Tribal Advisory Committee (TAC) Meeting
March 21-22, 2019
National Institutes of Health (NIH)
Suite 1100, 6700B Building
6700 B Rockledge Drive
Bethesda, Maryland

Meeting Summary

I. Call to Order, Introduction, Welcome and Meeting Goals

The Tribal Advisory Committee (TAC) in-person meeting began at 9:00 a.m. with a call to order from David Wilson, Ph.D., director of the Tribal Health Research Office (THRO). Co-Chairperson and California Area Delegate Lisa Sundberg gave the invocation before leading introductions around the table and around the room. Ms. Sundberg, of the Trinidad Rancheria, also read the Federal Advisory Committee Act meeting requirements.

Turning to the meeting goals, Dr. Wilson said TAC members should have a clear understanding of THRO priorities by the end of the meeting. TAC members might also identify additional goals the office is not addressing within its current activities. Through these in-person meetings, TAC members also can continue to learn more about various NIH Institutes and Centers.

A. Roll Call

1. **Tribal Advisory Committee Members**
   Chester Antone, Tucson Area Delegate
   Beverly Cook, Nashville Area Delegate
   Debra Danforth, National At-Large Delegate
   Denise Dillard, Ph.D., National At-Large Delegate
   Donna Galbreath, M.D., Alaska Area Delegate
   Lynn Malerba, D.N.P., National At-Large Delegate
   Aaron Payment, Ed.D., Bemidji Area Delegate *(via telephone)*
   Bobby Saunkeah, Oklahoma Area Delegate
   Andrew Shogren, J.D., Portland Area Proxy
   Lisa Sundberg, California Area Delegate

2. **Technical Advisors**
   Breannon E. Babbel, Ph.D., National At-Large
   Lyle Best, M.D., Great Plains Area
   Christy Duke, Nashville Area
   Vanessa Hiratsuka, Ph.D., National At-Large
   Tyler LaPlaunt, Bemidji Area
   Michael Peercy, Oklahoma Area
   Yvette Roubideaux, M.D., National At-Large
   Suzanne Sisley, M.D., California Area
   Teshia G. Arambula Solomon, Ph.D., Tucson Area

Timothy K. Thomas, M.D., Alaska Area

3. **National Institutes of Health**
   James M. Anderson, M.D., Ph.D., NIH Deputy Director for Program Coordination, Planning, and Strategic Initiatives
   Lawrence A. Tabak, D.D.S., Ph.D., Principal Deputy Director, National Institutes of Health
   David R. Wilson, Ph.D., Tribal Health Research Office Director
   (see attached attendee list for other federal staff in attendance, but not at the table)

B. Meeting Agenda

- Comments from the National Center for Complementary and Integrative Health (NCCIH)
- A discussion with NIH
- Center for Scientific Review (CSR) presentation and discussion
- Highlights of Tribal activities at NIH
- Plant-based therapy research update from the National Institute on Drug Abuse (NIDA)
- Presentation from the National Institute of Dental and Craniofacial Research (NIDCR)
- NIH Tribal Consultation Protocol discussion
- American Indian/Alaska Native (AI/AN) Health Research Advisory Council (HRAC) Transition, and
- Discussion of 2019 TAC Priorities and Next Steps

C. Action Items

- TAC members will continue discussing the NIH Tribal Consultation Protocol during the monthly conference calls.
- The TAC co-chairs will draft a letter expressing disdain for the decommissioning of the AI/AN HRAC without Tribal input. Chairperson Payment planned to get a draft of the letter to Ms. Sundberg by Sunday, March 24, 2019.
- Dr. Hiratsuka will draft a standing in-person meeting agenda within two weeks to demonstrate how the TAC could use its time most effectively.
- TAC members seek follow-up regarding ongoing issues with CSR. TAC members also want details on the AI/AN representation on CSR external advisory committees.
- TAC Technical Advisors proposed formal consultation on the dissolution of HRAC to address systemic issues and potential new TAC duties.
- Dr. Wilson will provide to the TAC the follow-up letter from the October 2018 In-person Meeting.
- TAC and THRO will identify ways to use videocasts, Webinars and other technologies to educate Indian Country and assist TAC members who cannot attend monthly conference calls or in-person meetings.

II. NCCIH Presentation and Discussion
Helene Langevin, M.D., Director
National Center for Complementary and Integrative Health

Dr. Langevin explored possible commonalities between integrative health and traditional medicine.

AI/AN traditional medicine focuses on respect, symbolism, and the nurturing of the mind, body and spirit of individuals, families and communities. These aspects align with the definition of integrative medicine, said Dr. Langevin.

Western medicine has for a long time suffered from a fragmented approach to understanding health and disease. Radical thinking during the Renaissance period opened the door to the scientific study of the physical body -- distinct from the mind and spirit. This approach dominated Western scientific thinking until the 20th century, said Dr. Langevin.

In recent years, another view has emerged: The body is more like an ecosystem. A greater understanding of the natural, interconnected world has inspired this approach.

In contrast to the organ-specific disease model that is predominant in conventional Western medicine, integrative health follows a more holistic biopsychosocial model where "symptoms" of health such as physical and emotional well-being are more integrative concepts. Integrative health also addresses the entire health system and serves in the management of chronic pain, although there is little research in this area. Further, natural products such as food, botanicals, probiotics and natural nutritional supplements can preserve and prevent loss of health. Whole plants or a combination of plants/plant extracts can play a role in health restoration.

NCCIH continues to engage in research to explore these dimensions of natural products and understand how these products serve as part of an entire health system. Such research remains crucial in light of dwindling biological diversity and disappearing knowledge about medicinal value and usages of plants. Recording and preserving such knowledge is a vital task.

The boreal forest of Canada is home to Aboriginal people who have used medicinal plants in traditional health systems for thousands of years. This knowledge, transmitted by oral tradition from generation to generation, has eroded in recent decades due to rapid cultural change. A review of the traditional uses of these plants revealed treatments for 28 disease and disorder categories, with the highest number of species being used for gastrointestinal disorders, followed by musculoskeletal disorders. Herbs were the primary source of medicinal plants, followed by shrubs.

Additional ethnopharmacological interviews of AI/AN traditional healers resulted in the documentation of 19 medicinal plants used to treat various ailments and diseases, including symptoms related to Parkinson's Disease. Future ethnobotanical research should focus on documenting the knowledge held by Aboriginal groups; however, this process also raises such critical issues as the legal, ethical and cultural aspects of the conservation of medicinal plant species and the protection of the associated traditional knowledge.

