

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

Tribal Consultation Advisory Committee (TCAC)

**February 1 - 2, 2011
Minutes of the Meeting**

Table of Contents		Page
February 1, 2011		
Acronyms		4
Opening Prayer / Welcome / Introductions		6
Director's Update: Office for State, Tribal, Local, and Territorial Support		6
Financial Management Office Update		14
Division / Branch Updates: Office for State, Tribal, Local, and Territorial Support		21
CDC Tribal Consultation Policy		28
TCAC Housekeeping Issues / Closing Prayer		35

Table of Contents		Page
February 2, 2011		
Welcome and Opening Prayer		37
Briefing of CDC / ATSDR Opportunities: Public Health Associate Program and Internship / Recruitment Opportunities		37
Reports from The TCAC Members		51
CDC / ATSDR Program Update & Activities in Indian Country: <ul style="list-style-type: none"> → National Center for Environmental Health / Agency for Toxic Substances and Disease Registry → Office of State, Tribal, Local, and Territorial Support → National Center for Chronic Disease Prevention and Health Promotion → Supporting Efforts of Tribal Health Officials to Address Public Health Ethics → National Voluntary Accreditation for Public Health Departments 		74
Revision of TCAC Charter		93
Recap and Closing Prayer		98
Roster		99

Acronyms

AAIHB	Albuquerque Area Indian Health Board
ACD	Advisory Committee to the Director
AD	Assistant Director
AHRC	Atlanta Human Resources Center
AI/AN	American Indian / Alaska Native
AISES	American Indian Science and Engineering Society
ANHB	Alaska Native Health Board
ANMC	Alaska Native Medical Center
APHL	Association of Public Health Laboratories
ARRA	American Re-investment and Recovery Act
ASTHO	Association of State and Territorial Health Officials
ATSDR	Agency for Toxic Substances and Disease Registry
BIA	Bureau of Indian Affairs
BRFSS	Behavioral Risk Factor Surveillance System
CDC	Centers for Disease Control and Prevention
CE	continuing education
CHR	Community Health Representative
CMS	Centers for Medicare and Medicaid Services
COO	Chief Operating Officer
CORD	CDC Organizational Resource Directory
CR	Continuing Resolution
CSTE	Council of State and Territorial Epidemiologists
DC	District of Columbia
DCPC	Division of Cancer Prevention and Control
DGHA	Division of Global HIV / AIDS
DNPAOP	Division of Nutrition and Physical Activity and Obesity Prevention
DOI	Department of the Interior, BIA
DOJ	Department of Justice
DPHCD	Division of Public Health Capacity Development
EEO	Equal Employment Opportunity
EIP	Emerging Infections Program
EIS	Epidemic Intelligence Service
EJ	Environmental Justice
ELC	Epidemiology and Laboratory Capacities
ELP	Emerging Leaders Program
EPA	Environmental Protection Agency
FACA	Federal Advisory Committee Act
FDA	Food & Drug Administration
FEMA	Federal Emergency Management Agency
FOA	Funding Opportunity Announcement
FTE	full-time equivalent workers
GPS	Grants and Program Support
HHS	Department of Health and Human Services
HIV	Human Immune Deficiency
HRAC	Health Research Advisory Council
HRSA	Health Resources and Services Administration
HSHPs	Hispanic Serving Health Professions Schools, Inc
ICNAA	Inter-Departmental Council on Native American Affairs
IGA	Intergovernmental Affairs
IHS	Indian Health Service

IT	Information Technology
ITCA	Inter-Tribal Council of Arizona
ITCM	Inter-Tribal Council of Michigan
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
KSA	Specific knowledge, skill, or ability
KPI	Key Performance Indicator
MASO	Management Analysis and Services Office
MAST	Midwest Alliance of Sovereign Tribes
MC/PHSI	Morehouse College/Public Health Sciences Institute
MPFB	Management and Policy Fellowships Branch
NCDDPHP	National Center for Chronic Disease Prevention & Health Promotion
NACCHO	National Association of County and City Health Officials
NARCH	Native American Research Centers for Health
NCAI	National Congress of American Indians
NCEH	National Center for Environmental Health
NCIRD	National Center for Immunization and Respiratory Diseases
NCUIH	National Council of Urban Indian Health
NGO	Non-Governmental Organization
NICOA	National Indian Council on Aging
NIH	National Institute of Health
NIHB	National Indian Health Board
NPHII	National Public Health Improvement Initiative
NWCPHP	Northwest Center for Public Health Practice
NWPAIB	Northwest Portland Area Indian Health Board
OCAITHB	Oklahoma City Area Inter-Tribal Health Board
OD	Office of the Director
OGC	Office of the General Counsel
OJJDP	Office of Juvenile Justice and Delinquency Prevention
OMB	Office of Management and Budget
OMH	Office of Minority Health
OPM	Office of Personnel Management
OSELS	Office of Surveillance, Epidemiology, and Laboratory Services
OSTLTS	Office for State, Tribal, Local, and Territorial Support
PEPFAR	President's Emergency Plan for AIDS Relief
PHAB	Public Health Accreditation Board
PHPS	Public Health Preventive Service
PPACA	Patient Protection and Affordable Care Act
PMF	Presidential Management Fellows Program
PGO	Procurement and Grants Office
PHAP	Public Health Associate Program
PSA	Public Service Announcement
QI	Quality Improvement
SAMHSA	Substance Abuse and Mental Health Services Administration
SNS	Strategic National Stockpile
SPIEC	South Plains Inter-Tribal Epidemiology Center
STAC	Secretary's Tribal Advisory Committee, HHS
STD	Sexually Transmitted Disease
TB	Tuberculosis
TCAC	Tribal Consultation Advisory Committee
USET	United South & Eastern Tribes, Inc.
VFC	Vaccines For Children
WHO	World Health Organization

**Centers for Disease Control and Prevention (CDC)
Agency for Toxic Substances and Disease Registry (ATSDR)
Tribal Consultation Advisory Committee (TCAC) Meeting**

**Minutes of the Meeting
February 1, 2011**

Opening Prayer / Welcome / Introductions

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

Mr. Seneca offered the opening prayer, following which Ms. Hughes welcomed everyone to the February 2011 Centers for Disease Control and Prevention (CDC) Tribal Consultation Advisory Committee (TCAC) meeting. She indicated that because some TCAC members were still traveling, they did not have a quorum. Therefore, no roll call was taken at this time nor was a vote taken on the agenda or the August minutes. Given Dr. Monroe's tight schedule, Ms. Hughes indicated that they would move forward with the agenda and would address these pending items later in the meeting when others arrived.

Director's Update: Office for State, Tribal, Local, and Territorial Support

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

Dr. Monroe, Director of the Office for State, Tribal, Local, and Territorial Support (OSTLTS), bid everyone a good morning and welcomed them to CDC. She offered a special welcome and gratitude to Kathy Hughes, Co-Chair of TCAC. She also recognized the other TCAC Co-Chair, Mr. Chester Antone, and wished him a speedy recovery as he was unable to attend due to illness. This meeting represented Dr. Monroe's second opportunity to meet with TCAC members, and she indicated that she wanted to offer a few updates since they met in Montana. She submitted a letter in the fall with a few updates, for which there were more details. She reminded everyone that under Dr. Frieden's leadership, CDC had recently gone through an organizational improvement effort. Currently, nearly all of the Center Director positions have been filled, with the exception of one. There are tribal activities taking place throughout CDC's centers and offices.

OSTLTS heard loudly and clearly the recommendation for a Tribal Liaison to be appointed who reports directly to Dr. Frieden. As a part of the organizational improvement process, OSTLTS was created as a separate office. The previous iteration of this office had been in a branch. Melanie Duckworth has been serving as the Senior Tribal Liaison over the last few months. OSTLTS has also undergone some reorganization, and will now elevate the Senior Tribal Liaison position Associate Director for Tribal Affairs. This individual will report directly to Dr. Monroe, and the position will be moved into the Office of the Director (OD). Dr. Monroe reports

directly to Dr. Frieden. The last time TCAC met, the OSTLS office had not been officially approved, and was awaiting its Management Analysis and Services Office (MASO) package. That package was received in August 2010, which gave them the opportunity to complete the paperwork needed to announce positions. They recently received the approval for the Associate Director for Tribal Affairs position, and planned to announce it shortly. Dr. Monroe said she was looking to TCAC to help OSTLTS recruit for this position. She reminded everyone that in her letter a few months earlier, she requested that the TCAC members share their recommendations for this position related to qualifications, skills, and experience the individual should have to serve in this leadership role. The other concern that OSTLTS staff heard regarded the number of staff working on tribal activities within OSTLTS. The office now has a total of five staff working on tribal activities who will report to the new Associate Director for Tribal Affairs, so they really want to hire the best qualified individual for that position.

Dr. Monroe was recently made aware that there is a coalition of American Indian, Alaska Native, Hawaiian Native individuals who work for CDC. They approached her to ask if she would serve as executive sponsor for them to become an official CDC workgroup. She agreed to complete the paperwork, and she has been signing letters to make sure that this coalition becomes formalized. This coalition will work across CDC. OSTLTS is excited about this because a workgroup can accomplish more than just a coalition. Because the process formalizes the group, it offers the OSTLS office and the new Associate Director for Tribal Affairs an opportunity to turn to that group as yet another resource across CDC to deliberate issues and offer input. After meeting with the TCAC membership in Montana, Dr. Monroe immediately met with Dr. Frieden to relay to him the recommendations she heard during that meeting. He was quite supportive of the coalition becoming a formal workgroup as another effort within CDC.

With respect to activities over the last six months, OSTLTS staff members have been busy continuing to stand up a new office and manage many efforts. The national voluntary accreditation for public health departments begins in the fall of 2011. This process includes tribal health centers that can become accredited. Special work is being done with focus groups on tribal health. Special think tanks have been formed to address various topics such as chronic disease, laboratory medicine, tribal health departments, et cetera. OSTLTS is the CDC lead for accreditation. OSTLTS has also been conducting health officer orientations, which have been going quite well. The last orientation was in September 2010. Melissa Gower, Group Leader for Cherokee Nation Health Services, and Ron His Horse Is Thunder (Ron McNeil), the Executive Director of the Great Plains Tribal Chairman's Health Board, attended. The discussion was very rich, and Dr. Monroe personally appreciated the fact that they were able to get state, local, tribal, and territorial health officials around the table discussing meaningful public health issues and improvements that need to take place. The next orientation is planned for May-3, 2011 at CDC. The goal is to conduct these orientations once or twice a year depending upon scheduling. OSTLTS welcomes tribal health directors and encourages their attendance to make the dialogue much richer. When Dr. Frieden came to CDC, he stood up the Advisory Committee to the Director (ACD), which was established to advise him about state, tribal, local, and territorial issues. Sally Smith from Alaska; Melissa Gower from Cherokee Nation; and Anna Whiting-Sorrel, Health Officer in Montana and member of a tribe, are members of the ACD.

Dr. Monroe reminded everyone that when last they met she concluded her remarks by saying that she wanted to contemplate what is within her control and what is out of her control. She thought some of the recommendations made by TCAC probably needed to be sent forward to others. A great deal of work is being done within the Department of Health and Human Services (HHS) as well. President Obama and Secretary Sebelius have taken great interest in

the concerns and recommendations from the tribes. She heard during the last TCAC meeting in Montana that many of the tribes have differences with the states. CDC has cooperative agreements with the Association of State and Territorial Health Officials (ASTHO) and National Indian Health Board (NIHB). Following the summer TCAC meeting, CDC requested assistance on this matter from ASTHO and NIHB. In fact, ASTHO and NIHB were to meet on February 4, 2011 following the TCAC meeting and Tribal Consultation with the intent of assessing the issues between tribes and states to ponder how that might be facilitated or improved upon. It was Dr. Monroe's understanding that this would represent the first time ASTHO has been involved with this pressing issue. Again, this was a direct result from the TCAC recommendations.

Through the Public Health Associate Program (PHAP), which used to be the apprentice program, OSTLTS places associates in the field. The current class has 65 participants who will be placed in health departments. The purpose of this program is to provide front line, entry level experience to individuals interested in a career in public health practice. To enter the PHAP program, an individual must have at least a Bachelor's Degree. Dr. Monroe remembered that the last time she met with TCAC, a question was raised regarding whether there was a way to revise the minimum requirement to allow for an Associate Degree. She took this recommendation forward to Dr. Frieden, and this recommendation is currently being taken into consideration. She did not have a final answer on this yet, because it is a somewhat complicated question; however, OSTLTS is anxious to recruit tribal members into the PHAP program and to have tribal health departments participate as sites. Currently, PHAP associates are assigned to 23 states, 1 territory, and the District of Columbia (DC). OSTLTS hopes to bring in a class of 50 in the summer of 2011. While 65 participants were admitted last year to boost the numbers, the standard plan is to enroll 50 per class. This is a 2-year program, so at any given time, 100 participants would be working in the field. Since the last TCAC meeting, another exciting initiative was that the National Public Health Improvement Initiative (NPHII) was implemented. This is a grant being administered through OSTLTS that is a part of the Patient Protection and Affordable Care Act (PPACA). NPHII funding has been awarded to 8 tribes through this new funding opportunity.

CDC has also been very involved in HHS activities. Secretary Sebelius established the Secretary's Tribal Advisory Committee (STAC). Dr. Frieden requested that Dr. Monroe serve as his representative on this committee, so she attended the first meeting that was convened. There is also the Inter-Departmental Council on Native American Affairs (ICNAA), which is being revitalized under Secretary Sebelius, which has met a couple of times. A key topic addressed by the ICNAA is budget consultation.

CDC has Tribal Program Field Staff in Albuquerque, New Mexico where an epidemiology interagency agreement is in place. Dr. Yvette Roubideaux, a member of the Rosebud Sioux Tribe of South Dakota and Director of the Indian Health Service (IHS), visited CDC on November 3, 2010 to meet with Dr. Frieden. During the time that Dr. Monroe joined Drs. Frieden and Roubideaux for part of their meeting, the focus was to assess which of the winnable battles CDC and IHS could work more closely on. The overall focus of the meeting was to encourage collaboration and success between CDC and IHS, and to determine how the agencies could work better together.

