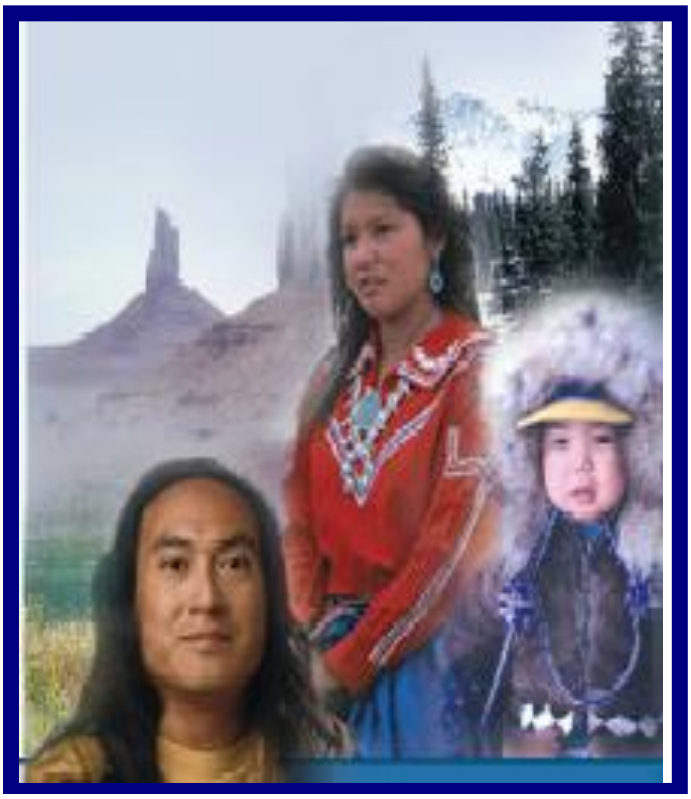
Department of Health and Human Services
Centers for Disease Control and Prevention
Agency for Toxic Substances and Disease Registry

Tribal Consultation Advisory Committee (TCAC) Meeting



July 26-28, 2010
Minutes of the Meeting

Acronyms

AAIHB	Albuquerque Area Indian Health Board
AAP	American Academy of Pediatrics
AATCHB	Aberdeen Area Tribal Chairman's Health Board
ACD	Advisory Committee to the Director
AI / AN	American Indian / Alaskan Native
ARRA	American Recovery and Reinvestment Act
ASTHO	Association of State and Territorial Health Officials
ATS	Adult Tobacco Survey
ATSDR	Agency for Toxic Substances and Disease Registry
BIA	Bureau of Indian Affairs
BLM / DEQ	Bureau of Land Management / Department of Environmental Quality
BMI	Body Mass Index
CCCP	Colorectal Cancer Control Program
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid Services
CPPW	Communities Putting Prevention to Work
CRIHB	California Rural Indian Health Board
CSTE	Council of State and Territorial Epidemiologists
DC	District of Columbia
DCPC	Division of Cancer Prevention and Control
DDT	Division of Diabetes Translation
DEOC	Director's Emergency Operations Center
DFO	Designated Federal Official
DNPAO	Division of Nutrition, Physical Activity, and Obesity
DPHCD	Division of Public Health Capacity Development
DPHPI	Division of Public Health Performance Improvement
DRH	Division of Reproductive Health
DUIP	Division of Unintentional Injury Prevention
EOCs	Emergency Operation Center
FACA	Federal Advisory Committee Act
FMO	Financial Management Office
FOA	Funding Opportunity Announcement
GPRA	Government Performance and Results Act
HECAT	Health Education Curriculum Analysis Tool
HHS	Health and Human Services
HO	Health Official
IHS	Indian Health Service
ILI	influenza like illness
IOM	Institute of Medicine
MAPPS	Media, Access, Point-of-Purchase / Promotion, Price, and Social Support and Services
MASO	Management Analysis and Services Office
MCHB	Maternal and Child Health Branch
MOU	Memorandum of Understanding
NACCHO	National Association of County and City Health Officials
NBCCDP	National Breast and Cervical Cancer Detection Program
NCAI	National Congress of American Indians
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion

NCIPC	National Center for Injury Prevention and Control
NHTSA	National Highway Traffic Safety Administration
NIH	National Institutes of Health
NIHB	National Indian Health Board
NNCTAPN	National Native Commercial Tobacco Prevention Abuse Network
NTCP	National Tobacco Control Program
OFEA	Office of Formulation, Evaluation, and Analysis
OGC	Office of General Council
OSH	Office on Smoking and Health
OSTLTS	Office of State, Tribal, Local, and Territorial Support
PECAT	Physical Education Curriculum Analysis Tool
PHAP	Public Health Apprentice Program
POC	Point of Contact
PPACA	Patient Protection and Affordable Health Care Act
PRAMS	Pregnancy Risk Assessment Monitoring System
PSAs	Public Service Announcements
REACH	Racial and Ethnic Approaches to Community Health
RPMS	Resource and Patient Information System
RWJ	Robert Wood Johnson Foundation
SAMHSA	Substance Abuse Health and Services Administration
SHI	School Health Index
SME	Subject Matter Expert
TCAC	Tribal Consultation Advisory Committee
TSCs	Tribal Support Centers
WHO	World Health Organization
YRBS	Youth Risk Behavioral Survey

Centers for Disease Control and Prevention (CDC)
Agency for Toxic Substances and Disease Registry (ATSDR)
Tribal Consultation Session

Minutes of the Meeting
July 26-28, 2010

Monday July 26, 2010

Site Visit to Fort Belknap

The TCAC meeting convened at 7:45am. Co-Chairs Kathy Hughes and Chester Antone each offered opening remarks, welcoming the group to Havre, Montana. Mr. Tracy “Ching” King, President of the Fort Belknap Indian Community, then led the group in an opening prayer.

Though not all areas were represented, it was established there was a quorum, so the meeting could officially continue. Loren "Bum" Stiffarm, Fort Belknap Chief Administrative Officer, made brief remarks, orienting the group to the day's agenda and logistics. TCAC members then shared updates on regional activities. Kathy Hughes officially adjourned the meeting at 10:00 am.

The group then traveled by bus to Fort Belknap, approximately 43 miles, and reassembled in the Tribal Council Chambers. There, the group was welcomed by the Fort Belknap Council and President Tracy “Ching” King.

Les Cramer, Eagles Watch Organization, presented a portion of his film, documenting the environmental situation in the Zortman / Landusky mining area.

The group was escorted to Swift Gulch, part of the Zortman / Landusky mining area for a tour. There, Chris Rye, a representative of the Bureau of Land Management and Geology in Lewistown, Montana walked the TCAC assembly through a tour of the water treatment solution currently in place in the stream, running from the mining area onto the reservation. He reported that the naturally occurring iron seeping became apparent around 1998, making the rocks appear orange in color. They are treating the water with lime to increase the pH balance, aerating it, and collecting it in ponds to allow the iron to settle out. The filtered water seeps into the ground water and is then reintroduced into the stream. Mr. Rye reported there were high levels of heavy metals (e.g., zinc, cadmium, and aluminum) in the water, and that those metals are also being settled out. The sludge is collected, transported to the top of the hill, and buried in the leach pads. No samples have been collected at that site, though there are plans to sample next year. Mr. Rye pointed out that metal has been seeping into the water for about 10 years.

The group traveled upstream to the top of the Zortman / Landusky Mining Area, just off the reservation, to a state-of-the-art water treatment facility that serves residents not on the reservation. That facility has been in place since 1987.

From the Zortman / Landusky area, the group traveled to Beaver Creek Youth Ranch where tribal members testified to the many health problems facing their population. Many important topics were covered in the testimonials:

- Environment / Environmental Health Issues
- Suicide
- Cancer
- Diabetes
- West Nile
- Safety

After the testimonials, the group was treated to a feast, followed by an evening of music and dance.

Tuesday July 27, 2010

Site Visit to Rocky Boy's Reservation

A meeting for TCAC members and CDC was held on July 27, 2010 at the Rocky Boy Health Board. The meeting officially convened at 10:00 am. Jonathan Windy Boy, Vice Chairman, Chippewa Cree Tribe Business Committee, Montana State Senator, offered the opening remarks and welcomed the entire group to Rocky Boy. Sam Windy Boy, elder, led the group in an invocation.

Captain Pelagie "Mike" Snesrud, Senior Tribal Liaison, CDC, offered opening remarks, reiterating CDC's and OSTLTS' commitment to listen to and attempt to respond to the health needs of tribal communities. TCAC Co-chairs Kathy Hughes and Chester Antone were introduced. CAPT Snesrud remarked that while CDC has had a close relationship with the states, there has been a "disconnect" with cities, counties, and tribes. Over the past 10 years or so, CDC has extended a hand to the tribes in an effort to bring them to the table.

Dr. Judith Monroe, Director OSTLTS, addressed the group, introducing herself and articulating the role OSTLTS will play in serving the needs of the tribal communities. Anna Whiting Sorrell, Director, Montana Department of Public Health, introduced herself to the group, making clear her commitment and the Governor's commitment to serving the tribal population. Lisa Evers, Acting Director, Montana Governor's Office of Indian Affairs, introduced herself to the group as well. Introductions of the full group were then made.

Tim Rosette, Assistant CEO, Rocky Boy Health Board, addressed the group, updating everyone on the status since the recent flood. He reported that there had been a tremendous loss of infrastructure, and that much help is needed. The primary concern is the total loss of Rocky Boy's only health care facility, which leaves them unable to provide even basic services. A new clinic must be built, and Rocky Boy Health Board is requesting CDC funding to aid in the creation of a clinic to serve the reservation.

Ben Murnel, Environmental Engineer, Rock Boy Health Board, concurred with Tim Rosette's presentation, clarifying some of the work that has been done to clean up the water and septic systems. He reiterated that with the loss of the 56,000 square foot clinic, the 6,000 square foot replacement is terribly inadequate. He also requested funds to help with this urgent need.

Vice Chairman Jonathan Windy Boy briefly addressed the need for emergency / disaster preparedness. This was followed by a brief discussion regarding how CDC might assemble the right type of assistance. The comment was made that IHS simply is not providing the support tribes need in this key area.

Kathie Avis, Chief Administrative Officer, Native American Programs / Benefis Health System, addressed the group regarding the work of Benefis Health System. She reported on a new program where 18 nurses will be trained over a 3-year program.

Vice Chairman Jonathan Windy Boy addressed the group on the importance of sustaining the Indian tradition and culture.

Videl Stump, Tribal Elder Advisory Committee, concurred with Jonathan Windy Boy's comments regarding the importance of the preservation of the culture.

Janet Runnion, Public Health Nurse, Rocky Boy Health Board, spoke about the rise of Hepatitis C in the community.

Mike Geboe, Clinical Supervisor at White Sky Hope Center, addressed the group documenting the holistic approach they are currently taking to address the problem of teen substance abuse.

Aaron Morsette, Rocky Boy Health Board, addressed the group to discuss the incidence of PTSD and anxiety disorders in the youth population.

Kenny Bradburn from the White Sky Hope Center spoke advocating for a cultural identity program to educate the children about the traditional way of tribal life, as a way to reduce the numbers of mental health issues.

Lena Belcourt, Self Governance Coordinator for the Rocky Boy Health Board, addressed the group with a presentation detailing the enormous issues affecting the community.

Elder Sam Windy Boy spoke to the group about the devastating effects of cross-cultural confusion, advocating for a traditional spiritual healing approach.

Closing remarks were made by Vice Chairman Jonathan Windy Boy, who officially adjourned the meeting at 4:30 pm.

Wednesday July 28, 2010

Call to Order, Welcome, and Introductions

Kathy Hughes, TCAC Co-Chair
Vice Chairwoman, Oneida Business Committee

Chester Antone, TCAC Co-Chair
Legislative Councilman, Tohono O'odham Nation

Kathy Hughes officially called the meeting to order, welcoming everyone to the beautiful, wide open spaces of Montana. She emphasized that there was a long agenda with many presentations, and expressed her hope that there would also be a lot of discussion.

Chester Antone extended his welcome, articulating his hope that they would come away from this meeting with a lot of information and that there would be movement forward. He welcomed CDC staff, stressing that he hoped this partnership / working relationship between CDC and Tribes would continue.

Ms. Hughes subsequently led those present in a round of introductions. The participant roster may be found at the end of this document.

Office of State, Tribal, Local, and Territorial Support (OSTLTS)

Judith A. Monroe, MD, FAAFP
Deputy Director, Centers for Disease Control and Prevention
Director, Office for State, Tribal, Local and Territorial Support

Dr. Monroe presented an overview of the new Office of State, Tribal, Local, and Territorial Support (OSTLTS), discussing the following topic areas: OSTLTS's values, mission, and working model; 15 in 12; the proposed organizational structure; OSTLT's value to its partners, the Public Health Apprentice Program (PHAP), and new funding available. With respect to values, which came from the OSTLTS staff members, success for this office means demonstrating the values of service and stewardship internally and externally. The values are illustrated in the following graphic:

When Dr. Monroe came in as the new Director, she assembled the staff members to ask them what they valued. In the circles are the values that the staff articulated that day. One that speaks to her very loudly is that they have to be an office of awareness. She believes they need situational awareness just as in preparedness. Because this is a cross-cutting office, the more that they know about what is happening in within and across CDC and in the field, the better this office can serve everyone to advance health. They will do this by listening and communication. Especially in preparedness, communication is incredibly important and it is also incredibly difficult. She has never been in an after action review of any disaster or exercise in which she has not heard that one of the top three things they could have improved upon was communication. It is just the nature of how difficult and complex communication can be. One thing Dr. Frieden said to everyone on a national call during the H1N1 pandemic was that the only thing that spreads faster than the flu are rumors. She thought that was a testimony to how difficult communication can be.

Certainly, honesty, trust, and integrity are important as well. In terms of community focus, there is the community within CDC, and there also needs to be a community focus outwardly. They all comprise the community that is trying to improve public health. Teaching, appreciating, empowering, and encouraging are very important, as are competency, credibility, and visibility. The new office needs to be visible. Having been the State Health Official in Indian for five years, in a very simple way Dr. Monroe believes that public health needs to be public. This also comes back to communication. Great work is done in public health all of the time, but it is not visible. When they do their best work, it means that they prevented something. It is difficult to make visible the invisible. When deaths are prevention from lack of motor vehicle accidents and youth never pick up the first cigarette, it is a challenge for public health to make that visible and for people to value that. Overall, she thought the success of the office would be to value service and stewardship.

OSTLT's mission statement is simply to improve the capacity and performance of the public health system, with improved health outcomes always being the endpoint. Dr. Monroe emphasized that she was speaking here across governmental public health for starters. Obviously, public health touches all lives, but they system needs to be improved within CDC and across all systems (e.g., state, tribal, local, and territorial).

In terms of OSTLT's working model, the Concept of Operations provides the overarching framework and functional foundation for OSTLTS. This includes the concepts of identifying standards, policies, and best practices and bringing them to light; validating the relevance, quality, and integrity of standards, policies, and best practices; disseminating this information across the public health system; and supporting adoption, implementation, and effective outcomes in the field, which is critical to success. If the best research / best practices in the world are left in the pages of journals or at the podium at a meeting rather than being put into action, they are meaningless.

The efforts the OSTLT staff wants to deliver on in the first year are being called 15 in 12. The clock began ticking in March for this effort. The 15 deliverables the staff decided upon include the following:

1. Five best practices will be identified and disseminated via state, tribal, local, and territorial networks. The first best practice focuses on how health departments are dealing with the economic crisis. The first dissemination of that was a couple of weeks prior to this meeting at the State Deputy Health Commissioner Meeting. There is a lot of work on-going within CDC on this effort. The consensus definition of what constitutes a "best practice" within CDC has been a long journey.

2. Regarding grants standardization and optimization, at least 5 improvements will be identified and made to CDC grants process, guidance, approach, or standards. This will be on-going work, and there is a lot of work to be done here. At the end of the day, the goal is to achieve the greatest impact. Are we getting the best buy and return on investments made by CDC?

3. A Health Officials welcome packet is being developed. A system is in place to recognize incoming Health Officials and trigger a welcome packet from OSTLTS. In May 2010, an introductory program was done to test the model. This Health Official orientation was done differently than past Health Official orientations in order to make it much more engaging. Dr. Frieden attended all three days for an hour each day, engaging the Health Officials. The bulk of the orientation focused on Dr. Frieden's six "winnable battles," and that was very engaging. They had a Subject Matter Expert (SME) from CDC talk about the science and evidence for what can be done about a particular problem, and then a seasoned Health Official who had shown impact within their jurisdiction speak about how they had done that. This was followed by open dialogue, which was very robust. They hope to continue to improve on this process and widen their invitation for attendees.

4. The Public Health Apprentice Program (PHAP) has been expanded to add 50 more apprentices in 2010, for a total of 75. This program has been in place for a while, but the numbers had shrunk. This program leads to Public Health Advisors, who have a very long and rich history at CDC for the impact that they have had on public health across the nation. In terms of the pipeline, those entering the program have to have at least a Bachelor Degree. When they apply for the program, they are matched to a health department. This is an area in which they would love to see more tribal involvement. In July 2010, 65 new apprentices started in health departments. Part of their training will be at CDC, and the entire curriculum and competencies have been revamped.

5. An STLT Partner Web Portal is under development. Some major strides have been in terms of establishing and managing this one-stop information center and service for STLT partners to gain information and have a two-way conversation.

6. At the state level, score cards are being developed. Two to three prototypes will be developed with health department partners by the third quarter of 2010. These will be sent to leadership in states (e.g., Governor, legislators, others) who can have an impact on policies to improve health. This will begin by addressing the six winnable battles. They are working with others who put out score cards to ensure that this is complementary.

7. Field training will be developed for and delivered to CDC field staff and the staffs of state and local health agencies. Because OSTLTS is a cross-cutting office, it has been charged with assuring that field staff are well-trained, and a lot of work is being done in this effort with regard to E-Learning to provide access to electronic use of improved and better training.

8. The Health Official Orientation was described with respect to the orientation packet. This re-designed, 2-day orientation to CDC will be provided for all new Health Officials (appointed within 2 years). This is still being developed.

9. Public health law falls under the OSTLTS office. It is known that policies can make a major difference in health. This office is currently focused on helping with the CDC winnable battles and providing public health law support for Communities Putting Prevention to Work (CPPW) grantees.

10. A CDC Organizational Resource Directory (CORD) is being developed. This is an external portal for STLT public health professionals to be able to reach people within CDC, which is complementary to the STLT Partner Web Portal, which is to access information (Seligman and SharePoint; not duplicative of anything).

11. An STLT Work Group to the Advisory Committee to the Director (ACD) has been established. The first meeting is planned for September 2010 in Atlanta. This group will be advising the ACD on state, tribal, local, and territorial issues.

12. Completion of a "beta-test" of the national accreditation standards, measures, and site visit process is underway. Several tribes have been involved with the beta test. All of the data gleaned from that will be utilized over the next year to improve the accreditation process. Health departments can become nationally accredited in the Fall of 2011.