Traditional medicine practices in AI/AN communities also focus on a connection between the body, mind and spirit, as well as nature. A survey of AI/AN healers identified lack of cultural identity as a factor hindering post-trauma recovery. Alternatively, a strong cultural knowledge and identity seems to provide a protective factor.

NCCIH-funded research has explored drum-assisted therapy for Native Americans and mindfulness in

Tribal communities to address diabetes. Dr. Langevin also highlighted a pilot study of a spirituality program in an urban Indian community and a paper comparing the traditional healing practices in Africa and North America. NCCIH continues to focus on training the next generation of researchers who can offer cultural knowledge and sensitivity, develop infrastructure in community research, and provide feedback to grow the field. NCCIH also supplements awards for scholars pursuing complementary health research career development.

Following the presentation, Ms. Sundberg ceded to California Area Technical Advisor Suzanne Sisley, M.D. Dr. Sisley asked about the NCCIH budget and typical grant size. Dr. Sisley also requested information on how NCCIH might help researchers navigate federal barriers to research. A study on cannabis for military veterans with post-traumatic stress disorder cost $2.3 million and required 10 years to overcome regulatory hurdles. Although NCCIH is a small center, its budget is $145 million each year, said Dr. Langevin. NCCIH has an interest in natural products as well as cannabinoids and offers active funding opportunities right now. The center also welcomes partnerships. Dr. Sisley ceded the seat back to Ms. Sundberg.

Chief Malerba highlighted the effects of pollution and other environmental issues on traditional medicine. NCCIH also must consider protections for Tribes while researching traditional practices. Researchers must have agreement as to how a study will occur, and NCCIH must address intellectual property. Dr. Langevin agreed, noting the importance of respect. Chairperson Payment requested more appropriate research on historical trauma, adding that Tribal communities suffer the highest rates of alcoholism, suicide, accidents and nomadic lifestyles. Traditional medicine has helped the Sault Ste. Marie Tribe of Chippewa address some of these issues and even cure cancer, said Chairperson Payment. Researchers using scientific methods can investigate any question related to traditional healing/medicine, said Dr. Langevin.

Regarding the next generation of scholars, Oklahoma Delegate Bobby Saunkeah asked about funding available for Tribes seeking to develop experts in opioid treatment or alternative pain management strategies. NCCIH continues to nurture clinician scientists who can pair up with researchers. Tribal leaders also asked the center to consider funding a cohort of people selected by Tribes so Native communities can assist in training those who have a specific set of skills. Although current opportunities focus on acupuncturists and naturopaths, the center could adapt its initiatives and remains open to further conversation, said Dr. Langevin. National At-Large Delegate Denise Dillard, Ph.D., asked about providing flexible time for clinicians. Participating in Native American Research Centers for Health (NARCH) funding also could help NCCIH build Tribal research capacity, said Dr. Dillard.

A discussion on traditional healing/medicine should open the door for more transparency between patients and doctors, said Nashville Area Delegate, Beverly Cook. Western practitioners might feel threatened by healing ways, ceremonial practices or medicine societies due to lack of familiarity. Traditional healing seems to demand study and legitimacy, said Chief Cook, chief of the Saint Regis Mohawk Tribe. Making traditional medicine part of medical school curriculum could spark greater understanding and ease the fear of liability. Oneida Nation provides electronic and face-to-face cultural awareness training for health division staff, said National At-Large Delegate Debra Danforth. PowerPoint slides offer guidance on ceremonies and traditional stories and how those practices apply to community health care.

Ms. Sundberg posed this question: What is health care today to Tribal people? Current practice sends people to 20-minute doctor's visits for a prescription. Those efforts do not heal the entire person, said Ms. Sundberg. Ms. Sundberg requested guidance in identifying the healing botanicals available in the Redwood country of California. Tribal communities need research to reframe local health systems and encourage traditional medicines and practices. Native languages play a vital role as well, said Dr. Langevin. Tribes also need a framework for evaluation, so research does not invalidate healing practices and indigenous ways of knowing, said Chief Malerba. Further, review committees should include people who are familiar with traditional medicine.

Native communities also should expand the topic of health and well-being to include financial wellness, quality food, and other topics, that answer such questions as these: What is health? What is a whole person? What does that look like? Tribal leaders must address these issues to foster total health, said Ms. Sundberg. Chairperson Payment and Tucson Area Delegate Chester Antone wrapped up the conversation with comments on the Tribal Behavioral Health Agenda, which recognizes traditional practices and highlights how full treatment, recovery, and wellness connects to adapting medicine to meet Tribal needs.

Following the discussion, TAC members adjourned for Tribal Caucus until noon.

III. Discussion with NIH
Lawrence A. Tabak, D.D.S., Ph.D.
Principal Deputy Director, NIH

Dr. Tabak offered updates on these NIH priority initiatives:

- The Opioid Crisis: In 2017, opioid overdose deaths were almost 10 percent higher than in 2016. Death rates for AI/ANs have increased dramatically, as is true for many other racial groups. Rural and Tribal communities face geographic, socioeconomic, and medical system challenges. NIH continues to use scientific approaches to address these issues, including research projects through NARCH. The National Drug Early Warning System Program is studying the extreme disparity in overdose deaths for AI/AN residents in Minnesota.

- Helping to End Addiction Long-term Initiative: This trans-NIH research effort seeks to enhance pain management and improve prevention and treatment strategies for opioid misuse and addiction. NIH is coordinating with the Surgeon General, federal partners, local government officials, and communities.

- The *All of Us* Research Program: This initiative seeks to bring together one million or more volunteers from across the United States to enroll and participate for research. This program will likely be the largest, and certainly the most diverse cohort in the nation, a key element in precision medicine, an approach for disease prevention and treatment. This revolutionary approach ensures that researchers, health care providers, and patients work together to develop individualized care. The AI/AN engagement/consultation timeline for the *All of Us* Research Program includes a June 24, 2019 Tribal consultation at the mid-year conference of the National Congress of American Indians (NCAI).

TAC members began the question-and-answer period with comments about the consultation for the *All of Us* Research Program. Chairperson Payment noted adverse reactions from minority groups regarding the rollout of the program. TAC members remain disappointed that the program launch did not include Tribal consultation or pre-informed consent. Although NIH gave attention to the issue and scheduled listening sessions, that was not consultation, said Chairperson Payment. Further, access to data without ethical expectations could result in reports about genetic inferiority and other insensitive topics. NIH should send a communication out to Tribes that acknowledges the need for greater consultation and highlights the listening sessions or consultations that will occur between now and the session at NCAI as well as afterward, said Chairperson Payment.

