Tribal Nations and federal officials alike. It is time for a Tribal Nation-defined consultation model, with dual consent as the basis for strong and respectful diplomatic relations between two equally sovereign nations. In the short term, we must move beyond the requirement for Tribal consultation via Executive Order to a strengthened model achieved via statute.

In the long term, we must return to the achievement of Tribal Nation consent for federal action as a recognition of sovereign equality and as set out by the principles of the United Nations Declaration on the Rights of Indigenous Peoples. Our recommendations focus on general principles of how federal departments and agencies must improve their coordination and consultation efforts, as well as specific issues Tribal Nations have encountered with CDC/ATSDR actions and activities.

Evolve Consultation to Consent

The U.S. must move beyond a "check the box" method of consultation and instead work to formalize diplomatic relations with and seek the consent of Tribal Nations individually. This directive is reflected in Article 19 of the U.S.-endorsed United Nations Declaration on the Rights of Indigenous Peoples, which states that nations, "shall consult and cooperate in good faith", with the governmental institutions of our Tribal Nations, "in order to obtain [our] free, prior and informed consent before adopting and implementing legislative or administrative measures that may affect [us]."

Due to the COVID-19 pandemic, virtual and teleconference consultations have had to take the place of in-person, face-to-face, consultations. While this is not a preferred method of consultation, it does offer the federal government another opportunity to engage, communicate, and consult at a Leader-to-Leader level. These methods of consultation provide the federal government with the opportunity to engage and communicate directly with every Tribal Nation.

Standardize and Codify Consultation Requirements

For far too long, Tribal Nations have experienced inconsistencies in consultation policies, the violation of consultation policies, and mere notification of federal action as opposed to a solicitation of input. Letters are not consultation. Teleconferences are not consultation. Providing the opportunity for Tribal Nations to offer guidance and then failing to honor that guidance is not consultation. Accountability is required to ensure Tribal consultation is meaningful and results in corresponding federal efforts to honor Tribal input and mitigate any concerns. All federal agencies, including independent federal agencies and the Office of Management and Budget, must be statutorily required to adhere to consultation policies with additional oversight from the White House and Congress. USET SPF strongly supports the codification of consultation

requirements for all federal agencies and departments, including a right of action to seek judicial review of consultation when the federal government has failed to engage, communicate, and consult appropriately. We further urge the Biden-Harris Administration to use its authority, in consultation with Tribal Nations, to create and implement a standard consultation process for use by all agencies.

Tribal Consultation Should Occur on a Nation-to-Nation, Leader-to-Leader Basis

Although consultation can pertain to very specific programmatic issues requiring technical and subject matter expertise, true consultation should occur at a Leader-to-Leader level. Duly elected or appointed Tribal Leaders must be afforded the respect and opportunity to directly voice Tribal Nation concerns to those federal officials with actual decision-making authority. We must further have the opportunity to include and confer with our respective expert staff during every consultation, just as federal officials do. In addition, because the U.S. is engaged in a diplomatic relationship with each federally recognized Tribal Nation, greater effort must be made to consult with Tribal Nations on an individual basis. Due to the COVID-19 pandemic, virtual and teleconference consultations have had to take the place of in-person, face-to-face, consultations. While this is not a preferred method of consultation, it does offer the federal government another opportunity to engage, communicate, and consult at a Leader-to-Leader level. These methods of consultation provide the federal government with the opportunity to engage and communicate directly with every Tribal Nation.

No Delegation of Federal Consultation Obligations

The trust relationship exists between the federal government and Tribal Nations exclusively. To this point, the federal government must not delegate its consultation obligation to third party entities, which include non-profit organizations, industries/corporations, hired consultants and contractors, non-Tribal archaeologists and anthropologists, and other units of government. When other entities are party to or involved in federal actions, the federal government must exercise appropriate oversight in ensuring Tribal interests are not adversely impacted. Tribal Nations, and not any other entity, are the final arbiters of whether a federal action impacts our governments, homelands, cultures, public health, or sacred sites.

Consultation Should be Early and Ongoing, with Advance Notice and Sufficient Response Timelines

One of the guiding principles of E.O. 13175 is to establish regular, meaningful consultation and collaboration with Tribal Nations in developing and implementing federal policies. However, this principle has been exercised using methods that have not always taken into consideration the direct and in-direct implications for Tribal Nations. Under the current consultation framework, federal departments and agencies often unilaterally conduct their own internal review of proposed policies and actions, which frequently results in a finding of no impact. This fails to recognize and adhere to the federal government's fiduciary trust and treaty obligations to Tribal Nations. Rather, consultation and collaboration must recognize Tribal Nations as equal sovereigns. Tribal Nations must always be engaged at the earliest stages of federal decision-making process. In addition, our authority to initiate consultation in response to federal action (or proposed federal action) must be recognized and honored.

Deference to Tribal Nations

E.O. 13175, Section 3 lays out a set of policymaking criteria that have been implemented unevenly over the last two decades. In particular, this includes directives to extend "maximum administrative discretion" to Tribal Nations by encouraging Tribal Nations to develop our own policies and standards to achieve objectives as well as consult with us on the necessity of any federal standards. USET SPF urges CDC/ATSDR and the Biden Administration to consider how this section can be better operationalized and consistently applied throughout the federal government. In addition, the Indian Canons of Construction should always be applied during Tribal consultation, the policymaking process, and beyond. That is, any ambiguities in law or policy should be interpreted in favor of Tribal Nations.

Flexibility for Tribal Waivers

Similarly, E.O. 13175, Section 6 encourages the federal government to facilitate and streamline Tribal applications for waivers of statutory and regulatory requirements. With some notable exceptions, this section does not appear to be actively implemented across the federal government. CDC/ATSDR and the Biden Administration should also revisit this section and examine what further Executive action is necessary to ensure its widespread operationalization.

Transparency in Decision-making

All too often following Tribal consultation, the federal government renders a decision without further explanation as to how that decision was reached. This is particularly true in the case of "check-the-box" consultation, where Tribal Nations provide input and that guidance is ignored completely. Not only does this run counter to the federal government's consultation obligations, it undermines our Nation-to-Nation relationship. In recognition of and out of respect for our governmental status, as well as in the spirit of transparency, each federal agency should be required to publish a summary of all comments received, how that guidance influenced the agency's decision, and why the decision was reached.

Educate Federal Employees on Tribal Sovereignty and U.S.-Tribal Nation Relations

It is critically important that all employees of federal departments and agencies receive comprehensive training on working with and communicating effectively with Tribal Nations. Federal actions impact Tribal Nations and our citizens. Every right-of-way permit, application for land into trust, and environmental and cultural review document are reviewed by federal employees. However, many of the same federal employees engaging in decision-making that impacts our interests do not fully understand the history of U.S.-Tribal Nation relations and the federal trust obligation. This lack of education and understanding regarding the fiduciary trust and treaty obligations contributes, at least in part, to federal failures to properly consult. USET SPF has long recommended mandatory training on U.S.-Tribal relations and the trust obligation for all federal employees. This training should be designed in consultation with Tribal Nations.

Invest in Diplomacy

CDC/ATSDR must fully recognize and uphold our Nation-to-Nation diplomatic relationship. This directive extends to ensuring both the department and Tribal Nations have access to resources that support diplomatic activities. True diplomacy, as evidenced by activities conducted by the U.S Department of State, would involve U.S. ambassadors appointed to liaise with each federally recognized Tribal Nation on behalf of the federal government, rather than facilitating this relationship through national or regional consultations. While we recognize retooling the consultative relationship to allow for a truly diplomatic relationship involves many steps, funding for these activities is certainly one of them. We encourage CDC/ATSDR to consider how it might include diplomacy in future budget requests. This would include funding for the department to build and sustain diplomatic infrastructure, as well as increased funding for Tribal Nation participation in these processes. CDC/ATSDR budgets should reflect a broad commitment to improvements in our Nation-to-Nation relationship, including its own functions.

CDC/ATSDR Consultation and Communication with Tribal Nations Should be Consistent and Responsive

As Tribal leaders stated during the August 5th consultation session, CDC/ATSDR consistently fails to properly consult with and implement the guidance of Indian Country. For example, it frequently treats the two annual meetings of its Tribal Advisory Committee (TAC) as consultations. While TACs can help inform and are vital parts of the consultation process, they should only supplement—never supplant—consultation.

Another example can be found in CDC's failure to honor Tribal guidance amid the COVID-19 pandemic. During the onset of the pandemic, $40 million was allocated to CDC for Tribal Nation public health activities

under the first COVID-19 relief package. Despite Tribal advocacy, CDC rejected requests to transfer funding through IHS—which would have expedited access for Tribal Nations—instead distributing these funds through non-competitive grant funding for direct service Tribal Nations and Tribal Nations with a ISDEAA Title I or Title V contracts and compacts. This process ultimately led to unacceptable delays in funding and resulted in unequitable distribution to all Tribal Nations seeking funding. CDC must actively seek to prevent this from happening again. In doing so, CDC must work with IHS and Tribal Nations to determine how the agency can ensure all mechanisms for the funds it administers are reflective of the federal trust obligation to Tribal Nations.