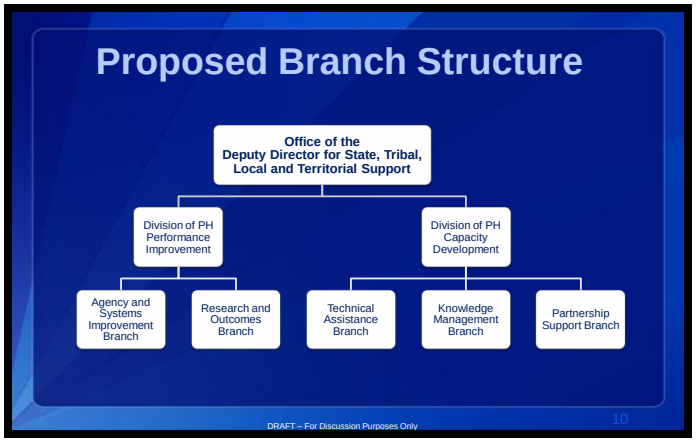
13. Develop Version 3 of the National Public Health Performance Standards Program assessment and improvement tools for use by state, tribal, and local health departments. This program has been used to engage partners. This is anticipated to be a new model and much more of engagement tool for the broader partners. Accreditation will be measuring the work of the health departments.

14. Deliver an annual training program to 120 National Public Health Performance Standards Program and Mobilizing for Action through Planning and Partnership (MAPPs) users from state, tribal, and local health departments.

15. In terms of partnership that CDC funds (e.g., ASTHO, NACCHO, et cetera), improve management by increasing performance, improving reporting, and aligning products and efforts with priorities. Have the wisest investments been made by CDC and have those been aligned properly.

The proposed division structure of OSTLTS reflects the mission of the Office, with a focus on public health performance and capacity. The office will explore and support system-wide collaboration for the efficient, effective, and equitable delivery of core public health functions and essential services. Dr. Monroe emphasized that the structure was proposed, not approved, at this point. The approval of the package that was submitted to the Management Analysis and Services Office (MASO) is pending. Two divisions are planned: 1) The Division of Public Health Performance Improvement (DPHPI), which will lead standards and best practices identification and evaluation activities; and 2) The Division of Public Health Capacity Development (DPHCD), which will serve as the implementation, training, and grants management arm of the office.

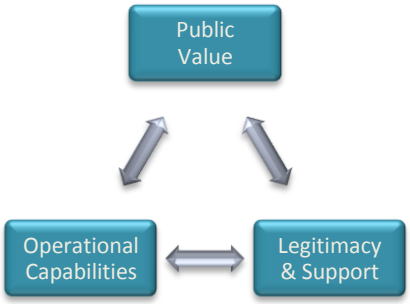
The OSTLTS branch structure, as shown below, is informed by the Concept of Operations:



The following reflects the proposed leadership staff, which again, has not yet been approved and for which there will be several vacancies if approved:

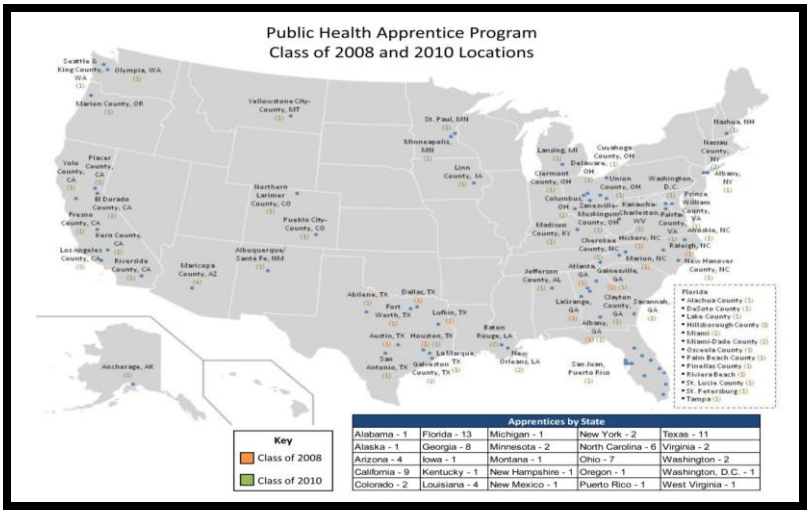
The proposed organizational structure is designed around the concept of value creation for the public health system [The "Strategic Triangle Test" for Creating Public Value; Mark Moore, Creating Public Value], which Dr. Monroe often used in Indiana, which states that any public health organization must bring its strategies into alignment by meeting three broad tests illustrated by the following questions and triangle:

- ❑ Does this produce value for the public we serve?
- ❑ Is it able to attract support and money from the political system to which we're ultimately accountable?
- ❑ Can it feasibly be accomplished given our resource equation?



If any one of the components of the triangle is cut off, success is cut off as well.

Dr. Monroe shared further information about the PHAP program. The purpose of the PHAP is to provide frontline, entry-level experience to individuals interested in a career in public health practice. A new class of apprentices starts each July. As noted, this year's class has 65 new apprentices. PHAP's focus for next year, which begins in July 2011, is to expand the program to states and localities that are not currently represented. Tribal public health agencies are also encouraged to submit an application to host an apprentice. Currently, apprentices are located in 23 states, 1 territory, and the District of Columbia (DC). The following map shows the class of 2008 and 2010 locations:



There remain some areas of the US that need to be filled in. There is more of a concentration on the East and West Coasts, so there are opportunities for the future.

In conclusion, Dr. Monroe emphasized that they had spent four months attempting to stand up a new office that had not yet been approved and for which they could not yet hire anyone. Health Reform passed on March 21st, she began her new position with CDC on March 22nd, and Health Reform was signed into law on March 23rd. Early on, it became clear that OSTLTS would be responsible for the funding opportunity to build public health infrastructure. Information about this opportunity included the following:

- ❑ The Funding Opportunity Announcement (FOA) can be found on grants.gov
- ❑ Application Deadline: August 9, 2010 5:00 pm EDST
- ❑ If you have a question about the FOA, you may submit it to CDC via email at OSTLTSFUNDING@cdc.gov
- ❑ CDC will respond to all questions and will post the responses at www.cdc.gov/ostlts

Dr. Monroe acknowledged that the application deadline caused frustration to the field, but it was either that or not having funding in 2010. They had to move quickly and much had to be done. They conducted three technical assistance calls to try to cover all of the time zones. They were happy that they were able to get this initial FOA out the door.

Discussion Points

- Ms. Hughes thanked Dr. Monroe for her presentation, noting that everyone had been wondering what was happening with the development of the office. The fact that is was yet approved offered a better understanding of why the vacant positions had not been posted. They have all been watching for postings and are anxious to see what is going to occur, particularly with regard to CAPT Snesrud's and Dr. Bryan's positions in light of their retirements. There is also interest in many other areas. She was recently asked to write testimony for the Senate Committee on Indian Affairs in regard to the CDC Consultation Session in which the name change was requested for OSTLTS. That committee is looking for successful / unsuccessful factors pertaining to consultation policies and practices. She was sure they were asking for her to cite that discussion as one of the successes of consultation. The development of this office continues to be closely monitored in Indian Country, and she wondered what the anticipated timeline was for approval. She also wondered what the process would be for reviewing and selecting individuals to fill the vacant positions, and what involvement TCAC might have.

- Dr. Monroe responded that while she wished she could offer a definitive answer, it was her understanding that approval of their MASO package would be within the next three weeks. Following that, they would be able to post positions. There is no question that they have had some challenges. With respect to the process for filling vacancies, she has not yet been able to hire anyone during her short tenure and she is new, so she said she was not entirely positive about the process. They will post the positions and applicants would be free to apply. There will be a review of the applicants, and the best candidates will be invited to interview. Regarding TCAC's involvement in the hiring process, she suggested that if they knew of good candidates, they should encourage them to apply. Beyond that, she was not personally clear about how / if the federal hiring process involved the consultation process.

- Dr. Duckworth added that they plan to share the announcement broadly to make sure that it is widely distributed, so that the best candidates can be identified.

- Mr. Antone noted that in January 2010, when they met Dr. Frieden, the information that was passed on was that we would able to have two or three staff members to support the tribal liaisons. He wondered whether the OSTLTS includes a provision for this.

- Dr. Monroe responded that they hope to be able to hire a number of staff throughout OSTLTS, including support staff. Her understanding was that once they were approved, they would continue to have some flexibility down the road as they continued to mature.

- CAPT Snesrud said she did not really have access to the package, but the preliminary plan was to bring on two staff members in Atlanta to support the Tribal Liaison there, and one staff member to support the Tribal Liaison in Albuquerque. Stressing that she was speaking from her own impression and understanding, she said it has been somewhat like a "shell game." As the directives come down from the agency as there is more stability as a result of the agency as whole completing the reorganization process. The office is trying to be responsive to those priorities within its broader function. It is unfolding, which is the difficult aspect because the office is looking at those functions for states, tribes, and territories. She emphasized that Dr. Monroe is in a very difficult position because she is one of Dr. Frieden's Deputy Directors, and the way the office is positioned is clearly to work across the whole agency with all of the national centers to empower them to work more effectively at the state, local, tribal levels.

- Dr. Monroe added that there will also be flexibility to shift staff within each division once individuals are hired. The bottom line is that they want to make sure that there is support for the liaisons.

- Mr. Antone asked Dr. Monroe, in her position, how much weight she could put on the Agency for Toxic Substances and Disease Registry (ATSDR). They once discussed at least 8 support staff, but right now there is just 1.

- Dr. Monroe replied that so far in her position, she really had not interfaced with ATSDR very much. Thus, she was not yet certain how much influence she would have there.

- Mr. Antone mentioned to Dr. Frieden during the last consultation that there are over 565 federally recognized tribes. There is one person from the Office of Tribal Affairs (OTA) at ATSDR, Annabelle Allison, and there were discussions about at least getting one more person. Since Dr. Monroe has access to Frieden, he requested that she carry this forward.

- Dr. Monroe responded that as she gained a better understanding of the needs, she certainly would be taking those issues forward to CDC leadership.

- Mr. Antone added that TCAC would be more than happy to write something up for Dr. Monroe about this issue.

- Mr. Phillips-Doyle (Nashville, Passamaquoddy Tribe: Pleasant Point Reservation, Tribal Governor) wondered about Dr. Monroe's item #11, the ACD and whether there is tribal seat on that.

- Dr. Monroe replied that there is, and that Anna Whiting Sorrell and H. Sally Smith had been invited to sit on the Work Group.

- Mr. Trudell (Aberdeen, Santee Sioux Tribe of Nebraska Chairman) said that he was not sure how to approach this comment without sounding negative or offensive, but it seemed like they reached a certain point in making progress with various federal departments, and have relied on staff, realizing that people turn over and move on. Basically, they are going to have Dr. Duckworth. While he did not want to be offensive to her, he did not know her knowledge of Indian tribes and the tribes' diverse philosophies. CAPT Snesrud and Dr. Bryan had a pretty good handle on a lot of that, but now there are vacancies and it does not seem like a lot of progress has been made. He wondered how committed CDC really is to this, or if they would just come to this point and stand still for several years until somebody got fired up again. It seemed like the President's philosophy was to create some type of improved services to the Tribal Nations. Unfortunately, he cannot do it himself. He has to rely on others. However, Mr. Trudell did not see this happening. The loss of personnel, the inability to hire staff, and the lack of movement forward of this office were just going to lead to frustration and he could not see "the light at the end of the tunnel."

- Dr. Monroe agreed that there is no doubt that continuity and long-term continuity are good. There is a lot of change taking place, and she would hope there is "light at the end of the tunnel." She will work toward this, but she has been handed a new office and cannot help the timeline. She realized that it sounds like they are in limbo, which they are until they can hire and so forth. She reiterated that even before the positions are posted, she would encourage them all to think of who some good candidates are and use that as an opportunity.

- Mr. Trudell (Aberdeen, Santee Sioux Tribe of Nebraska Chairman) stressed that because there are no concrete timeframes, they could be sitting there several months down the road with no one hired and no conclusions. The President and his administration are only there for a certain amount of time. He has seen the practices over the years in which people in the mid-level or people who never turn over in federal agencies tend to control what the federal agencies do, such that the good intentions of good people are never brought to fruition. He wondered whether they were in that situation again. While he was sure Dr. Monroe had good intentions, she is a new appointee, which means that she does not have a lot of longevity to carry out a lot of these things. Thus, it was not clear to him whether there was really a change in the philosophy to try to resolve health disparities on reservations. Tribal people continue to have rising cancer rates, rising diabetes rates, et cetera. There are a lot of best practices to be implemented, but nobody wants to put up the resources to implement those. Therefore, tribal people continue to lose ground healthwise. In his mind, nobody cares because they are an insignificant population. If they all die off, who is going to miss them? He does not see the commitment from CDC.

- Ms. Hughes thought TCAC needed to take action during this meeting to send a letter to Dr. Frieden with their recommendations on the establishment of OSTLTS, and with their recommendation on the vacancies in terms of posting them and placing timelines on this effort if possible. TCAC is established as an advisory committee for that purpose, so she felt that offering TCAC's encouragement through a letter would be helpful.

- Dr. Monroe thought that it would be very helpful. Being new to the federal government, she could not speak to its history in terms of such matters, but she emphasized that as Director of OSTLTS, she is committed to getting the office stood up. While she cannot control how

quickly they are approved, as soon as they are approved she can move as quickly as the process will allow them to get the right people hired. She stressed that she does not want this dragged out because she wants to get moving on making an impact on outcomes.

- While Mr. Valdo (Pueblo of Acoma, National Congress of American Indians) thought it was great that Dr. Frieden put "Tribal" in the name of the office where they requested it and he was very happy to see that, to see that tribes were being buried within a branch below a division troubled him. He thought they should be getting traction at a higher level, but instead it seemed that they would just get buried within the system. If this was truly consultation, it would be the cabinet members face-to-face with the tribal leaders. They will also lose traction because two of their advocates within the system are retiring. The success and strides in Indian Country have come from people working inside the system. Losing CAPT Snesrud and Dr. Bryan will result in the loss of a lot of operational knowledge. They hear the same things in Atlanta, Albuquerque, and Tucson, and Dr. Monroe has a learning curve as well. He was once in a planning meeting during which a consultant said he would just go to the tribes and say, "I'm here to help." Mr. Valdo advised against this approach because the consultant was a 6'5" Anglo American. He reminded him that 300 to 400 years ago, many people like him came over on ships and tribes have been pissed off ever since. There is a very different protocol required in Indian Country because it is a very different world. Sometimes people are rubbed the wrong way, which strains relationship. His recommendation was to keep their two best advocates to help Dr. Monroe learn the history. Letting them go is taking two steps back.

- Dr. Monroe said she appreciated hearing this, and emphasized that she was there to learn and make adjustments where she had the ability to do so. She, too, applauded that the name of the office ultimately included "Tribal." They are known by their name, and it gives her the authority to go across all of CDC to bring together all resources across CDC to elevate tribes. She did not believe tribes were meant to be buried. They also do not have any offices that say "State" or "Local" or "Territorial" in the functions of the office because the name of the office itself brings that together. In the Office of the Director, there will be an Associate Director for Strategic Partnerships and Alliances as well, so she envisioned that individual having a role as well.

- Mr. Secetaro (Albuquerque Area Indian Health Board Chairman) agreed with Mr. Valdo and Mr. Trudell in that he thought they had CAPT Snesrud "broken in" just right. He hated to see her and Dr. Bryan leave, and it will be a big loss for all of them. He thought they needed to hire someone who is familiar with Indian Count—somebody who grew up on the reservation. It is like starting over. They have all been all over the country, and they have had CAPT Snesrud beside them all the way. It will be hard to get going again. TCAC needs more input into CDC. He agreed with the suggestion to send letters to Dr. Frieden.

- Ms. Galvan (Navajo Nation) reported that when they work on our tribal budgets, they see budget instruction manuals that tell them what they can and cannot do. They are told that they cannot reorganization after the third quarter. There must be similar timelines for the federal government, because right now their budgets are coming out of embargo. Obviously, there are timelines. She pointed out that the PowerPoint Dr. Monroe shared about the organization stated that "the concept below is informed by the concept of operation." Why would the timeline not be shared? While Dr. Monroe said they tried not to make it specific to state and local, #7 of the 15 in 12 states, "Field training will be developed for and delivered to CDC field staff and the staffs of state and local health agencies." Tribal and territorial are not included. Navajo Nation is working to create a state-like health

department, but that means tribes will not be included in that kind of training. Tribes need capacity-building. While they go to county trainings, she has to fight to put their foot in the door. They say tribes do not pay taxes, but they do. They contribute a lot of their minerals to the state—well over $3 million in coal, oil, and gas coming out of the Navajo Nation. She requested that CDC be careful when they describe state and local. They are all sovereign nations. Tribes have different treaty obligations. Where is the fix in the proposed branch stricture? Where is the dotted line where CDC-TCAC come into play? This does not appear to be part of the structure. If there is going to be an advisory committee, there should be a dotted line. Otherwise, tribes will be included in the Technical Assistance Branch.

- Dr. Monroe replied that there was a timeline. The package was submitted, and they were hopeful that it will be approved within 3 weeks, at which time jobs will be posted and disseminated. She has not learned all of the federal rules at this point, but once they post the positions, they will need to allow time for eligible applicants to know that those positions are open. Then they must go through the interviewing / hiring process. While she could give an estimated timeline, she could not offer a firm date because of the nuances. OSTLTS is quite anxious to fill the positions. They are also trying very hard not to mention just state and local. They really are there to support state, tribal, local, and territorial in everything. That is a correction that needs to be made. Everything coming from this office should include state, tribal, local, and territorial. She expressed appreciation for the comment about the dotted line and TCAC, indicating that she would review the slides to determine how to demonstrate where TCAC fits in.

- Ms. Galvan (Navajo Nation) noted that the slides reflected the existing program, with the services and functions of the branches currently. Then proposed branches are coming into play. She requested clarification about what changes are proposed. The Tribal Liaisons are currently under the Technical Assistance Branch. That is moving to a new branch. She wondered if there was anything new that would move over or be deleted as a function.

- Dr. Monroe responded that what was reflected in the chart represented the way they are currently functioning. They proposed the office and stood it up in this fashion. The Technical Assistance Branch is functioning close to the way it will function, although the difference pertains to whether they will be able to hire and fill all of the positions. Once approval is received, nothing will really be different in terms of responsibilities. The Tribal Liaisons are the same.

- CAPT Snesrud added that this has been a huge process. She, Dr. Bryan, and many other staff members within OSTLTS have many more questions than answers. Each of them has tried to be diligent in maintaining their respective scopes of work as they understand them. TCAC is an advisory committee to Dr. Frieden. Tribal leaders have been trying to establish a government-to-government relationship with CDC. That means that the highest elected officials of tribes should have a relationship with the leaders at CDC. TCAC is the advisory committee to the CDC Director. The question is: Now that tribes are within this office, where are those lines that connect this office? What are the assurances when you make recommendations to Dr. Frieden through Dr. Monroe? What she thought she heard Dr. Monroe saying was that she is listening and hearing, and that tribal leadership should keep talking to her as they are formulating and establishing the office and those linkages. Many TCAC members have been on board from the onset. She acknowledged that they had all given a lot of time and commitment to CDC away from their communities and elected council positions. Allison Sage is not a TCAC member, so he traveled 800 miles on his own dime. TCAC members received a little assistance, but clearly the time and commitment to travel to

TCAC meetings, where ever they are, is considerable. She heard Dr. Monroe making a commitment that they need to work this out as soon as possible, and that the TCAC Co-Chairs need to be engaged in that process. CAPT Snesrud and Drs. Bryan and Duckworth should set up conference calls, and perhaps have Mr. Antone and Ms. Hughes travel to Atlanta, when Dr. Monroe has more answers, to meet with leadership and engage Dr. Friedman as CDC's federal tribal advisory committee to him.

