Tribal Advisory Committee Meeting
October 3-4, 2018
Cox Convention Center
Second Floor, Room 14
1 Myriad Gardens
Oklahoma City, Oklahoma

Meeting Summary

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

The Tribal Advisory Committee (TAC) in-person meeting began at 9:04 a.m. with a call to order and welcome from Navajo Area Delegate Walter Phelps, who serves as TAC co-chairperson. Oklahoma Area Delegate Bobby Saunkeah gave the invocation, after which Councilman Phelps read the Federal Advisory Committee Act meeting requirements. Councilman Phelps next led introductions around the table.

David Wilson, Ph.D., director of the Tribal Health Research Office (THRO), addressed meeting goals with a look at the agenda. In keeping with TAC recommendations, Native scholar Madison Esposito was on hand to kick off the presentations. The first day also would include discussions on traditional medicine and cancer within the Navajo Nation, said Dr. Wilson. A late-afternoon conversation on the evolving NIH tribal consultation protocol would touch on ideas raised during a recent meeting of the Secretary's Tribal Advisory Committee.

Consultation protocol also remains a priority for the *All of Us* Research Program, scheduled to provide an update on October 4. Clear guidance will help *All of Us* staff and other NIH programs serve tribal communities effectively. As the meeting got under way, Dr. Wilson invited the committee to think about priorities for next year. Dr. Wilson remains excited about the trajectory of THRO but wants to stay aligned with the TAC's vision as well.

Dr. Wilson also requested e-mailed nominations for TAC chair and co-chair following the departure of Chairperson and At-Large Delegate Liana Onnen. Following Dr. Wilson's comments, introductions of the technical advisors and other meeting participants continued. James M. Anderson, M.D., Ph.D., also gave a welcome on behalf of NIH. NIH has made good progress with tribal communities in the last few years, said Dr. Anderson, NIH Deputy Director for Program Coordination, Planning, and Strategic Initiatives. NIH can get input from the TAC and understand committee interests. In addition, the consultation protocol will help NIH Institutes and Centers (ICs) obtain broad input relevant to developing programs. Researchers and colleagues continue to seek an outline for conducting an effective tribal consultation, said Dr. Anderson.

A. Roll Call

1. **Tribal Advisory Committee Members**
   Chester Antone, Tucson Area Delegate (*via telephone*)
   Denise Dillard, Ph.D., National At-Large Delegate
   Rodney Haring, Ph.D., Nashville Area *(proxy for Delegate Beverly Cook)*
   Tyler LaPlaunt, Bemidji Area *(proxy for Delegate Aaron Payment, Ed.D.)*

Co-Chairperson Walter Phelps, Navajo Area Delegate
Yvette Roubideaux, M.D., National At-Large *(proxy for Delegate Lynn Malerba, D.N.P.)*
Bobby Saunkeah and David Wharton, Oklahoma Area Delegate and Alternate
Lisa Sundberg, California Area Delegate
Jeromy Sullivan, Portland Area Alternate
Lisa Rey Thomas, Ph.D., National At-Large *(proxy for Delegate Alison Ball, Ph.D.)*
Tina Woods, Ph.D., Alaska Area (*proxy for Delegate Donna Galbreath, M.D.*)

2. **Technical Advisors**
   Lyle Best, M.D., Great Plains Area
   Christy Duke, Nashville Area
   Vanessa Hiratsuka, Ph.D., National At-Large
   Michael Peercy, Oklahoma Area
   Andrew Shogren, J.D., Portland Area
   Teshia G. Arambula Solomon, Ph.D., Tucson Area
   Timothy 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

- Highlights of Tribal Activities at NIH
- Tribal Consultation Protocol Discussion
- Research Update from Native scholar Madison Esposito
- Use of Traditional Medicine in Tribal Communities
- Addressing Cancer on the Navajo Nation
- ECHO Research Program Update
- Discussion with NIH
- Traditional Practices in Tribal Communities
- Plant-based Therapies
- *All of Us* Research Program Update

C. Action Items

- During the November TAC conference call, Dr. Wilson will present the edited NIH consultation protocol for review and discussion.
- Dr. Wilson asked TAC members to review the 2019-2024 NIH Strategic Plan for Tribal Health and return comments within two weeks.
- Dr. Tabak suggested revisiting the Navajo Nation's conversation with the National Cancer Institute, perhaps during a special conference call.
- TAC members who want to renew onto the committee at the end of their term should inform Dr. Wilson.

2. Highlights of Tribal Activities at NIH and Discussion
David R. Wilson, Ph.D., Director, Tribal Health Research Office (THRO)

Dr. Wilson began the day with a review of THRO efforts and projects, including the 2018 tribal consultation on opioids, the NIH Strategic Plan for Tribal Research and the interactive Web tool for accessing grant information for Native communities. As the office's busy year winds down, Dr. Wilson noted these follow-up activities:

- NIH plans to publish a request for information (RFI) for those who could not attend the opioid consultation, led by NIH, the Indian Health Service (IHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA). Further, many of the recommendations received during the event may develop into future funding opportunities. TAC members should consider possible research questions for the 2019 consultation.
- Work will continue with the Navajo Nation to develop a thorough, comprehensive data sharing agreement for the Environmental influences on Child Health Outcomes (ECHO) program.
- THRO will develop future partnerships with SAMHSA and other agencies as federal staff look for ways to get out of Washington, DC, and into tribal communities.
- Staff will schedule ongoing conversations with the Rapid City and Pine Ridge communities regarding the Strong Heart Study as well as suicides.

The discussion also addressed funding opportunities, the American Indian/Alaska Native (AI/AN) Portfolio Analysis, the 2018 Native American Heritage Month, and summer internship activities.

In addition, THRO Health Science Policy Analyst Ted Keane gave a demonstration of the Web-based Community Resource for Tribal Grants Information. The resource currently includes highlights of research occurring in AI/AN communities. These highlights come from the National Institute on Minority Health and Health Disparities (NIMHD). THRO assembled the highlights by IHS service area to enable geographic navigation.

Dr. Anderson asked TAC members to consider who needs such a tool. The Portfolio Analysis searches deeply throughout the NIH database for anything that has to do with tribes, with additional hand-curation to identify research that focuses on AI/AN communities. NIH also produces annual reports that are samplings of interesting projects. Those projects are in the Web tool, said Dr. Anderson. The resource could serve researchers, private citizens, grant managers or tribal leaders who are not researchers.