National At-Large Technical Advisor Yvette Roubideaux, M.D., reemphasized Chairperson Payment's comments. Tribes do not feel consultation has already occurred, and one session is not adequate. Tribes want to have more consultation sites, and NIH should send a contrition letter as soon as possible. Further, even though recruitment for the study has already begun, Tribes want to halt access to data, if AI/ANs are included, until NIH resolves Tribal concerns.

TAC members also asked additional questions and expressed the following concerns:

- Who is the highest decision-maker for the *All of Us* Research Program?
- What are the Tribal Collaboration Working Group (TCWG) recommendations, and what can NIH accomplish? Consultation should allow Tribes to influence a pending decision.
- Other racial/ethnic groups also are not happy with how NIH has handled the *All of Us* Research Program. This is an opportunity for NIH to right the ship.

Chief Malerba reminded Dr. Tabak that consultation is government-to-government, and should occur before a federal agency makes a decision. NIH should align its consultations with the annual regional sessions that already occur as part of the consultation policy for the U.S. Department of Health and Human Services (HHS). NIH also could reach out to the major Tribal organizations. Chief Malerba noted that during colonial times, eastern Tribes had diplomatic relations with the crowns of Europe. That protocol continues with what is now the United States. TAC and NIH should review the committee charter and the HHS Tribal Consultation Policy to inform and improve the *All of Us* Research Program rollout and benefit NIH and the Tribes. As a member of the TCWG, Chief Malerba expressed disappointment that the program launched without appropriate consultation.

Andrew Shogren, Technical Advisor for the Portland Area, said that the *All of Us* Research Program recruitment process should stop until TAC and NIH sort out all the issues. The research program continues to actively reach out to local communities, and that recruitment will certainly include Tribal members. Tribes have not signed on as to how NIH will hold or share the data. Mr. Shogren noted the University of Arizona Banner facility, which has a large population of AI/ANs, will play a large role in the program. The *All of Us* Research Program continues to actively recruit members from that facility.

Moving on to the topic of research funding access, Dr. Dillard requested more Native investigators and more investment in AI/AN research. TAC members hope to overcome barriers by reviewing an analysis of the number of applications from AI/AN investigators. Possible questions include these:

- How many secure funding?

- Are technical issues in the review process keeping Native investigators from funding?
- What are the key scientific reasons for a poor score?
- How often will THRO conduct its portfolio analysis, and when will the TAC receive that data?

TAC members hope to see more investments from different Institutes and Centers over time, but need data to verify if NIH is achieving this goal, said Dr. Dillard.

Tribes also want more input in shaping the funding announcements to ensure these projects focus on issues that are important to Native communities. Traditional healers could serve as research project investigators even though most healers do not have doctorate or medical degrees. However, these healers might not make it through the scientific review process. TAC seeks more influence on that issue. Tribes also need protections in place for certain types of research. Lastly, Dr. Dillard noted that traditional medicine often incorporates songs and ceremonies as part of a holistic process, which might not suit funding announcements that promote more Western approaches.

Regarding the CSR process, Dr. Dillard asked when NIH would accept and finalize the Points to Consider document. TAC members also requested details on how NIH will deploy the document. Tribal leaders believe reviewers should have sufficient capacity to assess AI/AN applications appropriately. Reviews continue to occur, and Native communities feel disheartened when investigator applications are continually denied funding, said Dr. Dillard. The TAC seeks some sort of audit to determine the reasons for the multiple rejections, added Ms. Sundberg.

Dr. Tabak mentioned that NIH must continue to address the loss of trust. NIH funds one out of five, so most investigators face that same rejection. NIH hopes the review process does not lead to distrust in Native communities. Dr. Dillard noted that funded research remains a competitive field. Even so, longstanding data shows potential racial/gender bias. NIH must consider these biases in addition to the field's competitiveness. TAC members also seek research from a Tribal perspective. Available grants often do not match community needs, said Ms. Sundberg. Dr. Dillard noted such successful funding announcements/projects as NARCH, and recommended more encouragement and dedicated budgets for those announcements. Chief Malerba called for more AI/ANs in review committees.

Mr. Saunkeah said the TAC has moved away from one of its primary purposes: to play an early role in the discussion and development of NIH policy. Unlike NIH staff, TAC members are not aware of the upcoming policies that might affect AI/AN research. Initiatives and programs seem to come before the committee a little late in the process, said Mr. Saunkeah. In-person meetings also include more presentations from Institutes and Centers than in the past. Mr. Saunkeah requested a return to early discussions on ideas and policy before NIH fully develops its initiatives. The TAC, for instance, has not completely resolved its concerns about the data sharing policy, Mr. Saunkeah added. TAC members also recommended more caucus time during in-person meetings and a pre-meeting for the Technical Advisors.

Dr. Dillard ceded to National At-Large Technical Advisor Vanessa Hiratsuka, Ph.D., who highlighted the NIH TAC Orientation Handbook. This guide for incoming TAC members and Technical Advisors could inform staff across NIH. Dr. Hiratsuka encouraged NIH to provide such materials sooner for Technical Advisors to provide appropriate feedback. Dr. Hiratsuka also requested regular updates on the AI/AN

Research Strategic Plan listed in the handbook and more participation from the NIH Tribal Health Research Coordinating Committee during TAC in-person meetings.

Chairperson Payment had additional comments on the dismissal of the AI/AN HRAC without consultation. During a conference call, HRAC members learned that the committee no longer existed. Chairperson Payment asked if some of HRAC's work could carry over to the TAC with informational reporting up to the Secretary's Tribal Advisory Committee (STAC).

Mr. Saunkeah ceded to Oklahoma Area Technical Advisor Michael Peercy for additional HRAC comments. HRAC heard reports from all of the operating divisions of HHS, including the Centers for Disease Control and Prevention (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHSA). Mr. Peercy asked about the TAC's authority to review those operating divisions should HRAC's work move under NIH. Further, does THRO have the resources to take on additional work? Mr. Peercy ceded the seat back to Mr. Saunkeah.