- Mr. Freddie (NIHB, Navajo Nation Council Delegate) emphasized that this is a very important meeting, and one key word that needs to be drawn out is "transparency." Indian Country has made recommendations about improving their knowledge of CDC. They should have knowledge about the formulating of the administrative process, strategic planning, et cetera. There should be transparency to what was recommended for this office. CDC's mission is very important. It is very important that CDC resources be filtered down to the community to the citizens. They need to be proactive, not reactive. There is a disaster impacting the whole area in which this meeting was taking place. CDC resources going to Indian Country is an excellent investment. Indian Country has issues in area of homeland security, environment, natural gas lines coming from Houston to California through their land, power plants in Indian Country, need for surveillance, environmental issues, how influenza vaccines have to come through supply centers, et cetera. It is important to make sure that Indian Country is on the same priority level as counties and states. American Indians are "burning both ends of the candle" trying to preserve their society. Children are contributing members of society, and tribes need to retain what is very important to them. Indian Country is taking care of their own and not relying on CDC federal resources to do that. The bottom line is that there needs to be transparency to sit with CDC to dialogue as they plan how to organize and how to program some of the resources that should ultimately go directly to tribes.

- Mr. Antone said that what they were really saying was that they understand the government-to-government relationship, and they want to have that with CDC. That means that elected officials and Dr. Frieden must discuss things together. In 2004, the reports submitted to HHS always reflect an organizational structure within CDC for tribes. They must understand that in the TCAC charter, the purpose is sated as "The federal delivery of health services and funding of programs to maintain and improve the health of American Indians and Alaskan Natives are consonant with and required by the federal government's historical and unique legal relationship with Indian Tribes as reflected in the Constitution of the United States." That is where everyone is coming from and why they were having this conversation. One of the things he planned to suggest the next day during the Consultation Session would be for CDC to report on an annual or bi-annual basis where the testimonies offered during Consultation Sessions go. There were certain places where they went before, but since the reorganization, this is not clear. A lot of tribes testify, and when there is no feedback, they wonder what happened. He suggested that when the office is approved, perhaps they should outsource the consultation process to someone with expertise in the consultation process. He stressed that education must continually be delivered to federal agencies becomes the tendency is that it becomes a race issue, when it is not. There must be a clear understanding of the government-to-government relationship.

- Ms. Hughes noted that at the end of the day, TCAC members would discuss any formal recommendations they would like to send forward to Dr. Frieden.

- Ms. Reft (Alaska, Karluk Ira Tribal Council) agreed with what had been said. While she had not been on TCAC for very long, she has been involved in other consultation sessions over the years. It is frustrating. It feels like advisory committees are created to "pass the buck." It is somebody for the tribes to be angry with. TCAC members heard issues from the tribes the previous two days. The issues are real, but what authority does TCAC have? They have to deal with this all of the time in Alaska. It is frustrating, and their hearts go out to tribal people. But it feels like advisory committees are created just to listen and serve as someone to be angry with, but have no power or authority to do anything. It felt like ever since consultations started, it is just making tribal communities angrier. They are dealing with this in her area where their health care services are limited. They have to fight just to receive basic services, nobody is listening to them, and everyone is angry. The South Central Foundation Alaska Native Tribal Health Consortium has given a resolution to the Regional Non-Profit Health Corporation that is pulling their health care. Her tribe met with the South Central Foundation the previous day, and there are still no definitive answers. This is frustrating and she feels very angry that people are hurting but their needs are not being met, nothing is being done, and nothing is changing.

- Ms. Hughes thought they were all in the same frame of mind and were feeling the same level of frustration. As a TCAC member, she believed her responsibility was to be part of the tool to break down the barriers between CDC and tribes. Tribes do not understand what all is involved within CDC and vice versa. She emphasized that she is not there to be a roadblock. She is there to help CDC understand what is occurring on reservations, and for CDC to help her understand what they have to help tribes with their problems. She expects the CDC staff to attend TCAC meetings to ask TCAC for their advice about how to improve what is occurring. For example, Dr. Monroe mentioned that the grant process is being reviewed and some changes have been made. It would have been helpful if that process and the five changes referenced had been presented to TCAC so that they could offer input with respect to whether those five changes would have an impact in Indian Country.

- Dr. Monroe responded that she firmly believes in transparency. When she first came to CDC, this was one of the tasks with which her office was charged. The Deputy State Health Commissioners, through the Association of State and Territorial Health Officials (ASTHO), made about 25 recommendations to CDC two years ago about how to improve the grants process. OSTLTS was charged with moving that forward. This is the starting point, and she would like to have this conversation with tribes, because they are very early into this. In terms of the discussion regarding how long things take, the Deputy State Health Commissioners were quite frustrated that two years had passed since they submitted their recommendations.

- Mr. Trudell (Aberdeen, Santee Sioux Tribe of Nebraska Chairman) emphasized that it was not beneficial to make the tribes compete against one another for funding to address important health issues. Whoever has the best grant writer is going to get the funding, and in one to three years, they will be back in the same situation. Part of his intent with sitting on TCAC is that there is a great shortfall in I.H.S., which leaves many health issues unaddressed. CDC seems to be funded and should be able to pick up slack without it being competitive to tribes. The states are given block grants by CDC, which he did not believe required a competitive procedure. He inquired as to why tribes have to compete for very

limited dollars while the gap of disparities widens. They are being made to compete against each other to address health problems they all have. It is a vicious cycle to compete with each other. Somewhere someone has to step in to ask: Why are cancer and diabetes at greater rates for tribes than for anyone else? Tribes have been studied more than any other people. Nobody wants to put the effort foreword to implement the best practices on Indian Country. Nobody wants to put up money for prevention or implementation for practices that have been developed, even though some of them are not that costly. While some practices may not work universally, surely that can be adapted to tribes if they have been established and proven. The whole budget process is too frustrating. He recommended getting out of the competitive process and helping the Indian people.

Tribal Public Health Accreditation Process & Tribal Public Health Profile

Rick Haverkate, MPH
Director of Public Health Programs
National Indian Health Board

Mr. Haverkate indicated that he is an enrolled member of the Sault St. Marie Band of Chippewa Indians in Northern Michigan. He presented on the PHAB process that is being done on behalf of the tribes, and the Public Health Profile that the National Indian Health Board (NIHB) recently completed. They have been working with PHAB since about 2007. This was funded by CDC and the Robert Wood Johnson (RJW) Foundation to develop an accreditation process similar to that which hospitals and clinics go through. This is specific to public health, so there is a much broader spectrum of accreditation. They wanted to make sure there are standards in place, that specific areas of the public health domain are addressed, and that policies are in place to bring people up to a standard in order to ensure comprehensive services. They believe that they are just as well-positioned to receive accreditation as any other state or local health department. Three tribes are currently going through the beta testing for the Public Health Accreditation process: Navajo Nation, Cherokee Nation, and Keweenaw Bay Indian Community in Upper Michigan. The site visits were all schedule to begin the week after this TCAC meeting. Mr. Haverkate planned to travel from the TCAC meeting to the Keweenaw Bay Indian Community to help them with their accreditation process. This is really a quite exciting process. An advisory board was developed to begin this entire process, and now there is a call for participants to be in a very specific Tribal Public Health Accreditation Work Group that will adapt current policies to make them specific to what tribes need. Those who may be interested were instructed to visit the website: www.nihb.org. He then shared an overview from President via video.

The NIHB is very proud to represent all tribes throughout the country in the PHAP process. They are working closely with other national organizations in this effort: ASTHO, National Association of County and City Health Officers (NACCHO), PHAB, CDC, and RWJ. In order to begin the process of accreditation, a couple of things need to be set in place. NIHB believes they have completed a fantastic profile based on surveys directly from tribes letting them know whether tribes stand on this. The objectives for the PHAP were to establish and advisory panel; review past accreditation efforts in Indian Country; explore the potential for voluntary public health accreditation, including assessing the benefits, challenges, and barriers; and gathering recommendations from Indian Country about how to do this. Navajo Nation, Cherokee Nation, and Keweenaw Bay Indian Community took a bold step in volunteering to be involved in the beta testing of this program. It is somewhat intimidating and scary. The coordination has been astonishing. He has been privileged to go to two other state reviews, Washington and

Oklahoma, that worked very closely with their tribes. They were very inclusive and brought their tribes to the table as full partners in those states. Mr. Haverkate has not been to a county health department interview, although their other consultant, Aleena Hernandez, has.

This is a fairly lengthy process that involves a lot of effort. NIHB is helping tribes to prepare for these reviews. Three documents must be in place for anyone going through the public health accreditation process as a voluntary beta site, and in the future for voluntary full accreditation: a health department strategic pan, a community health assessment, and a community health improvement. This all has to do with the goal of quality improvement, which pertains to the entire systemic, intricate involvement of all departments at a corporation, tribal health department, or organization. This is not about placing blame about how things went wrong, but instead tries to address how to keep things moving at the most excellent pace possible and preventing a breakdown of systems.

Mr. Havertake then referred participants to the NIHB website for a copy of the Tribal Public Health Profile, which is located at the following URL:

http://www.nihb.org/docs/07012010/NIHB_HealthProfile%202010.pdf

Surveys were disseminated, for which there was approximately a 42% response rate, so a little over 170 tribal health organizations responded. This is in a program called "Click Books." He talked the group through how to manage this site, which can be read just like a book. This can also be shared on Facebook. This document was set up this was because NIBH is making an effort to go green versus printing millions of copies of this book. Mr. Haverkate shared the following highlights from this publication [page 17]:

- 44 percent of Tribal Health Organizations have conducted a community health assessment in the past 3 years. Of these, 42% were developed and facilitated by an outside party, 15% were developed by a group of partners led by THD/O, and 43% were developed and led primarily by the THD/O.

- Lack of staff and resources and the need for training were identified as the top 3 barriers to conducting community health assessments.

- 100 percent of participating Area Indian Health Boards indicated that they have a data sharing agreement with local tribe(s).

Community health assessments should be a living, breathing document for tribes. Looking at the chart on the bottom of page 19, clearly tribes do know their demographic characteristics; social and environmental factors; death, illness, and injury characteristics; maternal and child health characteristics; social and mental health characteristics, behavioral risk factors, quality of life, health resource availability, and socioeconomic characteristics. Referring to page 38, Mr. Haverkate pointed out areas to address in the future. A common concern among tribes is an unwillingness, fear of, and lack of preparedness for conducting research. By tribes own responses, this page demonstrates that some tribes are involved in research, and reads as follows:

Over 40 percent of Tribal Health Organizations have a research policy or ordinance that outlines protocols for reviewing and participating in health research. Research review and approval protocols include research review committees or boards to serve in that capacity. Tribal Health Organization research review and approval process descriptions fell into four primary categories:

1) Health Board/Committee (17 percent) Authority is given to a Health Board/Committee to review and approve research on behalf of the tribe, tribal association/consortium.

2) Health Board/Committee and Tribal Council (9 percent) The Department Head/Administrator is responsible for reviewing and preparing the proposal for review by a Health Board/Committee, Advisory Board, or other group, that provides recommendations for approval to Tribal Council. Process may include a Tribe's legal counsel. Tribal Council is responsible for the final review and approval decision.

3) Tribal Council only (17 percent) Tribal Council is the sole body to review and approve research. Process usually includes a Tribe's legal counsel.

4) Institutional Review Board (IRB) (52 percent) IRBs, also known as an independent ethics committee, are a committee that is formally designated to approve, monitor and review biomedical and behavioral research involving human subjects with the aim to protect the rights and welfare of the research subjects. IRBs are governed by federal regulations, Title 45 CFR Part 46. (http:// ohsr.od.nih.gov/guidelines/45cfr46.html)

The majority of Tribal Health Organizations require approval from an IRB, whether tribal, IHS, or university. Most other approval processes involve a health board/committee and/or Tribal Council. Although IRB approval of research involving human subjects is legally required, most Tribal Health Departments did not identify it in the Tribe's review and approval process. IHS Facilities and Area Indian Health Boards most commonly identified a process that includes staff review, IHS IRB approval within the formal IHS Research Guidelines, and Tribal Council approval by participating tribes. Most Urban Indian Health Centers described processes that include staff review and formal IRB approval, either through IHS or a university.

In conclusion, Mr. Haverkate encouraged participants to review the full document to read what tribes are saying, and to see their status in terms of community health assessment and planning.

CDC's Budget Updates and Discussion of Options / Opportunities for Tribes

Michael Franklin, Budget Analyst
Financial Management Office
Centers for Disease Control and Prevention

Mr. Franklin shared several tables representing CDC / ATSDR resources committed to programs that benefit American Indian and Alaska Native populations and communities from 2009 compared to 2008. Fiscal information was summarized in the data presented according to organizational and disease-specific programs, and by defined funding allocation categories. Recovery act funding was not included in this information. Total CDC / ATSDR funding with VFC (73%) is $168,275,464. Total funding without the VFC is $46,009,312 (27%). Excluding

ATSDR, total funding with VFC is $167,637,959 and without is $45,371,807. Funding resources aligned with coordinating centers is reflected in the following table:

Funding Resources Aligned with Coordinating Center Center/Institute/Office (CC/CIO)	Total Funding FY2009 w/ VFC	Total Funding FY2009 w/o VFC
Coordinating Center for Infectious Diseases	**$129,574,394**	**$7,308,242**
NCVZED	$106,000	$106,000
NCHHSTP	$3,542,458	$3,542,458
NCIRD$45,371,807		
	$122,605,845	$339,693
NCPDCID	$3,320,091	$3,320,091
Coordinating Center for Health Promotion	**$27,568,187**	**$27,568,187**
NCBDDD	$200,000	$200,000
NCCDPHP	$27,368,187	$27,368,187
Coordinating Center for Health Information and Service	**$1,665,361**	**$1,665,361**
NCHS	$1,665,361	$1,665,361
	$2,240,561	**$2,240,561**
Coordinating Center for Environmental Health and Injury Prevention		
NCEH	$788,371	$788,371
NCIPC	$1,452,190	$1,452,190
National Institute for Occupational Safety and Health	**$322,140**	**$322,140**
Coordinating Office for Terrorism Preparedness & Emergency Response	**$4,651,716**	**$4,651,716**
Office of the Director	**$1,615,600**	**$1,615,600**
OWCD	$496,079	$496,079
OMHD/OD	$1,119,521	$1,119,521
CDC- CC/CIO Grand Total	**$167,637,959**	**$45,371,807**
ATSDR Total	**$637,505**	**$637,505**
CDC/ATSDR Grand Total	**$168,275,464**	**$46,009,312**

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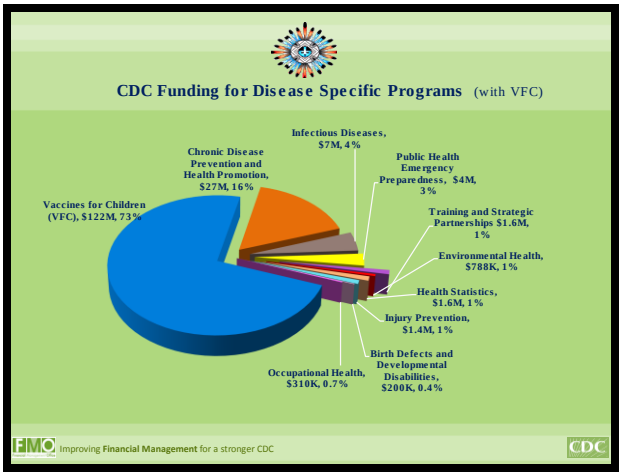
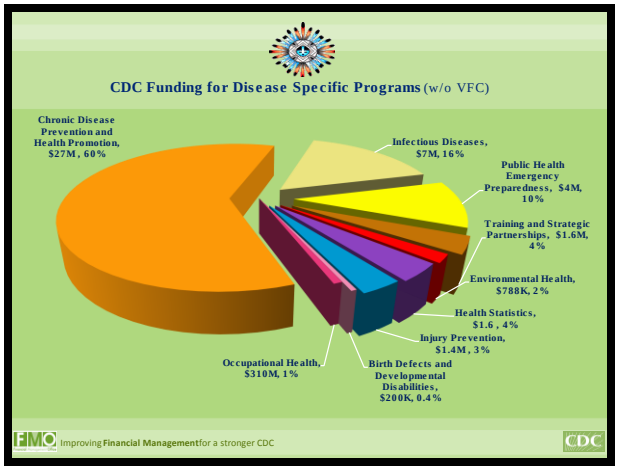
Funding resources aligned with disease specific programs (with ATSDR) are shown in the following table:

CDC Funding Resources Aligned with Disease Specific Programs (with ATSDR): A Comparison	FUNDING LEVEL FY 2008	FUNDING LEVEL FY 2009	Percent of Change
Chronic Disease Prevention and Health Promotion	**$ 25,884,960**	**$ 27,286,210**	**5%**
Cancer	$11,502,097	$14,077,332	22%
Cross- cutting Programs	$7,178,202	$5,613,762	- 22%
Diabetes	$3,349,585	$4,039,402	21%
Tobacco	$2,162,395	$2,064,618	- 5%
Heart Disease and Stroke Prevention	$1,010,000	$975,000	- 3%
Maternal Child Health	$292,584	$147,749	- 50%
Adolescent and School Health	$390,097	$368,347	- 6%
Infectious Diseases	**$ 7,715,374**	**$ 7,390,219**	**- 4%**
Infectious Disease Prevention (new category for FY 09)	N/A	$46,000	N/A
Infectious Diseases in Alaska Natives	$2,631,565	$3,380,091	28%
HIV/AIDS	$3,194,327	$2,493,544	- 22%
STDs	$1,117,005	$898,891	- 20%
Vaccine- preventable diseases (non- VFC funds)	$321,477	$339,693	6%
Viral Hepatitis (not reported for 09)	$217,000	$232,000	7%
Other	$234,000	$0	- 100%
Public Health Emergency Preparedness	**$ 5,192,034**	**$ 4,651,716**	**- 10%**
Public Health Capacity, Strategic Partnerships and Training (OD)	**$ 1,612,545**	**$ 1,627,600**	**1%**
Environmental Health	**$ 614,686**	**$ 788,371**	**28%**
Environmental Public Health Services/Research	$614,686	$788,371	28%
Health Statistics	**$ 1,424,746**	**$ 1,665,361**	**17%**
Injury Prevention	**$ 581,920**	**$ 1,452,190**	**150%**
Unintentional Injuries	$435,920	$150,000	- 66%
Violence Prevention	$146,000	$1,302,190	792%
Birth Defects/Developmental Disabilities	**$ 250,000**	**$ 200,000**	**- 20%**
Occupational Health	**$ 310,140**	**$ 310,140**	**0%**
Health Marketing	**$ 229,000**	**$ -**	**- 100%**
CDC Total w/o VFC	**$ 43,815,405**	**$ 45,371,807**	**4%**
Vaccines for Children	**$ 64,263,901**	**$ 122,266,152**	**90%**
CDC Total with VFC	**$108,079,306**	**$167,637,959**	**55%**
ATSDR Improving Financial Management for a stronger CDC	**$ 682,470**	**$ 637,505**	**- 7%**

Funding for disease-specific programs with VFC and without VFC is illustrated in the following pie charts:





Funding allocation categories include the following:

AI / AN Awardees (Direct)
Competitively awarded programs (i.e., grants, cooperative agreements) where the awardee is a tribe / tribal government, tribal organization, tribal epidemiology, Alaska Native organization, tribal college, tribal university, or urban Indian Health program.