If the tool is a subset of all research that might involve tribes or AI/ANs, it should include a disclaimer or note, said National At-Large Technical Advisor Yvette Roubideaux, M.D. Dr. Wilson said the terminology does not mention that the tool includes all the AI/AN research that occurs at NIH. The tool may include a link that would provide all the information. Even then, the tool would not mention unidentified subawardees. Dr. Roubideaux suggested including the word "highlights" to avoid unnecessary misunderstanding. Other TAC members proposed including details on how to get additional information.

Rodney Haring, Ph.D., representing Nashville Area Delegate Beverly Cook, said the tool serves as a good first step and can continue to evolve. The Website, for instance, could integrate National Library of Medicine links to help users find background information and offer suggestions on how to write grants. Dr. Haring also suggested adding Native Hawaiians on the Website map. Bemidji Area Proxy Tyler

LaPlaunt requested including hot topics or key words such as diabetes or traditional medicine that will bring up all the projects on that subject. Alternatively, the site could include a search bar, said Dr. Wilson.

Vanessa Hiratsuka, Ph.D., a national at-large technical advisor, noted that the data sources are project grants. The title, therefore, should note that the data source is a health research project. Further, the tool can serve as a way to find grant partners. Dr. Hiratsuka also recommended highlighting links to THRO resources. California Area Delegate Lisa Sundberg requested links on work occurring in other research facilities on similar subjects. Getting updated information into the site quickly also would assist substance abuse counselors and other health providers, said Portland Area Alternate Jeromy Sullivan.

Dr. Wilson wants to launch the tool, so users have an opportunity to visit the site and give feedback. The committee will be informed by Dr. Wilson on how THRO uses the TAC recommendations to improve the site.

Dr. Wilson also asked TAC members to review the 2019-2024 NIH Strategic Plan for Tribal Health and return comments within two weeks. Activities for next year include

- 2019 NIH Tribal Consultation
- Consultation Protocol
- NIH-led Traditional Healing Summit
- Support for Intra- and Extramural Research Programs
- Ongoing plans to build the AI/AN research community, and
- Enhanced communication

Denise Dillard, Ph.D., recommended a discussion on intellectual property as NIH considers expanding research into traditional healing or plant-based practices. TAC members do not want tribal communities to feel exploited, said Dr. Dillard, a national at-large delegate. The topic also could rise to the level of consultation. Dr. Anderson noted similar concerns. Small Business Innovation Research also could warrant a future conversation, said Tucson Area Technical Advisor Teshia G. Arambula Solomon, Ph.D. Tribal leaders also discussed tenure-track opportunities for AI/AN researchers.

3. Consequences of Vitamin B12 Deficiency in Embryonic Development and Neonatal Survival
Madison Esposito
National Human Genome Research Institute
Social and Behavioral Research Branch

Ms. Esposito shared details on a research project that looks at vitamin B12 deficiency and how it might relate to infertility and birth defects. Vitamin B12, also known as cobalamin due to its cobalt central atom, is synthesized by bacteria found in the gut. Most dietary intake comes from animal products in the diet. Vitamin B12 is also used to fortify cereals**.**

Some populations are at risk for Vitamin B12 deficiency. Ms. Esposito's research focused on those who have increased needs for B12, which includes pregnant and nursing mothers. Vitamin B12 deficiency can lead to megaloblastic anemia, characterized by the presence of large, immature and dysfunctional red blood cells in the bone marrow, which leads to a lowered red blood cell count. Other effects of B12

deficiency include general fatigue/weakness, poor memory, possible depression and neuropathy, or a lack of feeling in the fingers and extremities.

Ms. Esposito examined how Vitamin B12 deficiency is a risk factor for neural tube defects, such as spinal bifida and anencephaly. Neural tube defects result from a failure of the fetal spinal column to close during the first few weeks of pregnancy. These profound birth defects often lead to death or life-long disability.

Vitamin B12 deficiency is a public health problem for reproductive-age women worldwide, especially in countries that have a low meat consumption. Ms. Esposito hopes to shed some light on how this deficiency might affect these communities. Possible future experiments will address questions about the elderly population. Neuropathy, a side effect of B12 deficiency, can lead to accidental falls and injury in older adults. Older adults also experience weight loss, which could be related to the anemia caused by B12 deficiency. Follow-up questions addressed the best ways to take B12 and other aspects of the study. Whereupon, luncheon recess was taken at 11:00 a.m.

4. Use of Traditional Medicine in Tribal Communities
Michelle Kahn-John, Ph.D., RN, PMHNP-BC, GNP
Assistant Professor, Nursing
College of Nursing, University of Arizona

Following an introduction from Dr. Solomon, Dr. Kahn-John led a discussion on traditional approaches to health and wellness in the American Indian population. Dr. Kahn-John's research focuses on American Indian resilience-strength based models, the health benefits of American Indian spirituality and ceremony and American Indian mental health. Efforts to research cultural wisdom and teaching as well as spiritual, ceremonial practices call for the highest level of respect and humility. Further, honoring the rules might mean not taking the next step in a research process. Researching traditional practices also requires a commitment to the authenticity of the culture.

Traditional medicine varies across indigenous populations but remains a way of life for Native people, said Dr. Kahn-John. This pre-existing health care/wellness system involves diagnosis, spiritual communication, herbal medicine, stories, ceremony, ritual and more. Communities typically practice traditional medicine collectively among families, tribes and groups. Traditional healing integrates air, spirits, animals, natural elements and sacred deities. The process also involves moving toward a state of balance and wellness. Interest in traditional medicine continues to grow as AI/AN communities seek to reconnect to this effective health care system that is sensitive to tribal culture. Traditional medicine is an element of healing and wellness that Indian Country cannot ignore, said Dr. Kahn-John.

Children, adolescents, adults and elders use traditional practices, and Dr. Kahn-John noted that these efforts have become almost trendy in non-indigenous communities. Increased awareness and interest call for authenticity and safety to avoid misuse or misinterpretation.

Reviewing efforts to integrate traditional medicine in an IHS setting, Dr. Kahn-John noted that not everyone believes in or respects such practices. Multidisciplinary turf battles might arise, and those in support might face pressure to modify traditional practices or ceremonies. Persistence and evidence helped knock down initial barriers. Traditional medicine, however, often receives limited reimbursement

or funding. Dr. Kahn-John recommended appropriate settings with access to fire, water and smoke to ensure authentic and respectful delivery.