Discussion Points

- Ms. Hughes was pleased to hear about the progress being made on the reorganization of the office and its staffing. Dr. Duckworth and Ms. Cantrell have been great to work with, and they are gradually getting to know everyone who is working on tribal affairs within OSTLTS.

She was aware that PHAP was moving through Indian Country, given that she sees the emails and announcements coming through. In the Mid-West, there does not seem to be much progress yet, but they do participate in the discussions, so she hopes over time to see more participation by more tribes. Perhaps TCAC members can provide information about what hurdles need to be overcome to achieve greater participation. It was a challenge to prepare anything for this meeting because it came about on rather short notice. She was not sure how the ultimate turnout would be due to the snowstorm.

- Mr. Finkbonner was pleased to see at the conclusion of the TCAC Consultation Session there was going to be a meeting with ASTHO and NIHB. One issue that is not a focus of the winnable battles discussion, but which was discussed in their meeting with Dr. Frieden consultation regarded H1N1 with respect to the vaccine distribution system. There was some comfort in the fact H1N1 immunization distribution was done through the Vaccines For Children (VFC) program rather than the Strategic National Stockpile (SNS) program that distributes antivirals. There were mixed reviews in the Northwest. Their Chairman of the Board spoke to this issue during the last Consultation Session. At that time, they requested that CDC take an active role in helping to shape distribution so that would at least be an option for tribes to receive direct allocations. Different models were used in each of the three states in the Northwest. The model that seemed to work well was when the state distributed directly to tribes or gave tribes the option to have it distributed to the local health jurisdiction. There seemed to be an incredible amount of frustration with the other models, and increased tensions between local agencies and tribes as a result of the mechanics of distributing the vaccine supply. Fortunately, H1N1 was fairly mild. Had it been a virulent virus, things would have been much worse. He emphasized that CDC should still assess distribution methodology, and not defer that request just because the outbreak was mild. Other pandemics will occur, so CDC / tribal / state relations should be worked out in advance of that.
- Dr. Monroe responded that while she did not review the full structure of OSTLTS, another change since last they met was that the Division Director position was filled with Craig Thomas, who used to work in preparedness. He was very involved in determining best practices with regard to H1N1. He is now in a very good location in the OSTLTS office to assess H1N1 and other vaccine distribution with respect to tribes. It has become clear that some strategies work better than others, and they definitely want to take lessons learned into consideration in the future. She indicated that she would send Dr. Thomas an email to let him know that the subject had been raised, so that he could address it the next day during his presentation.
- Regarding the Associate Director for Tribal Affairs position, Ms. Hughes asked whether it would be possible for TCAC to review the resumes submitted and offer input about the potential applicants.
- Mr. Pietz responded that he did not believe there was a precedent to engage the TCAC in a review of the applications. Instead, they would look to TCAC members to help disseminate information about the announcement and with the recruitment process in order to have a large catchment. TCAC members could offer input with respect to the qualification requirements they believe the position should have, which would have to be vetted through internal CDC systems to ensure that they do not run afoul of the Office of Personnel Management (OPM). They do not want to do anything that may cause unnecessary delays.

- Ms. Hughes reported that the Department of the Interior (DOI) with the Bureau of Indian Affairs (BIA) has utilized tribal leaders in the Midwest area for screening applicants for Area Directors. She was one of the participants in the screening process for the Minneapolis Area Director. DOI took care of the background work (e.g., screening applications, et cetera) and reduced the pool to 5 candidates. Information on those 5 candidates was sent to the tribal leaders for their input. This was not a part of the formal process itself, but was for review to ensure that the person selected had a background working on Native American issues, preferably direct experience with tribes in terms of funding needs, political issues, et cetera.
- Mr. Pietz responded that it would be beneficial for TCAC members to offer input regarding direct tribal experience in terms of budget / financial issues, governmental / structural issues, individual governments, et cetera. Then CDC could seek candidates with these backgrounds. The federal government no longer assesses applicants based on specific knowledge, skills, or abilities (KSAs) because the system recently underwent a significant change in this process. However, interview questions can be included that can be checked off to meet particularly qualification requirements.
- Mr. Valdo inquired as to whether the solicitation could include a preference for a tribal member. A tribal member would give the agency greater entrée than typical “federal guys in suits” and Commissioned Corps Officers. Reviewing his comments from the last meeting, while he was not a believer of historical trauma, the issue always arises. Having the announcement include NA / AN preference would help the agency tremendously. New Mexico has utilized their system to include over 160 tribal citizens throughout the various committees, structures, and governmental agencies within the state of New Mexico. This has helped to bridge the gap. The intent is the same for CDC—to help bridge the relationships and improve the probability of success.
- Mr. Pietz responded that they are still investigating this issue. They have had some conversations with the Atlanta Human Resources Center (AHRC), CDC’s personnel department, to determine the laws about including such a stipulation. They also want to have the flexibility to hire a candidate who also understands public health and how the federal government operates so that they can bridge the two systems together. If they lean too far to one side, the other side would be lost. They will continue to look into these issues.
- Dr. Taveras pointed out that this is a “slippery slope.” They wanted to hire Latinos, but could not necessarily state this outright. Instead, they articulated the experience needed such as cultural competence, being bilingual, background working with Latino populations, et cetera [did not use a microphone, so it was difficult to hear him in the room and was not picked up on the backup tape, so this may not be entirely accurate].
- Ms. Hughes thought that the title Associate Director of Tribal Affairs would establish the standard. While she did not know whether they would require a Bachelor’s or Master’s Degree in Public Health, they should at least expect the candidates to know about tribal affairs, and have an understanding of traditional practices and cultural sensitivity.
- Mr. Pietz replied that these were exactly the criteria that we would be considered. Instead of identifying a blood trait or having something that says a person is inherently better because of their heritage, they want to find someone who has real experiences. Hopefully that will elevate up in the recruitment efforts, giving them a wide catchment from many of the tribes.

They have identified a pretty good catchment area already, thought that TCAC members may be aware others. They can send out listservs and develop a flyer for TCAC members to disseminate. They will probably announce this as a Health Scientist position, which would not necessarily require a degree. However, due to OPM rules, it would require 30 semester hours of health science. Within CDC, having a Masters Degree or a PhD definitely shows that a candidate has persevered. It would not necessarily mean that if someone had a PhD with no tribal experience they would be offered the position. They realize the importance of actual on-the-job training, outreach, cultural sensitivity, traditional medicines, governmental structure, sovereign nation aspects, the right to individual governance, et cetera. The primary purpose of this position is to improve CDC's engagement in the improvement of health and wellness amongst tribal people from a public health perspective.

- Mr. Secatero cautioned about those with degrees and no direct tribal experience. In the Albuquerque area, they see many degreed people come and go in a couple of weeks. They did not know how to work with the tribes. Tribes are asking to participate in the hiring process.
- Dr. Monroe reiterated that they want to make sure that this announcement is widely circulated.
- Ms. Hughes asked whether TCAC could review the job description prior to it being formally posted, so that they could offer input about the qualifications. If so, she suggested placing a time limit on their responses in order to avoid delay in the process.
- Dr. Monroe thought this was an excellent idea, and Mr. Pietz did not think there was anything that would preclude them from being able to do this. He emphasized the importance of leaving the announcement open long enough to reach the best catchment area, but not leaving open so long that they are inundated given the current job market. They were informed by the OPM that 30,000 people applied for another open position.
- Ms. Hughes said that while 30,000 was frightening, one week seemed entirely too short to get notifications out. She thought that at least two weeks would be better.
- Ms. Moore suggested that to speed up the process, TCAC members could begin to tell people about the impending announcement so that they would have ample opportunity to prepare their resumes and get them into the government system, which takes a while. If that is already done, they can easily tailor their invoice to the specific position and answer the questions. This can be done on <http://usajobs.gov/>.
- Mr. Secatero requested a list of the 8 tribes that were awarded funding.
- Dr. Monroe explained that the NPHII awards included two components. Component I was non-competitive and was based on population, while Component II was competitive. The specific awards are shown in the following table:

Awardees	Component I \$	Component II \$	Total Funding \$
Alaska Native Tribal Health Consortium	100,000	-	100,000
Cherokee Nation	100,000	1,660,128	1,760,128
Gila River Indian Community	100,000	-	100,000
Mille Lacs Band of Ojibwe	99,866	-	99,866
Montana-Wyoming Tribal Leaders Council	100,000	-	100,000
Navajo Nation Tribal Government, The	100,000	-	100,000
Northwest Portland Area Indian Health Board	100,000	-	100,000
Southeast Alaska Regional Health Consortium	100,000	-	100,000

<http://www.cdc.gov/ostlts/nphii/awardees.html>

- Regarding the current economic situation, Mr. Valdo reminded everyone that President Obama had recently stated in his State of the Union Address that funding is going to revert to 2008 and possibly 2006 levels. This is of great concern to Indian Country because approximately 95% of its programs are funded through the discretionary component of the federal budget. Other funding is awarded through earmarks. From the perspective of the National Congress of American Indians (NCAI), it seems that funding cuts go to those with the smallest voice. He thought it was more important to consider good return on investment. Indian Country represents a good area to implement programs that have the potential for good return on investment, as well as expansion. In his State of the Indian Nations Address, President Keel talked about “throwing a hot rock into the pond and having the ripples reverberate throughout the pond.” CDC must find ways to bridge gaps with Indian Country. CDC has the scientists who are very educated, knowledgeable, and experienced. They must help to implement projects in Indian Country that are worthwhile in terms of helping the overall system. Ultimately, they are all one people of one nation.
- Dr. Monroe agreed that there was question they are all one people, and that together they must try to improve health and take care of one another. In order to do this, OSTLTS is focusing on implementation of the science to specific communities, understanding that there are cultural differences and issues. She has personally become much more interested in implementation science, which the National Institutes of Health (NIH) refers to as translational science. This science focuses on taking basic research to the bedside quicker. In public health, it is more implementation science of taking what is known into the field to improve health. The network is about how to disseminate information about one tribe that has had success and is a good return on investment to other tribes. This is not just a good buy—it is a best buy. At CDC, it is often said that prevention is a best buy. If clearly improved health is observed due to a program, it should be replicated throughout the country. OSTLTS would like to engage TCAC in the specific issue of implementation science to determine how to move forward.
- Ms. Hughes pointed out that data collection overall is an issue in most cases because American Indian / Alaska Native (AI/ANs) are not part of a defined system from which

statistics are easily retrievable. They are often buried within a larger group. One of the requirements under the PPACA legislation is better data collection on AI / AN populations. She emphasized that lack of data has always been a challenge for tribes when applying for competitive funding. They often do not have the statistical data to support the request for funding. She thought it was interesting that this was made a part of the PPACA legislation.

- Mr. Pietz indicated that data definitely helps them identify strategic planning. Their mission base is to assess the evidence to determine how to translate what works into practice. They have to tell the story to educate Congress in terms appropriations. There is an opportunity through this new office with this new leadership to address these specific tasks and developed some concrete steps to determine what needs to be done. If they dilute themselves too much, they will not be able to have real impact. If they can decide with the leadership what the needs are, based on the science, they can determine the next steps. They must provide the evidence and the stories at the same time to really get the message across.
- Mr. Secatero reported that there is a new governor in New Mexico who is the first Latino governor. They also have new public health people there, who can work with IHS to train them to help work with the doctors.
- Dr. Espey reported that the Division of Cancer Control and Prevention is going to work on updating death information for AI / AN. He said he would be speaking the next day, and would provide further information [did not use a microphone, so it was difficult to hear him in the room and was not picked up on the backup tape, so this may not be entirely accurate].
- Mr. Finkbonner said that perhaps it was because he was sleepy and cranky that he wanted to “ruffle the waters” somewhat. During their discussions, the word “precedent” was used a couple of times, which to him was code for, “We want to stay the same.” The point of this TCAC committee is to determine how to change the way business is being done so that it is more effective. If everyone always acted on what the science had proven or what precedent has been set, the first immunization would never have been given. Until the first one is given, there can be no science to prove whether it works. There are other ways to demonstrate efforts that make sense. IHS has been using tribal leaders for a long time in selection of Area Directors, Clinic Directors, Equal Employment Opportunity (EEO), et cetera. Thus, there is a demonstrated process that illustrates that the involvement of tribal leaders in selecting a key position works. While it is a new process and understandably there will be a learning curve, that is what TCAC is about. They are there because they are making a statement that CDC does not work the best for tribal people, and tribal representatives was to contribute input in a constructive manner about what will work well for tribal people. That includes every process, including recruitment of a key position within OSTLTS. He stressed that he was not trying to pick a fight, but was trying to change a mindset.
- Dr. Monroe expressed her gratitude for the input. She said she was not aware that the Department of Interior engaged in this process. She was not aware of whether precedent was considered in terms of only CDC, or if the practices of other agencies were examined as well. She agreed that the reason to have TCAC was to seek advice for agency improvement, and that they could not improve by staying the same.

Financial Management Office Update

**Rob Curlee, Deputy Director
Financial Management Office
Centers for Disease Control and Prevention**

**Michael Franklin
Financial Management Office
Centers for Disease Control and Prevention**

Mr. Curlee presented data representing CDC / ATSDR resources committed to programs that benefit AI / AN populations and communities. Fiscal information was summarized according to organizational and disease-specific programs, and by defined funding allocation categories. The total funding allocation for AI / AN programs was \$192,594,374 FY2010, of which \$131.3 (68%) was VFC funding and \$58.1 million (31%) was funding without VFC. This has been typical in the past. Not including ATSDR funding, the total allocation was \$190,213,314.