To take on the HRAC work, NIH would need to develop a strategy with its sister agencies, said Dr. Tabak. NIH already works across various HHS operating and staff divisions to accomplish many federal tasks. Dr. Tabak also noted that although THRO cannot do everything, staff can develop a framework with assistance from others. NIH does not want to lose the good work of HRAC. The issue will require further discussion. Tribal leaders stressed that the TAC and THRO should play integral roles in the planning. Dr. Wilson noted the HRAC topic on the second day's agenda for the in-person meeting.

IV. Flash Talk
Stacy Carrington-Lawrence, Ph.D.
Health Science Administrator, Office of AIDS Research

Dr. Carrington-Lawrence met with the TAC the day after National Native American HIV Awareness Day. Through its research, NIH aims to end the HIV/AIDS pandemic and improve the health of people with, at risk for, or affected by HIV. NIH accomplishes this goal through research, data, and policy. The Office of AIDS Research (OAR):

- Coordinates the largest public investment in HIV/AIDS research globally.
- Establishes scientific priorities.
- Allocates research funds in line with scientific priorities to nearly every NIH Institute and Center.
- Manages HIV/AIDS research across the NIH: scientific, budgetary, legislative and policy components.

During the past 30-plus years, HIV has become a chronic condition with treatment. Even so, the rate of new diagnoses each year in the United States has not declined. About 40,000 people are diagnosed each year. A new initiative seeks to reduce new infections by 75 percent during the next 5 years, and by 90 percent during the next 10 years. The plan will focus resources in the 48 highest-burden counties as well as Washington, DC; San Juan, Puerto Rico; and 7 states with a substantial rural HIV burden.

The Indian Health Service (IHS) serves as a principal partner in the HIV initiative. Dr. Carrington-Lawrence reported a 34 percent increase in HIV diagnoses among AI/AN populations between 2012 and

2016. The majority of infections occurred in the Southwest, with Arizona as the biggest hotspot for new infections among the AI/AN population. Dr. Carrington-Lawrence reported:

- A 26 percent increase in linkage to care following an HIV diagnosis in AI/AN since 2010.
- Substantial improvements in retention in care (a 34 percent increase between 2010-2015).
- An increase in viral suppression (63 percent between 2010-2015).

Mr. Shogren provided additional data, noting that from 2012 to 2016, HIV diagnoses among whites decreased 8 percent, among African Americans decreased 5 percent, and among Hispanic Latinos remain stable. The 34 percent increase presents a huge diversion from what is occurring in the rest of the populations, said Mr. Shogren.

THRO, OAR and IHS have begun to explore opportunities for collaboration within the framework of the Ending the HIV Epidemic Initiative. Further, the President's proposed budget for FY2020 includes $25 million in new investments to establish the Eliminating Hepatitis C and HIV/AIDS in Indian Country Initiative.

The Indigenous Wellness Research Institute at the University of Washington, Seattle, hosted a March 4th OAR Constituency Engagement Meeting with participation from OAR Director Maureen M. Goodenow, Ph.D. Tribes raised these concerns during the meeting:

- Significant health disparities among AI/AN population.
- Surveillance and reporting systems – lack of standardization.
- Racial misrepresentation hinders designing better interventions.
- Stigma, access to care affect testing, loss to follow-up.
- Need for initiatives to specifically target AI/ANs, particularly linking HIV with comorbidities such as sexually transmitted infections and intravenous drug use.

Following the flash talk, Mr. Saunkeah asked for more details on the IHS/Tribal partnership. Dr. Carrington-Lawrence noted the effort remains under development; however, tentative plans include a coordinated effort across HHS divisions, including the Health Resources and Services Administration and NIH Centers for AIDS Research (CFAR).

Chief Cook noted that in 2016, the CDC released a report outlining 220 counties at risk of an HIV or a Hepatitis C outbreak as a result of the opioid epidemic. However, the only demographic indicator used in the research were non-Hispanic whites, with no AI/AN representation.

Dr. Carrington-Lawrence said AI/AN populations often are grouped with "other" categories because the population numbers are small. The initiative hopes to get at those numbers to identify problems as well as drivers of the epidemic.

Mr. Shogren said the $25 million in new investments, if distributed as grants, would result in $43,000 for each Tribe, which would not make much of a difference. Further, challenges in health funding link back to the IHS budget. Issues such as HIV/AIDS in Native communities remain symptomatic of chronic IHS underfunding, Mr. Shogren added.

Dr. Dillard asked how NIH plans to partner with Tribes in addressing HIV/AIDS health disparities. Dr. Dillard also reminded NIH that risky behaviors can signal childhood trauma or sexual assault. Native women, in particular, experience high rates of sexual violence. Dr. Carrington-Lawrence said OAR conducts research that focuses on training AI/AN populations. That training is supported with HIV/AIDS dollars to draw the right people into research and prepare the way for future NIH applications. In addition, some research partnerships at the CFAR receive funding from various Institutes and Centers. These CFAR have established partnerships as well.

Following the March 4, 2019 event in Seattle, Dr. Goodenow also plans to continue reaching out to Tribes across the country. Dr. Wilson also highlighted upcoming conversations and collaborations between THRO and OAR.

Councilman Antone requested information on the number of American Indians affected by HIV in Arizona. Dr. Carrington-Lawrence noted substantial numbers, adding that most of the new infections and people living with HIV live in Maricopa County, Arizona, close to the Mexican border. That area includes numerous Tribal communities. Ms. Sundberg requested short videos for Tribal Websites and health clinic waiting rooms on AIDS awareness, prevention and treatment.

Alaska Area Delegate Donna Galbreath, M.D., ceded to Alaska Area Technical Advisor Tim Thomas, M.D. Dr. Thomas asked about measures of the proportion of AI/AN people who have been screened. The numbers of new cases do not reflect those who are infected. Many people do not know their status and contribute to the continued epidemic.

Dr. Thomas, who works in an HIV clinic, noted new cases in Alaska that manifested with full-blown AIDS before doctors could provide appropriate treatments to slow the disease's progress.

Dr. Carrington-Lawrence said OAR could go back and look for such data as the CDC might not track that information. Stigma plays a role in keeping Tribal members from HIV screenings, Dr. Thomas added. Access to care presents another challenge for groups heavily impacted by HIV, said Dr. Carrington-Lawrence. Dr. Thomas ceded back to Dr. Galbreath.