Intramural AI / AN
Intramural programs, the purpose of which is to primarily or substantially benefit AI / AN.*

**This category would include costs (e.g., salary, fringe, travel, et cetera) associated with CDC staff or contractors whose time / effort primarily or substantially (50% or better) benefit AI / AN.*

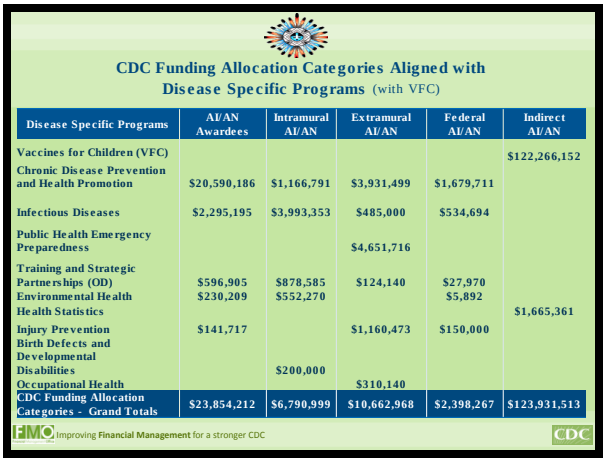
Extramural AI / AN Benefit
Competitively awarded programs for which the purpose of the award is to primarily or substantially benefit AI / AN.

Federal AI / AN Benefit
Federal Intra-Agency Agreements wherein the purpose of the agreement is to primarily or substantially benefit AI / AN.

Indirect AI / AN
Service programs for which funding for AIs / ANs can reasonably be estimated from available data on the number of AIs / ANs served**

***This category applies only to the Vaccines for Children program and to NCHS.*

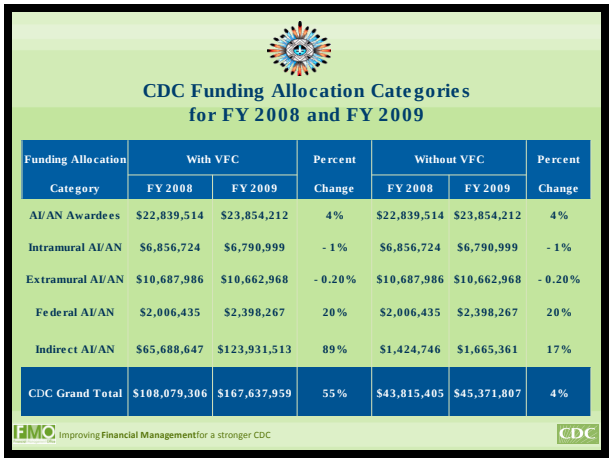
In comparison to 2008, 2009 indirect AI / AN awards (with VFC) increased from $65 million to $123 million. Funding allocation categories aligned with disease-specific programs (with VFC) and a comparison of allocation categories for fiscal years 2008 and 2009 are reflected in the following tables:



CDC Funding Allocation Categories Aligned with Disease Specific Programs (with VFC)

Disease Specific Programs	AI/AN Awardees	Intramural AI/AN	Extramural AI/AN	Federal AI/AN	Indirect AI/AN
Vaccines for Children (VFC)					$122,266,152
Chronic Disease Prevention and Health Promotion	$20,590,186	$1,166,791	$3,931,499	$1,679,711	
Infectious Diseases	$2,295,195	$3,993,353	$485,000	$534,694	
Public Health Emergency Preparedness			$4,651,716		
Training and Strategic Partnerships (OD)	$596,905	$878,585	$124,140	$27,970	
Environmental Health	$230,209	$552,270		$5,892	
Health Statistics					$1,665,361
Injury Prevention	$141,717		$1,160,473	$150,000	
Birth Defects and Developmental Disabilities		$200,000			
Occupational Health			$310,140		
CDC Funding Allocation Categories - Grand Totals	$23,854,212	$6,790,999	$10,662,968	$2,398,267	$123,931,513

EMO Improving Financial Management for a stronger CDC CDC



CDC Funding Allocation Categories for FY 2008 and FY 2009

Funding Allocation Category	With VFC FY 2008	With VFC FY 2009	Percent Change	Without VFC FY 2008	Without VFC FY 2009	Percent Change
AI/AN Awardees	$22,839,514	$23,854,212	4%	$22,839,514	$23,854,212	4%
Intramural AI/AN	$6,856,724	$6,790,999	- 1%	$6,856,724	$6,790,999	- 1%
Extramural AI/AN	$10,687,986	$10,662,968	- 0.20%	$10,687,986	$10,662,968	- 0.20%
Federal AI/AN	$2,006,435	$2,398,267	20%	$2,006,435	$2,398,267	20%
Indirect AI/AN	$65,688,647	$123,931,513	89%	$1,424,746	$1,665,361	17%
CDC Grand Total	$108,079,306	$167,637,959	55%	$43,815,405	$45,371,807	4%

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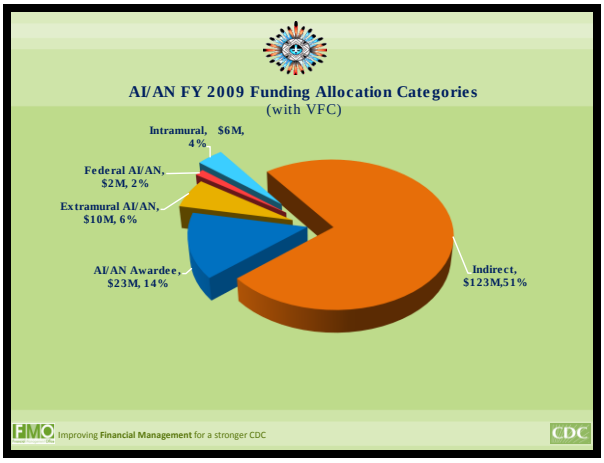
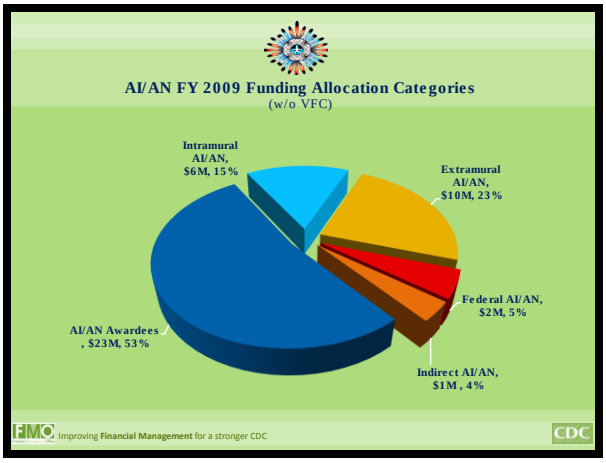
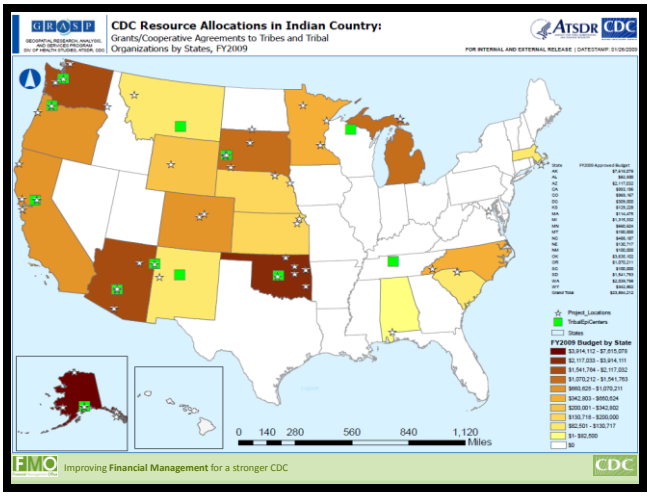
The following pie charts reflect the AI / AN 2009 funding allocation categories with the VFC and without the VFC:





AI / AN Fiscal Year 2009 funding (with VFC) in the amount of $168 million represents 2% of the total CDC / ATSDR budget, while the $45 million in AI / AN funding represents 1% of the total CDC / ATSDR budget.

Grants to tribes broken down by state, by HHS area, and by I.H.S. area are reflected in the following three maps respectively:


CDC Resource Allocations in Indian Country:
Grants/Cooperative Agreements to Tribes and Tribal Organizations by States, FY2009
ATSDR CDC
0 140 280 560 840 1,120 Miles
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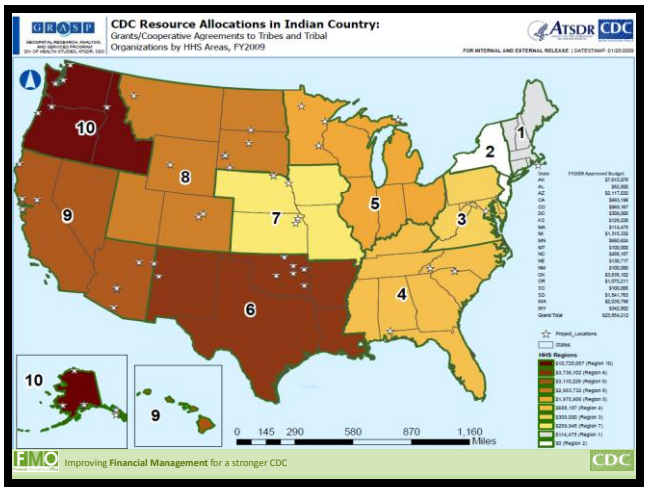
CDC Resource Allocations in Indian Country:
Grants/Cooperative Agreements to Tribes and Tribal Organizations by HHS Areas, FY2009
ATSDR CDC
10
8
9
7
5
2
1
3
6
4
10
9
0 145 290 580 870 1,160 Miles
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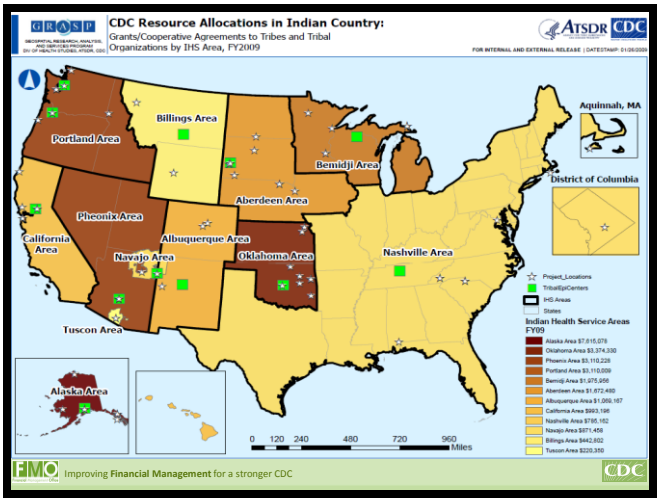
CDC


CDC Resource Allocations in Indian Country:
Grants/Cooperative Agreements to Tribes and Tribal Organizations by IHS Area, FY2009
ATSDR CDC
Billings Area
Portland Area
Bemidji Area
Aquinnah, MA
District of Columbia
Aberdeen Area
Pheonix Area
California Area
Albuquerque Area
Navajo Area
Oklahoma Area
Nashville Area
Tuscon Area
Alaska Area
0 120 240 480 720 960 Miles
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In the above maps, green boxes represent the Tribal Epidemiology Centers and the stars are the actual project locations of the awarded tribal programs. These maps depict only those funds that are directly awarded to tribal government, tribal organizations, Alaska Native health corporations, urban Indian organizations, and tribal colleges.

TCAC CDC / ATSDR strategic funding direction is to engage in sub-budget committee collaboration; expand division-based involvement for health impact across CDC / ATSDR; engage in program project initiatives with CDC / ATSDR Financial Strategies Committee; increase visibility in budget submission health initiatives; align with CDC / ATSDR health goals and objectives for performance- and results-based management; and collaborate further with HHS and operating division (OPDIV) shared resource initiatives.

The CDC budget process represents timing and events that occur over a period of time. The time has come and gone for the planning of 2010; however, calendar year 2011 has not arrived, but because of the events that have occurred for the fiscal year, the planning has passed and there is no opportunity to affect the 2011 budget. Now that they are planning 2012, that phase for planning does not really occur until December. Starting in January, formulation is going to be taking place for all of 2011. It is at these particular phases that attention should be paid for that particular year's fiscal budget. When and at what time is the best time for anyone to have input in the budget planning process? The President presents the budget to Congress on the fourth Monday in February. In 2011, the President will present the budget for 2012. What does that mean to us? If the President is going to present the budget for 2012 in 2011, the planning has already been done, so can anyone make any input? The answer is "no." Referring to the budget process sheet and the planning phase for 2011, this is where 2013 would move up. In calendar year 2011, the President presents fiscal year budget for 2012 to be executed October 1, 2011. During that time period, the planning for the next budget will be 2013 in calendar year 2011. FMO will be submitting their Budget plan requests for fiscal year 2013 to the CDC Office of Formulation, Evaluation, and Analysis (OFEA). Any budget requests, planning activities, and needs that are to be submitted to the Hill would be proposed in late March through April of 2011 for the fiscal year budget 2013.

Mr. Franklin provided participants with an Excel file that included a step-by-step breakout by month and by phase that reflected what occurs during each month and phase any time of the year. The important thing to understand is how this budget flows. He noted that CAPT Snesrud requested that he speak to TCAC about the opportunities and how to make their needs known to CDC. A working relationship and partnership with stakeholders at CDC is critical, and this can be found in OSTLTS. Now there is a named representative at CDC, Dr. Monroe, who heads that office. He reminded the members of Dr. Frieden's six winnable battles. With regard to the nature of how the federal budget process works, it is typically the efforts and activities that address the priority areas that are the focus of the winnable battles that will be supported first. The tribes have needs within those winnable battles, and have offered testimony about these. CDC has "marching orders" from Dr. Frieden, who has articulated what he would like to accomplish and programs assess the avenues to make this happen.

With respect to how that relates to tribes, programs start planning those efforts that Dr. Frieden has said the agency is going to engage in to accomplish the winnable battles. Mr. Franklin emphasized that everyone must remember that CDC does not serve a particular group—the agency serves the nation as a whole. That means tribes and everyone else is competing for CDC dollars. Therefore, they must be at the front of the line stating their challenges within CDC's health priorities. In March and April, the programs will submit their budget requests to the Office of Formulation, Evaluation, and Analysis and prepare documentation to the Office of

Management and Budget (OMB), which will go all the way to Congress. American Indians and Alaskan Natives will work through their partnership with OSTLTS to present tribal health challenges, and OSTLTS will articulate these to their peers. If there are particular activities the centers are working on that relate to the health issues that challenge American Indians and Alaskan Natives, there is a connection. This ties them into what is going on with CDC "marching orders" across the nation. The information tribes provide to CDC partnerships will be sent out across the CDC community. The other venue that is available to tribes is through their relationship with legislation. That is, the budget process can be influenced by tribes' communication with those who are developing the budget.

FMO does not decide who gets what. Congress makes the final decisions. There is an established protocol regarding how a budget is executed through federal agencies. It is all accomplished through the budget planning process. The window of opportunity is for tribes to work with their partner within CDC. There is a format to use to present this information. Mr. Franklin provided a template for tribes to use. While he pointed out that it was not "written in stone," but the topics are more or less what they would address. Utilizing those topics makes it easier for CDC to incorporate tribal information into their overall information. Basically, the budget is just a translation of someone's needs, with a dollar sign. Mr. Franklin referred participants to a document in their packets dated April 26, 2010 that included conversations from Dr. Ralph Bryan, which he requested that they read. He explained that document submitted to request funding needs should include certain information such as current statistics about particular health issues. This administration is looking at performance. Do we get what we pay for? Do we get a return on our investment? He stressed that if they write a document to CDC, it should be fluent, complete, and include certain items so that Dr. Monroe can articulate past performance, past outcomes, needs, rationale, expected outcomes, and the plan to measure outcomes.

The programs of the national centers within CDC execute FOAs and disseminate funding. CDC executes 80% of $12 billion through grants. Congress is in charge of approving budgets, and CDC makes them work using the vehicles currently available to them—grants. The approval of the money is based upon what Congress is told that CDC needs. In essence, CDC is not saying "rubber stamp" you get the money. CDC works with partners to determine what to articulate in the agency budget format presentation, which in turn goes to HHS, OMB, and then Congress.

Discussion Points

- Rick Doyle (Governor, Passamaquoddy Tribe at Pleasant Point) inquired as to whether all of the phases were occurring simultaneously.

- Mr. Franklin replied that CDC is currently working on 2012, so Congress will review this in 2011. There are still some internal presentations and adjustments underway. There are a lot of details behind the scenes, but he wanted them to know the opportunities.

- A request was made for further insight into the planning phase. The concern for tribal representatives is that it seemed that this was the only phase in which they had an opportunity to articulate their needs. Given structural limitations, it was not clear how they could make the most impact in order to get something into the planning phase. Their elected officials are analogous to Senators, and they are expected to return to their communities to demonstrate results in terms of resources.

- Mr. Franklin offered the disclaimer that while he could not speak for Dr. Frieden, he could speak as a US citizen. TCAC and other representatives have opportunities to make their concerns known. US representatives who are in Congress receive feedback from their constituents, and offer input at that time. If American Indians have representation, they too have the same opportunity at the same time. Tribal stakeholders within CDC hear tribal testimony, and Mr. Franklin said he truly believed in his heart that they are taking that with them to the planning phase of the budget in March and April. He feels certain that this information will not be forgotten. The challenge pertains to the focus of the agency, CDC, HHS, the administration, and the health status of the world. CDC is dealing with the nation as a whole and the whole world. He stressed that he was not offering this as an excuse, but was saying that all of the challenges have to go back and forth until one rises to the top. He expressed his hope that TCAC would present a formal plan that OSTLTS could use to articulate tribal needs to the CDC community when they start planning their budget for the next year.

- An inquiry was posed regarding whether CDC envisioned having tribal representation in the planning phase on one of the subcommittees. It sounded like Mr. Trudell had occupied that position at some point.

- Mr. Franklin replied that the subcommittee was an idea that was born last year. He, CAPT Snesrud, Mr. Antone, and Ms. Hughes engaged in a conversation about how they could best utilize the subcommittee to take information back to their constituents, and submit data for budget requests.

- CAPT Snesrud added that TCAC appointed a Budget Subcommittee. It was originally appointed in 2007, and then Ms. Hughes and Mr. Antone addressed this in the January 2008 meeting with respect to re-establishing this subcommittee and requesting volunteers. Ms. Hughes, Mr. Antone, Mr. Trudell, and Mr. Valdo volunteered on site, and Ms. Hughes requested that CAPT Snesrud send the call for volunteers to all TCAC members, along with the budget template. The Budget Subcommittee attempted to "wrap their arms around it," but it was a lot a little too late. She reminded everyone of a comment that was made by the former TCAC Chair in November 2006 who said that while they were three years out, CDC needed to clear with them about what they needed to do and when in order to organize their thoughts, strategies, and plans to influence CDC's budget planning process. It is just another one of those tasks she placed on them. She offered a toll free telephone number so that the TCAC Budget Subcommittee could meet via teleconference. CAPT Snesrud asked Mr. Curlee if they could use Mr. Franklin as a technical assistance person from FMO to answer questions. She hoped they heard her saying that CDC wanted to do everything they could to support TCAC and the TCAC Budget Subcommittee in their work, but CDC staff cannot do the work. In order to remain in compliance with the Federal Advisory Committee Act (FACA) exception, the TCAC and any subcommittees it stands up must include elected tribal leaders or designees who are appointed by tribal leaders.