In terms of historical funding in AI / AN programs, in FY 2008 CDC funding was ~\$43.8 million; VFC funding was ~\$64.3 million; CDC with the VFC funding was ~\$108 million; ATSDR funding was ~\$682,470; and the total allocation was ~\$108.7. In FY 2009, CDC funding was ~\$45.3 million; VFC was ~\$122.2 million; CDC and VFC combined were ~\$167.6 million; ATSDR was ~\$637,505; and total funding was ~\$168 millions. In FY 2010, CDC was ~\$58.9 million; VFC was ~\$131.3 million; CDC plus VFC was ~\$190.2 million; ATSDR was ~\$2.3 million; and total funding was ~\$192.5 million. The breakdown aligned with specific diseases and programs is reflected in the following table:

CDC/ATSDR Funding Resources Aligned with Disease Specific Programs	Funding Level FY 2009	Funding Level FY 2010	Change
Chronic Disease Prevention and Health Promotion	\$27,286,210	\$31,123,084	⬆️
Cancer	\$14,677,332	\$15,590,951	⬆️
Cross-cutting Programs	\$5,613,762	\$9,991,519	⬆️
Diabetes	\$4,639,402	\$5,372,730	⬆️
Tobacco	\$2,064,618	\$2,414,590	⬆️
Heart Disease and Stroke Prevention	\$975,000	\$975,000	⬆️
Maternal Child Health	\$147,749	\$1,168,210	⬆️
Adolescent and School Health	\$368,347	\$362,989	⬆️
Other Reproductive Health		\$42,055	⬆️
Infectious Diseases	\$7,390,219	\$9,295,331	⬆️
Infectious Disease Prevention	\$46,000	\$50,000	⬆️
Infectious Diseases in Alaska Natives	\$3,380,091	\$3,030,000	⬆️
HBV/AIDS	\$2,493,544	\$4,586,035	⬆️
SIDS	\$808,201	\$776,516	⬆️
Vaccine-preventable diseases (non-VFC funds)	\$339,601	\$406,272	⬆️
Viral Hepatitis for Alaska Natives	\$232,000	\$232,000	⬆️
Other		\$21,448	⬆️
Public Health Emergency Preparedness	\$4,651,716	\$4,351,918	⬆️
Public Health Capacity, Strategic Partnerships and Training (OD)	\$1,627,600	\$4,141,709	⬆️
Public Health Infrastructure		\$2,260,148	⬆️
Environmental Health	\$788,371	\$609,844	⬆️
Environmental Public Health Services/Research	\$788,371	\$609,844	⬆️
Health Statistics	\$1,665,361	\$2,046,307	⬆️
Injury Prevention	\$1,452,190	\$2,002,914	⬆️
Unintentional Injuries	\$150,000	\$886,413	⬆️
Violence Prevention	\$1,302,190	\$1,122,501	⬆️
Birth Defects/Developmental Disabilities	\$200,000	\$274,291	⬆️
Occupational Health	\$310,140	\$332,070	⬆️
CDC Total w/o VFC	\$45,371,807	\$58,906,296	30%
ATSDR	\$122,668,152	\$118,007,018	7%
CDC Total with VFC	\$167,637,959	\$190,213,314	13%
ATSDR	\$6,356,615	\$2,314,000	273%
CDC/ATSDR Grand Total with VFC	\$168,275,464	\$192,594,374	14%

The National Center for Chronic Disease Prevention & Health Promotion (NCDDPHP) had almost a \$3 million increase between 2009 and 2010 compared to infectious diseases, with a \$1.9 million increase in 2010—slightly less than public health preparedness. There was some relationship to what was occurring with PPACA activities in terms of CDC and decisions being made in state and local areas to include AI / AN activities. The PPACA funding provided in 2009 was 2-year funding, so there was some carryover in 2010. That funding mechanism is now completed and is no longer available in 2011, except for a couple of highly specialized areas that were identified. In the percentage areas without VFC, CDC funding is still at a 23% increase between 2009 and 2010. The VFC had a 7% increase and ATSDR had a very large increase compared to the previous year of 273%. Mr. Curlee shared two pie charts showing FY

2010 CDC / ATSDR funding for disease-specific programs broken down without and with VFC funding.

Funding allocation categories included the following:

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

- **Intramural AI / AN:** Intramural programs whose purpose is to primarily or substantially benefit AI/AN (*this category would include costs [salary, fringe, travel, etc.] associated with CDC staff or contractors whose time/effort primarily or substantially benefit AI / AN*).
- **Extramural AI / AN Benefit:** Competitively awarded programs where the purpose of the award is to primarily or substantially benefit AI / AN.
- **Federal AI / AN Benefit:** Federal Intra-Agency Agreements where the purpose of the agreement is to primarily or substantially benefit AI / AN.
- **Indirect AI / AN:** Service programs where funding for AI / ANs can reasonably be estimated from available data on the number of AI/ANs served (*this category applies only to the Vaccines for Children program and to NCHS*).

Without VFC, extramural direct funding comprehensively makes up a large proportion of the \$192 million allocating in AI / AN funding. In 2010, indirect funding was \$133 million (69%), extramural direct funding was \$30 million (16%), extramural benefit was \$12 million (6%), federal award (IAA) was \$3 million (2%), and intramural was \$12.6 million (7%). Compared to 2010, extramural direct had a 14% increase compared to FY2009. The federal award was larger at 20% comparatively. Intramural probably had the largest increase from a percentage standpoint as compared to the amount in 2009 at 86%. Without VFC, there was a 23% increase from \$45.3 million to \$55.7 million in 2010. With the VFC, it is 12%.

With regard to areas to consider, the federal government continues to operate without a finalized budget under a continuing resolution (CR) until March 4, 2011. It is uncertain whether there will be an enacted appropriation by that date. The House recently voted on a bill known as the Rollback Resolution, which basically recommends funding at the 2008 level or less. It was not clear at this time what that meant for CDC. CDC had already been operating under the premise that there would be at least level 2010 funding. The strategic plan is to compare 2010 to 2008 to determine how Congressional decisions with respect to the Rollback Resolution may affect the agency. This is very difficult in the fifth month of a fiscal year. Given the uncertainty, full granting decisions are also difficult to make. Under the continuing resolution, they must operate under a formula provided by the Office of Management and Budget (OMB), which requires them to work off of an average of historical funding over the last several years. While they were hopeful that there would be some type of year-long enacted appropriation, the actual totals remained a mystery.

With respect to what this means for next year, there is still no official President's budget. The anticipated release date for that budget was anticipated to be February 14, 2011. Once that date has come, CDC's budget will be public and they can provide information from that. CDC

has made efforts to consider activities for AI / AN in the upcoming President's budget in terms of indicating the importance of such efforts / funding. In the 2010 budget, there was some House language that made mention of funding being considered for AI / AN areas. There are a couple of areas in the Senate language as well. A block grant makes a reference to local and tribal areas. CDC has been trying to work closely with OMB, Congress, and HHS to be as inclusive as possible. This is an on-going process. Previously they discussed working on a specific project area and to get some language in the budget about that. This has been a difficult and slow process, but Mr. Curlee said he thought they were still making progress. They will continue to discuss this in upcoming HHS meetings. OSTLTS staff are also working on visibility for AI / AN areas, and Dr. Frieden is being kept informed so that he can be well aware of the activities being proposed in this area. There have certainly been some milestones over the past few years. In terms of the health goals and objectives for performance, it is likely that where federal funds are provided, some type of performance and results will be expected. If anything, there is likely to more accountability expected from everyone given the potential budget changes that might be coming. He emphasized the importance of showing results in order to garner funding.

Discussion Points

- Ms. Hughes expressed concern about the rollback language, particularly given that there had finally been progress in funding to Indian Country. If the rollback funding occurred as proposed, Indian Country is likely to be the hardest hit because progress has only been made in the last three to four years. Tribes work on funding issues daily in Washington, DC In terms of the project initiative, she recalled that TCAC submitted suggestions for the 2012 budget. Their suggestion pertained to the First Lady's announcement about her initiative on obesity. Ms. Hughes asked whether Mr. Curlee was suggesting that TCAC members discuss those initiatives with their legislators to increase the potential for consideration.
- Mr. Curlee replied that continuing the communications strategy is very important. In addition to verbalizing tribal needs, it is import to make themselves visible by making appropriate contacts where there has strong support for several years. Obesity is probably an area that will continue to have a lot of support. However, he stressed that he could not answer the question about what would happen from a funding perspective. It is important to show performance and results. That is the type of communication that is very helpful with Congress.
- Mr. Seneca requested a copy of the initiative the developers submitted to CDC for the proposed obesity project.
- Ms. Hughes responded that she would check with her staff. Oneida specifically submitted a proposed project, and she thought others had discussed submitting something as well.
- Ms. Moore indicated that the call came from the Associate Director for Policy at CDC, because OSTLTS responded. She did not receive anything specific to tribal, but there was something for the First Lady's "Get Moving" campaign. She could probably acquire a copy of that, but the tribal request did not come through her.
- Mr. Curlee added that FMO continues to provide support for AI / AN activities in formulation area in the execution office. Mr. Franklin spent a lot of time gathering information and putting it together for this presentation. Obviously, they have administer what is provided

from Congress and the President, but if there are areas where they think they can work strategically as they have in the past with TCAC.

- Ms. Hughes noted that they are trying to tap into Dr. Frieden's winnable battles to access funding available in those areas. The on-going issue regards being able to compete competitively to obtain additional funding through CDC. That has always been the problem for Indian Country. This combined with the lack of specific data makes it very difficult to navigate the CDC system to ensure that their voices are heard. While her own tribe has had some success, she has heard from others that the process is simply too complicated and the bureaucracy is too large. If tribes with some technical capabilities are really floundering. That is not just a budgeting concern—it is a concern with the entire process and making it more accessible to tribes.
- Mr. Curlee noted that PGO has been engaged in some collaborative efforts to try to make the process more transparent for tribes in addition to trying to place some requirements on states who received funding in terms of working with tribes.
- Ms. Hughes indicated that she has been seeing more notifications about announcements from CDC. They have their own listservs and share the information that way. As an example of lack of information, a person going on the CDC website would be very challenged to find information about this TCAC meeting. That should be relatively simple to take care of. An individual called her who was interested in this meeting, but they were not able to get even a copy of the agenda. More work needs to be done in communications, though she was not quite sure whether that should begin. The budgeting process seems to be too broad. Perhaps that was a discussion they should have had with Dr. Monroe when she was there earlier in the morning.
- Ms. Moore reported that OSTLTS has been charged by Dr. Frieden to complete a grants improvement process. The feedback from this discussion could inform that process. This effort is being led by Craig Thomas' group. She said she would mention this to him as something TCAC would like to hear more about.
- Mr. Seneca noted that with some Funding Opportunity Announcements (FOAs) there have been some pre-applications workshops for potential applicants. He thought this should occur with all of the cooperative agreements.
- Mr. Valdo wondered if Mr. Curlee could speak to the overall expectations of leadership within CDC in light of the rollback discussion in terms of what center directors are being told, and in terms of the notion of performance-and result-based management. Tough decisions have to be made in the next 18 months to 5 years. He wondered how Indian Country programs were stacking up against the metric that would be used for key performance indicators.
- Mr. Curlee replied that broadly speaking 2008 averaged about 5% less funding than 2010. That varies based on program and disease line. Some had increases in 2010 compared to 2008, some were level, and some had less funding in 2010. There is some impact because NCCDPHP Chronic played into funding for AI / AN. There is approximately 10% less funding in 2008 as compared to 2010 for the NCCDPHP lines overall. In terms of potentially operating the rest of this year at the lower level, FMO has sent target information to center office directors and management officers to assess how they would make decisions if they

had 5% less for the remainder of the year. While this may or may not occur, they want everyone to think about this possibility strategically.

- Regarding Mr. Valdo's question about how Indian Country is stacking up, Mr. Franklin said that looking at the overall allocation, he thought it would be wise to say that if performance was basically at a minimum or lower, allocations would not continue to rise. To him, that would be the logical approach. They do not have details regarding performance per disease line. He recommended communicate with their liaisons in national centers to determine this.
- Ms. Moore added that they are working on Prevention Status Report for states, and perhaps some tribal health departments. These will go to state health and other health officials. The Prevention Status Report is focused on the winnable battle areas, at least as a start. Several other key measurement items will be Healthy People 2020 indicators and how they apply to measuring health impact in tribal areas. HHS publishes an annual report about the accomplishments made with tribal funding. She agreed that they needed to have a better vision of resources and performance. The measurement systems are different at state, local, and federal levels. Therefore, it is difficult to compile information. Through TCAC, her office can help assess the measures or indicators that might be most applicable and make some recommendations in that area to be incorporated at a national level.
- Mr. Valdo emphasized that during every meeting, they discuss data with Dr. Monroe in terms of being suspect and siloed in different areas. Indian Country experiences health issues at sometimes as much as 500% higher than the general population. This is where tremendous improvements can be made value can be shown in terms of where funds are allocated. Even improvements that reduce health disparities from 600% to 300% are valuable. He is from the pueblo where they are 55 miles from the nearest urban center, so they provide a lot of services to neighboring communities. There must be a better communication process with them to show that they are helping to build infrastructure and offer access to services.
- Ms. Moore replied that two other resources would help, one of which was to get more data in one place. Sometime in the month, HHS planned to launch a Health Indicators Warehouse. This brings all of the Healthy People 2020 health indicators and CDC's classic surveillance data together in one place. This tool will permit assessment of these data by state and other variables, so it should be very useful. Component I, which the 8 tribes received, is about performance management. Best practices in these 8 tribes can help identify how to set up performance management systems for the tribal arena.
- Mr. Pietz acknowledged that making the application process more transparent is an area in which OSTLTS can help make significant process. This would have to be a joint effort that would require an understanding of what the impediments are and how a unified approach could be taken. The initial funding from PPACA last year was the first that they had done which was non-categorically based. Therefore, the Health Department Executive Officer, State Health Officer, Local Health Officer, Tribal Health Office, or Territorial Health Officer could direct that performance improvement funding from an infrastructure base versus a particular categorical disease. Barring the budget news, they hope to see more funding come forward PPACA legislation so that they can expand from the current 8. Of course, funding drives the overall numbers. If funding dries up, they will have to be creative in order not to lose the ground gained in these 8 tribes during the last 2 years. They have had the same discussion with health departments in terms of why some of them are more or less competitive. He thought they could identify the strategies necessary to make the process

less difficult, but it could not be done in just two TCAC meetings per year. It would be helpful for TCAC members to offer input about how the membership could be further engaged between meetings. This is going to require active participation, site visits, and in-depth development of a performance plan that says how the competition process can be made more egalitarian. He did not envision having to set up multiple systems for everyone to compete through their own venues. They must figure out how to encourage participation for the many.