Dr. Galbreath highlighted the interrelationship between opioids, Hepatitis C and HIV. Chief Cook added that the focus on opioids takes attention away from methamphetamines, other drugs, and alcohol. Trading sex for drugs continues to occur, and one HIV infection can affect an entire Tribal community, said TAC members. Tribal leaders need access to funding to push diagnoses, diagnostics, and treatment out to the communities, said Chief Malerba. Further, rural communities face steep challenges in accessing treatment, so Tribal leaders need helpful action plans.

V. CSR Presentation and Discussion
Noni Byrnes, Ph.D.
Director, Center for Scientific Review

CSR ensures that NIH grant applications receive fair, independent, expert, and timely reviews – free from inappropriate influences – so NIH can fund the most promising research. CSR reviews 62,000 applications every year and relies on more than 18,000 reviewers. CSR does not have its own funding authority. The center's $140 million budget funds reviewers, operations and staff.

CSR offers a two-stage peer review system. The first level is a scientific review group which looks at the scientific content or merit of the application. The second level is at the NIH Institute or Center advisory council. Each Institute or Center has an external advisory council that advises the director and makes funding recommendations. CSR conducts about 75 percent of the initial reviews using study sections or special emphasis panels. Some of these study sections or panels convene in other locations outside of CSR. At the second level, the advisory councils consider the CSR review scores while also assessing broader programmatic priorities.

The scientific review officer (SRO) serves as the designated federal official in charge of the peer review process. The SRO selects, recruits and trains reviewers; manages conflicts of interest; conducts the review meeting; and prepares a summary statement to report the outcome of the review. CSR reviewers are recognized authorities who can work effectively in a group and demonstrate impartiality. The Center also seeks women, minorities, and geographic representation.

Addressing the scoring and peer review process, Dr. Byrnes said reviewers will provide an overall impact score to reflect the likelihood for the project to exert a sustained, powerful influence on the research field(s) involved. NIH policy and CSR reviewer training does not define the "field" for reviewers and does not tell reviewers how to weigh the five review criteria -- significance, investigators, innovation, approach, and environment in determining the overall impact score. To address errors in the process, CSR can re-orient reviewers, re-review applications, or use a built-in appeal process.

Following the presentation, Chairperson Payment asked about investigative reviews to identify systemic problems in the CSR process. Chronic denials could signal deficient applications or undetected issues. CSR is currently conducting a study to identify systemic biases regarding gender, ethnicity, race, age, and career stage. Dr. Byrnes expects to share results by fall 2019. Chairperson Payment gave further clarification, requesting a review to determine whether a person with chronic application denials simply has not met the standard or whether the reviewers simply do not understand the application.

Dr. Byrnes said the CSR study aims to identify systemic bias, and CSR will take action to address any identified problems. James M. Anderson, M.D., Ph.D., noted that NIH has never done an individual review to determine why one person cannot get funded. NIH has suspicions of women and minorities being funded at a lower rate for certain types of awards. The agency has completed detailed analyses on the factors that contribute to such biases. Chairperson Payment asked if anything would preclude a review of a particular coalition or area health board to determine whether an application has been denied repeatedly due to a scientific issue or a systemic bias. A cross-sectional review of individual applications that have faced repeated denials might show what is going on, said Chairperson Payment.

Identifying such a trend would require a broad analysis, said Dr. Byrnes. Dr. Anderson agreed, adding that each application receives individual treatment. Applicants also can call the program officer and ask about repeated denials.

Chief Cook noted that reviewers might know science, but they do not know Tribal communities or circumstances. The Saint Regis Mohawk Tribe has worked for about 30 years with the State University of New York, Albany, to study polychlorinated biphenyls. Chronic exposure to such chemicals occurs during a period of years. Tribal members know what is occurring, but the work requires follow-up, said Chief Cook. The inability to secure more research means the community gives up and people go on dying.

In response to a question from Dr. Dillard, Dr. Byrnes said the application success rate includes investigators who have been more successful and who have multiple funded applications. Dr. Byrnes also called for more AI/AN reviewers.

Dr. Dillard asked about CSR's approach and strategy for addressing the issue that women and minorities are funded less often. Dr. Dillard also noted inappropriate comments from reviewers. One possible remedy is the Points to Consider document that is near completion. Rather than wait for the document, applicants should inform CSR of inappropriate comments or other issues, said Dr. Byrnes. Broadening the reviewer pool also will improve outcomes for women and minorities.

Chief Malerba ceded to Dr. Roubideaux, who raised a question about applications that serve only one population. Dr. Roubideaux said the head of CSR previously stated that an application that focused only on one population would not be scored as well as an application that had an interest in more than one population. Tribal researchers already face disadvantages if reviewers wonder why an application does not address other races and ethnicities. Dr. Byrnes reiterated that reviewer guidelines and training do not call for broad applications. Dr. Roubideaux ceded back to Chief Malerba.

Mr. Shogren requested that NIH policy call for 1 percent of reviewers to be AI/AN. Councilman Antone ceded to Tucson Area Technical Advisor Teshia Arambula Solomon, Ph.D. Dr. Solomon asked how much power a program officer has in determining whether an application receives funding. Dr. Byrnes said any reviewer can call back any application into discussion for any reason. Funding is the role of the program, so an application not scored highly can be chosen for other reasons.

Dr. Solomon ceded the seat back to Councilman Antone. Councilman Antone suggested that top NIH leadership must call for investigative reviews of systemic problems, not CSR. Dr. Anderson recommended forming a committee that discusses what the TAC seeks to investigate. At the current time, men and women receive funding at the same rates, added Dr. Anderson. That issue improved when more women got involved with reviews and more women joined the workforce. After further TAC discussion, Dr. Anderson proposed that NIH look at how many times individuals apply and do not receive funding, and look at those who do not receive funding several times in a row. Possible questions to address:

- Who are these researchers?
- What are the topics?
- What can NIH learn or identify?

VI. Highlights of Tribal Activities at NIH and Discussion
David R. Wilson, Ph.D.
Director, THRO

Dr. Wilson, who has led the THRO for two years, reviewed a brief timeline of activities. Whereas previous years focused on communication, engagement and professional development, THRO staff now concentrate on research. The office seeks to expand the Tribal research portfolio and understand how Tribal research receives funding across the agency. Year four goals include implementing the THRO strategic plan, which has gone to the NIH director for final approval.

Upcoming activities include:

- A meeting with the National Institute of Allergy and Infectious Diseases
- Congressional visits
- Coordinating the second 2019 TAC In-person Meeting in Fairbanks, Alaska
- Traditional Medicine Summit
- NIH Tribal Consultation on Intellectual Property Rights
- Regional training hubs
- Strategic plan
- Midwest Alliance of Sovereign Tribes (MAST)
- IHS Annual Tribal Epidemiology Centers (TEC) Directors Meeting.