As CDC's existing consultation policy states, "it is essential that Indian Tribal governments and CDC engage in open, continuous, and meaningful consultation." This involves soliciting Tribal input from across Indian Country, and then honoring and implementing the guidance that is given during the consultation process. CDC must work to ensure its consultation policy better reflects these directives, including through mechanisms providing for fulfillment of the policy's requirements on the part of the agency.

CDC/ATSDR Should Establish Specific Tribal Consultation Protocols for Data Collection and Sharing in Indian Country

The collection, use, and publication of sensitive data on Indian Country's demographics has long been an issue affecting Tribal Nations and citizens. Prior to the adoption of enhanced privacy and confidentiality protocols, Tribal Nations and citizens were among those communities that were exploited in research through deceptive actions and the unscrupulous sharing of data among other research individuals and entities. While improved privacy and confidentiality protocols have been adopted since then, there still needs to be enhanced protocols developed and adopted that recognizes the sovereignty of Tribal Nations to determine how and if their data is collected, used, and shared with federal partners. We recommend that CDC/ATSDR consult with Tribal Nations to develop defined protocols regarding data collection, retention, and privacy in Indian Country. The objectives identified through these consultations should inform revisions to CDC/ATSDR's Tribal Consultation Policy. Since the beginning of the COVID-19 pandemic Tribal Nations have been subject to increased data sharing measures that involve sensitive data on Tribal government operations and individual citizens. Tribal Nations should be informed as to how their data is being collected and used by CDC/ATSDR as well as empowered to review, authorize, or disallow the sharing of sensitive data with CDC/ATSDR's federal partners.

Similarly, CDC must improve data sharing with Tribal Nations and Tribal Epidemiology Centers (TECs). Last year, the CDC refused to provide access to TECs and Tribal Nations seeking vital public health data regarding the incidence of COVID-19 among our citizens. While state public health agencies report public health data, including data collected from and about Tribal citizens, to the CDC, this is not routinely shared with Tribal Nations and TECs. This data is then shared with the CDC through cooperative agreements. However, Tribal Nations and Tribal Epidemiology Centers (TECs) continue to experience frequent challenges in accessing not just public health data on both the federal and state level, but Tribal data as well, which often is not reported back to the Tribal Nation. This includes vital COVID-19 data. This lack of access to quality public health data has hindered the ability of Indian Country to respond to the public health crisis in our communities due to COVID-19.

Despite being designated as Public Health Authorities, both Tribal Nations and TECs continue to experience frequent challenges in accessing data on both the federal and state level—including vital COVID-19 data—on top of the consistent lack of investment in TECs and Tribal public health capacity. TECs continue to petition both the CDC and state public health departments for this vital information but have only received state data where there are positive Tribal-state relationships and some extremely limited COVID-19 testing data from CDC. While CDC was ultimately given a directive to share data with TECs, this information was of poor quality and further hindered the work of TECs, including USET. In turn,

COVID-19 response at the Tribal level was without an accurate picture of the reach of the disease into our communities.

CDC must ensure that TECs have access to critical public health data from federal and state governments. Both should be statutorily required to share all available public health data with TECs and Tribal Nations. This should be made a requirement of state cooperative agreements with CDC. In addition, CDC must take steps to improve the quality of public health data shared with TECs and Tribal Nations. This includes requiring states to collect race/ethnicity data, as well as working with states and Tribal Nations to correct racial misclassification. Now and after the pandemic, CDC must work with TECs and Tribal Nations on an ongoing basis to ensure quality public health data, including health data related to the COVID-19 pandemic, is provided to TECs and Tribal Nations.

Conclusion

An essential aspect of the federal trust responsibility and obligations to Tribal Nations is the duty to consult on the development of Federal policies and actions that have Tribal implications. This requirement is borne out of the sacred relationship between the federal government and Tribal Nations, as well as numerous treaties, court cases, laws, and executive actions. It is a recognition of our inherent sovereignty and self-determination. For too long, the United States has failed to fully uphold and implement E.O. 13175 and other consultation directives. This has resulted in irreparable damage to Tribal Nation homelands, sacred sites, and interests, as well as costly litigation against the federal government. Recent events, including the COVID-19 crisis, have underscored the urgent need for radical transformation in the recognition of our governmental status and the delivery of federal obligations to our people.

We can no longer accept the status quo of incremental change that continues to maintain a broken system. The federal government must enact policies that uphold our status as sovereign governments, our right to self-determination and self-governance, and honor the federal trust obligation in full. This includes evolving away from the current broken model of Tribal consultation and into a future in which Tribal Nation consent is sought for federal action. We ask that CDC/ATSDR join us in realizing this change and advocate for this change among its partners in the Executive Branch. Should you have any questions or require further information, please contact Ms. Liz Malerba, USET SPF Director of Policy and Legislative Affairs, at LMalerba@usetinc.org or 615-838-5906.

Sincerely,

Chief Kirk Francis
President

Kitcki A. Carroll
Executive Director

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September 7, 2021

VIA ELECTRONIC MAIL ONLY

The Honorable Xavier Becerra
Secretary
United States Department of Health and Human Services
Washington, DC 20201

RE: Centers for Disease Control and Prevention Tribal Consultation Policy

Dear Secretary Becerra,

On behalf of the Winnebago Tribe of Nebraska (the "Tribe"), please find our comments on the Centers for Disease Control and Prevention ("CDC") Tribal Consultation Policy. Thank you for holding consultation and the opportunity to provide input on this matter. We especially appreciate that Dr. Rochelle Walensky participated in your most recent Secretary's Tribal Advisory Committee meeting – the first CDC Director to do so.

Through treaties, the supreme law of the land, the United States made promises to the Winnebago people and other tribes. We have never forgotten those promises and will continue to advocate for our county to keep them. True consultation can achieve real solutions that better the lives of American Indian, Native Hawaiian and Alaska Native people.

I. THE WINNEBAGO TRIBE OF NEBRASKA

The Winnebagos make our home on a reservation along the banks of the Missouri River in Northeastern Nebraska and Northwestern Iowa. We have over 5,000 tribal members and numerous tribal enterprises that employ thousands of employees in a five-county area, Nebraska, Iowa, and around the world. The Tribe formed Ho-Chunk, Inc., the economic development corporation of the Tribe, in 1994. Ho-Chunk, Inc. is now the largest minority-owned company in Nebraska and has received numerous awards for its innovative approaches to tribal economic development. The Tribe owns two gaming operations in Nebraska and one gaming operation in Iowa which provide approximately 40 percent of the Tribal government revenues that are integral to support tribal government operations and programs. These enterprises also provide hundreds of local jobs to both tribal members and non-members alike and are respected and important pillars in our communities.

II. WINNEBAGO COMPREHENSIVE HEALTHCARE SYSTEM

The Tribe established the Winnebago Comprehensive Healthcare System ("WCHS") to carry out health care services on behalf of the Tribe. WCHS is comprised of two divisions: the Winnebago Public Health Department and Twelve Clans Unity Hospital. Prior to the establishment of WCHS, the Health Department was operated as a program within the Tribe and the hospital was managed by the Indian Health Service ("IHS"). The Health Department was originally formed by the Tribe in the late 1970s starting with Public Health Nursing and Community Health Representatives. Since then, it has grown to more than sixteen different programs to provide the vast array of health services now available to the Winnebago community.

In 2015, the Tribe established a Self-Governance Steering Committee to plan and prepare for expanded public health services and eventual assumption of the hospital, formally known as the Omaha-Winnebago Hospital. In 2018, the Tribe completed negotiations with the Indian Health Service and entered into a Tribal Self-Governance Compact pursuant to Title V of the *Indian Self-Determination and Education Assistance Act* to carry out the health programs for the Tribe. On July 1, 2018, the Tribe assumed management of the hospital through WCHS and it was renamed Twelve Clans Unity Hospital in honor of the twelve traditional clans of the Winnebago Tribe.

III. TWELVE CLANS UNITY HOSPITAL

The United States promised the Winnebagos a physician and medical care for our people. We never forget that promise and about fifteen years ago, we planned on assuming the Indian Health Service hospital. But in 2015, when the federal government's operation of the hospital became life threatening, the Winnebago people suffered loss of life and CMS revoked the hospital's Medicare and Medicaid certification. We worked twice as hard to have our own hospital and the Twelve Clans Unity Hospital was born to serve the Winnebago people and surrounding tribes. We took the hospital into our own hands and opened our state-of-the-art hospital in 2018, the first one of its kind in the Great Plains Region.