- Ms. Moore pointed out that it was performance-based in a two-fold sense: Impact and performance as an organization. Do you have the right people. Do you have the right tools? Do you have the budget structures in place to disseminate funds and use them efficiently where they are needed. Having a performance manager will help with this, and the accreditation piece fits as well. Going through that process will enable groups to assess their organization and how they are contributing to public health impact. Raising performance and capacity can lead to being more competitive for funding announcements. The view of being more efficient and effective is holistic.
- Mr. Pietz stressed the importance of understanding how CDC does business. Those who do not understand this are already “way behind the curve” in trying to understand how to be competitive in terms of grant writing. It would be beneficial to conduct some regional training, and to educate people about how CDC is different from IHS, NIH, BIA and others in terms of how and for what funds are granted. OSTLTS has been including language in its grants requesting more cross-jurisdictional collaboration in order to break down some of the jurisdictional boundaries. Funding is not dedicated to specific groups unless it is an earmark. The program piece is to determine what the evidence supports maximized use of funds. OSTLTS is leading a lot of discussion internally to emphasize that they want a better understanding of how funding is benefitting the most constituents within a given area. There will be discussion during the ASTHO / NIHB meeting about this as well.
- Ms. Moore said that they really need to “think outside the box.” For example, health economists can help with some of it. Every health department might not need health economists, but certainly those services are needed from time-to-time. How could they partner with universities or other health departments to find a shared health economist resource?
- Mr. Pietz indicated that there are also creative ideas for which CDC can provide technical assistance. In terms of the Technical Assistance Branch of OSTLTS, PGO is taking a long step forward to provide some of the mechanisms they have for contracting that are available to health departments through their awards. They are looking to get a new process in place, although he was not sure when this would go live. This would allow tribes to contract through the Technical Assistance Branch that some health departments may not be able to get. Some health department’ legislatures, Michigan for instance, do not approve some funding so the health department never receives it. Then the legislature is “sitting on” some money that CDC would like for them to spend. CDC is trying to figure out how to help the health departments get those funds. As he understands it, in many tribes there are lot of people within the tribal governmental areas and offices that have to sign off on everything, so if there was a mechanism so that tribes could go directly to the Technical Assistance Branch, that would be of benefit to some tribes. For example, through this mechanism someone might be hired on a short-term basis for a critical need through a contract rather than hiring somebody until that infrastructure got developed and funding started.

- Mr. Valdo indicated that indirect funding always is one of their key strategy points. Regarding the increases from 2009 to 2010 and the \$11 million that is primarily intramural, tying page 7 with page 13 of Mr. Curlee's slide set, he wondered who makes these decisions. On Page 7, his guess was that cross-cutting programs, maternal child health, HIV / AIDS, public health capacity, strategic pharmacists training, health statistics, and violence prevention and unintentional injuries was that these probably align with the director's winnable battles. He presumed the \$12 million that is intramurally allocated is for full-time equivalent workers (FTEs) to manage some of these programs.
- Mr. Curlee responded that some of these activity area funds are allocated to IHS, whether it is through a grantee or a contractor. Some proportion of that that might be related to a CDC salary, but most of that is going out into other areas for management. For example, it might go to Chickasaw Advisory Services Group that would be doing some aspects of intramural support and administration. OSTLTS can probably answer this better.
- Dr. Duckworth responded that one thing they were seeing in terms of overall budget numbers was information they have received directly from the programs. They plan to tease out all of that information to better understand the specifics of how the funds are being spent, and will inform TCAC members of their findings.
- Mr. Seneca pointed out that the American Reinvestment and Recovery Act (ARRA) funds are also included in these figures, which would take additional resources to administer and may impact intramural funds as well.
- Ms. Moore added that in general, when they are deciding what to allocate and how to allocate intramural funds, it is directed toward staff needed to manage and administer programs. Some funds are kept in-house to cover the cost of meeting expenses, pay for products that are going to support the activities, et cetera. Often, it is decided on a case-by-case basis what activities will be supported in a year and what support will be needed to accomplish the activities. These decisions are made in the planning stages each year, depending on the anticipated projects.
- Mr. Secatero reported that he was recently in Washington, DC where there was nothing but bad news. He requested that this be relayed to Dr. Frieden. He has 30 tribes in New Mexico that are going to probably throw rocks at him if they go back to 2008 levels. This would be like taking one step forward and two steps back. There is TCAC at CDC, there is a Substance Abuse and Mental Health Services Administration (SAMHSA) advisory committee, there is an HIS advisory committee, there is an HHS advisory committee, and so forth. It took a long time to get these committees going. Tribes are being provided information through these committees. He wondered what would happen to this with a return to 2008 funding levels and all of the people who are providing information. Maybe Dr. Frieden could vouch for them whenever he asks for money. The increase was great and they enjoyed it for a while, but what happens if they take it back? That is his concern as a tribal leader. It looks like tribes will not do well with the cuts. His 33 health committees in New Mexico are now all gone because there is no money. He is barely staffing his clinic. Commander Alonso used to be his doctor there, but now they barely have a part-time pharmacist who they may also have to give back. He would like this relayed to Dr. Frieden as well. People send him to Atlanta to talk. He talked to Republicans in DC who told me, "Do not worry about it." It is a trust responsibility from the federal government, but he was hearing different stories. He was in DC with NIHB trying as hard as they could to get the message across. He stressed that he would like the minutes to reflect that they would like

for Dr. Frieden to bring this up with somebody in DC because they are not listening to Mr. Secatero. Perhaps they will listen to CDC. His request is that tribes receive no cuts if at all possible.

Division/Branch Update: Office for State, Tribal, Local, and Territorial Support

Division of Public Health Capacity Development

**Dan Baden, MD, Division Director
Division of Public Health Capacity Development
Office of State, Tribal, Local, and Territorial Support
Centers for Disease Control and Prevention**

Dr. Baden indicated that this was his first TCAC meeting, and that he was very excited to have this time to spend with the TCAC membership. He began his federal career in Alaska at the Alaska Native Medical Center (ANMC). There, he spent three years running the Community Health Aid Program. Following that, he went to the Health Resources and Services Administration (HRSA), and then CDC about 8 years ago where he is now in the Division of Public Health Capacity Development (DPHCD). DPHCD has housed tribal activities since this division was stood up in May 2010. It is being elevated to the OD as a direct response to a request made during the last TCAC meeting.

DPHCD is responsible for multiple activities, one of which is PHAP that Dr. Monroe briefly described earlier in the morning. One focus this year for PHAP is to try to increase tribal participation with tribal sites and Native American associates in the program. He invited those who had not received site applications to let him know so that he could make sure they received them and had the opportunity to apply to be a site to host one of the PHAPs. He noted that Lynn Gibbs-Scharf would be presenting during the second day and would tell them more about this program. The PHAP site application window would be closing in about 2 weeks, while the applicant window would be opening in the next week or so and would remain open for about 6 weeks. They are trying to encourage increased tribal participation.

DPHCD also houses the Community of Practice activities at CDC. Communities of Practice are basically groups of people with similar interests who come together on various topics. The division's role is to provide a group of skilled facilitators who are able to foster the discussion and keep it alive so that it does not dwindle off when interest wanes or when people get too busy. This is an activity that can be facilitated with tribes as well. They plan to do this with some of the tribes they support through the infrastructure program.

DPHCD is also responsible for the health officer orientations, which they conduct twice per year. Tribal health department leaders are invited to attend these orientations. As noted earlier, there is an orientation in May and there will be another in the late summer or early fall. These are 2- to 3-day sessions in which new health directors who have been in their job less than 2 years visit CDC, interact with CDC staff and each other, and try and build another community of practice.

In addition, they have been directed by Dr. Frieden to find best practices and disseminate them to health departments across the country. He invited those who knew of a health department

that is really successful at acquiring CDC funding to let them know, so that DPHCD can help to facilitate discussions between that health department and other tribal health departments. Implementing best practices across locations can help to elevate everyone.

A number of partnership agreements are also housed in DPHCD with partner associations such as ASTHO, National Association of County and City Health Officials (NACCHO), and several others. Sam Tavares is in charge of that branch. DPHCD also has cooperative agreements with NIHB and the Northwest Portland Area Indian Health Board (NPAIHB). Some funding comes directly to DPHCD, but the division really coordinates funds from across the entire agency to those organizations. They have been quite successful at continuing to raise that number. The division also houses the NPHII.

Technical Assistance Branch

**Harald Pietz, Acting Branch Chief
Technical Assistance Branch
Office of State, Tribal, Local, and Territorial Support
Centers for Disease Control and Prevention**

Mr. Pietz reported that the Technical Assistance Branch is primarily responsible for the NPHII program, which is the \$42.5 million cooperative agreement announcement that was opened for the first time ever to states, tribes, locals, and territories as a catchment area to focus on performance improvement. It was a non-categorical funding opportunity designed to help health departments improve their internal capacity and be able to make better decisions, especially with harder choices due to the economic times. This program is designed to determine where within CDC's historical granting formulas categories should be placed (e.g., HIV, smallpox, et cetera). This can be thought of as a tree. The health department is really the trunk (the core) and some of the branches (programs) can be trimmed, but the tree will survive and come back. However, if the trunk dies, all the programs die with it. This funding is to ensure that the tree trunk is healthy and is able to adapt to the change the environment place on it. While they were unable to include as many tribes as they wanted to, they did engage in discussions with individuals who had some historical perspective before writing the cooperative agreement. The ultimate intent is to add additional tribes eventually.

Another area this branch addresses are the state health officer welcome packages, which show what CDC's investment is within a given state. Within any given state, CDC may allocated several million dollars, tens of millions of dollars, hundreds of millions of dollars, but it is not understood by the health officer where that investment goes. Not all of that investment goes to the health department at the state level. Some of it may be allocated to a university, a non-governmental organization (NGO), a tribe, and / or a local health department. CDC discovered some years ago that health officers were missing opportunities to know what else CDC was funding within a given state that they could leverage and collaborate across. For example, about one-third of New York State's funding went to New York State, one-third of it went to New York City, and about one-third went to a variety of non-governmental organizations, community-based organizations, et cetera. The state health officer probably knew that New York City was receiving money, but did not know transparently how much, why, or how it was allocated. With clear information come clear opportunities for engagement. This was first done in 2008, and is continuing for all new health officers. Once this is better solidified, the branch would like to develop a tribal portfolio to show how these funds are allocated, and where intersections could link together between what tribes are receiving and what states are receiving.

This branch is also charged with conducting field services for the agency, which is defining the policy for how CDC would allocate direct assistance in terms of people in the field. One person was charged to do this, but recently retired. Therefore, they are trying to determine the future for this activity. This branch is also responsible for coordinating with the Chief of Staff's Office to arrange Dr. Frieden's site visits to health departments in terms of logistics and his agenda. Given that this is the Technical Assistance Branch, the branch is also responsible for anything else that arises that requires technical assistance. Tribal activities were a part of this branch before two heroes, Drs. Snesrud and Bryan, retired. In their absence, the branch has been learning as they go. Thankfully, they have had others to coach them along in understanding the issues. Now that the position of Senior Tribal Liaison will be elevated to Associate Director for Tribal Affairs, the branch will be working on the transition of that position to the appropriate level in order to ensure that the programmatic activities remain in the branch and the right activities move forward with the position.

The branch was approached by the Association of Public Health Laboratories (APHL), which is like an ASTHO or NACCHO, and they are very interested in understanding what the current laboratory capacity is amongst tribal health departments and how they can provide technical assistance. Several individuals in the branch are working to link with the appropriate contacts to determine basic capacity and services for laboratories within a tribal health department or clinic. They will likely have to conduct an initial assessment to understand the services, and to develop a set standard based on culturally identifiable issues, what the winnable battles support, et cetera. That would be another activity the branch would engage with in terms of supporting technical assistance requests.

Discussion Points

- Ms. Hughes asked how much of this information appears on the website.
- Mr. Pietz responded that not enough of this information appears on the tribal website. The branch is transitioning that information from Office of Minority Health (OMH), and has been a little slow in getting that transferred. Some basic information is included in the tribal site at this point. He invited input about what additional information would be useful to include.
- Ms. Hughes suggested that the best practices mentioned by Dr. Baden would be of interest to tribes because it offers them ideas about what is working elsewhere that others might be able to do as well. She also suggested including information about the collaborative agreements to give them an idea of the possibilities.
- Dr. Baden indicated that there is a link from their website directly to the *Community Guide*, which is perceived in multiple venues as the gold standard for determining best practices. A great deal of work has gone into that effort. Also included are links to NACCHO and some other external websites to their best practice activities. They do intend to identify other non-*Community Guide* best practices to make those more widely available. They are now focusing on how to best get the word out about all of these efforts. The *Community Guide* has been in place for years, but many people have never heard of it and few have successfully implemented the best practices in the guide. Representatives from the Office of Surveillance, Epidemiology, and Laboratory Services (OSELs), which has responsibility for the *Community Guide*, are working with the branch to determine to get the *Community Guide* implemented across the country. With regard to the cooperative agreements, some information is included on each of the 8 tribes that received funding (e.g., funding amounts

and activities). The branch is working to increase the amount of information available on all of those. This information is also available on all the rest of the 67 grantees.