Dr. Wilson introduced new THRO Assistant Director Juliana Blome, Ph.D. THRO also has added two health science policy analysts: Maria (Jay) Jamela R. Revilleza, Ph.D., and Laura LaRue Gertz, MSW.

Ms. Sundberg requested more information on training hubs to encourage Tribal youth to get more involved. Chief Malerba reiterated the disconnect between the TAC and the *All of Us* Research Program and asked Dr. Wilson to advocate for good consultation. THRO continues to inform the program on proper consultation timelines, notices and expectations, and follow-up, said Dr. Wilson. THRO staff also can put more focus on HHS regional consultations.

Chief Malerba ceded to Dr. Roubideaux, who reminded TAC members of the upcoming consultation on intellectual property rights and the pre-consultation Webinar. Dr. Roubideaux also asked NIH to consider developing review policies to protect Tribes from commercialization. Dr. Roubideaux ceded the seat back to Chief Malerba.

Responding to questions about THRO priorities and the office's budget, Dr. Wilson said the office must leverage collaboration. THRO staff hope to train partners in the Institutes and Centers so those colleagues also can promote Tribal initiatives at NIH and in the community. Dr. Anderson added that the NIH Division of Program Coordination, Planning and Strategic Initiatives helps the entire agency engage in such critical topics as Tribal health. The THRO strategic plan serves as the rallying call to get everyone on board.

VII. Traditional Medicine Summit Planning Discussion

Dr. Wilson requested TAC priorities for the summit, which will occur September 30-October 2, 2019, in Aurora, Colorado. The event will include about 100 participants to encourage openness and sharing from spiritual healers. THRO expects participation from such HHS operating and staff divisions as the SAMHSA and the Centers for Medicare and Medicaid (CMS). THRO also has received information from previous traditional medicine events to assist with planning and creating a unique experience.

TAC members discussed cannabis and other botanicals that researchers are not allowed to study. Tribes should have special status to conduct research that impacts opioid abuse and other issues, said Ms. Sundberg. Councilman Antone said the idea for the summit stemmed from understanding that different types of healing and research exist. Further, Tribal members have lost some of the traditional ways of

knowing that have sustained communities. Further, greater understanding might encourage CMS to reimburse for traditional healers and practices.

NCCIH hopes to learn different practices that are important to study as well as research outcomes. These efforts will inform the center's research priorities, said Lanay Mudd, Ph.D. Dr. Galbreath encouraged preliminary conversations with the traditional healers to promote a sense of safety and respect. Dr. Wilson said the summit will include time on the front end to come to some consensus about what the healers will share. Chief Malerba said the summit may be a two-part process. The summit will move into consultation when the discussion turns to a proposed research agenda.

Following closing comments and a blessing from Chief Cook, the meeting adjourned, to resume at 9:00 a.m. on Friday, March 22.

VIII. Plant-Based Therapy Research Update and Discussion
Steven W. Gust, Ph.D.
Director, International Program
National Institute on Drug Abuse

The second day of the TAC in-person meeting opened with a welcome and a brief Tribal caucus. Dr. Gust next gave a presentation on cannabis policy and research. NIDA tends to focus on the harms of cannabis use, but also coordinates some studies on its potential benefits.

Cannabis remains the most commonly used illicit drug in the United States. More than 26 million people age 12 and older report past month cannabis use. Public opinion has changed rapidly during the past several decades, particularly since 2010. A majority of Americans support legalization of cannabis for various reasons. Dr. Gust reported 33 legal medical marijuana states in addition to Washington, DC, and 10 legal recreational marijuana states, along with Washington, DC.

State legalization butts heads with federal policy. Cannabis remains a Schedule 1 controlled substance subject to restrictions for its use. Cannabis also has no federally approved medical use and is illegal to use or possess recreationally. Responding to a question from Mr. Shogren, Dr. Gust said vaping is incorporated into the rates of cigarette use. Dr. Gust also highlighted the changing landscape for cannabis, noting the increasing potency and new types of use in foods, drinks, or vaporizers.

Dr. Gust examined both the negative and therapeutic effects of cannabis. Cannabis contains at least 100 different cannabinoids as well as other chemicals in varying concentrations. Researchers have developed several into medications. Marinol, Syndros and Cesamet, for example, have tetrahydrocannabinol (compounds that have been purified and available medically for decades). The Food and Drug Administration has approved plant-derived medications such as Sativex. Epidiolex is a plant-derived formulation of cannabidiol (CBD) for treatment of epilepsy.

Dr. Gust highlighted about 50 conditions that CBD is purported to treat. Marijuana is approved by states for at least 52 medical conditions. Most of the indications are not yet supported by clinical trial data or prospective research data. Recent meta-analyses support the use of cannabinoids for chronic neuropathic non-cancer pain, but the studies are generally short, small with modest effect sizes.

Despite the research barriers and challenges, NIH supports a significant amount of research related to cannabis. Dr. Gust estimated about $146 million worth of research funded by NIH. Categories related to cannabis include therapeutic cannabinoid, CBD and endocannabinoid research.

Ms. Sundberg requested more work in the area of research because cannabis could serve as an alternative to the opioid epidemic in Tribal communities. People hear about the benefits but do not know which strain or which dosage is most effective. Cannabis is also helpful for post-traumatic stress, which is similar to historical trauma, said Ms. Sundberg.

Ms. Sundberg ceded to Dr. Sisley, who noted that the majority of funding seems to go toward basic-science/receptor-level research at the molecular level. Tribes report a tremendous patient base that uses cannabis without any understanding of how to harness the medical potential. For instance, which varieties are best for which illnesses? These clinical questions need immediate answers, and millions invested in basic research will not produce answers right away. The balance of funding needs to change from only looking at safety to assessing both safety and efficacy in clinical trials, said Dr. Sisley. Dr. Sisley also encouraged licensing other growers for research, before ceding the seat back to Ms. Sundberg.

Dr. Gust noted that Tribes in California are in a unique position to establish patient registries, track type of use within the state, and complete significant work. Dr. Gust recommended focusing on the basics instead of all the other potential varieties and genetic mixes. However, NIDA supports efforts to increase manufacturers and growers.