Our hospital serves an estimated 10,000 Native Americans who live on the Winnebago Reservation and in the surrounding region. Health care services provided by the hospital and the Tribe's Public Health Department include an ambulatory care clinic, inpatient care, express care clinic, pharmacy, radiology, emergency care, medical laboratory, physical therapy, social services, dental, optometry, audiology, and behavioral health. Twelve Clans is in the process of completing CMS certification and is implementing a strategic planning process to ensure the hospital services are designed to meet the needs of the population it serves.

IV. PANDEMIC

For the past year and a half, the COVID-19 pandemic wreaked havoc upon our lives and threatened our very existence. Our government quickly pivoted to operate remotely to protect our tribal members. We shuttered our enterprises to protect our employees. We made decisions to best serve the needs of our people and preserve our resources as the economy declined.

On March 24, 2020, we declared a public health emergency to protect our people and our homelands. On that same day, we created the Winnebago Pandemic Task Force to ensure the health, safety, and welfare of Tribal members during the public health emergency. The Tribe provides critical health resources and operates social services, law enforcement, education and numerous other important services to our Tribal citizens and other community members.

Further, we are responsible for protecting our invaluable workforce who provide these services and protections through our Tribal government and Tribal enterprises. We made the difficult decision to close our government and gaming operations on March 17, 2020. We implemented a curfew on April 15, 2020, and a mandatory face mask policy on April 27, 2020. To date, we have experienced 382 positive cases of COVID-19 and seven tragic losses of life. However, our swift and diligent actions to protect of tribal members and other employees likely saved countless lives.

On December 16, 2020, the Tribe secured its initial allotment of sixty-five (65) doses of Pfizer-BioNTech vaccines from the Indian Health Service. The Tribe sent two healthcare professionals to Eagle Butte, South Dakota, to transport the vaccines to Winnebago. Following a traditional blessing ceremony, we immediately launched our efforts to vaccinate the Winnebago people. The Tribe's health system has since administered more than 5,055 vaccinations and the number continues to increase each week. The Tribe's vaccination rate is 74 percent for those age 12 and older for at least one dose.

This past year, through the Winnebago people's resolve, we were able to do a lot with limited resources. Once, around the globe, we learned how to protect ourselves from the virus and with the coming of lifesaving vaccines, we are fortunate to be able to recoup some of our economic activity. The leadership of our Tribe was tested, as we have been many times, in our history of removal, war, and survival.

The pandemic laid bare what we need to more adequately provide for the Winnebago People. We are committed more than ever to ensuring we have a safe environment, clean water, adequate housing, and energy sovereignty for the resilience and self-sufficiency of the Winnebago People. The pandemic only strengthened us as we had to make and must make the best decisions we can for the future of our people.

V. LITTLE PRIEST TRIBAL COLLEGE

Dozens of tribes have prioritized building their own institutions of higher learning over the last few decades. These schools are hubs of our communities, families, and tribes, to educate

tribal members so they can climb to new heights and create more opportunities for themselves, their families, and the next generations. Tribal colleges and universities are a natural path for those who wish to live in, work in, and serve their tribal communities including corresponding federal programming and services that are built-in to tribal governments.

In 1996, the Tribe opened the doors to the Little Priest Tribal College to fulfill the goal of its namesake, Chief Little Priest, to "Be Strong and Educate my Children." The college prepares students to succeed in a multicultural world by emphasizing quality education of the highest level, humanistic values, and life skills.

The school is accredited by the Higher Learning Commission with an enrollment of 113 – slightly down from 121 due to the pandemic. On average, 10-12 students graduate each year. The college issues the two-year degrees - Associate of Arts (A.A.) and Associate of Science (A.S.). Generally, the classes taken at Little Priest represent the first and second years of study at a four-year institution. The college has agreements with five colleges and universities that allow our students to transfer, with no loss of credit, to a four-year school including the University of Nebraska-Omaha, Briar Cliff University, and Wayne State College.

Like the rest of the country, the COVID-19 pandemic forced Little Priest to find creative solutions to new problems. The college moved to fully online classes on March 16, 2020. Our sports seasons were cancelled. Our students were sent home. We created an internet café off-campus to allow for students without reliable access to internet a place to complete schoolwork while the Little Priest campus was closed.

Little Priest worked closely with the Tribe to address issues brought on by COVID-19. For example, the college and tribal health department worked together to use newly vacant dorms as quarantine housing for COVID-19 positive members of the community. The Tribe used the college's electronic billboard, located on the busiest stretch of road in the community, to display up to date COVID cases, hospital contact information, and now vaccination numbers for the community.

There is no part of society that has been more directly impacted by COVID-19 than education – the pandemic has become a pivot point where some are left behind in a stone age and others are thrust into the future. COVID-19 has forced us to develop remote learning and rely on high-speed internet. It has changed education as we know it and will be a necessity going forward. TCUs need resources to keep up in a post COVID-19 world.

The ultimate goal of the Tribe is to be self-sufficient, and our college plays an important part is reaching that goal. Little Priest provides Winnebago tribal members high quality education and they can use the skills they have gained to improve their quality of life. Several of our tribal leaders have graduated from Little Priest, and Little Priest continues to play a critical part building a brighter future for the Winnebago people and educating future leaders.

VI. CDC Owes a Trust Responsibility to Tribes

CDC needs to factor in and consider longstanding treaty and trust obligations in policy decisions and interactions with Congress. The United States *as a whole* made promises to Indian tribes and signed legally binding treaties, which the founding fathers understood to be the *supreme law of the land*. These promises and obligations of the United State continue to this day and are an obligation of the entire Federal government, not simply one agency or department. This includes all 535 Members of Congress and the President and all federal agencies, including CDC.

VII. CDC Must Uphold Native Political Status

Native Hawaiians, American Indians, Alaska Natives have a political status within the United States. Such status has been upheld by the U.S. Supreme Court in decisions such as *Morton v. Mancari*. CDC must strive to strengthen hiring, consultation and outreach policies to ensure that native populations are being served.

CDC staff should have a working knowledge of treaty and trust obligations and how they impact their program areas and the President's Budget. CDC should include and consider Native Hawaiians, American Indians, and Alaska Natives in all aspects of programming and research.

CDC should have high level staff with expertise in Indian law and policy. CDC's institutional structure should have Indian law and policy built into it.

XIII. CDC has an Obligation to Consult With Tribes

President Joe Biden made it a priority of the Biden-Harris Administration "to make respect for Tribal sovereignty and self-governance, commitment to fulfilling Federal trust and treaty responsibilities to Tribal Nations, and regular, meaningful, and robust consultation with Tribal Nations cornerstones of Federal Indian policy." We welcome this opportunity to work with CDC to ensure that the United States works toward fulfillment of its constitutional, treaty and trust responsibilities to tribes.

Consultation is a two-way street where we expect proper notice, the courtesy of regular communication, either government can initiate consultation, and adequate time to respond. We expect consultation to be conducted for any action or decision that potentially impacts or involves the Tribe. CDC must have an overarching goal of weaving tribal priorities into its fabric, as an institution, and in carrying out its duties. This requires Federal agencies to respect tribes as sovereign nations.

IX. Food Sovereignty

We believe in and are prioritizing our food sovereignty. We are and need to be responsible for exercising and protecting it. CDC must understand the historic, political and

legal bonds for tribes to fully realize self-governance and self-determination in the life of our own food systems. We are innately connected to food by our culture, tradition, land, sovereignty, health, elders and the next generations. It is our very essence.

X. DATA

The collection and use of data are underdeveloped for Indian tribes across the board. CDC should make collection of data relating to American Indians, Native Hawaiians, and Alaska Natives more robust. CDC should include and consider such data in the development of the President's Budget. Treaty and trust obligations to tribes are historical and longstanding and consideration of them should be a mandatory part of the fabric, not a discretionary one.

XI. NATIVES CANNOT BE LEFT BEHIND

CDC should be working hard to ensure that all federal health research includes American Indians, Alaska Natives, and Native Hawaiians. President Biden's directive to executive departments and federal government agencies to develop a comprehensive approach to advancing equity for all will help to better serve and uplift all Americans, especially those who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Few groups have been more historically underserved or marginalized than Indian people. This is especially tragic in light of the fact that treaty and trust obligations to tribal nations are historical and in perpetuity. CDC leadership should always bear this in mind in making policy decisions that touch the lives of Native Americans on a daily basis.

XII. EQUITY AND PARITY

The United States Congress and the Administration ensured that tribes are included in national relief and recovery packages. The Administration is conducting extensive consultation on implementation of these critical programs for our people's public health and our tribe's economic recovery. CDC needs to strive to ensure inclusion of tribal citizens in all research and health equity of tribal citizens across the country.