- Ms. Hughes said she knew that there was a lot of information about tribes, but even as a TCAC member, she found it challenging to know where to go on the website. They have only recently been added to the listserv for the alerts that are distributed.
- Dr. Baden agreed that they need to do a much better job of organizing the website in general. They also see themselves eventually as being the one-stop shop for health departments (tribal, state, local, or territorial) where everyone can go to one main website to find best practices, funding announcements, et cetera. This needs work and they are happy to receive input on this.

Research and Evaluation Branch

**Dr. Tim Van Wave, Acting Branch Chief
Research and Evaluation Branch
Office of State, Tribal, Local, and Territorial Support
Centers for Disease Control and Prevention**

Dr. Van Wave indicated that while the Research and Evaluation Branch has numerous projects underway, he wanted to highlight one that he thought would be of the most interest to this group. He has been working with PGO for the last 9 months on a project Grants and Program Support (GPS). This project started with a letter from ASTHO which suggested 22 areas that they thought CDC could improve upon to make the exchange of information and funding between CDC and awardees friendlier, less painful, and more efficient. He said he understood this because before coming to work at CDC, he worked in state public health for 12 years and county public health for 13 years. Thus, he was a beneficiary or a victim of those transactions depending upon one's perspective. Since coming to CDC and working with this project, PGO has demonstrated true interest in making improvements.

This process began last June with the selection 5 of the business processes that ASTHO suggested CDC improve in order to clarify and improve the transparency of PGO's processes. The system is very confusing in that project officers sometimes give different responses to the same questions, and some of the manuals or information on the website may not be clearly understandable. For those on the inside, the process may look clear. However, for those on the outside, it is not so clear. Another suggestion was to make it very apparent or what key signoffs are required during the PGO process, and to develop a timeline so that applicants and awardees know where their grant is in the review process and where interaction is needed between the awardees and PGO.

Efforts are also being made to improve the perception that budget cuts are masked with integrating budgets. Three or four categorical programs may be rolled together into one funding pot, but then sometimes the funding is lower. There is a perception that it is a budget cut when it is really not. Another suggestion was to initiate an appeals process for state challenges regarding PGO decisions that may not be perceived as being in a state's best interest. Another suggestion was made to convene internal focus groups comprised of PGO project officers, grants management officers, and fiscal management officers to deliberate what awardees could do to help the process. There are two sides to the equation after all.

So far, the project is progressing well in terms of the 5 suggestions selected. To Dr. Van Wave's knowledge, no input was received from tribes as this came from ASTHO. He invited

tribes to offer input into the next 5 suggestions that they planned to begin addressing in about March or April 2011.

Discussion Points

- Ms. Hughes indicated that TCAC had actually offered input to PGO about improving the process, especially in terms of making it simpler for tribes. PGO has presented during a couple of TCAC meetings, and each time, TCAC members have offered input. PGO's process is not the only one that needs attention. Any system review that affects activities outside of CDC is typically thought of in terms of states; however, tribes are usually affected as well. TCAC is the body which could provide useful input, and this would likely be simpler than trying to seek feedback from individual tribes. She suggested conducting an initial review with TCAC to speed the effort along. In previous discussions with PGO, TCAC members have recommended that they understand the competitive process, but believe that there should be set asides or direct access to funding for tribes. They also suggested seeking more proposal reviewers who have some experience or background with AI / AN issues. This would afford tribes better opportunities in the competitive funding process.
- Dr. Van Wave indicated that they could make TCAC review a first step in obtaining feedback. He requested information about what mechanism the members would like to use for the review process.
- Ms. Hughes replied that TCAC convenes two in-person meetings each year, several teleconferences, and sometimes use email for consensus.

Technical Assistance Branch

Melanie Duckworth, PhD, Senior Tribal Liaison (Acting)
Technical Assistance Branch
Office of State, Tribal, Local, and Territorial Support
Centers for Disease Control and Prevention

Dr. Duckworth presented further information about the NPHII program and the grantees receiving that award. This is a very exciting time for CDC and the grantees to be able to highlight this issue of performance improvement. She referred TCAC members to their binders for additional information about the initiatives in general to better understand what CDC wants to accomplish. As mentioned earlier, the funding includes two components. Component I basically focuses on hiring a full-time Performance Improvement Manager. All of the grantees received funding for this component. One tribal grantee, Cherokee Nation, received funding for Components I and II. As noted earlier, the 8 tribal grantees include the Alaska Native Tribal Health Consortium, Cherokee Nation, Gila River Indian Community, Mille Lacs Band of Ojibwe, Montana-Wyoming Tribal Leaders Council, Navajo Nation Tribal Government, Northwest Portland Area Indian Health Board, and Southeast Alaska Regional Health Consortium.

Most of the grantees are currently working to get their Performance Improvement Manager on board. This process should be complete within a month or so. The grantees are also working to identify their technical assistance needs. OSTLTS has partners assisting in this area. Once the technical assistance plans are submitted, they will have a better sense of how CDC is going to provide technical assistance. There are many cross-cutting issues across many of the grantees (e.g., training staff, increasing the public health workforce, accreditation, relationships / improved relationships with state and local health departments, et cetera).

In terms of what grantees are proposing, the Alaska Native Tribal Health Consortium's plan is to develop a Performance Improvement Office to be led by the Performance Improvement Manager. They felt that would help them to focus full-time on performance improvements. Cherokee Nation will focus on workforce development within their funding Component II, which is in excess of \$1.6 million. They also will focus on public health law and policy. The plan is to develop and fully implement a public health code. In addition, they would like to focus on health information technology. Gila River Indian Community has several systems in place that are working as silos, so they plan to consolidate those systems into one system to improve performance. Mille Lacs Band of Ojibwe's focus is on training in terms of performance improvement. They also want to strengthen systems, particularly those focused on chronic disease. The Montana / Wyoming Tribal Leaders Council will focus on accreditation, and will develop an accreditation resource guide. By the end of this cooperative agreement, they would like to have one of the tribal health centers prepared to go through the accreditation process. The Southeast Alaska Regional Health Consortium currently has a Quality Improvement Office, and they plan to transition this to be a Performance Improvement Office. The Northwest Portland Area Indian Health Board has already hired their Performance Improvement Manager, and plan to first ensure that this individual is fully knowledgeable about the accreditation standards and measures. They also plan to conduct training, primarily focused on quality improvement for tribal health systems. They hope to enlist some natural partners, who for them are the State of Oregon, the State of Washington, and the Northwest Center for Public Health Practice (NWCPHP). NWCPHP is in the process of establishing a public health management tract, which should entail some form of performance improvement curriculum as well. The hope is to bring tribes up to speed on the quality improvement (QI) process.

In terms of next steps, the current focus is communications. The TCAC's recommendations pertaining to communications can be applied to this cooperative agreement as well. On the OSTLTS website, information is provided on the initiative with regard to who received awards, the award amounts, and a brief description of each grantee's plans. Much of the information will be duplicated in the tribal portion of the website so that people do not have to search several locations to find it. There is on-going communication with all grantees, and they are working to determine the best means of communication and how frequently they would like to communicate. There will be calls for all grantees, but there will also be separate monthly calls for the tribal grantees as well in order have a better sense of the issues, how to share general information, how to share lessons learned, et cetera so that all tribal partners will be aware of the progress of this initiative.

Division of Public Health Performance Improvement

**Craig Thomas, PhD, Division Director
Division of Public Health Performance Improvement
Office of State, Tribal, Local, and Territorial Support
Centers for Disease Control and Prevention**

Dr. Thomas indicated that he was new to OSTLTS having been in the job approximately 3 to 4 months. He explained that the Accreditation Program is part of the portfolio of the division, as is the GPS program. He understood from Dr. Van Wave that TCAC members would appreciate an opportunity to review and provide input on any recommendations pertaining to the GPS program before they go forward. Dr. Thomas assured TCAC members that the recommendations would be provided to them as the review process continued to move forward. He emphasized that the work underway was merely the beginning, and that there are likely

more grants and procurement initiatives that could address and support state, tribal, local, and territorial health departments. In addition, the Division of Public Health Performance Improvement supports a number of the NPHII activities. More specifically, the Performance Improvement Network resides in this division. This initiative crosses all of OSTLTS, so the division will be working closely to support the funded tribes as they develop the Performance Improvement Network.

The major task with which this division was recently charged is to conduct an assessment of project officers. This falls under the broader category of health systems improvement, and is intended to assess how CDC can improve the way it provides support to state, tribal, local, and territorial health departments. This assessment is obviously not new to CDC. Project officer improvement has long been recognized as very important to the success of the public health system. This is certainly an area for which they would appreciate significant input as the process moves forward. Clearly, they will seek feedback from TCAC members as they kick off this project. The division realizes that they need a better understanding of barriers to working with project officers in various programs across the agency.

In conclusion, Dr. Thomas indicated that he would have an opportunity to provide further information during the second day of the meeting.

Discussion Points

- Mr. Valdo supported having a measurement tool available, but emphasized the importance of being sensitive to the unique tribal issues. Many of the problems did not happen overnight and they are not going to be fixed with the flick of a light switch. He stressed that input must be sought from tribes in advance to come to a common understanding about measurement and accountability. They should know in advance what they are going to be measured against. Measures are often imposed rather than co-created. There is a requirement for a Public Health Director to have a Bachelor's Degree or higher, but tribes are asking for an Associate's Degree level because the further away from an urban center, the fewer the number of candidates. They have been trying to hire an Acoma Health Director for the last two years, and they have not received 30,000 applications. One reason is because they are 50 miles away from the nearest urban center, and there is no place for the person to live when they work for Acoma, so they are probably going to lose money traveling back and forth. It is just rural America, so it is just a different situation. It is much worse for Alaska. TCAC can provide information, and they must work together to make performance and process improvements?
- Dr. Thomas indicated that he would raise this issue again the next day during the voluntary national accreditation program discussion. They have done some beta testing, through which they learned a number of lessons from working with some of the tribes. Clearly, they must understand the context in which measurement is done, and the unique features of the tribes need to be taken into consideration.
- Mr. Nez emphasized that another priority is direct funding, and the experience with the H1N1 response. As the Coordinator for the Navajo Nation, funded through the state of Arizona, their funding limited any activities outside of the state. When vaccines became available, the vendors indicated that they could only deliver an entity's state. Resources are largely drawn out under the state's emergency plan, which fragments his plan. This causes him to have to send resources in three different directions. It is no longer his plan because

everything shifts to state plans. With direct funding, he would have some flexibility to maintain the whole tribal nation according to his plans.

- Dr. Thomas noted that he just came from the preparedness setting, and one of the greatest challenges faced is allocating funding. With H1N1, CDC disseminated funds to the states. Getting funds to the local level was the bigger challenge. This is an important area to address, and they are calling it “budget preparedness.” This is certainly not unique to tribes. It is a local health issue as well.

CDC/ATSDR Tribal Consultation Policy

Nakki Price, Policy Lead
Kimberly W. Cantrell, Tribal Liaison
Technical Assistance Branch
Office of State, Tribal, Local, and Territorial Support
Centers for Disease Control and Prevention

Dean Seneca, MPH
Partner Services Branch
Office of State, Tribal, Local, and Territorial Support
Centers for Disease Control and Prevention

Ms. Price indicated that the current tribal consultation policy under which CDC is operating has expired. It is the Technical Assistance Branch’s job over the next few months to revise this policy. From the branch’s point of view, this is an opportunity to reevaluate and perhaps restructure or reconfigure their relationship together. One of CDC’s main goals, according to HHS, is to consult with tribes appropriately and to the fullest extent of the law as it relates to the work done at CDC. Given the somewhat stringent timeframe for the process, and because the current policy has expired, the hope was to develop a product that could be presented during the next in-person TACAC meeting. This would require everyone’s assistance. She noted that the TCAC members were provided with a copy of the existing policy in their binders. An important goal is to ensure that the CDC tribal consultation policy does not supersede anything that is already in place.

Mr. Seneca agreed that expiration of the policy offered a good opportunity to improve CDC’s tribal consultation activities. They wanted to hear from TCAC members regarding potential improvements. Many CDC staff members believe there are infrastructure aspects upon which they could improve, or that need to be developed, in order to enhance tribal consultation activities. For example, the theme of improving communications had arisen repeatedly in terms of being better able work together. They had some discussion about possibly forming a workgroup that would be comprised of CDC and TCAC members to help move the process forward, and ensure that there is mutual understanding and agreement about the content of the consultation policy. There is universal commitment from OSTLTS to complete this product.

Ms. Cantrell added that HHS has recently revised its tribal policy. CDC has the opportunity to adopt the HHS policy the way it stands or to review it along with the CDC tribal consultation policy to make it unique to CDC and tribes. She stressed that this session offered an opportunity to engage in open discussion about the current policy, the new HHS tribal consultation policy, and / or the policy development process. They must cross-walk the CDC

policy with the HHS policy. They would like to involve TCAC members in the process, but the CDC policy will still have to go through the vetting process with the *Federal Registry* before it becomes a policy.