IX. Tribal Consultation Protocol Discussion

Dr. Wilson and THRO Health Science Policy Analyst Ted Keane presented updates on the Tribal Consultation Protocol. A protocol serves as a more detailed description of how NIH approaches consultation and honors the HHS Tribal Consultation Policy developed in 2010.

The HHS Tribal Consultation Policy provides a general framework on how to respect the government-to-government relationship with Tribes, said Dr. Wilson. In 2014, NIH drafted policy to form the Guidance on the Implementation of the HHS Tribal Consultation Policy. The new protocol will be part of the NIH's Guidance on the Implementation of the HHS Tribal Consultation Policy. The protocol will offer another layer of detail that will create more consistency for the Institutes and Centers. The protocol, for instance, spells out sequentially the tasks that must occur to fulfill consultation. Other operating divisions might also use the protocol in the future, which would promote even more consistency across HHS.

Dr. Wilson welcomed comments on both the NIH Guidance on the Implementation of the HHS Tribal Consultation Policy and the new consultation protocol. Chief Malerba noted that whenever any agency develops a consultation policy, the document goes out for consultation. The documents also might be good topics of discussion on the monthly TAC conference calls, Chief Malerba added. Chief Cook requested language regarding the federal government's trust responsibility. The document should reiterate such information to remind NIH staff member why the process remains important.

Dr. Wilson reminded the TAC that the protocol outlines when staff should mail a Dear Tribal Leader letter, put a notice in the Federal Register and manage communications to nongovernmental organizations. Councilman Antone said Tribes should be notified that a meeting is consultation.

Further, federal staff should not make a phone call and then "check off the box" to say consultation has occurred, said Councilman Antone.

Mr. Saunkeah recommended attaching the protocol to the Guidance on the Implementation of the HHS Tribal Consultation policy as an appendix. Dr. Wilson said that was the ultimate goal for the protocol. Given the time and review processes required, the protocol could be drafted into a policy later. TAC members and Dr. Wilson acknowledged some confusion surrounding the documents. THRO seeks to make appropriate changes to create an effective document for everyone. TAC members agreed to continue discussions during the monthly calls.

X. NIDCR Presentation and Discussion
Martha J. Somerman, D.D.S., Ph.D.
Director, National Institute of Dental and Craniofacial Research

NIDCR seeks to improve dental, oral and craniofacial health. NIDCR's 2018 appropriation was $446 million. In 2030, NIDCR imagines a world where:

- Dental, oral and craniofacial health and disease are understood in the context of the whole body.
- Research informs strategies to promote health, prevent and treat disease, and overcome disparities in health.
- All people have the opportunity to lead healthy lives.

In the coming decade, NIDCR also will focus on precision health, autotherapies, oral biodevices and workforce diversity.

Turning the conversation to health disparities, Dr. Somerman noted that Tribal groups remain burdened by poor oral health. For example, data report four times more dental decay in AI/AN children (ages 2-5) than white counterparts. AI/AN adults experience significantly higher rates of untreated dental caries, missing teeth and other concerns.

NIDCR works across the federal agencies to address these disparities. The Oral Health Coordinating Committee:

- Directs and coordinates a broad range of oral health policy, research, and programs across federal agencies, and between the public and private sectors.
- Developed the Oral Health Strategic Framework to coordinate efforts to improve the nation's oral health.

Dr. Somerman reported modest AI/AN research funding from 2014-2018. One area of funding is *Streptococcus mutans* and dental caries among Native American children. The study identified 17 unique types of *Streptococcus mutans* in the Northern Plains Tribal community. This bacterium is often, but not

exclusively acquired from mothers, and bacteria colonization occurs by 16 months in 58 percent of the children.

Dr. Somerman highlighted such delivery care interventions as the Primary Dental Health Aides and the Dental Health Aide Therapists (DHATs). A focus on storytelling and reducing sugary drinks in Alaska Native children remain ongoing efforts. NIDCR also serves as a partner in the Early Childhood Caries Prevention Program with the Hopi Tribe in Arizona and the Crow Tribe in Montana. This research effort conducts a formative assessment on oral health, and adapts a culturally tailored best-practices oral health intervention. Community health workers facilitate the study.

NIDCR also has given greater attention to oral cancers and innovative treatment for orofacial clefting in AI/AN communities. NIDCR also works to increase the AI/AN oral health workforce.

Following the presentation, Mr. Shogren thanked Dr. Somerman for leading the DHAT effort at the University of Washington. Dentists in Washington state took a clear aim at preventing the rollout of the DHAT program. After a seven-year process, DHATs are coming out of Alaska down to the lower 48 states, said Mr. Shogren.

DHATs not only provide dental care in Tribal communities but also prevent dental caries. Many AI/AN communities, however, do not have providers. Mr. Shogren recalled working at a clinic that had 32 cents for every dollar of need. Staff ran a small village clinic for $56,000. Tribal leaders must continue to advocate for adequate IHS funding to pay DHATs and dentists, said Mr. Shogren.

Ms. Sundberg requested educational video clips to inform Tribal communities of the dangers of sugary drinks. Clarifying the context of the issue, Dr. Dillard noted that a large proportion of people in rural Alaska do not have running water or access to fluoridated water. Oral diseases among Alaska Natives are really a result of colonization and the westernization of the traditional diet, added Dr. Thomas, who spoke on behalf of Dr. Galbreath. By age 6, 73 percent of Alaska Native youth have experienced full-mouth dental rehabilitation, Dr. Thomas added before ceding the seat back to Dr. Galbreath.

Mr. Saunkeah requested support for Tribal clinicians who spend most of their time providing treatment/patient care rather than conducting research. Dr. Somerman highlighted practice-based research networks, a program developed to recruit participation from practicing dentists that is applicable to actual patients. The program seeks more representation from different groups that experience health disparities.

XI. AI/AN Health Research Advisory Council (HRAC) Transition

Dr. Wilson updated the TAC on the recommendations from the Office of Minority Health (OMH) to decommission the HRAC. The OMH is under the HHS Office of the Assistant Secretary for Health. Originally, only a few HHS operating divisions, such as the CDC and IHS, worked closely with Tribes. As the TAC began to focus on the NIH research investment in Tribal communities, OMH identified overlapping priorities with HRAC. Further, Tribal leaders might have felt burdened with duplicative work/meetings.

TAC members received a copy of the decommissioning letter. THRO was not a part of the decision; instead, THRO staff will facilitate the transition of HRAC members. THRO also will assess where HRAC objectives might overlap with the NIH mission. For instance, the TAC can determine how the HRAC's focus on social determinants of health aligns with public health research.