There needs to be consistency across CDC so tribal leaders know what to expect. CDC needs to provide better opportunities for tribally driven research and funding for data sovereignty. CDC must have a dialogue about how urban Indians are portrayed in data. Racial equity should include tribes driving the federal research agenda. CDC needs to build strong partnerships with tribal colleges and universities.

With our country's history of exploitation of human beings and resources, on one side, and loss of generational wealth, on the other, federal policies must continue to incrementally level the playing fields for tribal health and well-being. The administration's laser focus on addressing these historic disparities would, in turn, strengthen tribal health care and ensure healthier outcomes for all Americans.

XIII. POLICY CONCERNS

1. The CDC consultations must be regular (at a minimum on an annual basis), robust and transparent. 'Dear Tribal Leader' letters are effective and now so are virtual consultations. Outreach and timely notice are key to ensure greater participation and true engagement.

2. The CDC policy ought to strongly align with the overarching consultation policy of the U.S. Department of Health and Human Services and President Biden's executive orders. HHS should monitor CDC to ensure that President Biden's directives for tribal consultation are being carried out.

3. In light of the pandemic, a strong tie between CDC and tribal governments is starkly important to reaching all Americans. CDC needs to devote adequate staff to regularly engage with tribal nations.

4. The policy is a living document not to be placed on a shelf. We hope to experience more respectful two-way communication and thorough follow up to tribal concerns.

5. CDC needs to account for the diversity, ruralness and remoteness of tribal nations to ensure that the public health needs of and treaty and trust obligations to our communities are met.

6. CDC needs to conduct outreach and build relationships with tribal colleges and universities in line with historically black college and universities and Hispanic serving institutions.

7. CDC needs to build on a more respectful exchange that tribes are beginning to experience with it and CDC must become more accustomed to.

Thank you for your time and consideration of our comments. Our deepest thanks to you especially for taking this nation-to-nation responsibility very seriously.

Sincerely,

Victoria Kitcheyan

Victoria Kitcheyan
Chairwoman

Confederated Tribes and Bands
of the Yakama Nation

Established by the
Treaty of June 9, 1855

Sept. 7, 2021

Sent via Email

Rochelle P. Walensky, M.D.,
Center for Disease Control
1600 Clifton Rd.
Atlanta, GA 30329

Re: Comments on Center for Disease Control and Prevention's Consultation Policy

Dear Director Walensky:

I write on behalf of the Confederated Tribes and Bands of the Yakama Nation (the "Yakama Nation") in response to President Biden's Memorandum of January 26, 2021, *Tribal Consultation and Strengthening Nation-to-Nation Relationships*. The Yakama Nation is a sovereign federally-recognized Native Nation pursuant to the Treaty with the Yakamas of June 9, 1855 (the "Treaty").[1] The Yakama Nation is pleased that the new Administration seeks to prioritize respect for tribal sovereignty and self-governance, to fulfill trust and treaty responsibilities, and to provide regular, meaningful, and robust consultation with Native Nations. Outside this comment letter, the Yakama Nation formally requests consultation with the United States Center for Disease Control and Prevention ("CDC") regarding further relationship development and the implementation of its consultation polices. This formal consultation must take place here, in Toppenish, Washington, at the Yakama Nation's governmental headquarters.

The following will set our overarching recommendations for the CDC to enhance its consultation efforts. It is the Yakama Nation's position that the CDC has not always treated concerns about impacts to tribal resources with appropriate care. We strongly encourage the CDC to put in place additional requirements to ensure that policies, rules, and decisions fully consider and address the concerns of Native Nations. At a minimum, these requirements should address what meaningful and robust

[1] Treaty with the Yakamas, U.S.-Yakama Nation, June 9, 1855, 12 Stat. 951.

consultation means, what actions require true consultation, when consultation should occur, and who should be involved in consultation.

I. NATION-TO-NATION RELATIONSHIPS REQUIRE FREE, PRIOR, AND INFORMED CONSENT

The United States endorsed the United Nations' Declaration on the Rights of Indigenous Peoples ("UNDRIP") on December 16, 2010. UNDRIP Article 32 directs nation-states to consult with Native Nations "in order to obtain their free and informed consent prior to the approval of any project affecting their lands or territories and other resources, particularly in connection with the development, utilization or exploitation of mineral, water or other resources." The Yakama Nation stands firm in its position that, given the directives of the Presidential Memorandum and Executive Orders discussed, that the free, prior, and informed consent of tribes must be required for project or agency decisions that would impact our resources. This policy direction would not be pioneering. In fact, the Advisory Council on Historic Preservation ("ACHP") developed a plan to support UNDRIP.[2] We therefore encourage the CDC to follow the ACHP's lead and incorporate the principles of UNDRIP in the CDC's programs.

To elaborate, the principle of free, prior, and informed consent parallels the CDC's objective in promoting and honoring self-determination. Tribes represent "separate sovereigns preexisting the Constitution" with the inherent right to self-determination. *Santa Clara Pueblo v. Martinez*, 436 U.S. 49, 56 (1978). The "United States recognizes the right of Indian tribes to self-government and supports tribal sovereignty and self-determination." Exec. Order No. 13175, 65 Fed. Reg. 67,249 (Nov. 9, 2000). And, UNDRIP Article 3 acknowledges that "Indigenous peoples have the right of self-determination." Accordingly, self-determination is sewn into the fabric of federal caselaw, federal statutes, treaties, UNDRIP, and the CDC's directive to honor tribal self-determination. Federal agencies must therefore both educate themselves and honor these established principles if it hopes to provide true, meaningful consultation.

II. CREATE A GENUINE, MEANINGFUL RELATIONSHIP THROUGH RESPECT

The Yakama Nation proposes three actions and policy directives the CDC must take if it is honest about this endeavor. First, Federal agencies like the CDC, must enter the consultation process not as a mere notification procedure of an Agency action, but with the goal of cooperating with the Yakama Nation and genuinely seeking to reach

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[2] ADVISORY COUNCIL ON HISTORIC PRESERVATION, *United Nations Declaration on the Rights of Indigenous Peoples* (last visited March 15, 2021) https://www.achp.gov/indian-tribes-and-native-hawaiians/united-nations-declaration-rights-indigenous-peoples.

common agreement on the matter at issue. This means the CDC must develop clear processes for documenting the consultation, ensuring protection of culturally sensitive information, complying with Tribal laws or protocols governing consultation, and implementing a certification process at the completion of consultation for both parties to agree that meaningful consultation had occurred. Simply cataloguing tribal concerns does not represent meaningful consultation. Instead, the CDC must communicate clearly to the Yakama Nation how its final decision addressed our input, and where the CDC is unable to fully address the Yakama Nation's concerns, it must clearly explain that reasoning.

Second, consultations should occur throughout the evolution of the project, providing constant and continuous communications between the CDC and the Yakama Nation. Meaningful and robust consultation is a dialogue that requires an unbroken mutual exchange of information, it must include federal agencies sharing internal reports, analyses, deliberations and pre-decisional documents with the Yakama Nation. Agencies should ensure that all information, including the potential impact of the decision, is provided to the Yakama Nation and is presented in a manner and form that is understandable to our communities and is culturally appropriate. Additionally, every department within the CDC must be aware of these responsibilities to meaningfully engage and share information with the Yakama Nation in their decision-making.

Third, the consultation and relationship goals that the CDC seeks can only be achieved thorough a genuine understanding of the culture and history of the Yakama Nation; an understanding that is only achieved by consulting the Yakama Nation here at our governmental headquarters in Toppenish, Washington. Meaningful consultation has not always occurred between the CDC and the Yakama Nation. Federal Agencies, like the CDC, believe "meaningful and robust" tribal consultation may occur through general, nation-wide phone calls to discuss policies that will impact tribal rights or interests. These general calls provide a few tribal leaders the ability to speak on an issue for perhaps two-to-three-minute increments. These alleged "consultations" are perceived as an insult, and stand in stark contrast to what a meaningful, robust nation-to-nation relationship represents.

The Yakama Nation therefore requests that the Department provide true, meaningful consultations to Native Nations and their leadership, to listen to our concerns, and to consciously develop policy around those concerns. For the Yakama Nation, a meaningful consultation must take place here, in Toppenish, when the Yakama Nation is represented by a full quorum of elected Tribal Council Members present and sitting in a regular or special session of Tribal Council. To honor the nation-to-nation relationship, the CDC must likewise send an official representative with decision-making authority over the activity or policy being discussed, rather than a mere agent

of such official. This needed, mutual and equal conversation between sovereign representatives would represent our robust nation-to-nation relationship.