Despite the challenges of integrating traditional medicine, the effort brought numerous benefits. Patients and community members expressed gratitude, and the effort enhanced cultural insights. The answers to healing historical and cultural trauma also are imbedded in culture and ceremony, said Dr. Kahn-John.

A 2017 study on the Navajo Nation measured emotional distress and inflammation before and after a ceremony. Dr. Kahn-John played a brief video before discussing the study's design and purpose. Reporting on the results, Dr. Kahn-John said symptoms of emotional distress were reduced 30 days post in 24 out of 25 participants. Self-reported psychological, physical and behavioral outcomes post-ceremony included improved sleep, better family relationships, more activity, and increased hope, coping and pain management. Dr. Kahn-John noted emerging evidence on herbal medicine although research on traditional medicine remains limited.

Sharing lessons learned on the 2017 study, Dr. Kahn-John said research protocols, processes and requirements make this type of work challenging. Such efforts also require patience and a willingness to honor community requests. Further, data should belong to the tribe.

Follow-up discussion addressed reproducing plants and herbs respectfully and finding creative ways to protect sacred tribal traditions. In response to a question from Mr. Saunkeah, Dr. Kahn-John said funding came from the University of Arizona with additional donations. Dr. Wilson noted NIH-funded research and interventions that incorporate some part of traditional practices but not as detailed or authentic as Dr. Khan-John's study.

Dr. Anderson recommended creating an acceptable research framework that might address legal/patent issues and acceptable research protocols. In addition, the National Center for Complementary and Integrative Health (NCCIH) would likely fund such innovative projects as part of its mission. The review process, however, could face challenges, said Dr. Wilson.

Mr. LaPlaunt discussed the challenges of bringing certain ceremonies inside a clinic. Mr. LaPlaunt also asked about follow-ups with comorbidities related to emotional stressors and whether the research measured any other physiological indicators pre- and post-study. Dr. Khan-John reported following a simple study design to honor participants, who did not want weight and vitals taken. Most of the older adults had comorbidities such as diabetes but the study did not control for any of those factors. Dr. Wilson added that the Centers for Medicare and Medicaid Services (CMS) is interested in funding traditional healers. IHS, the Health Resources and Services Administration and the Office of Intergovernmental and External Affairs also want to collaborate on this issue.

Ms. Sundberg noted that tribal clinic staff have challenged working in an environment that practices prayer. These staff have legal basis for complaint and could shut down efforts to use traditional medicine even in an Indian facility. Dr. Roubideaux added that each tribe has a different concept of traditional medicine, so researchers and others should avoid generalizing the topic. Further, in developing a framework, NIH must think carefully about applying a western scientific strategy to traditional practices and perspectives. Some tribes may want to do research on traditional medicine to prove it works; others may not. This work requires an ethical/cultural conversation, said Dr. Roubideaux.

The discussion also addressed mentoring junior faculty and developing methods to fund capacity building within communities, so tribes also can manage research. Other TAC members noted that some grants will not fund "religious" activities, and a sweat lodge might fall into the area of "health services." Dr. Dillard raised the issue of intellectual property and noted the possible need for an attorney. Recalling the White Earth Tribe's legal battle regarding wild rice, Ms. Sundberg encouraged the TAC to think about protecting indigenous foods and/or medicines before proceeding.

5. Addressing Cancer on Navajo Nation
Brandy Tomhave, J.D.
Tuba City Regional Health Care Corporation

Ms. Tomhave discussed current efforts to bring cancer treatment to the Navajo Nation. The tribe is on track to begin providing oncology at Tuba City Hospital in November 2018. No cancer treatment is available on any Indian reservation in the country. IHS, Medicaid and Medicare instead reimburse off-reservation providers. That money could be a catalyst for economic development in tribal communities.

The federal government's failure to provide cancer treatment on reservations imposes an access to treatment tax that only American Indians must pay. Families often must pawn or sell valuables to pay for gas and meals required during the treatment phase. Treatment might involve traveling three times per week to a hospital located hours away. This issue is a system failure that makes early detection the exception and late diagnosis the rule. It is no accident that cancer rates are decreasing for most other Americans but increasing for Navajos and other American Indians, said Ms. Tomhave.

The process of bringing oncology to the Tuba City Hospital has brought numerous challenges with no support from the federal government. Notable problems include a lack of data and a lack of facility and program funding. A cancer treatment program at Tuba City Hospital will cost $3 million for remodeling, installing a specialty pharmacy and hiring staff and equipment. The tribe has raised $12,000 through a GoFundMe campaign but has received nothing from the federal government.

To create new streams of federal funding, Tuba City is working to create new federal policy. The hospital has advocated for the passage of Arizona's new Medicaid state plan amendment. For the first time, tribal health care facilities will receive reimbursement for the cost of specialty drugs. The new coverage will create a benefit for drugs that treat other diseases as well.

Arizona congressman Tom O'Halleran also introduced the Uranium Exposure Treatment Enhancement Act of 2018 to authorize grants for cancer treatment programs for tribal communities impacted by uranium mining or milling. This bill has kick-started a conversation about how uranium mines on American Indian reservations continue to rob tribal members of their health long after the uranium mining and milling have ceased, said Ms. Tomhave.

Further, on September 26, the Senate Committee on Indian Affairs approved S465, the Outside Audit of the Indian Health Service Act, sponsored by Senator Rounds of South Dakota. This includes the final legislative act of Senator John McCain, and language calls for an assessment of the availability of cancer services for populations living on large, rural Indian reservations; individual billing information; and reimbursement claims of patients. Tribes also need a catch-up grant for cancer treatment, said Ms. Tomhave.

During the question-and-answer session that followed, TAC members discussed the connections between cancer and the environment and how to carry forward the issues of cancer on tribal communities. Ms. Sundberg recommended a strategy session on how to champion this message. Chairman Sullivan highlighted the Puyallup Tribe's Salish Cancer Center in Fife, Washington. Dr. Roubideaux said IHS does not have the funds to put a cancer treatment center on all the reservations. The IHS budget is $5 billion although tribes have estimated the need at $33 billion. IHS has the authority to provide tertiary care but not enough funds.

Dr. Roubideaux recommended asking the IHS to work with the budget committee to get more funds from Congress. Tribes also can help by participating in more NIH clinical trials. More tribal-university or tribal-cancer center partnerships could further draw more AI/ANs for clinical trials. Dr. Wilson noted that a lot of programs have attempted to reach out to tribal communities for clinical trials, but lingering distrust hinders those efforts. Working in partnership with the Navajo Nation to develop nongenetic data sharing agreements can build trust and lead to the clinical trial stage. The National Cancer Institute (NCI) also has developed new initiatives for cancer research in tribal communities, said Dr. Wilson.