- Ms. Hughes said that the process was becoming more understandable for her. She suggested that the template Mr. Franklin developed for them be sent out again so that everyone could be contemplating ideas for the 2013 process. They must eventually get into the process, although she was not yet comfortable that they had the input and influence in the CDC process that they should have. As a tribal leader, she is very comfortable working on the budget process through the President and Congressional Delegation, as she has been doing that for many years. Still, she was not comfortable with what is occurring within CDC. Discussions are taking place by CDC division, departments, and staff in which TCAC

is not involved. She can submit a detailed, nice, and neat paper, but has no idea what happens to it when it gets inside CDC. That is where she believes she should be able to have some discussion and input. She has no problem with her idea being rejected, but she needs to know why it is not working with whatever they already have on the drawing board.

- CAPT Tucker commented that CDC has longstanding, robust, multiple collaborations with states and local governments. Those are well-established, there is tremendous infrastructure, and they are in contact on a daily basis. Part of the loss of CAPT Snesrud and Dr. Bryan retiring was that CDC is in its infancy in terms of its engagement with tribes. This process has been person-dependent and it has been carried on the broad shoulders of CAPT Snesrud and Dr. Bryan, and that dependency is underscored here. There is not tribal engagement at all levels of CDC, and there is no on-going, daily engagement with tribes in a formal manner. There is so much riding, Dr. Monroe, on this engagement for access to the entirety of CDC. She underscored that it is so important to have persons with American Indian heritage speaking on behalf of American Indians at CDC because there are some things that just cannot be learned by someone who is not American Indian, and the learning curve is so steep and so protracted that American Indian representation is needed at this critical juncture because they have so far to go so fast. That is why the loss of the tribal liaisons goes so deep, because they have not begun to realize the relationship and engagement CDC needs to have with tribes.

- Ms. Trudell (Aberdeen, Santee Sioux Tribe of Nebraska Chairman) pointed out that they have been through a number of consultations and all of the needs have been presented repeatedly; however, but they do not go past the consultation process. Since their needs have been articulated over several consultations, it would seem that they would be reflected in the 2010, 2011, and 2013 budgets. While he appreciated Mr. Franklin's explanation of the budget, it did not seem that it was going to do them any good.

- CAPT Snesrud responded that they are stuck at a juncture because, in actuality, it is harder to see in CDC's budget how the agency has specifically responded to tribal needs articulated through testimonies. That is part of what they had attempted to do by presenting an AI / AN budget breakdown on an annual basis. At a time when CDC's total budget has been flat-lined and there have been significant decreases of funding allocated to states, the allocations to tribes have remained consistent or have increased, especially in the categorical areas that tribes have prioritized. Is it enough? No. Can CDC do better? Yes. CDC is at a juncture where the agency is trying to take apart how it does business internally with the states, and to make that influence more transparent. CDC is asking for tribal help in doing the critical analysis of the information that has been provided. This is where the importance of the Tribal Epidemiology Centers arises with respect to data. The data will help reflect need and drive the budget. There is a learning process internally for CDC. The TCAC Budget Subcommittee is very important. As Ms. Hughes noted, tribal leaders are very sophisticated in budget preparation, in particular with regard to the budget formulation they do with and for I.H.S. CDC is not at that place. The bottom line is that tribal health needs are huge, and often they are public health issues that fall within CDC's purview. The slices of the pie shown in the data provided are pretty thin slices of the pie. Tribes need to tell them clearly what is not there, and what additional information should be provided. Consideration must be given to how to work with Tribal Epidemiology Centers to acquire the data that tells the health status and profile of tribes in the US.

- Listening to everyone, Mr. Franklin said he could really see this coming closer to fruition. The allocations are being made. AI / AN are receiving allocations. The data has been pretty consistent. The data have been fairly consistent in the last two years, with the spike having to do with the H1N1 pandemic. The part that is not being executed is the articulation of the information. Dr. Monroe's office will now be providing information, because this particular office will have somebody to contact regarding particular needs. That is the beginning of a relationship, which he was sure would grow. From that growth, representation is beginning to increase. A lot of offices within CDC are already on the team. They are already providing allocations for certain activities. Tribes now have the avenue through Dr. Monroe's office to grow the relationships. The common denominator with I.H.S. and CDC is that they are both federal government, but I.H.S. has a direct concern with AI / AN health issues, while CDC has a concern with everybody's health issues.

- Mr. Trudell (Aberdeen, Santee Sioux Tribe of Nebraska Chairman) said he did not see what had been formulated out the consultations and what had been taken forward. If he could see that and know that something was happening with these consultations, he might have a better understanding. But he can slice a pie and make it look any way he wants to. Until he sees something to substantiate that someone has actually taken all of their testimony forward and has spoken on behalf of tribal nations, he will not believe anything is occurring.

- Jace Killsback (Council Member, Northern Cheyenne Tribe) indicated that he was on TCAC about four years ago. He echoed what Mr. Trudell was saying in that the discussion continued to be the same. He also wondered what had become of the testimonies. Even though they might want to make the distinction that process or faces are different in CDC versus I.H.S., to the tribal leader, they are the same federal government. They are not taking budgets as need-based budget, but are instead giving them pieces of the pie and saying "do what you can with it." What struck him was a comment by CAPT Tucker about the relationship with state and local governments. She was specific in saying local governments and not tribal governments. The problem they have in Montana is with their state and local governments. Even if they use tribal data to receive funding, this does not actually trickle down to tribes. That can be echoed from previous testimony. In terms of budget and planning opportunities, as a tribal leader, he saw it as the same. He wondered when things would come to fruition from these testimonies. While I.H.S. is specific to tribes, CDC deal particularly with state and local governments. Though they have mentioned trying to change that, on the face level, tribes are not receiving a needs-based budget. Also echoed two to four years ago was that there needs to be a change in how funding is allocated to tribes, in that tribes should be directly funded. Tribes and regions should be permitted to present needs-based budgets.

- Ms. Hughes indicated that as follow-up to this discussion, she would send the template out again to TCAC members, and ask that they send it onward to their health boards and / or others from whom they could acquire feedback on projects, initiatives, et cetera that TCAC can put forward for the 2013 budget cycle.

- Mr. Trudell (Aberdeen, Santee Sioux Tribe of Nebraska Chairman) inquired as to whether they were going to be presented with information about how prior testimony has been taken forward.

- Ms. Hughes indicated that they have the minutes from the Tribal Consultation. She pointed out that in Wisconsin, they have consultations. A matrix is prepared from each consultation so that every subject that a tribe brings forward that needs follow-up is included in the matrix. The state reports back to them what is being done with that request. Where appropriate, a timeline is included and staff members are assigned so that tribes know who to contact. This is also needed from CDC. That seemed to be what Mr. Trudell was requesting.

- CAPT Snesrud indicated that the summary document was a specific response to the testimonies, and that it was only a 20-page document. She thought Mr. Trudell was inquiring as to how testimonies had actually resulted in dollars and if so, how much. It sounded like he was asking for transparency.

- Mr. Trudell (Aberdeen, Santee Sioux Tribe of Nebraska Chairman) replied that this was what he was asking for. They could go through this process every week, but unless there was something visible to show him what happened with their testimony, he did not know whether it was being moved forward / addressed.

- Ms. Hughes expressed her hope that they would get a little more involved in that process.

- CAPT Snesrud responded that they have been involved, and that she never said that they had not been.

Overview of Comprehensive Tobacco Prevention and Control

Christopher Benjamin, JD, MPA, Deputy Branch Chief
Office on Smoking and Health, Program Services Branch
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

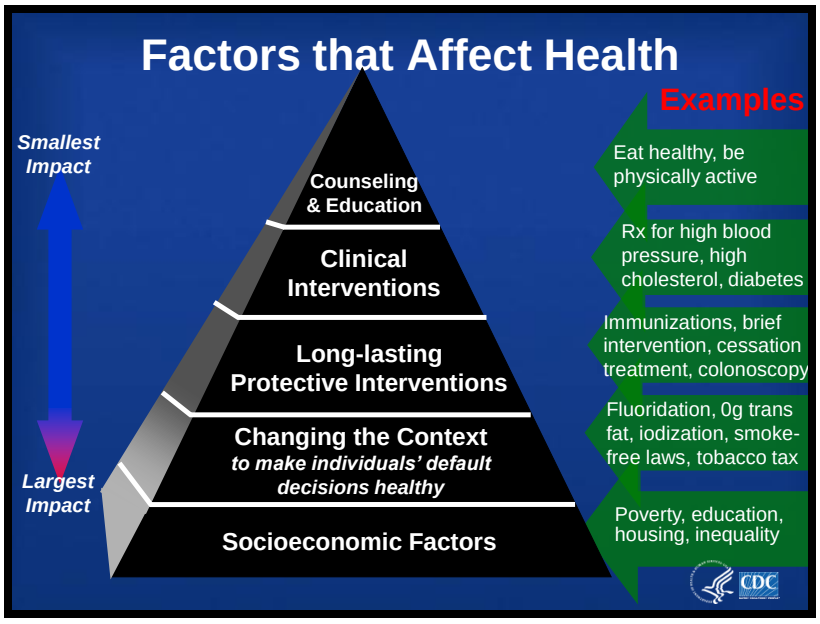
Mr. Benjamin indicated that Brick Lancaster, who was the scheduled presenter when the agenda was originally developed sent his warm regards. Mr. Benjamin began working for CDC in 1989. During seven years of his early career at CDC, he worked in the Division of Diabetes Translation (DDT) where he had the honor of working in four states that had significant populations of American Indians / Alaska Natives, and in which diabetes was a priority issue (e.g., Alaska , Nevada, Kansas, and Montana). While he said he is not an expert in Native American culture, traditions, or history, during those seven years he learned a tremendous amount about the AI / AN cultures. With that in mind, he said came to them during this meeting from a place of honor and respect, and expressed appreciation for the opportunity to present.

With regard to tobacco prevention and control, Mr. Benjamin emphasized that the approach focuses on a commercial tobacco perspective and recognizes that ceremonial use of tobacco has a very profound place in the AI / AN culture. None of the statements pertaining to prevention apply to ceremonial tobacco use. Everyone knows that use of commercial tobacco kills; however, 18.4% of adults smoke nationally. That includes AI / AN, African Americans, Caucasians, and Asians. Depending upon the state, approximately 9.3% to 26% of adults

smoke. Adult smoking rates among AI / AN populations is approximately 39.1%, depending upon the tribe. Given this, it is worth everyone's time to work together on this issue.
Mr. Benjamin offered insight into the Office on Smoking and Health (OHS) model, and discussed how they could continue to work together collaboratively. He explained that a comprehensive tobacco control program is a coordinated tobacco control effort that is intended to establish smoke-free policies and social norms; promote and assist tobacco users to quit; and prevent initiation of tobacco use. As the lead federal agency for comprehensive tobacco prevention and control, OHS develops, conducts, and supports strategic efforts to protect the public's health from the harmful effects of tobacco use. OHS's goals are to prevent initiation in youth; promote cessation; eliminate secondhand smoke exposure in all public settings; and identify and eliminate tobacco-related disparities.

There is a broad base of evidence to show that comprehensive tobacco prevention and control programs work. Surgeon General's reports, Institute of Medicine (IOM) reports, Community Guides, and best practices documents have provided this evidence. Experience has shown that tobacco control programs that are comprehensive, sustained, and accountable reduce smoking rates, tobacco-related deaths, and diseases caused by smoking. OHS's strategy is to focus on policy-based interventions that have broad population-based input. Taken together, these improve individual health behaviors by changing the community environment. These strategies employ the social norms change approach. The intent is for the interventions to increase media messages that drive people to quit; limit access to youth (the primary target of the tobacco industry); limit point-of-purchase advertising and promotion; increase prices; and increase social services and support for people who are ready to quit.

The following pyramid comes from a recent article by Dr. Frieden, the point of which is that the broadest impact occurs where the interventions are policy-based and focused, which is where OSH's efforts are focused:



The other framework that is now a foundation for OSH's work is MPOWER, the worldwide framework that the World Health Organization (WHO) developed to address the epidemic of commercial tobacco worldwide. While some people may be thinking that US tribes are not worldwide, OSH wanted to share what the thinking is at CDC to inform collaborative and grant writing efforts. MPOWER stands for the following:

M = Monitor tobacco use and prevention policies

P = Protect people from tobacco smoke

O = Offer help to quit tobacco use

W = Warn about the dangers of tobacco

E = Enforce bans on tobacco advertising, promotion, and sponsorship

R = Raise taxes on tobacco

MPOWER coincides with the Media, Access, Point-of-Purchase / Promotion, Price, and Social Support and Services (MAPPS) strategies. Thus, when they read an FOA that requires the selection of two to three MAPPS strategies on which to base a work plan, OSH wants tribes to know what the basis of this is and how to interweave those notions into their specific cultural needs in their specific communities. To achieve the intended impact, with its National Tobacco Control Program (NTCP), CDC supports all 50 states and the District of Columbia, as well as eight US territories or jurisdictions, six national networks, and seven tribal support centers to achieve the goals of preventing initiation among youth, promoting quitting among adults and youth, eliminating exposure to secondhand smoke, and identifying and eliminating tobacco-related disparities among population groups. The Tribal Support Centers are in the last year of a five-year funding period, which ends in September 2010. An objective review process is underway for those entities who submitted applications to gain access to those funds to engage in specific activities in their communities. The results were scheduled to be announced within about two months.

In closing, Mr. Benjamin referred participants to a document in their packets titled "Additional NCCDPHP Information for the TCAC Meeting." He pointed out that the first three bullets reported on some of the tribal entities that were funded with CPPW funds. He emphasized that in trying to tie in what he had heard during the morning was that OSH wants tribes to know as much as they know so that tribes can be strategic in their thinking. OSH understands the sovereign nature of tribal communities and that while MAPPS strategies and policy-based efforts are the focus, tribes may have to adapt to their communities. This is why the funding is in the form of a cooperative agreement. OSH truly hopes to be good partners. Clearly, he is not a Native American or Alaskan Native, but he stressed that he does have a great amount of empathy and there are those at CDC who really care. He commended Dr. Monroe for making herself available to tribes and answering their questions. He expressed his hope that as they heard from the various divisions, it would be clear that they really want to work together with tribes in a productive way.

Sustained Funding of Tribal Tobacco Support Centers

Sharanya Krishnan, Program Consultant
Office on Smoking and Health, Program Services Branch
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

Ms. Krishnan reported on the projects and work of the Tribal Support Centers (TSCs). The funding cycle for these centers began in 2000, so the upcoming cycle represents the third funding cycle, each of which has run 5 years. Currently, 6 grantees are funded and there are 7 cooperative agreements totaling $1.6 million per year in funding. There are two types of Tribal Support Center cooperative agreements: 1) Capacity-building programs that lead to tribal efforts to reduce abuse of commercial tobacco and secondhand smoke exposure; and 2) Implementation and evaluation of tobacco control strategies. The California Rural Indian Health Board (CRIHB) received awards for both. The Tribal Support Center awardees are as follows:

Capacity-Building

- Black Hills Center for American Indian Health
- California Rural Indian Health Board, Inc.
- Cherokee Nation
- Indigenous Peoples' Task Force

Implementation

- California Rural Indian Health Board, Inc.
- Muscogee (Creek) Nation
- Southeast Alaska Regional Health Consortium

Ms. Krishnan shared a map titled "CDC Funded Tribal Support Centers 2005 through 2010" reflecting the geographic breakdown of the Tribal Support Centers.

Tribes working with TSCs tend to have higher tobacco taxes than other tribes. In some instances, the tribal taxes are higher than state taxes. As a result of TSC work, several tribes are working with their gaming divisions to measure levels of secondhand smoke, provide health education around secondhand smoke to employees, and provide referral services to employees. Cherokee Nation TSC was selected as a grantee to receive ARRA CPPW funding in both the tobacco and obesity tracts. Three of the TSCs (e.g., CRIHB, Muscogee Creek Nation, and Cherokee Nation) also work with their states' respective quit lines to train counselors in cultural appropriateness when counseling AI / AN clients.

TSCs are implementing their own and working with other tribes to implement the American Indian Adult Tobacco Survey and the Alaska Native Adult Tobacco Survey. TSCs and the National Native Commercial Tobacco Prevention Abuse Network (NNCTAPN) are working with Legacy, RWJ, and other partners to expand surveillance systems and implement culturally appropriate interventions and evaluations. TSCs are also working with NNCTAPN on a REACH-US initiative that seeks to integrate tobacco control with chronic disease programs in tribal health systems. In addition, TSCs and NNCTAPN are working with tribal governments to

increase the number of tribes that adopt comprehensive commercial tobacco policies and smoke-free work policies.

The FOA for the 2010 Tribal Support Centers was released in May 2010. It is anticipated that five to seven TSCs will be funded. These are cooperative agreements, with awards ranging from $200,000 to $340,000. The purpose of the 2010 TSCs will be to reduce commercial tobacco use and abuse, eliminate exposure to secondhand smoke, prevent youth initiation, and promote commercial tobacco cessation. As noted, the framework models for the FOA included MAPPS and MPOWER. There is also a memorandum of understanding (MOU) with I.H.S. of approximately $75,000 per year to fund staff activities. The activities of the MOU are to provide data analyses on the American Indian Adult Tobacco Survey, develop tribal funding recommendations, and conduct strategic planning.

As a result of OSH funding, I.H.S. created an I.H.S. Tobacco Task Force. This task force works closely with the OSH-funded NNCTAPN in areas of policy advocacy and implementation trainings at the tribal level; and systems change in an attempt to mandate tobacco clinical guidelines within tribal health systems. NNCTAPN is in the third year of a five-year cooperative agreement, and works with all of the 500+ federally recognized and state recognized AI / AN tribes in the US. Funding for this efforts is approximately $450,000 per year. The Inter-Tribal Council of Michigan is the managing partner / grantee. NNCTAPN activities include training and technical assistance for tribes and tribal organizations on policy development and chronic disease integration. In June 2010, NNCTAPN convened an intensive policy training institute for tribes. With regard to chronic disease integration, NNCTAPN partnered with the Oklahoma Council on Education and Economic Development (CEED) to host a training for tribal health administrators and staff, also in June 2010. In terms of monitoring and surveillance, in partnership with the American Legacy Foundation, NNCTAPN is working on a project that will build capacity at the tribal college level in implementing and maintaining commercial tobacco surveillance systems. In July 2010, NNCTAPN partnered with OSH's Epidemiology Division, Health Education & Promotion Council, Inc., and JCW Research & Evaluation Group to provide technical training for AI / AN tribes on the implementation of the Adult Tobacco Survey (ATS). Currently, 11 tribes have implemented the ATS.

Discussion Points

- Ms. Hughes inquired as to how they could access data from the ATS survey that 11 tribes have implemented.