III. FURTHER DIALOGUE AND INQUIRY

The Yakama Nation is interested in how the CDC will weigh agency decisions that may impact the environment or tribal interests, including cultural and spiritual interests, against President Biden's Executive Order on *Protecting Public Health and the Environment and Restoring Science to the Climate Crisis*, E.O. 13990, 86 Fed. Reg. 7037 (Jan. 20, 2021). The Yakama Nation would like to understand how the CDC intends to address existing regulations, orders, policies, and agency actions that stand inconsistent with the Administration's efforts to combat climate change. What steps will the CDC and its sub-agencies take to ensure that decisions that are currently in process, particularly those involving greenhouse gas emissions and fossil fuel infrastructure, will incorporate climate change objectives?

The Administration's commitment to climate change is reiterated in *Tackling the Climate Crisis at Home and Abroad*, E.O. 14008, 86 Fed. Reg. 7619 (Jan. 27, 2021), "[i]t is the policy of my Administration to organize and deploy the full capacity of its agencies to combat the climate crisis to implement a Government-wide approach that reduces climate pollution in every sector of the economy." The Yakama Nation would like to discuss how the CDC intends to carry out these directives. Executive Order 14008 directs agencies to approach climate change in a way that protects public health, conserves land, waters, and biodiversity, and delivers environmental justice. The Yakama Nation would like to discuss with the CDC about opportunities to preserve tribal resources and the environment while fulfilling this mission. Given the short timeframe, the Yakama Nation has not had an opportunity to identify specific regulations and policies that are inconsistent with these directives. However, the Yakama Nation anticipates robust and continuing dialogue with the CDC about these issues in order to help identify specific problems and to find solutions.

In addition, the Administration's plan for *Advancing Racial Equity and Support for Underserved Communities through the Federal Government*, E.O. 13985, 86 Fed. Reg. 7009 (Jan. 20, 2021), calls for all agencies to ensure correction of historical inequities affecting people of color, marginalized communities, and those affected by poverty. The Yakama Nation would like to discuss how the CDC intends to amend, remove, or identify its policies and regulations that impair racial equity or have historically ignored tribal sovereignty. The CDC also holds a history of approving projects and taking actions that prove detrimental to the interests of the Yakama Nation and other Native Nations. There exists, however, a history of collaboration and we hope to build upon that collaboration. This collaboration should, among other things like meaningful consultation, open itself and recognize the value of tribes' Traditional

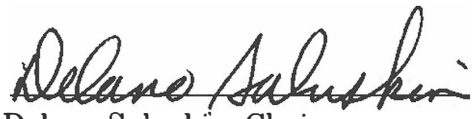
Knowledge. We therefore encourage the CDC to similarly revisit its policies in light of the recent Executive Orders to determine how Traditional Knowledge could be better integrated into its actions.

IV. CONCLUSION AND INVITATION

The Yakama Nation remains optimistic for our continued relationship. We hope that the CDC is genuine in its calls for a meaningful and robust relationship. To that end, we invite the CDC to meet with us, ask questions, listen, and authentically learn about us and our concerns. We therefore await your visit to the Yakama Reservation to discuss our inquiries and develop our mutual, equal relationship further.

If you have any questions or concerns regarding our Letter, please contact Mr. Ethan Jones, Lead Attorney for the Yakama Nation Office of Legal Counsel, at (509) 834-8005 or via email at Ethan@yakamanation-olc.org.

Respectfully,



Delano Saluskin, Chairman
Yakama Nation Tribal Council

Appendix B: List of Participants—August 5, 2021, Tribal Consultation

First Name	Last Name	Tribal Nation/Agency
Jessie	Adair	Stillaguamish Tribe of Indians
Cleopatra	Adedeji	Centers for Disease Control and Prevention (CDC)
Walter	Alarcon	CDC
Benjamin	Alford	Indian Health Service (IHS)
Alicia	Andrew	Karluk Ira Tribal Council
Julie	Armstrong	CDC
Vijay	Aspaas	IHS
Maria	Ayala-Perales	CDC
Connie	Barker	The Chickasaw Nation
Nicole	Barron	CDC
Elizabeth	Bell	CDC
Herlynn	Benoit	CDC
Eva	Bighorse	Arizona Department of Economic Security (AzDES)/ Division of Developmental Disabilities
Kelly	Bishop	CDC
Lydia	Blasini-Alcivar	CDC
Verne	Boerner	Alaska Native Health Board
Denise	Boggs	CDC
Anthony	Boone	CDC
Kailyn	Bostic	CDC
Christopher	Braden	CDC
Vickie	Bradley	Eastern Band of Cherokee Indians, Public Health and Human Services
Breanna	Branche	CDC
Pat	Breysse	CDC & Agency for Toxic Substances and Disease Registry (ATSDR)
Gia	Brooks	Chemehuevi Indian Tribe
Rebecca	Bunnell	CDC
Alisa	Burley	Snoqualmie Indian Tribe
Bridget	Canniff	Northwest Portland Area Indian Health Board
Hallie	Carde	CDC
Yulia	Carroll	CDC
David	Caruso	CDC
Thelma	Cela	Seminole Tribe of Florida
Zeshan	Chisty	CDC
Jason	Chou	CDC
Bryan	Christensen	CDC
Meghan	Clancy	CDC
Carmen	Clelland	Health Resources and Services Administration (HRSA)
Karen	Cobham-Owens	CDC
Fredrick	Dahlgren	CDC
Les	Dauphin	CDC
Winn	Davis	Alaska Native Health Board
Mark	Davis	CDC

Adina	de Coteau	CDC
Sonya	Diggs	Choctaw Nation of Oklahoma
Sonal	Doshi	CDC
Deborah	Dotson	Delaware Nation
Tyler	Dougherty	National Indian Health Board
Audrey	Dowling	CDC
Christopher	Earl	CDC
Rachel	Edwards	Nez Perce Tribe
Jessica	Elm	CDC
Marcelina	Flores	CDC
Stephanie	Foster	CDC
Melanie	Fourkiller	Choctaw Nation of Oklahoma
Rebekah	Frankson	CDC
Alean	Frawley	CDC
Herminia	Frias	Pascua Yaqui Tribe
Dan	Garcia	CDC
Athena	Gemella	ATSDR
CheBreia	Gibbs	CDC
Sheryl	Goodson	Chickasaw Nation
Melissa	Gower	Chickasaw Nation
Brittany	Grear	CDC
Nathan	Griffin	CDC
Dawn	Griffin	CDC
Karen	Hacker	CDC
Rebecca	Hall	CDC
S. Kayleigh	Hall	CDC
Todd	Hallmark	Choctaw Nation of Oklahoma, Choctaw Nation Health Services Authority
Katy	Halverson	Coquille Tribe
Summer	Hammons	Tulalip Tribes
Veda	Harrell	CDC
Jennifer	Hartnett	CDC
Lakesha	Hawkins	Choctaw Nation of Oklahoma
Lauri	Hayward	Pit River Tribe, Pit River Health Service
Karen "Kari"	Hearod	CDC
Noelle	Henderson	ATSDR
Diane	Henry	Tulalip Tribes
Jan	Hicks-Thomson	CDC
Ryan	Hill	CDC
Kim	Hoch	CDC
Brian	Howard	United South & Eastern Tribes (USET) Sovereignty Protection Fund
Joy	Hsu	CDC
Brandy	Humphreys	Confederated Tribes of Grand Ronde
Robin	Ikeda	CDC
Ikovwa	Irune	CDC

Georgia	Jackson	Native Village of Tazlina
Constance	James	IHS
Calla	Jamison	CDC
Dara	Jefferson	Native Center for Behavioral Health
Jill	Jim	The Navajo Nation, Navajo Department of Health
Candice	Jimenez	Northwest Portland Area Indian Health Board
Dolores	Jimerson	Quiletute Tribe of The Quileute Reservation, Quileute Health Center
Patsy	Jimmy	IHS
Hope	Johnson	IHS
Chris	Jones	CDC
Sherry	Jones	CDC
Karrie	Joseph	National Indian Health Board
Cassandra	Josey	CDC
Rhonda	Kaetzel	ATSDR
Samantha	Kessler	CDC
Martha	Ketcher	Cherokee Nation
Kyle	Key	The Chickasaw Nation
Laura	Kollar	CDC
Rebecca	Kone	CDC
Alfred	Koroma	CDC
Rachel	Kossover-Smith	CDC
Trinidad	Krystall	Riverside San Bernardino County Indian Health Clinic, Inc.
Jim	Kucik	CDC
Rhea	Lansang Tran	CDC
Fergus	Laughridge	Ft. McDermitt Paiute Shoshone Tribe, Fort McDermitt Wellness Center
Doreen	Fogg-Leavitt	Inupiat Community of the Arctic Slope
Santee	Lewis	Navajo Nation Washington Office
Philip	Ling	Chickaloon Village Traditional Council Health Department
Steve	Literati	CDC
Myron	Lizer	The Navajo Nation
A.C.	Locklear	National Indian Health Board
Julia	Lothrop	HHS
Katherine	Luce	CDC
Liz	Malerba	USET Sovereignty Protection Fund
Cynthia	Marshall	CDC
Nina	Martin	National Indian Health Board
Marisol	Martinez	CDC
Grace	Marx	CDC
Suzanne	Mason	Pit River Nation, Pit River Health Services
Monica	Mayer	Mandan, Hidatsa, and Arikara Nation
Victoria	McBee	CDC
Trevor	McCoy	CDC
Donna	McCree	CDC
Robert	McDonald	CDC