TAC members took a side-by-side look at the THRO strategic goals and initiatives and HRAC priorities. Chairperson Payment noted that HRAC focused on health disparities. The committee also addressed these issues:

- Building capacity for Tribal communities to conduct research.
- Encouraging a healthy skepticism of external investigators.
- Empowering Tribes to be more critical of research conducted in Indian Country while promoting such efforts.
- Developing protocols for research completed by federal agencies.
- Identifying additional funding for acute health challenges in Indian Country.

Chairperson Payment said many of these objectives could align with the TAC. Chairperson Payment requested an articulation and comparison between the former charge of the HRAC and the TAC. Former HRAC members also could fill TAC vacancies. Dr. Anderson cautioned TAC members not to take on tasks for which NIH has no authority, capacity, or budget. Committee members should select HRAC objectives that do not slow the TAC's momentum.

Out of the top 10 HRAC priorities, only 2 did not overlap with the THRO strategic plan, said Dr. Wilson. Ms. Sundberg requested more time for review. TAC members expressed frustration that OMH decommissioned the HRAC without Tribal consultation. Dr. Wilson recommended inviting to the next TAC conference call Capt. Damion Killsback, acting director of the OMH Division of Policy and Data. Dr. Wilson also noted that the issue has gone to the STAC.

Mr. Shogren made a motion, calling for the TAC co-chairs to draft a letter expressing disdain for the decommissioning of HRAC without Tribal input. Further, the issue should go before the STAC to determine whether the HRAC decision aligns with the HHS Tribal Consultation Policy. Chairperson Payment seconded the motion, and the committee approved the motion unanimously. Chairperson Payment planned to get a draft of the letter to Ms. Sundberg by Sunday, March 24, 2019.

XII. Discussion of TAC 2019 Priorities and Next Steps

After meeting separately for dinner, the TAC Technical Advisors asked the full committee to consider these recommendations:

Provide the TAC in-person agenda four months in advance: Dr. Wilson said agendas are usually available two months prior to the meeting. Mr. Saunkeah said three months prior to the meeting might be a more realistic deadline. After further discussion, the TAC agreed that THRO staff should identify a location four months ahead of the event and work collaboratively with the TAC to develop the agenda. Chairperson Payment encouraged full participation on the TAC conference calls to further promote good planning.

Maintain a standing agenda: Staff should structure the in-person agendas to include a place for follow-up items, comments from Technical Advisors, and updates on the THRO strategic plan. The agenda also could address cultural competency training for NIH researchers.

THRO always addresses Tribal sovereignty and the federal trust responsibility when presenting to Institutes and Centers, said Dr. Wilson. Mr. Shogren asked to review the presentation material.

Meetings should maintain a 50-50 ratio of presentations and policy discussions. Presentations also should have a 15-minute limit so TAC members can ask questions. The second day's agenda also might include time to revisit any issues from the previous day. The discussion with NIH also should occur on the second day so the TAC can prepare.

Dr. Hiratsuka will create a draft in-person meeting agenda within two weeks to demonstrate how the TAC could use its time most effectively. Agendas for monthly conference calls also should include time to discuss follow-up on action items.

Focus on Indian Country during meeting presentations: The presentation should address the research portfolio, actual research budget amounts per fiscal year, and community involvement. TAC members can use this information to make apples-to-apples comparisons among the Institutes and Centers. Further, seeing the presentations at least two weeks in advance will help the Technical Advisors conduct research before the meeting.

Include Tribal caucus on both meeting days: Councilman Antone recommended conducting a one-hour caucus each morning prior to the meeting.

Schedule a pre-meeting for the Technical Advisors: During this session, Technical Advisors can discuss issues in person and support delegates more effectively. THRO funding should support the pre-meeting.

Provide a follow-up response to the in-person meeting: Following an in-person meeting, the TAC should submit a letter to the THRO and expect a follow-up within two weeks of the next in-person meeting.

Feature NIH-centered presentations during monthly TAC calls: This strategy will provide more time during the in-person meeting for policy discussions. TAC delegates and Technical Advisors can request needed follow-up from the Institutes and Centers afterward. Sharing a videocast or a Webinar of a presentation on the THRO Website afterward, can help educate Indian Country and assist TAC members who cannot attend a meeting.

Offer more time for engagement with the Tribal Health Research Coordinating Committee (THRCC): TAC members would like to talk more with the Institute and Center colleagues who helped create the THRO. The THRCC continues to provide valuable resources and support. TAC members and Technical Advisors hope to meet with the broader THRCC group rather than the same three or four members.

Devote an in-person meeting to environmental research. Dr. Wilson hopes to coordinate a meeting in North Carolina with the National Institute of Environmental Health Sciences.

Plan more discussion with CSR and consider additional policy addressing TAC concerns: TAC members seek follow-up regarding ongoing issues with CSR. TAC members also want details on the AI/AN representation on CSR external advisory committees.

Assist Dr. Wilson: Technical Advisors can help Dr. Wilson write an annual paper.

Request consultation on dissolution of HRAC: Technical Advisors seek formal conversation to address systematic issues and potential new TAC duties.

The Technical Advisors also noted that talking circles might be more appropriate for the Traditional Medicine Summit than auditorium-style. Further, the agenda should include time for debriefing afterward. Dr. Wilson said the planning committee has already considered those issues.

TAC members wrapped up the meeting with request for more clarifications on the NIH Consultation Protocol and recommendations for the next meeting. Dr. Dillard requested more work on strategic goals and objectives. Dr. Dillard also asked about the follow-up letter from the previous TAC in-person meeting. Dr. Wilson said the letter went to former Navajo Area Delegate Walter Phelps. Dr. Wilson will send a copy of that letter to the TAC.

Kendra King Bowes will send a poll to TAC members to begin planning the August in-person meeting in Fairbanks. TAC members also requested more time to review agendas for the monthly conference calls or electronic meetings. TAC and THRO staff also will identify ways to use videocasts and Webinars for those who cannot attend the monthly meetings.

Dr. Wilson thanked the TAC for a productive meeting, and Chairperson Payment acknowledged Ms. Sundberg's meeting facilitation and leadership as TAC co-chair. Following the closing blessing by Chief Malerba, the meeting adjourned at 2:33 p.m.

NIH Tribal Advisory Committee Meeting
March 21-22, 2019

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