Although NIH cannot lobby, the agency could perhaps be a better ally in the effort to get more money from Congress for IHS, said Dr. Anderson. Responding to Dr. Roubideaux, Ms. Tomhave said tribes have attempted to find creative ways to secure funding. The Navajo Nation, for instance, asked the NCI for assistance in how to submit a competitive grant in an attempt to marry treatment with research. The tribe did not get much help, said Ms. Tomhave.

Further, Navajo Nation has met with members of Congress but cannot get a hearing, although legislation has been introduced. Meanwhile, the tribe plans to launch its cancer initiative in a trailer in November. Anything that can help the tribe have conversations with the right people would be welcomed. Further, good treatment is the key to drawing more tribal members in research, said Ms. Tomhave. Mr. LaPlaunt suggested a pilot project that would involve healing a community and researching that effort. That would be research that provides potential public health prevention techniques for the future.

Dr. Solomon asked if NIH could facilitate research capacity building within communities. Studies on access to care could serve as another avenue. Ms. Sundberg discussed the importance of holding companies accountable and creating a fund to compensate families. Councilman Phelps said the Environmental Protection Agency is going after companies, but the focus of the companies is simply reclamation of the abandoned mines rather than money going back to the impact on health.

6. Tribal Consultation Protocol and Consultation Topics for 2019
Dave Wilson, Ph.D.
Director, Tribal Health Research Office

Dr. Wilson presented a timeline of what the consultation process should look like for NIH. The document outlines critical steps that should occur six months, three months and one month prior to consultation as well as post-consultation. Tasks include

- Determine potential consultation focus
- Select a location
- Establish a strategy for event dissemination, and
- Send Dear Tribal Leader letters.

Post-event tasks include preparing a meeting summary and tracking follow-up issues.

In response to a question from Mr. Shogren, Dr. Wilson said NIH could get requests for consultation from individual tribal communities that have an interest in a particular topic. Dr. Haring highlighted the need for more support to serve all tribes nationwide. Dr. Roubideaux noted that during consultation, individual tribes want the ability to talk government-to-government. IHS has a staff of 10-12 people to assist in that process.

A critical event that impacts all tribes or a significant number of tribes can trigger consultation on a national or regional level. A critical event must happen to trigger consultation for all tribes. NIH must address how it will do consultation for all tribes. The draft protocol looks like a process to have an in-person event, said Dr. Roubideaux, who also asked about written comments. NIH should consider other options for situations that require a quick response. Dr. Wilson agreed on the importance of a strategy for critical events. Tribes also can submit written responses to consultation through the RFI process.

Dr. Wilson will rely on the TAC to determine what rises to the level of a consultation or a listening session. Mr. Saunkeah recommended sending out the Dear Tribal Leader letters three months in advance, with notice perhaps to TAC members who can alert a tribal leader's office. Within that schedule, NIH also could develop relevant questions for the tribal participants, said Dr. Wilson.

Dr. Dillard reminded NIH that tribal consultation must occur before making a decision. Dr. Wilson said the protocol will go to the members of the NIH Tribal Health Research Coordinating Committee, who serve as the contacts for each of the ICs. Topics that impact tribes or rise to the level of consultation would come back to the coordinating committee and then to the TAC. Dr. Dillard also encouraged the THRO to get feedback on the effectiveness of the follow-up process.

Mr. Shogren said consultation should include those who have the authority to make a decision. Otherwise, the event is just a listening session. NIH should create a policy that leads to meaningful consultation, so tribes can give input and someone on the other side can make a decision. Further, are the IC leaders the decision-makers for NIH? Dr. Anderson agreed to take that valuable recommendation back. Congressional appropriations generally go to the ICs so in many cases directors decide whether a program goes forward, what the program will look like and how to allocate money for it, said Dr. Anderson.

Discussing a document from IHS on tribal consultation, Dr. Roubideaux said a critical event requires a decision or an action on an issue or challenge. Input from tribal leaders should impact decisions on, for example, budget; new policies, regulations or legislation; or urgent health issues. A discussion on increasing support for cancer treatment might be an urgent matter that involves IC leaders. However, the NIH director is considered to be the tribal chair's equal so there must be evidence that the NIH director in rendering decisions after consultation somehow, said Dr. Roubideaux.

Chairman Sullivan suggested reviewing the CMS Tribal Consultation Policy for guidance. Once developed, the NIH protocol should come up for review at least every two years, Chairman Sullivan added. Mr. LaPlaunt said the protocol should highlight the policy or funding affected by the consultation, require more time for direct dialogue and allow ample opportunity for tribal leaders to speak. Ms. Sundberg encouraged NIH to find key contacts who can get dialogue started. Tribal leaders and councils also should identify the right people to be at the consultation table.

Turning to next steps, Dr. Wilson will talk to NIH Director Francis Collins, M.D., Ph.D., to discuss how to get approval on consultation decisions from top agency leadership. Further, after consultation, the THRO Website will include the recommendations that came in and how staff will address them. THRO also will look at the CMS template. TAC members will review edits and changes to the protocol in November during the monthly TAC call. Dr. Solomon closed the session with comments sent in from Tucson Area Delegate Chester Antone. Whereupon, TAC members went into closed tribal caucus at 3:40 p.m., to resume the open meeting at 9:15 a.m. on Thursday, October 4.

6. Welcome, Introductions and Elections

Councilman Phelps opened the second day of the meeting at 9:15 a.m. with brief comments and introductions. Dr. Wilson provided a recap before Councilman Phelps turned the conversation to the election of the TAC chair and co-chair. Following a brief caucus, the TAC selected Bemidji Area Delegate Aaron Payment, Ed.D., as chair and Ms. Sundberg as co-chair.

7. Discussion with NIH

Lawrence Tabak, D.D.S., Ph.D.
Principal Deputy Director

Dr. Tabak began by thanking Councilman Phelps for serving on the TAC and acknowledging Dr. Wilson as an enormous asset to tribal communities and NIH. Dr. Tabak also noted the TAC's interest in collaborative efforts around traditional medicine. NCCIH could serve as a good home for research related to traditional medicine and interventions to improve health. Dr. Tabak recommended introducing new NCCIH director Helene Langevin, M.D., Ph.D., to the advisory committee so members can directly express the TAC's interest and priorities.