- Ms. Krishnan replied that Stacy Thorne, the Epidemiologist in OSH, would be able to respond to this. Her contact information is: Phone 770.488.5366 and email: stacy.thorne@cdc.hhs.gov.

- Theresa Galvan (Navajo Nation) indicated that one of the objectives for the Winslow project in the Black Hills was to assist the Navajo Nation with legislative changes in existing tribal codes. She wondered whether OSH would assist other tribes with legislative input or assistance to amendments to existing codes or new codes dealing with tobacco. She heard that some areas have non-smoking casinos.

- Ms. Krishnan replied that OSH works with such partners as the Americans for Non-Smoker's Rights (ANR) and NNCTAPN. OSH's partners could assist with that upon request.

- Jace Killsback (Council Member, Northern Cheyenne Tribe) pointed out that it would be beneficial to have this type of policy data to share with their individual tribal councils to illustrate impact (health, economy, et cetera). A couple of years ago, his tribal council was concerned about implementing no smoking policies in casinos because they were concerned about losing business, but he was unable to acquire any data.

- Ms. Krishnan responded that TSCs, ANR, and NNCTAPN can assist with this. It is a matter of connecting, communicating, and figuring out what each tribe's needs are. Stacy Thorne would also be a good contact. It has been a challenge to collect the data, and this effort is still in the initial phase.

- Mr. Benjamin indicated that they would take this information back to OSH with them, because this is a way for them to illustrate that this type of project would be useful. This is how projects are generated.

- Ms. Krishnan agreed that many people would be interested in working on this. It is an issue for a lot communities OSH works with in general in terms of advocating for smoke free environments. Even in states with bars going smoke free these issues arise (e.g., losing business).

- Ms. Hughes emphasized that the data collection issue is one that is on-going over a vast plethora of subject matter. The Patient Protection and Affordable Health Care Act (PPACA) includes a requirement for the HHS Secretary to ensure that there is data collection being conducted within two years. The data collection issue must continue to be brought to the forefront. The regulations specify how that data is to be collected, including the distinguishing of AI / AN. That information has to be made available within two years.

- Ms. Kaslow (CRIHB, Family and Community Health Services Director) pointed out that CRIHB, as a TSC awardee, believes it is their responsibility to be responsive to tribal communities in its region. They conduct extensive outreach and offer opportunities for tribal communities to assess smoking issues in their particular tribe. The ATS is prohibitively expensive to administer in California because the tribes are so small. Given this barrier, they have tried to create opportunities such as electronic health record systems that are tobacco-oriented in their primary care settings so that clinics can their own data. It is part of the Government Performance and Results Act (GPRA) management through their Resource and Patient Information System (RPMS). Not everyone uses RPMS, but they are trying to offer other opportunities to collect the data and assess what the real rates are for various areas. This is an opportunity for TSCs to reach out to their constituencies. Based on the geographic locations of the TSCs, there are pretty significant gaps. Some of the states with the highest rates of smoking for American Indians were not awardees. This is a major concern.

Injury Prevention and Control: Motor Vehicle Safety

CAPT Holly Billie, Injury Prevention Specialist
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National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

American Indians and Alaska Natives (AI / AN) are at increased risk of motor-vehicle related injury and death, with rates 1.5 to 3 times higher than rates for other Americans. To address this disparity, CDC's Injury Center funded four Tribes from 2004-2009 to tailor, implement, and evaluate evidence-based interventions to reduce motor vehicle-related injury and death in their communities. CDC is now seeking more positive outcomes in more tribal communities, and would like to identify best practices in Indian Country in terms of what the critical components are for the funding agency and the tribal program. CAPT Billie suggested that agencies offering funding should make sure that the funding is multi-year, given that it is very difficult to show impact with only one year of funding. She described the components of the cooperative agreements for which 6 tribes would be funded for 4 years at $70,000 per year. Tribes and tribal organizations were encouraged to apply for this funding. After the FOA closed in June, 16 applications were received. They were reviewed and the award process was underway during the time of this meeting. With this funding, the goal is to add to a best practice manual that CDC is developing. This manual will include lesson learned from CDC-funded tribes and I.H.S.-funded tribes. I.H.S. also announced new funding at about the same time that the CDC funding was released, so many tribes were working hard to write applications. I.H.S. is also in the process of allocating funding for motor vehicle crash prevention. NCIPC will be working with I.H.S. to develop this best practices manual in order to include as many tribes as possible.

Another motor vehicle activity is multi-agency meetings to discuss the essential components to improve funding programs and developing a multi-agency RFP, which has not previously been done that they know of. The agencies include National Highway Traffic Safety Administration (NHTSA), Bureau of Indian Affairs (BIA), I.H.S., and CDC. Hopefully, the multi-agency RFP will be announced before the end of the year.

The Lifesavers Conference, an annual national conference pertaining to highway safety priorities, represents another important motor vehicle activity. That will be held in Phoenix on March 27-29, 2011. This is a fairly large, well-attended conference. On a recent partnership call between I.H.S., NHTSA, BIA, and CDC, it was announced that since this conference is being held in a region with a high native population, organizers are considering a tract specific to native traffic safety issues. The degree of interest will, of course, impact the likelihood of a dedicated tract. They have been trying to get the word out to tribes that this is an opportunity to help mold a tract that focuses specifically on tribal issues at a well-attended national conference. They have solicited input because they know there are many great motor vehicle injury prevention efforts underway in Indian Country. She invited suggestions on tribal highway safety topics, issues, potential speakers, et cetera the partnership would really like to hear about it. Self-nominations are completely appropriate. A few of the topics suggested so far include DUI court programs; whether Interlock programs would work in Indian Country; impaired driving demonstration projects; data challenges; reciprocity issues; culturally relevant materials; grant application workshop; combining injury prevention and enforcement; checkpoints on reservations; rules, regulations, and challenges; et cetera.

There is an Older Adult Falls Prevention Work Group between I.H.S. and CDC, the purpose of which is to develop recommendations for clinical personnel and community public health personnel to address older adult falls. Recommendations include screening for vision and medication, exercise, education, and home improvement. That is still slowly moving along, with the recommendations now in draft format. They should be released by Dr. Bruce Finke from I.H.S. when completed.

Discussion Points

- Ms. Hughes requested that CAPT Billie email her presentation to TCAC. She also indicated that they would notify their area tribes about the Lifesavers Conference, and request more feedback from them through that process.

- Theresa Galvan (Navajo Nation) requested a "Save the Date" flyer about the Lifesavers Conference.

- CAPT Billie responded that she was hoping to send one that says "Native American Tract-Specific." They will send one out. The abstract deadline has not been set yet, but is expected to be announced in November.

Youth Obesity

Division of Adolescent and School Health

Linda Crossett, PhD, Health Scientist
Bridget Borgogna, MEd, Health Education Specialist
Allison Nihiser, MPH, Health Scientist
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

Dr. Crossett noted that the Division of Adolescent and School Health (DASH) gave a presentation to TCAC during the January 2010 meeting in Atlanta. DASH's work with youth in schools is not specific to tribes, but transcends all school-aged youth. However, some funding is allocated specifically to three tribes. One of these is the Nez Perce Tribe, which is funded for Coordinated School Health known there as the Students for Success Program. This is a collaborative effort between the Nez Perce Education Department and four local school districts to support the development of coordinate school health programs in four K-12 schools on the reservation. This program targets efforts that improve the health and educational outcomes of young people; provides technical assistance and professional development on coordinated school health programs; teaches drug prevention curriculums to teens and parents; and works with coalitions to prevent alcohol, tobacco, and other drug use and HIV and promote cultural identity and wellness. One of their specific efforts has been professional development training with food staff about healthy eating. Dr. Borgogna has been newly assigned to the Nez Perce Reservation, and planned to make a site visit there in early September. The Winnebago Tribe of Nebraska and Cherokee Nation are provided with funding support for administration of the Youth Risk Behavioral Survey (YRBS).

Ms. Nihiser spoke briefly about DASH's work with obesity and youth. There are four ways that DASH addresses obesity, physical activity, and nutrition: 1) Surveillance and monitoring through the YRBS and the monitoring of school health policies and programs. The School Health Policy and Program Study is one of the largest studies on policies and programs for schools. She pointed out that was not certain whether they were collecting information on tribes with that survey, though she said she would follow up on this; 2) Research synthesis; 3) Addressing health behaviors through funding 23 states and Nez Perce for Coordinated School Health, Nutrition, and Tobacco; and 4) Evaluation in large school districts that implement strong research to determine whether it is still effective at the school level. Much of what is produced within in DASH are tools and resources for schools and school districts to use to implement policy and environmental change strategies, which can be found at the following url: www.cdc.gov/healthyyouth. All of these resources are free and are downloadable.

One of the documents is "Strategies for Schools to Address Childhood Obesity." This includes 10 health and environmental strategies that schools should be implementing to address obesity in schools, improve physical activity, and improve the eating environment. There are also resources that accompany all of the strategies so that schools and school districts can easily start implementing these strategies. One of these is the "School Health Index: A Self-Assessment and Planning Guide (SHI)." This is one of DASH's most popular tools. This is an assessment tool to help schools assess and improve their health and safety policies and programs in the context of a coordinated school health program. Another popular tools is the "Physical Education Curriculum Analysis Tool (PECAT)," which enables users to analyze written physical education curricula based on alignment with national standards, guidelines, and best practices for quality physical education programs. There is also a "Health Education Curriculum Analysis Tool (HECAT)," which help schools and school districts analyze health education curricula based on alignment with national health education standards and characteristics of effective health education curricula. DASH recently released a "Physical Activities Guidelines Toolkit," which is a toolkit to help schools and school districts help their students achieve the HHS recommendation for physical activity that all youth should be engaged in physical activity for 60 minutes daily. These toolkits can be request from website or all materials can be downloaded. These include fact sheets for parents and schools, PowerPoint presentations to help describe the importance of physical activity to decision makers, et cetera.

Additional resources include "Making It Happen! School Nutrition Success Stories" that tells the stories of schools and school districts that have implemented innovative strategies to improve the nutritional quality of foods and beverages sold outside of federal meal programs. This allows schools to see how other schools have improved their nutrition environments, and the impact of this. They can use this as a tool to try to make such changes in their own schools and school districts. DASH also sponsored the IOM "Nutrition Standards for Foods in Schools," which addresses competitive foods in schools that are served outside of the national school lunch program (e.g., vending machines, a la carte lines, fundraisers, school stores, et cetera). This is promoted as a gold standard in an effort to try to remove "junk food" from schools and promote healthy foods. The DASH website also includes a number of fact sheets for decisions makers for schools and families about how they can implement these changes at their schools. The site also includes a document pertaining to the emerging practice of measurement of body mass index (BMI) in schools. This article titled "Body Mass Index Measurement in Schools" describes the purpose of school-based BMI surveillance and screening programs, examines current practices, and reviews research on BMI measurement programs. The article summarizes the recommendations of experts, identifies concerns surrounding programs, and outlines needs for future research. Guidance is provided on specific safeguards that need to be addressed before schools decide to collect BMI information.

Plans for the future include the "School Health Guidelines for Physical Activity and Healthy Eating Among Young People," which is an update to the guidelines that were produced in 1996 and 1997. These guidelines describe all of the policies and environmental strategies that should be in place. This helps to guide DASH's work and states' work in promoting these activities to local school districts and schools. A number of complementary tools will be created about how to implement specific aspects of these guidelines. A second tool that is coming soon is the "Comprehensive School Physical Activity Program Guide." The plan is for this to be published soon after the guidelines and will inform states and school districts about how to implement a comprehensive school physical activity program, which includes quality physical education as the cornerstone, classroom-based physical activity, intramural sports and physical activity clubs, and walk and bike to school programs. DASH also offers a lot of training on these tools, which is free. There is a location on the DASH website to make a request for this free training. With respect to tribes specifically, perhaps some tribal schools could join together to request this training.

Division of Nutrition, Physical Activity, and Obesity

Kati Cooper, Orise Fellow
Alicia Hunter, JD, MSW, Team Lead for Policy and Partnerships
Michael Sells, MS, Health Disparities Lead
Lorraine Whitehair, Public Health Nutritionist
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

The vision of the Division of Nutrition, Physical Activity, and Obesity (DNPAO) is "a world where regular physical activity, good nutrition, and healthy weight are part of everyone's life." Its mission is to "lead strategic public health efforts to prevent and control obesity, chronic disease, and other health conditions through regular physical activity and good nutrition. DNPAO's goals are to: 1) Increase health-related physical activity through population-based approaches; 2) Improve those aspects of dietary quality most related to the population burden of chronic disease and unhealthy child development; and 3) Decrease prevalence of obesity through preventing excess weight gain and maintenance of healthy weight loss.

DNPAO principal target areas are to:

- Increase physical activity
- Increase the consumption of fruits and vegetables
- Decrease the consumption of sugar sweetened beverages
- Increase breastfeeding initiation, duration and exclusivity
- Reduce the consumption of high energy dense foods
- Decrease television viewing

DNPAO currently funds 25 states to address the problems of obesity and other chronic diseases through statewide efforts coordinated with multiple partners. The program's primary focus is to create policy and environmental changes that will improve the health of places where Americans live, work, learn, and play. working to build lasting and comprehensive efforts to address obesity and other chronic diseases through a variety of nutrition and physical activity strategies [http://www.cdc.gov/obesity/stateprograms/index.html]. Numerous tribal activities are underway in Montana, Michigan, New Mexico, and Minnesota.

Division of Diabetes Translation

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National Center for Chronic Disease Prevention and Health Promotion
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Amongst Division of Diabetes Translation's (DDT) numerous efforts, such as the Eagle Books, is the Native Diabetes Wellness program. The mission of the Native Diabetes Wellness Program is to "work with a growing circle of partners to address the health inequities so starkly revealed by diabetes in Indian Country. With social justice and respect for Native and Western science as grounding principles, we strive to support community efforts to promote health and prevent diabetes."

The goals of the Native Diabetes Wellness Program are to: 1) Support sustainable, evaluable ecological approaches to promote the use of traditional foods, physical activity, social support, and health policy change in communities; 2) Share messages, including stories and art, about survival and traditional ways of health that are remembered, retold, and talked about in homes, schools, and communities; 3)Share and evaluate Native and Western programs, including community outreach, talking circles, community-based interventions, and diabetes education in schools; and 4) Support meaningful tribal consultation at the state and federal levels.

Traditional Food Grantees include the following:

- ❑ Aleutian Pribilof Islands Association, Inc., Alaska
- ❑ Catawba Cultural Preservation Project, South Carolina
- ❑ Cherokee Nation, Oklahoma
- ❑ Confederated Tribes of Siletz Indians, Oregon
- ❑ Eastern Band of Cherokee Indians, North Carolina
- ❑ Indian Health Care Resource Center of Tulsa, Oklahoma
- ❑ Nooksack Indian Tribe, Washington
- ❑ Prairie Band Potawatomi Nation, Kansas
- ❑ Ramah Navajo School Board, New Mexico
- ❑ Red Lake Band of Chippewa Indians, Minnesota
- ❑ Salish Kootenai College, Montana
- ❑ Santee Sioux Nation, Nebraska
- ❑ Sault Ste. Marie Tribe of Chippewa Indians, Michigan
- ❑ Southeast Alaska Regional Health Care Consortium, Alaska
- ❑ Standing Rock Sioux Tribe, North/South Dakota
- ❑ Tohono O'odham Nation, Arizona
- ❑ United Indian Health Services, Inc., California

Discussion Points

- In terms of prevention, Mr. Killsback (Council Member, Northern Cheyenne Tribe) inquired as to how DASH addresses problems with youth obesity from a mental / behavioral health perspective.

- Dr. Crossett replied that most of the tools DASH has developed are related to physical activity and nutrition behaviors. Some are food services and some are facilities for recreation. Most of DASH's efforts do involve changing behavior of the students and the staff, but from a policy, environment, and classroom learning perspective. In some ways

changing the environment is behavior-related because that offers better choices. This agency does not address the mental health perspective to a great extent, even though it certainly is highly related. SAMSHA has historically engaged in more efforts in mental health. DNPAO may be addressing this aspect to some extent, but DASH is not addressing this except from the general standpoint of the influences on children. They try to affect issues from a policy and holistic standpoint.

- Ms. Nihiser added that mental health is addressed slightly in the "School Health Guidelines." In the YRBS data, DASH assesses obesity and bullying, for example, in terms of the psychosocial effects of obesity. In the document about measuring BMI in schools, some of the psychosocial and mental health concerns are addresses with respect to stigmatizing youth. That is why DASH also promotes an environment of physical activity and nutrition that is targeted to all youth in order to focus on prevention so that it is not targeted specifically to overweight and obese youth.

- Mr. Killsback (Council Member, Northern Cheyenne Tribe) added that recently, the Northern Cheyenne Tribe has made an effort to assess diabetes and obesity on their reservation from a mental / behavioral health standpoint because they believe that a lot of these issues are only being addressed through the physical aspect: exercise, exercise, exercise. A lot of times tribal members have mental and behavioral health issues which tie in to ailments. In terms of SAMSA and I.H.S., he understood that they did not want to see a duplication of services by agencies. If CDC is geared toward the physical aspect, perhaps they could work with the other agencies in regard to the mental / behavioral health aspects. At the same time, tribal communities have very unique cultural issues they deal with that involve mental health aspects. Perhaps tribal leaders could help. They utilize the I.H.S. more toward the mental health aspect. Tribes are already dealing with limited resources.

- Alicia Hunter replied that this is not an issue they overlook. CDC must work within the constraints of its resources and mandates. Especially outside the majority population, cultural competency and culturally relevant approaches. Her division addresses mental health from the perspective of stigma, discrimination, and self-esteem among children and adults—not the behavioral intervention approach perspective. Even with these environmental approaches, there still has to be a handoff between behavioral and mental health aspects, especially in terms of obesity and some of the other chronic diseases. The American Academy of Pediatrics (AAP) has been assessing obesity and mental health more closely than CDC has. Perhaps they could share some of their resources and insights into how to integrate that into a large framework.

- Candida Hunter (Phoenix, Hualapai Tribal Councilwoman) indicated that they provide physical activity in schools and teach youth about healthy meals. The problem is that they go home to whatever the family feeds them depending upon their budget. The children are going to eat it because that is what is provided for them. She inquired as to whether parents are being addressed.

- Alicia Hunter replied that they provide funding to 17 AI / AN communities, tribal organizations, and tribal colleges to increase access to traditional and local healthy foods and physical activities for diabetes prevention and control, and they also have the series of children's books, the Eagle Books, for Native American children about healthy eating. Parents are possibly reached through the Eagle Books, but beyond that, they have not developed anything specific for parents.

- Ms. Nihiser referred to NIH, which has a We Can! Ways to Enhance Children's Activity and Nutrition website found at: http://www.nhlbi.nih.gov/health/public/heart/obesity/wecan/. This is not targeted to Native Americans specifically, but it does include some nice parental resources.

- Alicia Hunter added that the First Lady's Let's Move initiative that specifically addresses what parents can do can be found at: http://www.letsmove.gov/. Getting parents involved in a hands-on way with initiatives that are underway is a good way to get parents involved. Another method is to use the workplace to educate parents about healthy eating. The by-product of students receiving information in school and parents receiving it in the workplace is a healthier home. Although its applicability to tribes has not been tested, Kokomo [not sure this is what she said] is known to be very different from what would occur at the state level. This includes eight categories as strategies that are effective at the community level for improving healthy eating and active living lifestyles. This includes support groups, mobilizing the community around particular initiatives like farmer's markets or Safe Routes to Schools to change environments. It serves as a way to have a physical change for the environment (e.g., increasing access) and to bring families and caregivers to the table so that they are informed and are able to practice those lifestyle changes in their family.