Discussion Points

- Ms. Hughes indicated that many of them had received a copy of the new HHS consultation policy. She thought it would be a good idea to incorporate segments of the HHS policy, but to include specifics to CDC and tribes. It is important for CDC to recognize the need to speak to individual tribal representatives. TCAC does not replace that component. While TCAC members try to assist CDC in getting information to AIs / ANs border to border, that is their only role. Talking to TCAC cannot be considered consultation with tribes.
- Ms. Moore clarified that Ms. Hughes was referring to the wider view of consultations through CDC's work, not just the policy itself. OSTLTS, across the board, has a mandate to raise its level of technical assistance to people on the ground working in health departments. That ranges from what is accessible now, such as the Public Health Law Program.
- Ms. Hughes indicated that tribes are invited to many consultation sessions, and are pleased to have the opportunities to provide input or exchange in discussions. Most of these occur once or twice a year. However, consultation should be occurring whenever a significant change or an improvement is needed. It should not be just once or twice a year in a formal environment. For example, they could reach out to tribes for input anytime with respect to the granting process.
- Mr. Seneca agreed that TCAC does not substitute for formal tribal consultation. TCAC is to advise the agency on how to consult with tribes on a government-to-government basis. There does seem to be a lot of confusion about the difference between the TCAC meeting and the tribal consultation meeting, and they will work to clarify that. He also agreed that formal consultation did not have to occur only twice a year. He thought any program needing input should be able to convene a consultation session.
- Ms. Moore suggested that they should probably consolidate a summary of all of the two-way communication opportunities available through OSTLTS, such as the new *Vital Signs* webinars. These are held once a month and are open to anybody who wants to sign into them. The purpose is peer-to-peer sharing among health department staff and CDC staff to learn from each other. This is a best practices intersection. The focus thus far has been primarily the winnable battles. This is a more informal sharing opportunity.
- Mr. Nez recognized that various US Presidents over the years have issued consultation policies through Executive Orders. He wondered whether these policies were actually enhancing the relations, and if any enhancements had been made to that end.
- Mr. Seneca responded that this marks the first time CDC is making a change in its policy, which was initially adopted in 2005. CDC's goal is to enhance collaboration and increase communication with tribes versus merely having a policy on the books. They would like it to be a workable product that will open up dialogue and open the agency to working on and addressing tribal health issues.
- Ms. Price added that the Executive Orders are developed to require the government to have special government-to-government relationships. This is constitutional, so her opinion is

that the Executive Orders are to remind them that they must develop a policy to consult with tribes. To her knowledge, there have not been any evaluation studies to assess whether these policies have resulted in change. Only those who participate in the process in terms of policy development and exercising those policies through forums such as this, can really determine whether the policy has been successful for them. This is an opportunity to revise CDC's policy to rectify anything that is not working. The process will involve CDC staff, perhaps HHS representatives, partner agencies that have a stake in tribal activities, et cetera. They are opening the opportunity for everyone to be involved, but she really would like TCAC members to be instrumental in the process because only they actually know what is occurring on the ground. The plan will be moot if it is not operationalized.

- Ms. Moore added that OSTLTS, as an office, is going to be engaged in strategic planning and will have performance measurements around its tribal activities to determine how the office is helping tribes build capacity and perform better. The office would like tribal input on that as well.
- Ms. Hughes noted that there is a small section in the CDC policy about providing timely feedback. She stressed that effectiveness of the consultation process is an issue with several agencies where policies in place and consultation has been occurring for quite some time. It is important for tribes to receive feedback regarding whether suggestions made through the consultation process went anywhere. Very specific recommendations are made about changes tribes believe are necessary. Clearly, some of these have to be legislative and cannot really be handled through that process. However, it is challenging on the tribes' end to determine what is being done with their recommendations. If it cannot be done, they would appreciate being told this. They simply do not receive the feedback that they should.
- Mr. Pietz reported that he had worked with Dr. Snesrud previously on some of the recommendation responses. There was a tendency to wait until everything was completed, but perhaps they need to consider a process for conveying interim information. Waiting for every issue to be addressed delays the entire process and the communications. Perhaps some effort needs to be made to prioritize issues into short-, medium-, and long-term and to plan responses accordingly. This takes a significant amount of resources and work. The hope is to be able to build upon the work done by Dr. Snesrud to move forward.
- Ms. Hughes indicated that for HHS Region 5, they conduct the regional consultation and then a workgroup is established to review the priority suggestions. To minimize costs, much of the work is done through conference calls. The workgroup attempts to help the agency determine what can be feasibly done and what cannot, so that they can get information back to all of the participants to show what was discussed and explain the next steps.
- Mr. Pietz emphasized that they do not want to add undue work on anyone, but they also do not want to bake a cake and give it to TCAC members. They want TCAC members to add to the ingredients and bake it with them. The goal is to bake a cake so that it is tasty for everybody.
- Dr. Duckworth agreed that it would be beneficial to provide progress reports on the recommendations. She wondered what the best method of communication would be for that for the entire TCAC membership. Sometimes a request is made by a particular individual and they have gotten back to the individual rather than everyone. The office can do more in terms of wider communication efforts.

- Ms. Price request input on TCAC members' perception of the tribal consultation process, and what that meant to them. In part, that will drive how they move forward in terms of modifying the CDC consultation policy.
- Ms. Hughes said her perception of the sessions she had attended with CDC was that the conversation was one-way. It is a listening session for CDC, but it is not clear if / how the testimony is acted upon. There needs to be a two-way exchange. Someone from the agency needs to respond to the testimony, which does not always occur during CDC consultation sessions. During the last TCAC Consultation Session, there was a point at which tribal leaders were giving testimony only to TCAC members because there was not a single CDC staff person in the room. However, that is not TCAC's role during the consultation process. TCAC members are observers like everybody else. When she attends an HHS Tribal Consultation, she is there as a tribal leader and expects to be able to say whatever she wishes to Secretary Sebelius or her designee. Typically, immediate feedback is provided even if only to indicate who will be responsible for following up on a particular issue. There is a two-way exchange.
- Ms. Moore suggested that to make the meetings more effective, they could poll attendees ahead of time about concerns, problems, and issues they want to discuss. That way, CDC can make sure that the right agency representatives are present and have put some thought into the issues.
- Mr. Finkbonner like the suggestion, but emphasized that tribal leaders may show up with other issues and what they want to talk about may not fit the priority issues determined prior to the meeting. In addition to having the right people in the room for the priority issues, it is important to be able to address other issues also and there should be a follow-up mechanism in case the right folks are not in the room. He has heard from some tribal leaders that they are sometimes not sure whether a session is an official consultation. In the room right then were elected leaders, subject matter experts, and CDC leadership, but it was not an official consultation session. Someone in the room should indicate when an official consultation session begins, and how follow-up will be handled. This would clarify misperceptions on both sides.
- Ms. Price wondered about reaching out to the whole group. With over 500 federally recognized tribes, it was not clear who they should reach out to. As far as TCAC policy, there is regional representation as well as representation from interested groups. To her it seemed that as CDC's primary consultation group, she would think TCAC as a whole would be a mechanism to assist in disseminating information. They would consider a meeting to be a consultation is if the diabetes program went to talk to its grantees about the Eagle Books and future direction. She would consider that to be informal consultation between a program and a specific tribe or group of tribes. She would consider consultation with the agency as a whole on agency priorities, agency initiatives, and the relationship with tribes to be formal consultation. She requested clarification on what TCAC members consider to be formal and informal consultation.
- Mr. Finkbonner thought TCAC could certainly facilitate information dissemination. There are also area health boards, NIHB, NCAI, and other partners who can contribute to information dissemination as well. This would include getting the word out when there is going to be a formal consultation session with CDC for which the agency wants tribal input. In terms of formal and informal, from my perspective policy implications are a different level of consultation than programmatic issues. For example, vaccine distribution directly to tribes

would constitute a policy change because CDC currently distributes vaccine to states, each of which has its own distribution mechanism. It seems that a potential policy shift to address public health issues should include consultation from tribes in terms of how changes would impact their health programs in their communities.

- Ms. Hughes indicated that for the last HHS consultation, she receives notification from 5 different sources, each of which sent her notification at least 3 times. National organizations should be approached to use their listservs to disseminate information about formal consultations. They have listings for the 565 federally recognized tribes. For TCAC per se, there are two formal consultation sessions per year on a separate day from the TCAC sessions. One is in Atlanta and the other is in Indian Country.
- Mr. Nez stressed that there appeared to be a gap even though tribal decision makers attended, brought issues forth, and presented recommendations to CDC's technical team. Given the apparent backlog, he suggested standing up a TCAC office so that a TCAC representative would always be present within OSTLTS working with CDC staff members to ensure that the issues continued to be addressed. Perhaps constant TCAC presence would improve communications, help address issues, and ensure that regular progress reports were prepared and distributed.
- Ms. Price responded that CDC has legislative authority to do engage in certain activities, but may not have authority to act on others. All of CDC's programs have some component that addresses tribes and American Indian issues. The point of the newly formed tribal team within OSTLTS is to bring more attention to those efforts. They also recognize that resources are limited, and that there is a need for states and locals to work together with tribes. They are aware that some of those relationships are very complicated, some do not exist, and some may be very contentious. One of their roles is to assist with that. While Mr. Nez's suggestion may be feasible, it was not clear to her whether TCAC represents tribes across the board. TCAC is a vehicle just like the national organizations. OSTLTS has a team that is dedicated to work with TCAC already. The national organizations are also resources. CDC has the conundrum of determining which voices actually represent the majority, since it is unlikely that someone from every federally recognized tribe would be able to attend even if invited.
- Mr. Pietz added that the Associate Director for Tribal Affairs would be the surrogate link to TCAC. That did not preclude them from having more visits, more discussions, rotations, et cetera to facilitate this type of discussion. He liked that concept of Mr. Nez's suggestion, but thought that they needed to have more facilitated discussion around that issue, and make sure that it was raised as a motion before the full TCAC.
- Ms. McKinley said she was an example of the lack of communication. She was nominated to TCAC last year. When first nominated, she was given all of the information and attended the meeting in Montana. However, following the transition, she longer received notification of anything. By the time she found out that TCAC was convening this meeting, it was very difficult to make contact with somebody at CDC who knew what TCAC was. She looked on the website and called the main number. Finally, she emailed someone who put her in contact with Dr. Duckworth. Now she was hearing that there is a team dedicated to work with TCAC, but she had no idea who was on the team. That is part of communicating to TCAC members. There are no updated emails. Their representative from the Phoenix area was not receiving notification even though she sent in her new email address. When Ms. McKinley was finally received a response and was included on the email, she emailed back

and received many emails that were no longer valid. Right then I knew that these people were not getting notification and did not know anything about what was going on. CDC emails and website information is not being kept up to date. That is the first breakdown. Her organization, the Inter Tribal Council of Arizona, works with all the tribes in Arizona. They also have a program that works with the tribes from Utah, Nevada, and Arizona that she is in. The Inter Tribal council meets with all tribes in those areas to understand their health issues, policy issues, et cetera. They also try to get them to attend and speak at federal advisory committee meetings held in those areas. The Inter Tribal Council can also speak these tribes because they have received their input. The Northwest Portland Area also represents a number of tribes, so they have the authority to speak on behalf of those tribes as well. There are numerous similar organizations that have the authority to speak on behalf of tribes in their areas. This includes NIHB. Therefore, it is not necessary to have every single tribe travel to Atlanta.

- Mr. Pietz clarified that the team was just recently formed.
- Ms. Price responded that frankly, the same thing happened to OSTLTS staff when they wanted to send out group emails. Many of them bounced back and they had to look up people, only to find that many were no longer in particular positions. They do count on TCAC members to update the agency with their current information. They also must understand that when transitions occur at CDC, things get lost in the shuffle. When Dr. Snesrud retired, there was a very short transition period. Tribal issues cannot be transitioned over the course of two to three weeks. Several months are needed because there are a lot of issues, topics, and idiosyncratic things that occur that do not occur across the board. OSTLTS staff members understand because it happens to them. One their jobs over the next few months will be to figure out the details. They are not going to get it right every time. If TCAC members know others who are not receiving information, they should ask them forward their information to the office. There is an email box for tribes. This is being redesigned, but there will be a link for the tribal mailbox. OSTLTS staff is working together to develop a website that will be useful to TCAC members. She invited input about what TCAC members would like to see in the site that would be useful to them. They are talking about this behind the scenes in terms of how to make everything accessible to tribes, locals, and states because they firmly believe everyone should be able to see the same information. She asked them to bear with the staff members for a little longer while they get this straightened. They cannot do it overnight, but they do understand the issues because again, the same thing happened to them in regard to this meeting. They were working with a group they had never worked with before and did not know who was supposed to be there or how to find them. They are working to address that.
- Mr. Seneca added that CDC and OSTLTS are committed to laying a lot of groundwork among the CDC centers about the consultation policy and TCAC to let them know that this is a formal mechanism to help them reach out to Indian Country. His office will take a firm role in redrafting the consultation policy, and they want to improve that policy. He apologized for any late notices related to this meeting. While the team is new, he emphasized that they were not trying to make excuses to Indian people, and they will work to make things better.
- Mr. Pietz pointed out that while the team was new, now that the decision had been made to elevate the Associate Director for Tribal Affairs position to the OSTLTS OD office, the new team would be comprised of a mix and reallocation of the old team moving forward. As Dr. Monroe mentioned earlier, there will be 4 to 5 FTEs assigned to the Associate Director for

Tribal Affairs. Those currently engaged in tribal activities within the Technical Assistance Branch will remain, such as Dr. Duckworth, Ms. Cantrell, Ms. Moore (on detail with then), and Ms. Price. Ms. Price provides services to everybody, so she is not 100% dedicated to tribal activities. She is a policy lead and works across a number of state, tribal, local, and territorial issues. Dean Seneca actually belongs to another branch, but they are negotiating some of his time to help them on their current work. There will still be some changes once the new position is filled and some of the other acting positions are filled on a permanent basis. As the Acting Branch Chief, he said he understand TCAC members' frustration and apologized for not having communications in order. Under development is the new CDC Organizational Resource Directory (CORD) to assist health officials in access the proper contacts within CDC. Though not yet live, Dr. Frieden charged them to develop this. Steps are being taken to improve CDC's transparency and responsiveness to the entire public health community. They would also like to make the tribal website more meaningful for particular tribal issues, to include a calendar of events, and so forth.