Dr. Tabak also discussed the Helping End Addiction Long-Term (HEAL) initiative that will develop projects to address opioids in traditionally underserved communities. The lead agency, the National Institute on Drug Abuse, has an open funding opportunity to support culturally relevant research to improve responding to the opioid crisis in tribal communities. SAMHSA also provides funding to tribal nations to build prevention, treatment and community-based recovery support systems with a focus on increasing access to medication-assisted treatment. The Centers for Disease Control and Prevention (CDC) also provide additional funding for tribal nations to address opioid overdosing by supporting the implementation of some evidence-based strategies.

Returning to the topic of cancer in tribal communities, Dr. Tabak said NCI recently designated the Stephenson Cancer Center at the University of Oklahoma as an NCI Cancer Center. This designation can bring in more resources. In addition, both the state and several tribal nations provided significant support for the specialized cancer center. Dr. Tabak suggested revisiting the Navajo Nation's conversation with NCI, perhaps during a special conference call. The effort could begin during the Oklahoma meeting with the understanding that follow-up would continue with more thorough consideration of the issue.

Councilman Phelps began the TAC response by giving Dr. Tabak an update on the status of the NIH tribal consultation protocol. Dr. Roubideaux raised the topic of more mentorship for AI/AN individuals and tribes that want to conduct research. Further, although there is a lot of assistance for early-career tribal

researchers, the support afterward is lacking. Tribes request that NIH do more to encourage the people who get the big center grants to do more around diversity and take a few tribal researchers under their wing. Dr. Tabak said NIH could act as a matchmaker if the TAC identifies an individual investigator. Dr. Tabak will take the issue back for further discussion. Dr. Haring further recommended a scan to identify how many American Indians have received K awards.

Dr. Solomon read comments into the record from Councilman Antone, noting that diverse, well-trained individuals often do not secure positions and can spend up to six years in a post-doc position at a cancer center only to learn there are no faculty positions available. Others give up due to the demands and lack of mentorship. Councilman Antone asked NIH to use its power and resources to motivate grantees and the ICs to indicate how they will mentor trainees along the pipeline to secure research positions and diversify the workforce. Dr. Tabak reported NIH is providing additional incentives for ICs to fund more early-stage investigators. During the past fiscal year, the agency funded more than 1,200 new early-stage investigators, the largest number ever. Too often, however, young scientists feel unprepared for an R01 and apply for other mechanisms.

Dr. Roubideaux said senior investigators often are not willing to help younger investigators secure R01 grants. Further, new researchers believe grants serving only one population will earn lower scores. Dr. Tabak said absolutely not. Dr. Haring agreed the R01 process is very challenging, and some American Indian colleagues have moved on to other professions due to the lack of mentorship and the inability to move forward.

Mr. Saunkeah asked about funding for tribal research infrastructure apart from actual research projects. Tribal communities do not have the capacity, staff or personnel to conduct research. Specific mechanisms could help these communities accomplish those goals. Further, research protection is a key part of research infrastructure, said Mr. Saunkeah. NIH typically includes that type of administrative infrastructure support in very large research programs as a component, said Dr. Tabak. Further, all NIH awards remain competitive, so this issue will require further discussion. Dr. Wilson said NIH has attempted to address infrastructure needs through funding for tribal epidemiology centers (TECs) but a research project must play a role. Mr. Saunkeah said TEC funding does not help at the tribal level.

Mr. Saunkeah ceded to Technical Advisor Michael Peercy, who discussed policy issues. The single institutional review board (IRB) policy for multicenter trials is in direct conflict with tribal policies requiring tribal review of all projects through a tribal IRB or research review board. The requirement to share genomic data openly with NIH also conflicts with tribal policies that state data collected during research, particularly genomic data, belong to the tribe. Tribes also are concerned that exemptions or exceptions included with grant applications might cause reviewers to look unfavorably on those applications.

This issue remains a work in progress, said Dr. Tabak. NIH, however, would rather have some participation rather than exclusion and no participation. Exclusions or exemptions are non-review criteria. NIH will redouble efforts to make sure that exception and exemption requests are not part of review, said Dr. Tabak. Mr. Peercy said the issue requires further education because the Chickasaw Nation has encountered this problem. Those receiving the funds had no idea the exemption existed. Dr. Roubideaux noted that the Common Rule states tribes have an automatic exemption.

Dr. Dillard sought an update on previous discussions about the Center for Scientific Review (CSR). TAC members asked for a status on the Best Practices document, so conversations could begin with the CSR about training and deployment plans. NIH continues to interview for a new CSR director, who should be in place by the end of the year. Dr. Wilson said the Best Practices document has just passed through CSR and THRO is answering follow-up questions.

Tina Woods, Ph.D., Alaska Area proxy for Delegate Donna Galbreath, M.D., requested that reviewers have access to culturally competent training to fully understand the applications received to conduct research. Dr. Solomon noted that the Native Research Network developed a training as well as a book on conducting health research with Native American communities. Dr. Tabak requested the TAC's best advice on navigating these issues appropriately.

Returning to the topic of cancer on Navajo, Mr. LaPlaunt asked if NIH can provide analysis on the health impact of mines and other environmental issues. Such analysis could lead to cancer control and cancer prevention. Dr. Tabak recommended opening up a broader dialogue with the National Institute of Environmental Health Sciences to frame the research questions. Mr. LaPlaunt noted that these environmental issues can affect future generations.

Dr. Haring added that these concerns affect tribes nationwide and must be addressed through comprehensive cancer centers and relationships with the tribes in the regions. Some cancer centers have memoranda of understanding (MOUs) with IHS, said Dr. Haring. Tribes want to bridge research, IHS and other departments to build a synergy, whether through contract or subcontracts, to streamline or expedite services. Dr. Tabak agreed that an increased number of MOUs between cancer centers and the IHS can act as a partial solution. Clinical and translational science awards (CTSAs) could serve as another vehicle. A broader conversation could piece together a more integrated approach, said Dr. Tabak.

Cancer centers are good, but tribes also want to prevent cancer from happening, said Ms. Sundberg. Tribes want to remedy the mines and other negative environmental projects in Native communities and show the impact before other projects begin. Councilman Phelps requested a letter of support from NIH that could leverage other conversations.