- Dr. Sells mentioned a few resources from his division: 1) How many fruits and vegetables do you need?; 2) Rethink your drink; and 3) Eat More. Weigh Less. He thought that these educational materials could be adapted for the purposes of the tribes.

- CAPT Snesrud requested that all links, program materials, and contact information be submitted to her.

- In terms of what can be done to reduce obesity among AI / AN children, Ms. Nihiser left the group with some examples. Urban and rural farming to improve the meals of children and expand economic options for farmers would allow instruction of community members in farming and gardening techniques, would allow for designating vacant space for community gardening, provide gardening surplus to childcare centers and schools to improve the dietary quality of the meals that they receive, and would teach children and parents about nutrition, healthy preparation of foods, and the importance of physical activity. Another is the Safe Routes to Schools Program, which creates safe walking and biking access to schools for children. Joint Use Agreements are very important. These allow for increased safe places to be physically active. For example, this would allow for the use of school or community facilities after hours by the larger community (e.g., school track, school gym, playground). Another important activity is supporting mothers who want to breastfeed in the workplace in terms of giving them the time and a clean, secluded place to lactate; and also through peer-to-peer groups in which women can talk to one another about overcoming barriers to breastfeeding. It is also important to develop health education materials that are culturally competent and communicate key health messages that are relevant to the particular population group. For example, the Eagle Books are a great effort that continues to be promoted across NCCDPHP. There has been discussion having the Eagle Books story line be reflective of other tribes so that more tribes can use it.

Updates Related to Maternal and Child Health Following H1N1

CAPT Myra Tucker
Tribal Liaison, Division of Reproductive Health
National Center for Chronic Disease Prevention and Health Promotion
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CAPT Tucker indicated that following her first trip to Indian Country, she returned to CDC and called CAPT Snesrud to tell her that she felt so small and so overwhelmed by the need. CAPT Snesrud told her that this and being around Indian people would keep her going. CAPT Snesrud has always been that Indian person, and has been her inspiration. One thing she could say unequivocally is that no one could outwork CAPT Snesrud. CAPT Tucker said that she was indebted to CAPT Snesrud for investing in her with her heart and eyes on what is best for the people and in trying to enable CAPT Tucker to be more effective. She expressed her gratitude to CAPT Snesrud.

CAPT Tucker reminded everyone that she was presenting on a specific topic at TCAC's request—an update on H1N1 influenza. An on-going theme for TCAC regards how to ensure that CDC is responsive to the needs in Indian Country. Though not precisely what was requested, CAPT Tucker began with stories to illustrate examples of using the H1N1 pandemic to build CDC capacity and programs that are more responsive to tribes. This is a good example of using a public health crisis to build infrastructure that serves tribes. With the H1N1 pandemic, a team was assembled for the first time within CDC history, the American Indian / Alaskan Native H1N1 Influenza Team. The team had a desk staffed by Craig Wilkinson in the Emergency Operations Center. Dr. Bryan led the scientific effort from his Albuquerque office. Tom Hennessy, with the Arctic Investigations Program, was a member of that team, as was CAPT Tucker. One of the efforts the Indian / Alaskan Native H1N1 Influenza Team engaged in was the development of public service announcements (PSAs) that were specific to tribes. CAPT Tucker shared an example of these PSAs that was narrated by Native American actor, Wes Studi. This is an example of a longer lasting benefit from the H1N1 crisis.

With regard to influenza in general, the key characteristics include rapid onset of symptoms, primary transmission though respiratory droplets, fever, chills, body aches, sore throat, runny nose, headache, and non-productive cough. Influenza complications include the development of pneumonia, worsening of chronic lung and heart problems, and potentially death. The national list of high risk groups for seasonal influenza includes women who will be pregnant during the influenza season, children less than four years of age, and infants under six months. From a historical perspective, the 1918 H1N1 epidemic resulted in 500,000 deaths in the US and 20 to 50 million deaths worldwide. During the 2009 H1N1 pandemic, the swine flu vaccine was tested from the 1970s swine influenza, which was a recurrence of 1918. The formula for the 1970s vaccine was effective on the 2009 H1N1 pandemic strain. The median age for 2009 H1N1 was 20 years, with a range from 3 months to 81 years of age. Of those who contracted 2009 H1N1 influenza, 61% were 18 years and younger. Pregnant women are at increased risk of complications and death from influenza historically, and this was also found to be the case with the 2009 H1N1 pandemic. CAPT Tucker pointed out that women who are pregnant during the influenza season should be vaccinated. There is no evidence to suggest maternal or fetal problems with influenza vaccination. She emphasized that this message must be carried back

to communities. In terms of treatment recommendations, CAPT Tucker indicated that she knew of one death of a pregnant Native American woman who was pregnant during that past influenza season. It was typically found that pregnant women who did not receive treatment early were the ones who died, given that delaying treatment increases the risk of complications and death. The recommendation is to treat as soon as a woman has symptoms, without waiting for H1N1 validation. Treatment options include Tamiflu® (oseltamivir) or Relenza® (zanamivir).

Of the deaths from H1N1 influenza in 2009 in the US, 6% were pregnant women who comprise only 1% of the general population. Young children, especially very young children, were at a 3- to 4-fold greater risk of death. It is known that there are increased mortality and death from pneumonia and influenza among American Indians / Alaska Natives. American Indian / Alaska Native infants have a 4-fold higher mortality from influenza than US Whites. American Indians across the board are 1.5 times more likely to die from influenza than Whites. Why is that? A recurring theme heard in TCAC meetings is that there is a high prevalence of co-morbid or chronic conditions among American Indians that places them at increased risk for complications (e.g., diabetes, end stage renal disease, obesity, childhood asthma, et cetera). Many American Indians and Alaska Natives live in remote areas where the poverty rate is quite high, there is household crowding, and often there is a lack of plumbing, which makes it difficult to engage in frequent hand washing to prevent transmission. Last fall, one of the early indications that H1N1 pandemic influenza would hit harder in tribal communities was that there were reports of increased risk of death in Arizona and New Mexico in October 2009. When CDC analyzed data from 12 states where there were fatal cases of influenza, they found that the age-adjusted mortality rate was four times higher among American Indians. The fatality rates of American Indians who had chronic conditions of diabetes and asthma were twice as high as Whites with diabetes and asthma, so something else is also contributing to risk of death. The potential explanations for increased risk include the higher prevalence of risk factors for severe disease, co-morbid conditions, reduced access to health care services, delayed care, and higher rates of viral transmission.

What do we need to do? It is what everyone's grandma has told them: community education, wash hands, act early to respond to illness, and vaccinate for prevention. CDC needs to conduct better surveillance in order to tell the story accurately. The I.H.S. worked with Indian Health Service and Tribal Hospitals to set up a surveillance system to monitor what was occurring with influenza in Indian Country. This is a voluntary system in which a number of facilities across the country participated. While it is an I.H.S. surveillance system, its purpose is to determine what is occurring at the community level. This system monitors influenza like illness (ILI), hospitalized cases, vaccine coverage, and adverse reactions to vaccines. The system illustrated that there was, indeed, a potential epidemic. The good news is that the Indian Health Service Surveillance System showed that overall vaccine uptake was higher among Tribal and Indian Health Services facilities in 6 months to 17 year olds and health care workers than for the overall US population. This is a success story, and more success stories are needed. Surveillance can help to document successes as well as needs.

In terms of next steps, it is important to look more deeply into risk factors for fatal influenza. As noted, even when co-morbid conditions are controlled for, the rate is twice as high among American Indians. A case controlled study is currently underway in which Tom Hennessy is involved. CDC has been lobbying for American Indians and Alaska Natives to be considered a priority group for vaccination. Right now, priorities are set on the basis of at-risk conditions (e.g., chronic condition, being pregnant, et cetera). The rationale for making Tribal communities a higher priority is that these communities have a higher prevalence of these conditions than other groups and should be priority for vaccination. This has already been done in Australia,

New Zealand, and some areas of Canada. CDC will continue to push for this. It is also important to improve reporting of race and ethnicity data on all US surveillance systems. This is an on-going issue for CDC.

CAPT Tucker shared another story to illustrate the use of a crisis to strengthen efforts in Indian Country. She feels very strongly that CDC needs to be certain that all of its data systems represent American Indians and Alaska Natives. Working at the division level, she has been pushing for this for six years. The largest surveillance system in her division is the Pregnancy Risk Assessment and Monitoring System (PRAMS) that sends questionnaires to new mothers to find out about their pregnancy experience and the health of their new babies. She and CAPT Snesrud agreed that PRAMS should be telling the story of American Indian women. They spoke with the PRAMS leadership who indicated that they would need additional resources in order to acquire these data, and they did not have the resources. This is where they started. She shared a map of the PRAMS states in the US. They identified that 10 of the PRAMS states have large American Indian and Alaska Native populations. They thought that they could get about half of all American Indian and Alaska Native births represented in the PRAMS surveillance system if they were able to achieve good response rates from among American Indians and Alaska Natives. When the PRAMS leadership told them more resources would be needed, they had to strategize about how to bring this issue forward without many resources. Therefore, they did an analysis of response rates among American Indian women, published a paper about this, went to the PRAMS national meeting, brought in tribal representatives to meet with state representatives, and began to talk to states about representation of the experience of American Indian women being an expectation. Simultaneously, the Santee Sioux Tribe in the Aberdeen Tribal Area Tribal Epidemiology Center applied for a point-in-time PRAMS. They examined all births to American Indian women for a six-month period in the nine tribes in South Dakota and part of North Dakota. The Tribal PRAMS program achieved response rates among American Indian women of 73%--higher than anything ever seen.

An opportunity then arose to submit a proposal, which had to be influenza-related. CAPT Tucker put forward a proposal stating that there were not good data about the influenza experiences of American Indian mothers and their babies, and that in order to acquire better influenza data, the PRAMS system should be improved to include tribes and American Indian women. They received nearly half a million in funding, which will go out with the new PRAMS announcement in the fall. States can apply for these funds, with the following caveats:

- States must provide H1N1 data to the tribes in their states so that tribes will have these data for their own use.

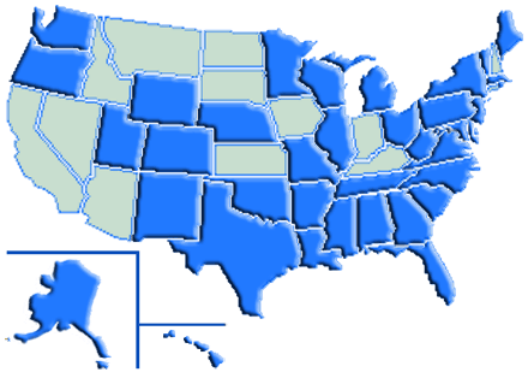
- States must hire a PRAMS American Indian / Alaska Native Coordinator, with preference to be given to hiring an American Indian or Alaska Native for this position.

- A PRAMS Tribal Oversight Committee must be established. There has never been tribal oversight of PRAMS other than in the South Dakota project.

While they are leveraging H1N1 resources to acquire better H1N1 data, if they obtain better H1N1 data from American Indian women in these states, they will also have better data about their pregnancy risk factors and the health of their babies. CAPT Tucker's hope is that by utilizing the H1N1 epidemic, they will begin to set a new standard for PRAMS, that tribes will be engaged, that there will be tribal oversight, and that the data are provided to tribal governments for their use in making decisions and improving health systems. Though this is a small

example, if they pushing in a lot of directions, directions will yield, and they will see progress as they make incursions into the organization to help CDC better serve tribes.

Thirty–seven states and New York City currently participate in PRAMS. Six other states previously participated [http://www.cdc.gov/PRAMS/states.htm]:



PRAMS represents approximately 75% of all US live births

TCAC Administrative Matters

Review and Approval of 2010 Meeting Minutes

CAPT Snesrud indicated that because the full minutes from the January 2010 meeting were so long and because they were meeting in a remote location, they elected not to try print them out. In addition to a significant amount of copying, they were also concerned about everyone having to take large amounts of materials home with them. They thought it would be less expensive to purchase a flash drive to send home with everyone with all of the materials. The minutes were sent out throughout the year, and they and the meeting presentation materials will be posted on the website.

Motion: Approval of Minutes

A motion was made by Roger Trudell and was seconded by Derek Valdo to approve the January 26-27, 2010 TCAC meeting minutes, the January 28, 2010 Tribal Consultation Session Minutes, and the April through July 2010 Teleconference Planning Minutes. The motion carried unanimously.

General Items

CAPT Snesrud reminded everyone that the previous day, Mr. Antone spoke about a fairly historic meeting that was convened September 21-23, 2009 in Washington, DC at the Substance Abuse Health and Services Administration (SAMHSA). CDC funded this meeting, which was a collaboration between CDC, I.H.S., and SAMHSA, to invite American Indian / Alaska Natives to discuss what is occurring in the field in suicide prevention. That is also approximately the time that the reorganization began within CDC. Mr. Antone was one of the invitees who kept contacting NCIPC to follow up. She indicated that a compilation of information from that meeting was distributed about six weeks prior to this TCAC meeting. During this TCAC meeting, they had also heard a lot about suicide, and she thought this compilation would help provide some more intentional questions back to that collaborative effort.

Some of the staff who used to be in the National Center for Health Marketing (NCHM), who are now in the new Office of Communications at CDC requested that CAPT Snesrud bring a new social media tool to them. They are very excited to work with TCAC and tribes to determine how this can be a usable tool for them. She encouraged TCAC members to review this toolkit, and suggested that perhaps it could be placed on the agenda for an upcoming monthly call.

CAPT Snesrud reminded everyone who had not submitted their area and national organization reports to do so in writing. She offered kudos to those who had already submitted their reports in writing. She indicated that she would resend the template to everyone, and requested that if at all possible, they submit them to the Writer / Editor who was on-site, David Silverman, before departing so that they could become part of the minutes. She emphasized the importance of these reports to OSTLTS, especially during this time of transition.

Funding Opportunities

There are currently a number of funding announcements that have been or will soon be published. Three tribal entities received large awards from the CPPW funding. Because of the size, breadth, and collaboration across NCCDPHP, this will afford them another opportunity to get to know a lot about tribes and how work with them. She did not remember the exact number of applications, but there were many. Every time a national center has an FOA for which a significant number of tribes apply, they are learning what is in the application, what they do to assist tribes in writing more successful grant applications, et cetera. Another new funding opportunity was released at the end of June to increase the number of policies and programs that support reduction in sodium intake in communities and expand the public health application and implementation of sodium-related policies, surveillance, and evaluation. This is a pretty narrow focus, but one of the reasons is that across CDC, the agency is being intentional about making sure tribes are eligible to compete.

Racial and Ethnic Approaches to Community Health (REACH), also through NCCDPHP, is in its third cycle. These funds are to assist communities that are organized to respond and evaluate REACH core. There are four awards under this program. Applications were due June 21, 2010 for this FOA and awards will be made at the end of September. There are at least 25 tribes and tribal organizations funded through the Division of Cancer Prevention and Control (DCPC). DCPC plans to make two $400,000 awards to national entities, for which the application due date is August 10th, and the award will probably be made shortly after that going into fiscal year 2011.

There is another announcement that focuses on demonstrating the capacity of comprehensive cancer control programs to implement policy and environmental cancer control, with tribal policy opportunities. Applications were due on July 26th. That relates to some of the testimonies and feedback that they had been hearing during this TCAC meeting from both of the tribes they visited. The on-going National Breast and Cervical Cancer Detection Program (NBCCDP) is in year four of a five-year cycle, so that FOA will be coming up in 2011.

The critical issue is the efforts of the national entities that are funded. Their role is to clearly be available to provide technical assistance and to help facilitate the dialogue at the state level. Even if a tribe is not funded under this program, the tribe's state is funded. Annie Fair is the contact for this program. Her contact information is as follows, and Dr. Duckworth can help make that connection:

Annie Fair, Public Health Advisor
NCCDPHP / DCPC / CCCB
Phone (602) 263-1200 X1351
annie.fair@cdc.hhs.gov

The Colorectal Cancer Control Program (CCCP) is in the second year of a four-year cycle, for which three tribal programs are funded.

There is an increasing opportunity, and CAPT Snesrud strongly encouraged everyone to sign up for alerts and check FOAs on a regular basis. Perhaps it is time to schedule another technical assistance workshop from the PGO office to help tribes write more successful grant applications. CAPT Snesrud spoke with them the week before this TCAC meeting, and they are interested and willing. Guidance and feedback are needed from TCAC members about where the best place would be to offer this workshop. Dr. Frieden is promoting the use of electronic web-based training sessions. With some planning, this might be a good candidate for this format. She requested that feedback about this be provided to Dr. Duckworth.

Discussion Points

- Ms. Hughes noted that they had been seeing a lot more webinar training. Centers for Medicare and Medicaid Services (CMS) and I.H.S. are doing a lot of work with webinar training. She likes the idea, and even if she cannot make it to the specific training time, the module is there and she can access it anytime she needs it.

- CAPT Tucker mention that Alison Sage was talking to her about the upcoming influenza season, and mentioned that there is a wide variability among tribes in terms of getting vaccine supplies and how well states have been working with tribes. She encouraged tribes that experienced issues previously to begin planning immediately to avoid a potential crisis. Those who experience vaccine distribution issues can contact CAPT Tucker and she will coordinate getting them in touch with the right people at CDC.

- Theresa Galvan (Navajo Nation) noted that a bullet about technical assistance would be good on the fact sheet that was distributed in the packet.

Transition of OSTLTS Points of Contact

With the retirement of CAPT Pelagie "Mike" Snesrud, Dr. Melanie Duckworth will be the point of contact (POC) for Tribal relations in OSTLTS. Her contact information is as follows:

404.498.0419 Phone
404.638.5553 Fax
melanie.duckworth@cdc.hhs.gov

CDC / OSTLTS Tribal Public Health Webpage

CAPT Snesrud reported that a Tribal Public Health webpage had been developed to make it easier to locate items of interest (e.g., minutes, presentations, articles, TCAC charter, upcoming meetings, membership, et cetera). NIHB is graciously posting information on their site as well. This page can be found at the following url:

http://www.cdc.gov/ostlts/tribal_public_health/index.html

Revisions to the CDC Tribal Consultation Policy

Ms. Hughes reminded everyone that Mr. Antone departed earlier in the day to attend the HHS Consultation Workgroup, which was convening its first meeting in Washington, DC. A representative from each areas and a delegate were to attend, and the national organizations were also to be represented. They have been dealing with consultation review for at least a year. The President sent out his directive in December, allotting everyone 90 days to develop consultation policies. TCAC has a working consultation policy with CDC. While everything is subject to improvement, given that the TCAC / CDC policy was working and they were engaged in consultations on a regular basis, she suggested waiting for the outcome from the HHS workgroup before engaging in any detailed work in reviewing the CDC consultation policy. A report was recently published by the White House on the consultation effort, which is titled "Forging a New and Better Future Together." Secretary Sebelius conducted regional consultations about the consultation process. The workgroup will utilize all of the information received during those consultation sessions to review the HHS policy. Secretary Sebelius has three priorities in reviewing those policies:

- ❑ Accountability of the policy itself
- ❑ Communication and outreach with tribes regarding the policy
- ❑ Annual / regional consultation process

Ms. Hughes was asked to testify before the Senate Committee on Indian Affairs, she knew that they were also interested in the consultation policy. She thought the hearing on the consultation policy took place earlier in the morning, so they should hear a report on that soon.