Abdeljalil	Mekkaoui	Department of Homeland Security
Marilyn	Metzler	CDC
Jenna	Meyer	CDC
Jessica	Miller	CDC
Maria	Mirabelli	CDC
Miranda	Mitchell	ATSDR
Jose	Montero	CDC
Meredith	Moore	CDC
Georgia	Moore	CDC
Javier	Morales	IHS
Michele	Morris	The Navajo Nation, Navajo Department of Health—Executive Office
Darcy	Morrow	Sault Ste. Marie Tribe of Chippewa Indians
Emily	Mosites	CDC
Daniel	Moya	New Mexico Department of Homeland Security and Emergency Management (DHSEM)
Karen	Mumford	CDC
Jean	Nahomni Mani	Great Plains Tribal Leaders Health Board
Debi	Nalwood	IHS
Nellie	Neal	CDC
Romni	Neiman	CDC
Maria	Ness	American Indian Health Commission of WA State
Travis	Noland	Cherokee Nation
Darla	Obi	Nisqually Tribe
Joanne	Odenkirchen	CDC
Keydra	Oladapo	CDC
Patrick	Papillion	ATSDR
Stacey	Parker	CDC
Aaron	Payment	Sault Ste. Marie Tribe
Chandra	Pendergraft	CDC/CSTLTS
Gene	Perry	Cherokee Nation
Neela	Persad	CDC
Melinda	Peter	Council of Athabascan Tribal Governments
Gunnar	Peters	Menominee Indian Tribe
Lori	Phillips	CDC
Lisa	Pivec	Cherokee Nation
Lindsay	Prescod	CDC
Daniel	Preston	Tohono O'odham Nation, Tohono O'odham Legislative Council
Lauren	Ramsey	CDC
Jeff	Reczek	CDC
Alicia	Red Hat	EPA
David	Reede	San Carlos Apache Tribe Department of Health and Human Services
Karen	Remley	CDC
Jim	Roberts	Alaska Native Tribal Health Consortium
Joel	Rosette	Chippewa Cree Tribe, Rocky Boy Health Center

Alyssa	Rowell	New York State Department of Health (NYSDOH)/Office of Health Emergency Preparedness (OHEP)
Jessica	Rudolfo	White Mountain Apache Tribe
Andrew	Ruiz	CDC
Vallee	Sain	Santa Clara Pueblo
Teresa	Sanchez	Morongo Band of Mission Indians
Aishwarya	Sasidharen	CDC
Delight	Satter	CDC
Vivian	Saunders	Tohono O'odham Nation
Laura	Sawney	Cherokee Nation
Laura	Schieve	CDC
Marilyn	Scott	Upper Skagit Indian Tribe
Natasha	Seaforth	Tribal Organizations: Sac & Fox Nation, Choctaw Nation, Squaxin Island, Jamestown S'Klallam
Sam	Sears	National Council of Urban Indian Health
Ryan	Seelau	National Congress of American Indians (NCAI)
Dana	Shelton	CDC
Arlene	Sherman	CDC
Joann Wu	Shortt	CDC
Caitrin	Shuy	Hobbs, Straus, Dean and Walker, LLP
Julia (Gia)	Simon	CDC
Candice	Skenandore	Oneida Nation
Nathaniel	Smith	CDC
Tyler	Smith	Big Fire Law and Policy Group
Richard	Sneed	Eastern Band of Cherokee Indians
Sharon	Stanphill	Cow Creek Band of Umpqua Tribe of Indians
Sunny	Stevenson	National Council of Urban Indian Health
Jon	Streater	CDC
Dia	Taylor	CDC
Andrew	Terranella	CDC
Candy	Thomas	Osage Nation
Phoebe	Thorpe	CDC
Thomas	Tortez	Torres Martinez Desert Cahuilla
Stephanie	Tran	CDC
Alston	Turtle	Ute Mountain Ute Tribe
Nate	Tyler	Makah Tribe
Mitchell	UNKNOWN	HHS
Jen	UNKNOWN	Native Village of Tazlina
Alberta	Unok	Alaska Native Health Board
Christine	Vanover	CDC
Malia	Villegas	Native Village of Afognak
Susan	Wacaster	CDC
Nicole	Wachter	CDC
Lisa	Wade	Chickaloon Native Village, Chickaloon Village Traditional Council
Bryan	Warner	Cherokee Nation

Nicholas	Warren	American Association for Cancer Research
Elizabeth	Watanabe	Snoqualmie Indian Tribe
Michael	Weahkee	IHS
Alleen	Weathers	CDC
Daniel	Weber	CDC
Jennifer	Webster	Oneida Nation
Seh	Welch	CDC
Rachel	West	CDC
David	Wharton	Choctaw Nation of Oklahoma Health Services
Erin	Whitehouse	CDC
Selwyn	Whiteskunk	Ute Mountain Ute Tribe
Brandon	Wisneski	Oneida Nation
Sharon	Wong	CDC
Jeremy	Woodruff	IHS
Jams (Patrick)	Young	ATSDR
Andrea	Zekis	CDC
Elizabeth	Zurick	CDC

In addition to the participants identified above, several people called in and did not identify themselves; for protection of their privacy, we have listed only the area codes and not the entire phone number:

1-301-xxx-xxxx
1-404-xxx-xxxx
1-404-xxx-xxxx
1-404-xxx-xxxx
1-404-xxx-xxxx
1-404-xxx-xxxx
1-404-xxx-xxxx
1-503-xxx-xxxx
1-580-xxx-xxxx
1-678-xxx-xxxx
1-712-xxx-xxxx
1-775-xxx-xxxx
1-906-xxx-xxxx

Appendix C: Current CDC/ATSDR Tribal Consultation Policy (dated 2020)

Category: General Administration
Policy #: CDC-GA-2005-16 (Formerly CDC-115)
Date of Issue: 10/18/2005, Updated 01/08/2013, Updated 11/12/2013, Updated 02/28/2020[1]
Proponent: Center for State, Tribal, Local, and Territorial Support (CSTLTS)
Application: All Locations, Domestic and International
Applicable Staff: CDC Employees

CDC/ATSDR TRIBAL CONSULTATION POLICY

Sections:

1. PURPOSE AND SCOPE

This policy provides direction regarding consultation between the Centers for Disease Control and Prevention (CDC)[2] and Indian Tribes. This policy applies to all CDC employees[3] at all locations, domestic and international, and to all Centers, Institute, and Offices (CIOs), Staff Offices, and Business Services Offices, which are hereafter called "CDC Components"[4] unless otherwise noted.

CDC and Indian Tribes share the goal of establishing clear policies that further the government-to-government relationship between the U.S. Federal Government and Indian Tribes. True and effective consultation shall result in information exchange, mutual understanding, and informed decision-making on behalf of the Tribal governments and the Federal Government. The importance of consultation with Indian Tribes was affirmed through Presidential Memoranda in 1994, 2004 and 2009, and Executive Order (EO) 13175 in 2000.

The goals of this policy include, but are not limited to, assisting in eliminating the health disparities faced by Indian Tribes; ensuring that access to critical health and human services and public health services is maximized to advance or enhance the social, physical, and economic status of Indians; and promoting health equity for all Indian people and communities. To achieve these shared goals, it is essential that Indian Tribal governments and CDC engage in open, continuous, and meaningful consultation.

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[1] This update is a non-substantive update limited to copy editing, revising the policy's format (such as moving or re-phrasing content to fit the template), changing nomenclature, and updating website addresses.
[2] References to CDC also include the Agency for Toxic Substances and Disease Registry (ATSDR).
[3] For the purposes of this policy, the term "employees" consists of members of the civil service, Commissioned Corps officers, and locally employed staff. For more information on these categories, refer to "Employee Categories (Updated July 2018)," available at: http://intranet.cdc.gov/ocio/docs/systems-tools/EmployeeCategoryHelp_July_2018.pdf.
[4] More information on CDC organizational nomenclature is available at: https://sbi.cdc.gov/DOA/pdf/orgnom.pdf.

The U.S. Department of Health and Human Services (HHS) Tribal Consultation Policy requires that all operating divisions of the department develop and implement Tribal consultation policies that are in compliance with the HHS Tribal Consultation Policy, effective December 14, 2010.