Dr. Dillard asked about long-term plans for the THRO and needed capacity to serve 500-plus tribes. NIH will continue to grow the office to meet the demand, said Dr. Tabak. Dr. Wilson said a senior-level person will join the office by the end of the year. Staff also continue to look for another contract support position to replace someone who cycled out of the office. Staff continue to discuss strategies, with plans to fill federal positions rather than contractor positions. Dr. Roubideaux asked how the NIH TAC might weigh in on the NIH budget formulation process. Although tribes do participate through the HHS budget consultation, perhaps the TAC could give recommendations before the agency makes decisions on funding priorities. Dr. Tabak noted that each IC receives its own appropriation from Congress. The intersection of where to provide a set of recommendations needs further discussion.

8. Environmental Influences on Child Health Outcomes (ECHO)
Research Program Update and Discussion
Matthew Gillman, M.D., Director

ECHO is a nationwide research program that seeks to enhance the health of children for generations to come. As part of this effort, ECHO remains committed to consulting with tribal nations and collaborating

with AI/AN partners by addressing cultural/historical/sovereignty issues and developing research that serves AI/AN communities directly while enhancing ECHO consortia-wide research.

ECHO components include observational studies and intervention trials. The observational studies or cohorts are longitudinal studies of mothers and children occurring nationwide. One cohort is the Navajo Birth Cohort Study based on the uranium mines. The mines, which have closed down, may still have substantial effects on a growing fetus or child. The broader ECHO-wide cohort of 50,000 children and their families will address research questions no single cohort can answer alone. This work will inform the interpretation of individual cohort findings and have broad impact on practices, programs and policies.

Conversations with Navajo Nation also have addressed data sharing as ECHO seeks to improve the health of children nationwide. A draft data sharing agreement protects against the risks of privacy violations and unfair stigmas. The agreement does not cover genetic data or biospecimens. There also should be no ancestry analyses. Further, the individual-level data from the cohort exist in only 3 places: Navajo Nation, the University of New Mexico and the Data Analysis Center at Johns Hopkins University.

The intervention trials are part of the Institutional Development Awards (IDeA) Program. The IDeA States Pediatric Clinical Trials Network provide access to state-of-the-art clinical trials in medically underserved and rural populations. The program seeks to build national pediatric research capacity. One trial is under way, another will start in Fall 2018 and three remain in development. The network also is participating in Accelerating Clinical Trials for Neonatal Opioid Withdrawal Syndrome (ACT NOW).

The Alaska Native Tribal Health Consortium (ANTHC) is participating in initial clinical trials to address how the body handles medications in routine pediatric practice. ANTHC also is involved in the ACT NOW effort.

Ongoing challenges include intellectual property, data/biospecimen sharing and protection of human subjects. The IDeA States Network uses a central IRB but ANTHC does not cede to it due to cultural, historical and sovereignty issues. All parties are working on resolving these issues in mutually beneficial ways, said Dr. Gillman.

Dr. Roubideaux noted again that tribes have an automatic exception to the single IRB in the Common Rule. Dr. Gillman said the ECHO program's Data Coordinating and Operations Center is on board so that should no longer be an issue. Mr. Saunkeah said the NIH policy also notes an automatic exemption where it is required by tribal law or policy. The information also must be cited in the grant application. So even though language regarding the Common Rule is available, the practical applications are a bit murky. Perhaps funding announcements for tribal research can include clarifying information.

Dr. Gillman asked the TAC's advice on working with tribal nations that may have less research infrastructure or may not have an IRB. Dr. Roubideaux said tribes have different research infrastructure regarding human subjects' protections but tribes also have different processes for research approval. Tribes without IRBs likely have some kind of review of research and still would qualify for the exception for the single IRB review. Tribal review must be involved due to sovereignty.

A confederacy of tribes or neighboring tribes might have an IRB or review process, said Dr. Haring. Researchers can ask for courtesy reviews from one tribal nation assisting another or even IHS and a

regional IRB as a courtesy review. Mr. LaPlaunt added that tribes in the Great Lakes region want to build capacity within the local health board to do similar reviews for the tribes.

Dr. Roubideaux also returned to Dr. Gillman's statement that intellectual property goes to the inventor, not source of data. That statement contradicts the idea of partnership because if ANTHC, for example, has an MOU as a partner, then the consortium is technically a partner in an invention rather than just a source of data. Dr. Gillman said partnership is clearly the best solution, and the ECHO program continues to work through all the details.

Alaska Area Technical Advisor Tim Thomas, M.D., requested more tribal input on what comes forward for clinical trials through the network. Dr. Gillman said the network will either import a completed protocol, work with another network to develop ideas or use a homegrown trial that comes from the Steering Committee within the network. Committee members have discussed using principles of community-based participation to drive study questions that are applicable to tribal nations as well as other communities.

Dr. Solomon asked about the quality of data and research outcomes. Dr. Gillman noted that on the observational side, the cohorts pre-existed. All the cohorts and some continue to recruit, but all have been funded before, and some have gone on for as long as 30 years before ECHO. Harmonizing the data already collected and deciding on new data to collect across the cohorts has been the issue that has required the most time during the first two years of launching ECHO. Fortunately, the Data Analysis Center at Johns Hopkins has been helpful, said Dr. Gillman. The trials all have protocols and collect the same data.

The principles of team science seem to be working as Dr. Gillman reflected on the program's working groups and the emerging research. On the cohort side, the pre-existing programs continue to publish, with more than 100 papers available already. Dr. Gillman now seeks consortium papers to bring even greater results. The program also hopes to become an example for other studies. The working group for stakeholders has AI/AN and Native Hawaiian representation. Following Dr. Gillman's remarks, the committee broke for lunch until 1 p.m.

9. *All of Us* Research Program Update and Discussion

Dara Richardson-Heron, M.D.
Chief Engagement Officer and Scientific Executive
***All of Us* Research Program**

Dr. Richardson-Heron and Project Team Lead Daozhong Jin led a brief discussion on the *All of Us* Research Program before seeking TAC input on ways to meaningfully engage AI/ANs in the program. The THRO and several TAC members have played key roles in moving the effort forward, including those who served on the Tribal Collaboration Working Group (TCWG), said Dr. Richardson-Heron.

Dr. Richardson-Heron provided the following recap:

- Finalized the **TCWG Report** – *April*
- Requested **listening sessions** with tribal organizations – *March to June*
- **Posted the TCWG Report** on the *All of Us* website – *August*

- Plan **consultation** – *ongoing*

Ms. Jin gave a follow-up of an August 2018 TAC conference call, noting that next steps include adding a tribal representative on the *All of Us* Advisory Panel. Regarding the other points raised in the report, program staff want to give all tribal leaders an opportunity to weigh in on the full report and share any additional input and feedback before the leadership team evaluates priorities.