CAPT Snesrud reminded everyone that CDC released its consultation policy in CDC consultations in 2002 and 2003, at HHS's consultation in 2004, and at the NIHB's annual meeting in 2005. CDC was the first agency following HHS to publish a consultation policy. She emphasized that a policy is meant to be a growing, working document as relationships grow and evolve. In addition, it is also part of the protocol within an agency that any and all policies be revisited within a five-year timeframe. It is highly relevant that CDC be informed by HHS's policy review. HHS is the umbrella policy, while CDC's policy pertains specifically to CDC. There is a commitment by OSTLTS to work with TCAC on this effort. She strongly encouraged TCAC members, as they heard back from their representatives who sit on the HHS workgroup, to assess the CDC policy [did not use microphone; please check for accuracy].

Revisions to the TCAC Charter

Ms. Hughes indicated that Stacey Ecoffey engaged in a couple of discussions with TCAC over the last couple of years regarding HHS's concern about the advisory councils overall in terms of FACA compliance. FACA is a federal regulation that relieves the burden of forming some of these councils, provided that the members of the councils are elected officials. The concern with the advisory councils is that the representatives must be designated as an elected tribal leader or someone delegated by an elected tribal leader t serve on the council.

CAPT Snesrud affirmed that Stacey Ecoffey has always been concerned about what will enable tribes to have the strongest voice. Thus, she collectively worked with the agencies that have existing policies and assisted CDC in acquiring advice from the Office of General Council (OGC) to assess FACA and the existing charters, looking across the departments for consistency and in compliance. The rationale behind this is that as TCAC makes decisions and puts forth its recommendations to CDC and HHS, the agencies must listen because this is an official advisory committee with the authority to do so. FACA is exempt because it is between federal leadership talking to tribal leadership. An elected tribal leader or designee may speak, and this applies to TCAC subcommittees as well (e.g., Budget Subcommittee, Public Health Preparedness Subcommittee, et cetera). It was suggested that CDC remove from the charter some statements that do not align with FACA. The following deletions / comments were read aloud [an electronic version of the tracked charter was not provided, but the marked up version could be inserted here to more fully reflect the suggested deletions].

- Tribal leaders in their official capacity or representatives from national or tribal organization with authority to act on their behalf . . .
- The meetings will be solely to exchange views, information, and advice concerning the management or implementation of CDC programs.
- Executive Orders that share intergovernmental responsibilities or administration . . .
- Seeking consensus, exchanging views, information, advice, or recommendations . . .
- The TCAC will be composed of 16 members and designated alternates who are either elected or appointed officials of tribal governments in their official capacity . . .
- Representatives from national tribal organizations designated by tribal leaders to act on their behalf . . . (comment from the OGC: There is no authority for these organizations to have a seat on TCAC; they may be designated as the alternate of an official member)

- Comment: NIHB Support section should be removed. The understanding was that when CDC was first starting its effort, they looked to NIHB because they already had the established infrastructure of Area Health Boards, so it seemed like a natural fit for NIHB to be involved with this. They graciously did this from about 2006 to about midway through 2008. In 2008, the continuing application was submitted, and a Branch Chief from PGO contacted CAPT Snesrud who inquired as to why a CDC advisory committee was being funded through a cooperative agreement, given that it was CDC's work. They could not understand why a cooperative agreement was being given to a partner to conduct CDC's work. She responded that that suggestion had come from PGO. The Branch Chief indicated that this was incorrect. It is CDC's responsibility, so nothing that was being suggested for deletion from the charter was in no way intended to take away from the strong working relationship that CDC has and will continue to have with NIHB. It is to address the directive from PGO.

- A note in the Appointment Process section states that this section seems inconsistent with FACA. In the policy, clearly CDC did not want to define how an area would designate who their primary and alternate representatives would be. CDC was very cautious about giving as much ownership and power to the tribes where it belonged as possible. This was written based on consultation with TCAC members. However, it does need to be CDC working directly with tribal designees. CDC still looks to the area consortia health boards to nominate and publish the announcement. This does not mean that a tribal leader has to be nominated only by a tribal area health board to be considered. Dr. Frieden ultimately makes the official appointment after receiving nominations.

- Within Period of Service, the section on Vacancy needs to be discussed further. Mr. Antone and Ms. Hughes have worked extremely hard to seek full representation because any empty seat is a missed opportunity to hear another tribal voice. They have talked to the area health boards to get them to make nominations. There has been a struggle with direct service tribes, and this area needs to be further addressed. They key point is that anytime there is a vacancy, a call must be sent out to all tribal leaders to offer an opportunity to nominate a primary and alternate member.

- Under Meetings, originally the determination was that TCAC would meet bi-annually, followed by the consultation (once in the summer in Indian Country; once in January at CDC). They have struggled over whether conference calls should be monthly or quarterly, and who should be hosting the conference calls. As the DFO, CAPT Snesrud tries to avail herself of what the TCAC Co-Chairs want to do and follows directions from them pretty well.

- In terms of meeting logistics, the precedent has been to try to solidify dates so that TCAC members and CDC staff know them well in advance.

- In terms of the Budget section, the bottom line is that there is not a lot of money for the TCAC meetings. Members decide where they would like to meet. A tribe or an area invites CDC / TCAC. To a degree CDC has been trying to reach all parts of the country, so it would be beneficial for members who represent areas where TCAC has not met to talk to their tribes and areas. July 2011 would be an excellent opportunity to convene the TCAC meeting in an area where CDC has not yet been.

- Regarding Terms of Service, there is no limit to the length of service on TCAC. TCAC members can suggest a term in the revised charter if they wish.

Discussion Points

- Ms. Hughes said that while she understood what OGC was saying about NIHB, from a council perspective, she is a Vice Chairwoman. To do the work on TCAC, she does not have time to develop and agenda, coordinate a conference call, to ensure that materials are being distributed as need, et cetera. However, this needs to be done and she still looks to CDC to determine how that is going to be done. As an advisory council to the CDC, she expects that the work will be done by the CDC. While she could understand the suggested deletion, it was not clear to her what would replace it to say how the work of TCAC would get done.

- CAPT Snesrud agreed, acknowledging that the members were already giving their time to serve on the committee. To a large degree, these tasks are the role of the Designated Federal Official (DFO). That is currently her and will now be Dr. Duckworth, or as otherwise determined within OSTLTS as some of the staffing issues are addressed.

- Ms. Hughes thought that even though someone needed to make a final appointment for the workgroup members, every tribe is afforded an opportunity to make that appointment. She represents the Bemidji area, which does not have an area health board. Her nomination comes from a tribal health consortium. But if a tribe wants to make a recommendation, she expects the tribal nomination to be considered as well. Tribes have the right to submit the names of whomever they want to serve. It is important that this is clear with regard to the appointment process in the charter. She requested direction on the kind of language that should be used the section about meetings and the DFO. It should read the OSTLTS DFO.

- CAPT Snesrud noted that the next TCAC meeting is tentatively scheduled for the third week in January 2011. Stacey Ecoffey requested that before the dates for the next meeting are finalized, they wait for the outcomes of the HHS meeting. CAPT Snesrud said she continued to feel that it was incredibly important for CDC to consult with TCAC members by themselves—not because they were being selfish, but because otherwise they do not get on tribes' agendas. CDC would like to continue to host its own consultation because in having participated in all of the national HHS consultation sessions, the top number of attendees they have ever had at the CDC breakout session has been 19. CDC needs to hear from tribes. A few regular members were not in attendance during this TCAC meeting because the CMS TCAC was meeting simultaneously. They need to coordinate when meetings are scheduled.

- Ms. Hughes noted that this is the only charter in which the term is not defined. She requested a copy of this tracked charter, so that they could all go through it carefully outside the meeting and deal with it before the tentatively scheduled January 2011 TCAC meeting. She suggested scheduling a conference call to review the tracked charter before the January 2011 meeting if possible.

- CAPT Snesrud reminded Ms. Hughes that during the January 2010 meeting, she and Mr. Antone appointed a Charter Revision Subcommittee that included Joe Finkbonner and Reno Franklin.

- Ms. Hughes responded that Mr. Finkbonner and Mr. Franklin would probably be very excited about the preliminary work that was accomplished for them. When she sends this out to them, she will ask them to craft some language for discussion on the conference call. She also requested that if any other members had suggestion on language they could draft to address some of the issues raised, that would be very beneficial (e.g., replacement of the NIHB language, how to address vacancies, et cetera).

- Theresa Galvan (Navajo Nation) pointed out that in the Purpose section, the Presidential Memoranda date has changed from September 23, 2004 to November 5, 2009 because that is when President Obama signed this.

TCAC Strategic Planning

Ms. Hughes said she had just learned that she would be joining a group in Alaska the week following this TCAC meeting. NIHB is having a retreat to discuss health care issues. Another committee on which she serves has developed a five-year strategic plan, and the work of that committee is based on that strategic plan. Every funding request is sent forward on an annual basis to CMS based on that strategic plan, and the committee has deliverables under that strategic plan. She requested that this be presented to TCAC as something that this council could work on to assist them as they move forward in their budget considerations, and to increase TCAC's funding from CDC with specific deliverables in mind. Development of a strategic plan cannot be accomplished in a few minutes or a few hours. This is at least a one-day task. They spent two days developing the CMS strategic plan, and it is now undergoing its second review.

Discussion Points

- CAPT Snesrud agreed that development of a strategic plan is a huge, arduous task. The next day, the Consultation Session, promised to be a long day and everyone was already tired. That said, she had some preliminary discussions with Kitty Marx, the lead for the tribal council at CMS, and inquired as to whether the TCAC Co-Chairs would be interested in hearing a presentation about how CMS went about their strategic planning process. Kitty Marx said she would be willing and able to do this.

- Ms. Hughes requested that they hear this presentation during the January 2011 TCAC meeting. She thought it would be beneficial to TCAC and terms of feeling more productive. She feels like they are merely talking and not achieving any real outcomes. A strategic plan would help to better guide their work.

- CAPT Snesrud requested that Dr. Monroe speak to how a TCAC strategic plan could align with CDC's plans.

- Dr. Monroe replied that generally speaking, a strong strategic plan would be beneficial to refer back to as they make decisions about how to move forward. It that ideally aligns with CDC's goals, that would be very helpful and the outcomes would be much greater. It will also help OSTLTS, which is charged to work inside CDC on TCAC's behalf.

- While she did not know what the TCAC budget looked like, Ms. Hughes pointed out that development of a strategic plan will take some time and will need some budgetary considerations.

- CAPT Snesrud indicated that she would help to facilitate Dr. Duckworth working with Kitty Marx on a CMS presentation for the January 2011 TCAC meeting.

Emerging Public Health Issues

In addition to H1N1, Ms. Hughes reminded everyone that during the field trips, it was brought to their attention that tribes in the area were experiencing issues with tuberculosis, hepatitis C, and helicobacter pylori.

Discussion Points

- ❑ Mr. Trudell (Aberdeen, Santee Sioux Tribe of Nebraska Chairman) indicated that they had brought to the attention of TCAC that there has been a re-emergence of tuberculosis across the Aberdeen area. There are some hot pockets. The issue of hepatitis C has been brought to the attention of TCAC on several occasions as well. He said he wanted to make a statement because it seemed like they always had to form tribal priorities based on whatever happens to be popular at the time nationally. To him, that is one reason tribes are always fighting on the same issue repeatedly. Tribes have to change their priorities to meet someone else's priorities. However, illnesses and disparities among tribes are not going away. He feels like someone should meet their priorities.

Formal Recommendations

Three formal recommendations were made during this TCAC meeting:

- ❑ Draft a letter to Dr. Frieden about OSTLTS approval and vacancies
- ❑ Develop a matrix to reflect the status of recommendations, and provide an analysis of the results of tribal testimony
- ❑ Set up a conference call to discuss scheduling a webinar for grant writing technical assistance training, and to address the revision of the charter

Ms. Hughes indicated that the formal recommendation for this TCAC meeting was for a letter to be written to Dr. Frieden that identifies TCAC's voicing of the urgency of approving the OSTLTS structure, approving the vacant OSTLTS positions, and posting and filling those positions as quickly as possible. She thought that the draft could be shared with TCAC members via email, and that they could come to consensus on the language via email as well. She suggested that this should be finalized within a month.

Motion: Letter to Dr. Frieden

A motion was made by Derek Valdo and was seconded by Jackie Kaslow to approve the recommendation to draft a letter to Dr. Frieden that identifies TCAC's voicing of the urgency of approving the OSTLTS structure, approving the vacant OSTLTS positions, and posting and filling those positions as quickly as possible. The motion carried unanimously.

CAPT Snesrud reminded everyone that there had been a fairly serious discussion about providing a matrix to TCAC that follows the pattern of the one the State of Wisconsin uses to quickly assess the status of recommendations, coupled with an analysis regarding how the testimonies offered during the five CDC Tribal Consultation Session have resulted in policy, practice, and / or budget responses. Ms. Hughes will send a request for a sample from Wisconsin's Department of Health Services, and she invited others to submit samples to her as well.

In addition, CAPT Snesrud reminded everyone that there was a recommendation for PGO to set up a webinar for grant writing technical assistance. TCAC should submit a formal request for this activity, with a suggested date, to be submitted to PGO. Ms. Hughes recommended convening a conference call in late October or early November 2010, during which the recommendation for PGO to schedule a webinar and the revision of the TCAC charter would be discussed. It would be beneficial for PGO to develop some preliminary information that could be presented on that call.

Wrap-Up and Adjournment

CAPT Snesrud reminded everyone that Dr. Monroe has talked about TCAC being inclusive of Tribal Health Officials. CAPT Snesrud has spoken with a few areas and has received some suggestions. She requested that TCAC members reach out to their tribes, and provide a list of new Tribal Health Officials. The criterion is that they have to have been on board for two years. Clearly, TCAC members are very busy and that the tasks of taking information back to their tribes and areas, and bringing information to CDC is a tremendous role. She emphasized that it would be beneficial for them to provide Dr. Duckworth with information about their area board chairs (e.g., contact information, including email addresses). This will be very beneficial in assisting Dr. Duckworth in knowing who the current contacts are, so that they can be added to the distribution list as additional players.

Ms. Hughes noted that several items had been listed for the next conference call and face-to-face meetings (e.g., PGO webinar, charter discussion, strategic plan) and that more suggestions were likely to arise during the next conference call. TCAC will continue to work on topics for those agendas.

In closing, CAPT Snesrud reminded everyone that the next TCAC meeting is tentatively scheduled for the third week in January 2011.

With no further business posed or questions / comments raised, the meeting was officially adjourned.

Participant Roster

Tribal Consultation Advisory Committee (TCAC) Members and Tribal Representatives

Folorunso Akintan, Epidemiologist, Rocky Mountain Tribal Epidemiology Center
Chester Antone, Tucson, TCAC Chair, Tohono O'odham Nation Councilman
Lena Belcourt, Rocky Boy Health Board / CCT, Self-Governance Coordinator
Dyani Bingham, Rocky Mountain Tribal Epidemiology Center, Project Coordinator
Kenny Bradburn, White Sky Hope Center
Joshua Brown, Rocky Mountain Tribal Epidemiology Center, CYP Coordinator Volunteer
Bridget Canniff, Northwest Portland Area Indian Health Board, Tribal Epidemiology Center Consortium Project Director
Les Cramer, Eagles Watch Organization
Elaine Dado, Northwest Portland Area Indian Health Board, Executive Administrative Assistant
Lori de Ravello, I.H.S. / Division of Epidemiology & Disease Prevention, Public Health Advisor
Rick Doyle, Governor, Passamaquoddy Tribe at Pleasant Point
Jerry Freddie, NIHB, Navajo Nation Council Delegate
Theresa Galvan, Navajo Nation
Mike Geboe, Clinical Supervisor, White Sky Hope Center
Taryn Hall, Montana Diabetes Project, Diabetes Epidemiologist
Rick Haverkate, NIHB, Director of Public Health
Steven Helgerson, DHSD / DPHHS, State Medical Officer
Kathy Hughes, Bemidji, TCAC Co-Chair, Oneida Business Committee
Candida Hunter, Phoenix, Hualapai Tribal Councilwoman
Michelle Jackson, FDA, Center for Tobacco Products, Regulatory Policy Analyst
Jackie Kaslow, California Rural Indian Health Board, Family and Community Health Services Director
Jace Killsback, Council Member, Northern Cheyenne Tribe
Tracy "Ching" King, Billings, Ft. Belknap Community Council President
Sharon Longknife, Fort Belknap, Tribal Health Administration, Assistant Director
Elizabeth McClain, Emeritus Professor, Fort Belknap College
Sherrilla McKinley, Inter Tribal Council of Arizona, Inc., Health Program Specialist
Aaron Morsette, Rocky Boy Health Board
Ben Murnel, Environmental Engineer, Rock Boy Health Board
Brenda Nielson, Northwest Portland Area Indian Health Board Secretary
Richard Phillips-Doyle, Nashville, Passamaquoddy Tribe: Pleasant Point Reservation, Tribal Governor
Mitzi Racine, Rocky Mountain Tribal Epidemiology Center, Project Coordinator
Alicia Reft, Alaska, Karluk Ira Tribal Council
Tim Rosette, Assistant CEO, Rocky Boy Health Board
Janet Runnion, Public Health Nurse, Rocky Boy Health Board
Allison Sage, Tribal Health Director, Wind River Indian Reservation
Lester Secatero, Albuquerque Area Indian Health Board Chairman
Kermit Snow, Jr., Ft. Belknap, Environmental Liaison
Audrey Solimon, Pueblo of Laguna, NIHB, Consultant
Shana St. Pierre, Rocky Boy Nation, Chippewa Creek, DETS Program Assistant
Loren "Bum" Stiffarm, Fort Belknap Chief Administrative Officer
Videl Stump, Tribal Elder Advisory Committee
Cecile Town, IHS / NCIRD / ISD / POB, Data Exchange Coordinator / Senior Research Officer
Roger Trudell, Aberdeen, Santee Sioux Tribe of Nebraska Chairman
Scott Tulloch, IHS, Public Health Advisor
Derek Valdo, Pueblo of Acoma, National Congress of American Indians
Anna Whiting Sorrell, Montana Dept. of Public Health & Human Services, Director

Jonathan Windy Boy, Vice Chairman, Chippewa Cree Tribe Business Committee; Montana State Senator
Elder Sam Windy Boy, Rocky Boy's Chippewa Cree Tribe
Donna Young, Forth Belknap Indian Community Environmental Department, Environmental Compliance Officer

Centers for Disease Control and Prevention /
Agency for Toxic Substances and Disease Registry

Annabelle Allison, Environmental Health Scientist, OTA / NCEH / ATSDR
Danielle Barradas, Epidemiologist, NCCDPHP / DRH / ASB / MCH
Christopher Benjamin, Deputy Branch Chief, NCCD / OSH / PSB
CAPT Holly Billie, Injury Prevention Specialist, DUIP / NCCDPHP / CDC (via telephone)
Letia Boseman, MPH, Public Health Analyst, NCCDPHP / CDC (via telephone)
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