- Ms. Moore indicated that new communications efforts feed into this as well. The first thing they need to do is take the communications issues back to their Communications Director. Their Communications Director has also been charged to develop some type of partner portal to include all technical assistance and direct partner information, calendars, links to meetings, link to the CORD, et cetera. Some areas in the portal will be password-protected for more sensitive communications.
- Ms. Allison asked what had been done internally to ensure that the correct contacts are listed within the CDC directory. Understandably, there has been a transition and loss of institutional knowledge.
- Mr. Pietz replied that his understanding is that information will be included in the CORD with respect to positions, but someone can also be searched by their name. He indicated that he would also take the communications issues and concerns discussed during this session to the lead for the CORD activities.
- Mr. Secatero expressed frustration. It was like the Veteran's Administration at Albuquerque that switches a caller to line A, and then someone else switches the caller somewhere else. After being transferred about 6 times, the caller is then returned to the main line where they began. He like Mr. Nez's idea about having a TCAC office within OSTLTS.
- Mr. Nez emphasized the importance of improving TCAC's relationship with CDC. At the end of the week, the TCAC members would return to their daily responsibilities, as would CDC staff members. Someone placed on the inside could continue to work on recommendations with subject matter experts and other staff members. He suggested that for the next meeting, they should completely outline a TCAC office to be placed inside the organization, along with the intent and responsibilities of that office.
- Dr. Duckworth reminded everyone that additional staff are providing support to tribal activities within OSTLTS. For example, Dr. Ortega is the Project Officer for NPHII and Craig Wilkins is an advisor to the team and he is also providing some support. Internal CDC communication is being assessed. They are aware that they need to determine who within the agency is working on tribal activities. Due to the re-organization, individuals have moved and now are a part of different programs. She thought that through the coalition and the workgroup, they could get some traction in terms of identifying where those individuals are.

- Returning to the issue of the policy revision, Ms. Hughes suggested that TCAC members forward their comments to Ms. Cantrell. It was agreed that this should be done by February 14, 2011.
- Ms. Price indicated that while TCAC members were reviewing the document, CDC staff would continue to consult with colleagues throughout CDC who are working on tribal activities to acquire their feedback as well. The goal is to work aggressively in order to have the product ready by the next in-person TCAC meeting. The revised policy would have to be published in the *Federal Registrar* for comment, and they would have to respond to any comments received. The target day to clear the product through CDC and HHS is October 2011, keeping in mind that the reality of the clearance process is typically long. The document must be vetted through CDC, the Office of the General Counsel (OGC), and the Intergovernmental Affairs (IGA) that will have the final sign-off on. It is likely to take approximately 2 to 3 months to get the revised policy through the entire process.

TCAC Housekeeping Issues

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

Ms. Hughes indicated that the first housekeeping issue pertained to vacancies. Going through the roster in the binder, it appeared that there are only designated alternates for certain areas. For Aberdeen, Albuquerque, Bemidji, Navajo Nation, Tucson, and NIHB there is a delegate in each area, but no alternate named. For Bemidji, Greg Miller was appointed. He is the Vice Chairman for Stockbridge Munsee. Ms. Hughes will provide written notification about his appointment. Albuquerque has also named an alternate named, which Mr. Secatero will submit.

Another housekeeping item regarded election of TCAC Co-Chairs, Chester Antone, was unable to attend this TCAC meeting due to health issues, but hopefully he will want to continue as a Co-Chair. Ms. Hughes indicated that she would prefer not to continue to be a Co-Chair after her term ends in July 2011. She is Vice-Chair for the Oneida Tribe, but does not plan to run for another term as the Vice-Chair. She still has a couple of months to decide whether she may run for one of the other positions. Since she does not plan to run for Vice Chair, she thought it was best not to run for the TCAC Co-Chair position again.

The final order of business during this session was to determine a date, location, and host for the next in-person TCAC meeting. Previously, there was discussion about California and the possibility of United South & Eastern Tribes (USET) hosting the meeting in the Eastern Region. However, USET is unable to host a meeting in July. Also suggested was that USET host a meeting in Buffalo; however, summer is the peak season for Niagara Falls and sufficient space was an issue.

Discussion Points

- Mr. Nez reported that the Navajo Nation recently engaged in an election process, and now has a new President and Vice President. The council originally had 88 members, but the people voted through a referendum to reduce the council to 24 members. That was a long, legal, political battle. This was followed by the election. Jerry Freddie, Evelyn Acothley,

Davis Filfred, and Alice W. Benally were not re-elected. His understanding before traveling to the TCAC meeting was that they submitted names to serve on TCAC. The primary representative will be the new Vice President, Rex Lee Jim. The alternate is going to be Robert Nakai, who is the appointed Health Director for Navajo Nation, and who Mr. Nez was representing during this TCAC meeting.

- Ms. Neilson offered for the Northwest Portland Area Indian Health Board to host the summer meeting. She agreed to conduct some research to determine availability of space.
- Mr. Finkbonner offered to check dates and optional sites as well. He pointed out that the end of July, the proposed date, is the conclusion of the Canoe Journey. This is a major event in the Northwest, so the end of July may not be possible in terms of hotel space.
- Dr. Duckworth requested a list of those who planned to attend the ASTHO / NIHB meeting on Friday. Ms. Hughes, Ms. Reft, and Ms. Abramson indicated that they would be attending and that they had registered through ASTHO.

Motion

Upon the determination being made by roll call that there was a quorum, Mr. Nez made a motion to table the election of TCAC Co-Chairs until the next in-person meeting. Ms. Reft seconded the motion, which carried unanimously.

With no further comments, questions, or business posed, Mr. Secatero offered the closing prayer and the meeting was officially recessed until 8:30 AM EST the next day.

Wednesday, February 2, 2011

Welcome and Opening Prayer

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

Ms. Hughes called the second day of the TCAC meeting to order, and Mr. Secatero offered the morning prayer.

Briefing of CDC/ATSDR Opportunities

Public Health Associate Program (PHAP)

**Lynn Gibbs-Scharf, MPH, Branch Chief
Knowledge Management Branch
Office for State Tribal, Local and Territorial Health
Centers for Disease Control and Prevention**

Ms. Gibbs-Scharf explained that the purpose of PHAP is to prepare entry level staff for public health careers. This is an opportunity to place individuals on the front lines of public health in state and local health departments through their fellowship with CDC. The program is a partnership between CDC and the host site (e.g., state, tribal, local, or territorial agency). All public health agencies are eligible to apply for an associate. This is a partnership because the individuals are hired as CDC employees, but placed in the field for their entire 2-year fellowship experience, so training is a shared responsibility. CDC provides core training and the host site provides specific training that relates to the duties required by their assignment.

The PHAP program began in 2007 as a pilot program. There were 10 associates, all of whom were in the State of Florida. In 2008, there were 27 associates in 5 states. During the pilot years, this was a 3-year program. In 2009, there was not a class as this was a transitional year when the program was soon to become a nationwide program rather than a pilot program. The program was also transitioned from a 3-year to a 2-year program. The class of 2010 is comprised of 65 associates who joined the class of 2008. There are 83 associates currently placed in the field in 23 states, 1 territory, and the District of Columbia. The locations are largely bi-coastal, so CDC would like to fill the gaps in the middle of the country with the class of 2011.

The associates are US citizens with Bachelor's Degrees who have minimum to no prior public health work experience, and who are willing to relocate. The host sites arrange two 1-year assignments, supervise the day-to-day work of the apprentice, provide relevant on-the-job training, and provide suitable worksite equipment. A CDC supervisor works in collaboration with the host site supervisor, but the associates are really somewhat indistinguishable from their state, tribal, local, and territorial colleagues. They are doing the same kind of work that everybody else in the health department is doing.

The goal for 2011 is to hire 50 new associates who will join the class of 65 who are already placed. This map shows a visual of the program's growth over the years, starting with the initial pilot year in 2007 when apprentices were assigned only to county health departments in Florida,

until today when there are apprentices located throughout 23 states, 1 territory and the District of Columbia as noted:



Although not limited to these areas, associates typically work in the following 8 program areas: sexually transmitted diseases (STDs), tuberculosis (TB), and / or human immune deficiency (HIV); other communicable diseases; chronic disease; environmental health; public health preparedness; global migration and quarantine; immunization; or injury prevention. There were many questions this year about where obesity prevention and breastfeeding and lactation support fit. The activities associates typically engage in include patient / client interaction; case investigation; contact tracing; basic data collection, analysis, and reporting; surveillance activities; education; provision of services; community involvement; and liaison with public / private providers and partners.

Ms. Gibbs-Scharf shared the stories of a couple of apprentices. Tiffany Huang is in Lansing, Michigan. She is the Healthy Homes University Program Specialist who works specifically with asthma prevention by performing in-home interventions and investigating environmental triggers. She conducts all of the 6-month follow-up visits, which either means she is conducting surveys with the healthy home participants / beneficiaries or she is inspecting their homes to ensure quality improvements. Kimberly Seals is in Galveston County, Texas. Her job title is Epidemiology Investigator, and she conducts disease investigation on reporting for notifiable conditions within her county. Disease investigation provides her with the opportunity to educate individuals on prevention / transmission methods, and identify any potential outbreaks. She also maintains databases for communicable diseases in the area schools, elevated blood lead levels in children, and Hepatitis B and C. Her recent project will be to work with other health district / departments to create a secure surveillance reporting portal for school nurses. Shane Ryan is located in Pueblo City-County, Colorado where he is a Health Educator. His job duties are to perform latent TB investigations; develop a hygiene presentation for high school students; talk to athletic directors; and assist with emergency preparedness exercises and drills. Among the class of 2010, 82% are placed at the local level working directly with their communities.

The recruitment process is currently underway. Host site recruitment began on January 10, 2011 and closes on February 21, 2011. State, tribal, local, or territorial health departments are welcomed and encouraged to apply. The process is simple and straightforward, and the application is available on the website: <http://www.cdc.gov/phap/>. The form basically asks the agency to describe the associate's first and second year assignments, explain how they will meet competencies during those assignments, and indicate who is going to supervise them (including background, experience, and level of commitment).

The associate application period starts February 15, 2011 and runs through March 1, 2011. This is a much shorter window because last time, over 1400 applications were received during a 10- to 14-day timeframe. This year, for the first time, an online application system is being launched. Notification has been sent to colleges and universities in the states that do not have an associate, as well as historically black colleges, Hispanic colleges, and Native American colleges. NIHB is also helping spread the word with their contacts.

The agency does not pay relocation expenses, so associates tend to stay where they go for their assignments. This is why it is important to recruit in tandem. That is, if there is a host site in California, it is often filled with someone from California. CDC pays the associate's salary and benefits for the entire 2-year period. The host site pays for extra training and travel as part of their local assignment. They start at the equivalent of a GS5, which is typically in the high \$20,000s to low \$30,000s depending upon where they live in the country. In their second year, they go up to GS7 Step 1, which is a few thousand dollars more. Other than that, they do not receive additional raises. CDC's expectation is that at the end of this 2-year period, they will qualify for an entry level professional position in a health department. The goal is to keep them in their state, local, tribal, or territorial assignments in order to build capacity in the field, not at CDC.

Discussion Points

- Ms. Hughes asked whether the work the associates do and any results from that work remain with the site, and if how they move on from the program has to do with their supervisors and follow-up reports.
- Ms. Gibbs-Scharf replied that the work remains with the site, and that the program is fairly structured. There are competencies for the program, so CDC will provide training and sometimes activities that they do on the job to meet those requirements. For example, if they are doing surveillance work, they might be asked to develop a report and share that with CDC to ensure that they meet the competencies. However, this would not be an extra assignment. CDC's hope is that associates will be hired where they are placed. Only one class has graduated, so it is difficult to tell at this point.
- Mr. Secatero asked what percentage of applicants are Native Americans, and Ms. Hughes wondered what percentage of associates in the program are Native Americans.
- Ms. Gibbs-Scharf indicated that they do not know what percentage of applicants or associates are Native American, given that they do not collect any information until an associate is hired. They have not received information from human resources yet, but that will show their demographic profiles. No associates are placed in tribal agencies yet. Some associates are working on tribal issues, but from a local health department. They are hoping to have some good tribal assignments where they can place associates.
- Ms. Hughes indicated that she circulated the information in the Bemidji area, but did not have much information herself about the program. She said when she returned after the meeting, she would encourage people to apply.
- Ms. Gibbs-Scharf said she would leave flyers, and could also send these electronically for anybody who wants to disseminate those. One of the flyers is targeted at host sites, one is

targeted at associates, and there is a basic fact sheet about the program. The program will be happy to provide any information anyone feels they need to disseminate.

- Mr. Valdo asked how many host applications are typically received, whether the public health agency applying has to be fairly large, and whether associates move from site to site.
- Ms. Gibbs-Scharf indicated that last year, they received about 200 in the first round and about 127 in the final round. In the last round, about 200 letters of intent were received and 127 were invited to submit full applications. With respect to health department size, the locations are fairly diverse throughout the country. The application is brief and includes points for each component the host applicant is required to address. Details may be found at: <http://www.cdc.gov/phap/docs/HostSiteApplicationDirections.pdf>. This information is on page 4. Individual associates do not move from site to site, but typically work in multiple programs within a site over the 2-year period. They did have one person this year who switched agencies in between. That was a joint assignment submitted by a quarantine station and health department. This is not the usual model because associates are engaged in hands on work in the community. It is important to be in one place so that they can establish roots, get to know that community, and gain experience in various program areas. This year, extra application points will be given to host applicants that have not yet had an associate in an effort to diversify. Host sites can apply every year because it is permissible to have more than one associate. Several host locations have more than one associate, although they may not be in the same program. For example, Louisiana has an associate in Baton Rouge and an associate in New Orleans. They are both part of the same health system, but are located in different locations. This is fairly common.

Internship / Recruitment Opportunities

**Julio Dient Taillepierre, MS, Team Leader
Initiatives and Partnerships Unit
Office of Minority Health and Health Disparities
Centers for Disease Control and Prevention**

Mr. Taillepierre reported that their office name has been proposed to be the Office of Minority Health and Health Equity. There are efforts underway to get every federal agency to open an Office of Minority Health at the federal level.

In terms of recruitment opportunities, several programs have been going on for many years now. Details about all of these programs can be found at <http://www.cdc.gov/OMHD/>. Two examples include:

- Hispanic-Serving Health Professions Schools, Inc. (HSHPS) / CDC Internship Program, which is a 9-week paid Internship Program that will provide the opportunity for medical students to work at the Centers for Disease Control and Prevention, and to gain knowledge about the federal government careers and skills related to prevention research, surveillance, public health policy and program development. Through this internship, students will have the opportunity to develop their awareness and skills for future careers in public health, focused on Hispanic health.
- IMHOTEP, which is an 11-week PHSI internship program designed to increase the knowledge and skills of undergraduate (juniors, seniors, and recent graduates) students in biostatistics, epidemiology, occupational safety and health, or the health sciences. It

provides participants with intensive research and data analysis experience with experts at CDC and other agencies and academic institutions such as Carnegie Mellon University. This program is a collaborative effort between the CDC and Morehouse College.