Consultation planning has involved gathering support from THRO and the TAC, developing strategies to inform tribal leaders and outlining details for the one-day event and follow-up activities. Staff based many of these plans on the draft consultation protocol, said Ms. Jin, who also presented a draft consultation agenda and potential consultation questions. Dr. Richardson-Heron noted additional questions for TAC input, such as the timing of consultation and the pros and cons of collaborating with other conferences.

Following consultation, staff members plan to collect and review all the input before *All of Us* leadership prioritize opportunities. With input from the TCWG, leadership will determine how to implement priorities and establish timelines. Last, NIH will share key tasks and reasoning with tribal leaders and the community.

Dr. Haring asked about the storage of data and how NIH would incorporate tribes in that process.
Dr. Richardson-Heron said all blood and urine samples will be housed in a biobank at the Mayo Clinic. Any time those samples are to be disposed, there are plans for a blessing. Dr. Roubideaux asked about researchers who can access the data. Dr. Richardson-Heron said the program offers tiered levels of access to data. The lowest tier will be basic data separated from name or any identifier. As researchers get into more depth and the potential for re-identifying information, data access will require a special process.

Researchers have no access to any of the specimens at this point. Only a limited amount of data from AI/ANs exist because NIH agreed not to actively enroll tribal communities. However, if people want to participate, NIH would not want to be in a position of turning anyone away. Further, the program does not ask for racial/ethnic demographic information right up front. There are no plans to hold off on access to data until formal consultation, but if consultation occurs in June 2019, researchers likely would not have access to the data before that time.

Councilman Phelps asked for further details on information regarding ethnicity. Dr. Richardson-Heron said the information includes specific columns on race and ethnicity if people choose to include that data. NIH does not require anyone to put in any tribal affiliation, but people can if they choose to do so.
Dr. Solomon briefly explained how the process works: A person generally is approached at a medical facility or a site. Demographic information is collected via a computer-assisted system.
Dr. Richardson-Heron said participants also can go home and fill out surveys and include demographic information. Others learn about the *All of Us* initiative through ads, Webinars or the program Website.

Dr. Dillard asked if an *All of Us* site is trying to get a large proportion of AI/AN people.
Dr. Richardson-Heron said the University of Arizona Banner facility has a large community of AI/ANs who use that health care system. Banner has identified itself as a regional medical center that has capacity to bring in AI/ANs but the site, just like other regional medical centers, is not actively recruiting and engaging AI/ANs until NIH conducts formal consultation and establishes the strategy.

Dr. Solomon added the University of Arizona has a tribal consultation process required for all research. The process for *All of Us* will include consultation with the individual communities most likely to have someone get an invitation to participate now. The process will differ for each community, said Dr. Solomon. The university also intends to create educational presentations that can occur on campus, in the community or within the tribe.

Dr. Dillard suggested two levels of consultation. One could occur at a national level, and then regional recruitment sites could conduct specific consultation with close adjoining tribes to demonstrate respect as well as transparency. The initiative should try not to undermine trust by appearing to slip into urban settings where tribal governments may not have as much oversight. Mr. Saunkeah added that such efforts bypass tribal research protections that are in place.

Dr. Richardson-Heron noted that Arizona is already beginning to build relationships with some of the communities. Regional medical centers in Wisconsin and Minnesota also have close ties to the AI/AN communities. Local interaction should occur in addition to national-level consultation, agreed Dr. Richardson-Heron.

Dr. Haring asked if protections set for the samples follow the samples to another institution for research. Dr. Richardson-Heron said very few samples will leave the biobank. Instead, researchers will come to the data. NIH is still considering protections for tribal samples that might leave the biobank. Dr. Wilson recommended fliers or brief communications around biospecimen storage and handling as well as genetic information storage and access. Dr. Dillard also proposed open time for visiting the specimen bank at the Mayo Clinic. Dr. Richardson-Heron noted a video that also describes what happens with the samples.

Ms. Jin added that when NIH releases data at some point in 2019, researchers will receive the survey and electronic health record data. That will not include access to the biospecimens as those policies are still under development.

Mr. Saunkeah expressed concerns about *All of Us* leadership reviewing responses and setting priorities after consultation as far as recommendations from the tribal workgroup. The TWCG submitted extensive recommendations; however, NIH only adopted the one that staff planned to do anyway. Mr. Saunkeah asked if others had reviewed the TCWG document and offered feedback.

Dr. Richardson-Heron said the senior team has the document and has posted it online. NIH also requested feedback from the TAC. Before implementing activities, NIH wants to get input from tribal consultation. Leadership may not implement all the TCWG recommendations but will likely adopt some. Further, when the TAC has concerns, members also should share ways to correct the issue. Mr. Saunkeah followed up with a request for tribal input when *All of Us* leaders review consultation feedback and set priorities. Dr. Richardson-Heron said the *All of Us* framing activity might ask whether there are specific parts of the TCWG report that tribes strongly support or dislike. NIH wants to get that level of input to set priorities.

Dr. Roubideaux encouraged consultation to begin sooner than April or May 2019. Dr. Roubideaux also asked if the IHS IRB reviewed the proposal because eventually some of the data will come from IHS and tribal sites. Last, the *All of Us* IRB should include a tribal representative. Responding to the last point, Dr. Richardson-Heron noted that the TCWG made a similar recommendation, which is still under

consideration with all the other feedback. The tribal member would likely be someone from the TCWG. This governing body will provide information back to the NIH leadership, which will decide what information goes out to various committees. There is no process to share information out to the 500-plus tribes.

Dr. Solomon said disseminating information remains critical. AI/AN communities want to have a voice in the process. Similarly, Mr. LaPlaunt asked for more than one tribal voice on the governing body, and tribal members themselves should select the representative. Dr. Richardson-Heron said the governing committee consists of about 16 to 20 people and reflects the diversity of the United States. Further, NIH will continue to leverage the TCWG, which consists of many different tribal representatives. Dr. Haring reminded NIH to keep Native Hawaiians in mind.

Dr. Richardson-Heron also noted that the NIH tribal consultation protocol takes the process at least until June 2019 or April at the earliest. Dr. Haring asked NIH to consider scheduling consultation in multiple locations.