2. BACKGROUND

Founded in 1946, CDC is the leading public health agency in the United States. The CDC collaborates with stakeholders and partners to (1) develop expertise, information, and tools to promote healthy people and (2) communicate on topics such as health promotion, prevention of disease, injury and disability, and preparedness for new and emerging health threats. CDC seeks to accomplish its mission by working with partners to monitor health; detect and investigate health problems; conduct research to enhance prevention; develop and advocate sound public health policies; implement prevention strategies; promote healthy behaviors; foster safe and healthful environments; and provide leadership and training. These functions are the backbone of CDC′s mission. Each CDC Center, Institute, and Office (CIO) undertakes these activities to conduct CDC's specific programs. The steps that are needed to accomplish this mission are based on scientific excellence and require well-trained public health practitioners and leaders dedicated to high standards of quality and ethical practice.

CDC shares its focus on health protection with its sister agency ATSDR. First organized in 1985, ATSDR was created by the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA) of 1980, more commonly known as the Superfund law. In 1986, Congress passed the Superfund Amendments and Reauthorization Act (SARA). The agency's mission is to serve the public through responsive public health actions to promote healthy and safe environments and prevent harmful exposures.

3. POLICY

A. Core Principles

Tribal consultation between CDC and Indian Tribes is built on two core principles, which are summarized below. Each of these principles supports the unique circumstances for who is engaged, why the engagement is significant, and guidance for how to engage. This relationship is derived from the unique political and legal relationship that Indian Tribes have with the Federal Government and is not based on race or ethnicity.

Tribal Sovereignty

Since the formation of the Union, the United States has recognized Indian Tribes as sovereign nations. As sovereign nations, Indian Tribes exercise inherent sovereign powers over their members, territory, and lands. CDC recognizes that each Indian Tribe sets its own priorities and goals, including those that establish a safe and healthy environment for its members and territory.

Government-to-Government Relationship

A unique government-to-government relationship exists between Indian Tribes and the Federal Government. This relationship is grounded in the U.S. Constitution, numerous treaties, statutes, Supreme Court decisions, and Executive Orders that establish and define a Federal trust relationship with Indian Tribes. This relationship is derived from the political and legal relationship that Indian Tribes have with the Federal Government and is not based upon race.

CDC is committed to continuing to work with Federally recognized Tribal governments on a government-to-government basis and strongly supports and respects Tribal sovereignty and self-determination in the United States.

This special relationship between the Federal Government and Indian Tribes is affirmed in statutes and various Presidential Executive Orders including, but not limited to the following:

- Older Americans Act, P.L. 89-73, as amended
- Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended
- Native American Programs Act, P.L. 93-644, as amended
- Indian Health Care Improvement Act, P.L. 94-437, as amended
- Personal Responsibility and Work Opportunity Reconciliation Act of 1996, P.L.104-193
- Presidential Executive Memorandum to the Heads of Executive Departments dated April 29, 1994
- Presidential Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, November 6, 2000
- Presidential Memorandum, Government-to-Government Relationship with Tribal Governments, September 23, 2004
- Presidential Memorandum, Tribal Consultation, November 5, 2009
- American Recovery and Reinvestment Act of 2009, P.L. 111-5, 123 Stat. 115 (Feb. 17, 2009)
- Children's Health Insurance Program Reauthorization Act of 2009, P.L. 111-3, 123 Stat. 8 (Feb. 4, 2009)
- Patient Protection and Affordable Care Act of 2010, P.L. 111-148, 124 Stat. 119 (Mar. 23, 2010)

As a Federal Government entity, CDC will comply, to the extent practicable and permitted by law, with all provisions in the HHS Tribal Consultation Policy to ensure meaningful consultation and timely input from Indian Tribes before actions are taken that will significantly affect Indian Tribes.

B. Philosophy

Indian Tribes have an inalienable and inherent right to self-government. Self-government means government in which decisions are made by the people who are most directly affected by the decisions. As sovereign nations, Indian Tribes exercise inherent sovereign powers over their members, territory, and lands. As a Federal organization, CDC recognizes its special commitment and unique relationship with Indian Tribes and is committed to fulfilling their critical role in promoting the health and safety of Indian Tribes.

C. General Requirements

CDC policy on Tribal consultation will adhere to all provisions in the HHS Tribal Consultation Policy.

CDC will honor the sovereignty of Indian Tribal governments, respect the inherent rights of Indian Tribal self-governance, and continue to work on a government-to-government basis. Government-to-government consultation will be conducted with elected Indian Tribal Leaders or their designated representatives, to the extent practicable and permitted by law, before CDC takes any action that will significantly affect Indian Tribe(s).

CDC will employ a process to ensure meaningful and timely input by CDC and Indian Tribes in the development of policies that have Tribal implications. This Tribal consultation policy does not waive any Tribal governmental rights, including treaty rights, sovereign immunities or jurisdiction; and nothing in this policy waives the U.S. Federal Government's deliberative process privilege. Nothing in this policy may be interpreted as diminishing or eliminating the rights of American Indians or Alaska Natives (AI/ANs) or entities under U.S. Federal law, contained in treaties, agreements and other constructive arrangements.

D. Tribal Consultation Process

An effective consultation between CDC and Indian Tribes requires information exchange, mutual understanding, full and equitable participation, and building and maintaining trust between all parties, which is an indispensable element in establishing an effective consultative relationship. CDC will adhere to the consultation process as outlined in Section 8 of the HHS Tribal Consultation Policy. Upon identification of an action (i.e., policy; funding/budget development; and program services, functions, and activities) significantly affecting Indian Tribes, CDC will initiate consultation regarding the event through communication methods as outlined in the HHS Tribal Consultation Policy.

The CDC Tribal consultative process shall consist of direct communications with Indian Tribes and Indian organizations as applicable, in various ways as provided in Section 9 on Consultation Procedures and Responsibilities of the HHS Tribal Consultation Policy.

E. Consultation Participants and Roles

The government-to-government relationship between the U.S. and Federally recognized Indian Tribes dictates that the principal focus for consultation by CDC is with Indian Tribes, individually or collectively. Consultation parties include:

- Indian Tribes represented by the Tribal President, Tribal Chair, or Tribal Governor, or an elected or appointed Tribal Leader, or their authorized representative(s)
- CDC Director, ATSDR Administrator, CDC Deputy Director for State, Tribal, Local and Territorial Support, or their designee(s)

CDC/ATSDR may gather information from Indian organizations in accordance with the Federal Advisory Committee Act (FACA), 5 U.S.C. App. 2, or with the "Unfunded Mandates Reform Act Exemption" to FACA found in the Unfunded Mandates Reform Act, P.L. 104-4, Section 204. The government does not participate in government-to- government consultation with these entities; rather the government communicates with these organizations in the interests of Indian Tribes and Indian People. CDC may also communicate with Native-serving organizations, including urban and rural Indian organizations, in the interests of Indian communities and Indian people. Government-to-government consultation at CDC will occur as outlined in the HHS Tribal Consultation Policy.

F. Budget Formulation

HHS conducts annual Department-wide Tribal budget and policy consultation sessions to give Indian Tribes the opportunity to present their budget recommendations to the Department to

ensure Tribal priorities are addressed. CDC will comply with Section 11 on Budget Formulation of the HHS Tribal Consultation Policy.

G. Performance Measures and Accountability

CDC will utilize the HHS and CDC Tribal Consultation Policies to address CDC's missions and performance objectives with respect to: assisting in eliminating the health disparities faced by Indian Tribes; ensuring that access to critical health and human services and public health services is maximized to advance or enhance the social, physical, and economic status of Indians; and helping promote health equity for all Indian people and communities. CDC will measure and report results and outcomes of the Tribal consultation performance and will follow the goals and objectives of the seated Secretary and Administration according to Section 12 on Tribal Consultation Performance and Accountability in the HHS Tribal Consultation Policy.

H. Evaluation and Reporting

The consultation process and activities conducted according to the policy should result in meaningful outcomes for CDC and for the affected Indian Tribes. To effectively evaluate the results of consultation activity and CDC's ability to incorporate Indian Tribes' consultation input, CDC will measure the level of satisfaction of Indian Tribes on an annual basis as outlined in Sections 12 (Tribal Consultation Performance and Accountability) and Section 13 (Evaluation, Recording of Meetings, and Reporting) of the HHS Tribal Consultation Policy.

I. Conflict Resolution

The intent of this policy is to promote partnerships with Indian Tribes that enhance CDC's ability to address issues, needs and problem resolution. CDC shall consult with Indian Tribes to establish a clearly defined conflict resolution process under which Indian Tribes bring forward concerns that have a substantial direct effect. However, Indian Tribes and CDC may not always agree, and inherent in the government-to-government relationship is the ability for Indian Tribes to elevate an issue of importance to a higher or separate decision-making authority.

Nothing in this Policy creates a right of action against the CDC or HHS for failure to comply with this Policy.