10. Traditional Practices in Tribal Communities

Terry Maresca, M.D., Seattle Indian Health Board
Patrisia Gonzales, Ph.D., University of Arizona
Teshia Solomon, Ph.D., University of Arizona

Dr. Maresca focused on indigenous plant medicine and issues clinicians should consider when working in Native communities. This topic involves relationships with land, places, and elders -- and using that knowledge to serve patients. Non-Native physicians working in IHS, tribal or urban sites often lack a basic knowledge of the role of traditional medicine in indigenous communities. Early-phase learners and trainees often do not understand how to explain traditional medicine, added Dr. Maresca.

However, some medical schools, tribal colleges and organizations have made traditional medicine part of the curriculum. Others provide indigenous teachers or have asked elders to speak to clinicians. The Division of Diabetes Treatment, for instance, has invited a number of practitioners to discuss traditional medicine. The Association of American Indian Physicians has offered annual cross-cultural medicine workshops that include traditional healers.

Due to the demographic shifts of indigenous people in the country, urban Natives also use traditional healing. Studies have shown that patients tend to use the advice of a traditional healer above that of a clinical provider. Recent polls also have shown that one in four American Indian college students also use traditional practices.

Even so, student doctors tend to question efficacy and evidence. Medical students also ask about liability and how to identify a traditional healer in the community. Practicing doctors or older residents ask similar questions but also want to know about correct dosing and how to document traditional medicine in a medical record. The use of traditional medicine in vulnerable populations such as children or pregnant women also raises questions. These issues also show the conflict between disease-oriented endpoint and patient-oriented evidence that matters.

Small studies have highlighted the use of traditional foods and practices for weight loss or depression management. These studies encourage other ways of healing such as exercise, healthy eating and stress reduction. Overall, traditional medicine needs much more translational research, said Dr. Maresca.

Dr. Gonzales serves as a traditional midwife and teaches three courses on indigenous medicine at the University of Arizona. Indigenous medicine involves intricate, interrelated webs of knowledge, healing and environmental systems. The United States also includes more ceremonial doctoring. The current generation, however, does not have a relationship to the natural world of their ancestors. Further, presumptions and assumptions about indigenous medicines hinder efforts to create collaborative medicine.

Efforts to restore and catalogue plants and manage natural resources not only benefit traditional medicine but also can connect elders with the younger generation and create potential knowledge keepers, said Dr. Gonzales. Indigenous women also are reclaiming traditional birth practices in intersectional ways that promote native language, traditional knowledge and tribal sovereignty.

11. Plant-Based Therapies
Gary Ferguson, N.D.
Healthy Communities Consultant

Dr. Ferguson focuses on population health and the roots of disease and well-being within the tribal health system in Alaska. Ancestral knowledge encourages health promotion and prevention rather than the current model of waiting to get sick. Similarly, the population health model inspires dialogue on the social, economic, cultural and environmental factors that determine health and well-being.

Indigenous ways of knowing and being also address these factors and will play a greater role in Native communities as tribal members reclaim their medicine and traditional practices. Dr. Ferguson has addressed such health behaviors as tobacco as well as such social and economic conditions as education, jobs and income. Environment also has become an important factor as climate changes affects plants and food systems. Tribal nations address basic needs -- food, safe water, medicine -- in a holistic way that moves beyond the individual to the community, thereby keeping a culture alive.

Dr. Ferguson noted that indigenous people had a health care system prior to contact. Western foods and lifestyles contributed to dental disease, as noted by Dr. Weston Price in 1933. The children of those who embraced a western lifestyle had dental challenges as well as metabolic changes. Price noticed these changes in indigenous communities around the world. Many people in Native communities see Type 2 diabetes at very young ages now. Researchers also report plummeting levels of Vitamin D in Alaska due to declines in traditional marine food intake. Traditional foods were protective, said Dr. Ferguson.

Dr. Ferguson continues to make an urgent call to reclaim Native ways in food, diet and medical practice. A growing number of culture camps in Alaska encourage residents to hunt, fish, gather and grow their own foods. As interest grows, Native people must learn how to share and protect indigenous knowledge of plants as food and medicine. Dr. Ferguson noted that food preferences connect to the issue of maternal/child health. Further, relying on elders to transmit knowledge of plants and traditional ways to youth can create a spiritual connection that reduces suicide, domestic violence and other societal ills.

Healthy family systems are part of the medicine, said Dr. Ferguson. Incorporating elders is part of healing a community.

The ongoing challenge is to handle intellectual property correctly so tribal communities receive recognition. Ms. Sundberg asked Dr. Ferguson for suggestions as tribal leaders create standards. Dr. Ferguson recommended getting elders on board first to demonstrate respect and address concerns. Elders also can remind youth and younger doctors of guiding values as communities relearn traditional knowledge.

Councilman Phelps asked about the NIH ICs that support these efforts. Dr. Wilson recommended NIMHD and the NCCIH. For such disease-specific interventions such as diabetes, Dr. Wilson pointed to the National Institute of Diabetes and Digestive and Kidney Diseases as well as NCI. The National Heart, Lung, and Blood Institute would be ideal for blood pressure interventions. TAC could start the conversation by inviting ICs to make presentations on currently funded research.

12. Wrap-Up Discussion

TAC members ended the second day with a discussion of 2019 meeting dates and topics. Offering feedback on the TAC meeting in Indian Country, Dr. Solomon noted that NIH staff must balance being visible in tribal communities and present to hear important information during the sessions. Mr. Saunkeah agreed, adding that the Bethesda site is probably better for TAC in-person meetings. TAC members will tentatively consider the week of March 18 for next year's meeting. Issues that need immediate discussion prior to that date can be part of the monthly conference calls.

Dr. Wilson will organize the follow-up letter to Dr. Tabak. Kathy Etz, Ph.D., announced a technical assistance Webinar October 16 at 4 p.m. regarding a request for application for leveraging SAMHSA and CDC funding to respond to opioid use disorder in tribal communities. TAC members who want to stay on the committee should inform Dr. Wilson within a week. After that deadline, THRO will begin making plans to fill vacant seats on the TAC. TAC members who are cycling off the committee can recommend new members.

Councilman Phelps thanked NIH and the presenters as well as the Oklahoma TAC members for planning the in-person meeting. Following a closing prayer, the meeting adjourned at 3:48 p.m.

NIH Tribal Advisory Committee Meeting
October 3-4, 2018

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