J. Tribal Waiver

CDC will fully comply with Section 15 of the HHS Tribal Consultation Policy on Tribal waivers and process all requests routinely received for waivers under existing program authorities with the statutorily set timeframes.

K. Effective Date

This policy is effective on the date of the signature by the CDC Director/ATSDR Administrator. This policy updates the Tribal Consultation Policy signed on October 18, 2005.

4. RESPONSIBILITIES

A. Center for State, Tribal, Local, and Territorial Support (CSTLTS)

- Designates, through the Deputy Director for State, Tribal, Local and Territorial Support, the Tribal Support Unit with the responsibility for implementation, coordination, and agency-wide adherence to CDC/ATSDR and HHS Tribal Consultation Policies

B. CDC/ATSDR Tribal Advisory Committee (TAC)

- Serves as an advisory committee to CDC/ATSDR providing input, guidance, and advice on policies, guidelines, and programmatic issues affecting the health of Indian Tribe(s)
- Complies with the requirements of the FACA, 5 U.S.C. App. 2, or with the "Unfunded Mandates Reform Act Exemption" to FACA found in the Unfunded Mandates Reform Act, P.L. 104-4, Section 204

5. REFERENCES

A. HHS. *Department Tribal Consultation Policy*, dated December 14, 2010, https://www.hhs.gov/sites/default/files/iea/tribal/tribalconsultation/hhs-consultation-policy.pdf.

B. Presidential Memorandum for the Heads of Executive Departments and Agencies, "Government-to-Government Relationship with Tribal Governments, Presidential Memorandum," dated September 23, 2004, https://www.govinfo.gov/content/pkg/WCPD-2004-09-27/pdf/WCPD-2004-09-27-Pg2106.pdf.

C. Exec. Order No. 13,175, 65 Fed. Reg. 67,249 (Nov. 9, 2000) – Consultation and Coordination with Indian Tribal Governments

6. ACRONYMS or ABBREVIATIONS

AIAN – American Indian and Alaska Native
ATSDR – Agency for Toxic Substances and Disease Registry
CDC – Centers for Disease Control and Prevention
CERCLA – Comprehensive Environmental Response, Compensation, and Liability Act
CIO – Centers, Institutes and Offices
EO – Executive Order
HHS – U.S. Department of Health and Human Services
SARA – Superfund Amendments and Reauthorization Act
U.S. – United States
USC – United States Code

7. DEFINITIONS

Agency – Any authority of the United States that is an "agency" under 44 USC § 3502(1) other than those considered to be independent regulatory agencies, as defined in 44 USC § 3502(5)

CDC Components – Organizational entities of CDC that are comprised of CIOs, Staff Offices, and Business Services Offices, as outlined in Organizational Nomenclature Used in Delegations of Authority

Communication – The exchange of ideas, messages, or information, by speech, signals, writing, or other means

Consultation – An enhanced form of communication, which emphasizes trust, respect and shared responsibility; is an open and free exchange of information and opinion among parties that leads to mutual understanding and comprehension; and is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues

Deliberative Process Privilege – Is a privilege exempting the government from disclosure of government agency materials containing opinions, recommendations, and other communications that are part of the decision-making process within the agency

Executive Order – An order issued by the Government's executive on the basis of authority specifically granted to the executive branch (as by the U.S. Constitution or a Congressional Act)

Federally Recognized Tribal governments – Indian Tribes with whom the Federal Government maintains an official government-to-government relationship, usually established by a Federal treaty, statute, executive order, court order, or a Federal Administrative Action
NOTE: The Bureau of Indian Affairs (BIA) maintains and regularly publishes the list of Federally recognized Indian Tribes.

Indian – Indian means a person who is a member of an Indian tribe as defined in 25 U.S.C. § 5129
NOTE: Throughout this policy, Indian is synonymous with American Indian or Alaska Native.

Indian Organizations – 1) Those Federally recognized Tribally constituted entities that have been designated by their governing body to facilitate HHS communications and consultation activities, or 2) any regional or national organizations whose board is comprised of Federally recognized Indian Tribes and elected/appointed Tribal leaders
NOTE: The government does not participate in government-to-government consultation with these entities; rather these organizations represent the interests of Tribes when authorized by those Tribes.

Indian Tribe – An Indian or Alaska Native tribe, band, nation, pueblo, village, or community that the Secretary of the Interior acknowledges to exist as an Indian tribe pursuant to the Federally Recognized Indian Tribe List Act of 1994,
25 U.S.C. § 5129.

Policies with Tribal Implications – Refers to regulations, statutes, legislation, and other policy statements or actions that have substantial direct effects on one or more Indian Tribes, on the relationship between the Federal Government and Indian Tribes, or on the distribution of power and responsibilities between the Federal Government and Indian Tribes

Self-Government – Government in which the people who are most directly affected by the decisions make decisions

Sovereignty – The ultimate source of political power from which all specific political powers are derived

Treaty – A legally binding and written agreement that affirms the government-to-government relationship between two or more nations

Tribal Government – An American Indian or Alaska Native Tribe, Band, Nation, Pueblo, Village or Community that the Secretary of the Interior acknowledges to exist as an Indian Tribe pursuant to the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. § 5129

Tribal Officials – Elected or duly appointed officials of Indian Tribes or authorized inter- Tribal organizations

Tribal Organization – The recognized governing body of any Indian Tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities, provided that in any case where a contract is let or grant made to an organization to perform services benefiting more than one Indian Tribe, the approval of each such Indian Tribe shall be a prerequisite to the letting or making of such contract or grant

Tribal Self-Governance – The governmental actions of Indian Tribes exercising self-government and self-determination

Appendix D: Dear Tribal Leader Letter for CDC/ATSDR August 5, 2021, Tribal Consultation

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30329-4027

July 6, 2021

Dear Tribal Leader:

The Centers for Disease Control and Prevention/Agency for Toxic Substances and Disease Registry (CDC/ATSDR) is seeking your recommendations and feedback on how we can improve the agency's policies and practices to better engage with Indian Country through meaningful consultation. To gather this feedback, CDC/ATSDR is hosting a tribal consultation session on Thursday, August 5, from 3:15–4:45 pm (EDT). You can register to attend this consultation session here:

https://cdc.zoomgov.com/meeting/register/vJIsfu-gqDgsGD1rTre7HPjbXyIF3v5jSp4

The consultation will be held on the implementation of Executive Order 13175 of November 6, 2000, consistent with the Presidential Memorandum of January 26, 2021 on Tribal Consultation and Strengthening the Nation-to-Nation Relationships. The Presidential Memorandum requires CDC/ATSDR to submit a detailed plan for implementing Executive Order 13175, which charges agencies to engage in regular, meaningful, and robust consultation with tribal officials in the development of federal policies that have implications for tribal governments and entities. CDC/ATSDR is committed to working with federally recognized tribal governments on a government-to-government basis and strongly supports and respects tribal sovereignty and self-determination for tribal governments in the United States. The current CDC/ATSDR tribal consultation policy is available at: https://www.cdc.gov/tribal/consultation-support/tribal-consultation/policy.html.

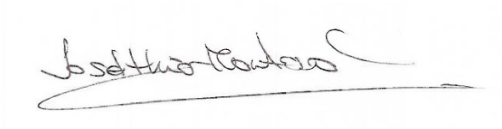
CDC/ATSDR is also committed to working in partnership with tribal nations and the Tribal Advisory Committee (TAC) that advises CDC/ATSDR in the planning and coordination of tribal consultation sessions and ensures that CDC/ATSDR activities or policies that impact Indian Country are brought to the attention of all tribal leaders. As the President's memorandum states, "History demonstrates that we best serve Native American people when tribal governments are empowered to lead their communities, and when federal officials speak with and listen to tribal leaders in formulating federal policy that affects tribal nations."

Specific questions on which we invite your feedback are listed below.

1. How do we strengthen our tribal consultation policy and process to ensure CDC/ATSDR is responsive and engaging with Indian Country in a meaningful way?
2. How do we improve communication and outreach regarding agency policy or program changes that impact tribal nations?
3. Are there specific areas where tribal officials would like more information or feel they are not getting adequate outreach to engage in a meaningful way?
4. How do we improve tribal consultations? Should we have sessions every year?

These topics will be open for discussion at the consultation session on August 5, 2021. For those who would also like to send in written remarks, please send us your initial comments and recommendations no later than 5:00 pm (EDT) on September 7, 2021, to tribalsupport@cdc.gov. This initial feedback will help guide us in next steps for further consultation.

Sincerely,



José T. Montero, MD, MHCDS
Designated Federal Official, CDC/ATSDR Tribal Advisory Committee
Director, Center for State, Tribal, Local, and Territorial Support

Appendix E: Federal Register Notice for CDC/ATSDR August 5, 2021, Tribal Consultation Policy