The programs all have different recruitment requirements and target populations, but what they all have in common is a focus on minority graduate students, medical students, or those who are already studying public health. There are currently 9 student recruitment programs.

Mr. Taillepierre clarified that his purpose during this session was to start a dialogue with TCAC. Given the reorganization process, these recruitment activities are being closed out this year after 20 years or so of funding these programs. Summer of 2011 is the last time these programs will run. Dr. Frieden charged this office to focus on undergraduate students who have not really thought about public health or their long-term career goals. They have committed to help 200 students per year through recruitment and placement in a public health institution. This office has never focused on undergraduate students before, so they have been meeting regularly internally to determine how to proceed with recruitment and placement.

At this point, the plan is to recruit 200 students, the majority of whom will be placed in public health institutions throughout the country and 10% to 30% of whom will be placed at CDC. They are attempting in this FOA to focus on institutions that have a history of working with minority, native, and tribal institutions as they know how best to recruit students from those institutions around the country. They can work in partnership with CDC to design this recruitment strategy. They are also working internally to engage partners to talk about what kinds of incentives can be provided to these students to engage in this summer exposure internship. These students will be exposed to the gamut of public health areas at CDC and other public health institutions, not just epidemiology or a particular research field. They will likely conduct direct services through a health department with direct recipients of services in the field. The hope is that this exposure will inspire these students to enroll in a graduate degree program focused on public health. The plan is to follow students who have completed the program for approximately a 2-year period so that the student can continue to consult with CDC and in order to determine the results of their experience in this program. They want to know the successes and the percentages by racial / ethnic categorization or representation of tribal communities. The plan is to publish the announcement at <http://grants.gov> by February. Mr. Taillepierre indicated that he could share few details because the announcement has not yet been made, but offered to return to another TCAC meeting to share further details.

It is also important to take advantage of lessons from the existing programs, even though they do not focus on undergraduate students and are much more extensive in terms of type of work that the student engages in and the length of time of the program. The new program will only be a 10-week program. Most of the existing internship programs span from 6 months to 2 years, with a medical or graduate student working on a particular research project. The undergraduate students will still be in school, so their availability will be limited. Though it is a short amount of time, the program wants it to be meaningful. Therefore, it is important to engage students who represent populations of concern who typically do not know about CDC, public health, or even their health department. The intern should finish the program with stronger capacities to compete in the public health career environment.

Discussion Points

- Ms. Hughes commended this office for taking on what appeared to be a humongous challenge. As a tribal leader with almost 24 years experience in that capacity, it has been

an on-going issue to motivate their young people in this direction. The challenge every year is to encourage them to go on to higher education, and then to focus on critical professions. In Indian Country, clinics are staffed primarily by non-tribal professionals. They are trying to turn that around, but it is a constant effort with extremely slow progress. The number of students per year seemed like a lot, but she hoped it would go well. It is ironic that they refer to themselves as minorities, because collectively all of the minorities together are the majority. She said it was good to see that CDC was recognizing that, and that it said a lot that CDC, as an employer with such a large employment base, was taking on this challenge.

- An inquiry was posed regarding whether there would be a set aside for Native American students applying for this program.
- Mr. Taillepierre responded that there has been significant discussion regarding how to put an appropriate proportionality to the number of students being recruited. They are developing formulas and strategies, and are taking a proactive approach in the guidance they plan to give grant recipients in order to ensure that there is appropriate demographic representation and geographic balance.
- A question was raised regarding whether there would be any curriculum standards, such as a focus on the culturally specific needs of American Indians.
- Mr. Taillepierre replied that there would be. The overall design of this FOA is to require that the first week of the 10-week exposure include training all 200 students at CDC so that regardless of where they are placed, they will have a common experience. As part of that conversation, there have been interesting discussions about how to link public health practice to the issue of the public and culture. They are assessing various curricula, keeping in mind that there will be many topics to cover in a very brief period of time.
- Mr. Valdo encouraged Mr. Taillepierre to use TCAC to help increase their sphere of influence. Morehouse typically goes through NIHB, but he requested that information be sent to Ms. Cantrell so that she could disseminate it to the TCAC membership. Through the 12 tribal regions throughout the US, they can increase recruitment impact in Indian County.

CDC Professional Student Programs

**Larry Cohen, MD, MPH, Lead Medical Epidemiologist
Student Programs
Scientific Education and Professional Development Program Office
Centers for Disease Control and Prevention**

Dr. Cohen pointed out that in addition to the post-graduate public health training programs offered by CDC, such as the Epidemic Intelligence Service (EIS), the CDC Preventive Medicine Residency, the Public Health Informatics Fellowship Program, and the Prevention Effectiveness Fellowship, CDC also offers 3 programs for medical students:

- CDC Experience Applied Epidemiology Fellowship, which is a year-long program for third- and fourth-year medical students at CDC in Atlanta, Georgia. This 10- to 12-month fellowship provides training through hands-on experiences in applied epidemiology and public health. The fellowship is held at CDC headquarters in Atlanta, Georgia and begins in August. Fellows receive a stipend for living expenses. Participants have an opportunity to learn while working with CDC epidemiologists to solve real-world public health problems.

Some examples of programs that fellows will begin in the fall including a project with the Division of Global HIV / AIDS (DGHA) on HIV / AIDS associated with blood transfusions; an assignment with the Division of Nutrition and Physical Activity and Obesity Prevention (DNPAOP) conducting an environmental scan of hospitals to assess their measures for impacting obesity (e.g., what is offered in their vending machines, if they have a fast-food restaurant on site, et cetera); a project focused on Giardia; a project focused on TB; a project focused on occupational health; and a project with the Influenza Division focused on pneumonia. Information about this program is located at: www.cdc.gov/CDCExperienceFellowship.

- CDC Epidemiology Elective Program, which is a 6- to 8-week program that offers fourth-year medical and veterinary students an introduction to CDC, public health, preventive medicine, and the principles of applied epidemiology. This program was established in 1975 and has had over 1500 students since that time, including many of CDC's current leaders. The students who are admitted to this program must be attending an accredited school of human or veterinary medicine, they must be US citizens or permanent residents, and they have to be available for the entire time frame. About 70 to 80 applications are typically received for this program. Dr. Cohen does his best to assign almost everyone who applies to the program as long as they meet the eligibility criteria. Last year, he had to turn away about 5 students because there were so many applications he was not able to find a position for everyone. This year, 67 students are participating in the program. The deadline for this program depends on when the student wants to begin at CDC. Basically, students participate in a short-term epidemiology project, which may include data analysis, helping their supervisor put a conference together, working on policy and making policy decisions, and literature reviews. One student who was in the program for 6 weeks completed an entire project and is the first author on the manuscript that she is submitting to a peer-review journal. Fellows also have the opportunity to participate in a two-week outbreak investigation, such as the pertussis outbreak in California and the pandemic H1N1 outbreak. Most of these fellows are assigned to one of the divisions in CDC headquarters in Atlanta, but some students rotate through IHS in Albuquerque, New Mexico; the Arctic Investigations Program in Anchorage, Alaska; or the National Center for Health Statistics in Hyattsville, Maryland. Information about this program is located at: www.cdc.gov/EpiElective.
- CDC-Hubert Global Health Fellowship, which is for third- and fourth-year medical students and third- and fourth-year veterinary students. This fellowship program was established in 1998 as the O.C. Hubert Student Fellowship in International Health, with an endowment by the O.C. Hubert Charitable trust to the CDC Foundation. It is designed to encourage students to think of public health in a global context. As noted, the fellowship provides opportunities for third- and fourth-year medical students and third- and fourth-year veterinary students to gain valuable public health experience in an international setting. Hubert Fellows spend 6 to 12 weeks in a developing country work on a priority health problem. Fellows are mentored by experienced CDC staff. During the fellowship, fellows establish relationships with, and receive training from, recognized experts from CDC and other national and international health agencies. Since its inception, 91 medical and veterinary students have participated in the CDC-Hubert Global Health Fellowship. This program has projects throughout the world in Central America, South America, Africa, Asia, and the Middle East. For the 2011-2012 fellowship year, examples of projects include rapid HIV testing in China, investigating HIV / AIDS in Nigeria, assessing the causes of community-acquired pneumonia in Thailand, investigating acute respiratory infection in Egypt, influenza sentinel surveillance in Kenya, a study on medication coverage among people with HIV / AIDS in Ethiopia, and surveillance for influenza viruses in domestic animals in Kenya. Two

fellows are slated to travel to Egypt at the end of March, so they are closely monitoring the situation there to determine whether to send these fellows there. Luckily, there are numerous projects to which they could be transferred. Contingency plans are always in place in case there is upheaval in a country. Information about this program is located at: www.cdc.gov/HubertFellowship.

People often ask Dr. Cohen what type of student he is looking for, and whether they have to have extensive experience in public health. They wrestle with whether to accept students with a lot of experience and a lot of understanding of public health, such that they are “preaching to the choir” or to try to bring in new people. There is a balance to this, and those who have extensive public health experience are not excluded from applying. The goal is to enroll students throughout the whole continuum of experience and understanding. Though Dr. Cohen’s programs focus on medical and veterinary students, there are other programs in which physicians and veterinarians can participate. One is the EIS program, which is the two-year fellowship in applied epidemiology. More information is available about that program at <http://www.cdc.gov/eis/index.html>. The second is the Preventive Medicine Residency and Fellowship program at CDC. This program is primarily for physicians who have finished the EIS program and want to obtain further training in preventive medicine. Physicians with equivalent experience to EIS are also accepted into this program.

They are hoping that ramping up minority recruitment and placing more minorities into these programs will pay dividends in the future if they continue to work in public health, or if they engage in careers as clinicians or veterinarians and understand both clinical medicine and public health. Dr. Cohen expressed his interest in being on the TCAC agenda in the future in order to present more details about all of these programs.

Discussion Points

- Ms. Hughes thought it was interesting that Dr. Cohen had to turn applicants away because there was no place to place them rather than due to lack of funding. In this case, it sounded like they could take a lot of applications if more sites were available.
- Dr. Cohen responded that for the Epidemiology Elective program for which they had to turn people away, there is no funding. Students have to pay for their trip to Atlanta and room and board. Funding is not as big an issue for this program, except that it is sometimes difficult to interest minority students. Culture is also a little different in terms being away from school. He went to Morehouse School of Medicine for his undergraduate education, and there was not a lot of buzz about taking a year off to complete an internship. The focus was more on staying at one’s institution. For the other two programs, they turn people away because they receive so many applications. For the CDC experience, the yearlong fellowship pays fellows a stipend each month. For that program, they receive about 50 applications for 8 positions. The Huber fellows receive a \$4,000 stipend to help cover their living expenses, plus airline tickets to travel to their projects. For this program, they usually receive over 100 applications for 10 positions. He indicated that he had left flyers on the information table for all three programs.

CDC Management and Policy Fellowships

Detrice S. Munir, MPH
Deputy Management and Policy Fellowships Branch
Division of Leadership and Practice

Scientific Education and Professional Development Project Office Centers for Disease Control and Prevention

Ms. Munir shared information about two of the fellowship program opportunities within the Management and Policy Fellowships Branch (MPFB): 1) Presidential Management Fellows (PMF) Program, and 2) Emerging Leaders Program (ELP). MPFB's goals are recruitment of individuals with an interest in and commitment to a career in leadership and management of public policies and programs; and provision of developmental opportunities and trainings that prepare fellows for a career in public service.

Since the mid-1980s, the PMF Program has played an integral part in CDC staffing by attracting outstanding Master's, Law, and Doctoral-level students. To date, CDC has hired over 200 fellows to the agency. The PMF Program is a 2-year program for graduate students from all disciplines who are nominated by their schools. After successful completion of the program, fellows convert to a career conditional appointment. The program usually begins in July, but individuals are eligible to be hired up to one year from the date accepted into the program. The program is administered by the Office of Personnel Management (OPM), so fellows have the opportunity to be based at CDC and because this is a federally based program, they can work anywhere across the country for any federal agency. Over 80 agencies participate in this program. Once fellows are placed, the focus of their work is on public policy and management of programs. Individuals typically have a Master's Degree, MBA, Masters in Public Administration, Masters in Public Policy, Law Degrees, and / or Doctoral level degrees.

In order to be eligible for the PMF program, applicants must be US citizens and have to demonstrate a breadth of knowledge, understanding, and commitment to working in public service, and a commitment to working with public policies and programs. They also have to demonstrate through their work experience or educational work that they would make a suitable candidate for the program. Once they have been nominated by their academic institutions, the finalists have to complete a rigorous two-part assessment. OPM makes the determination of who will be eligible to be named as finalists. From the pool of finalists, CDC is able to select candidates to be placed to appointments at the agency. When based at CDC, these individuals have an opportunity to complete one 4- to 6-month developmental assignment, which provides them with additional technical experience and expertise for the targeted position they have been selected for within the agency. Along with that 4- to 6-month developmental opportunity, the fellows also have the opportunity to complete 80 hours per year of training. To be eligible for the PMF Program, students have to apply during the final year of their graduate degree program, so those expected to complete their graduate degree between September 1, 2011 and August 31, 2011 would be eligible to apply in the fall for the class of 2012. The application period is typically from October 1 through October 15 each year. Students can either apply through <http://usajobs.gov/> or <http://pmf.gov/>. Fellows appointed to the agency typically begin at the GS9 or GS11 level, based on their academic experience and background, with promotion potential up to the GS12 or GS13 level.

The ELP program is a 2-year leadership and management program that is administered by HHS. Because it is administered by HHS, it has a definite emphasis on recruiting individuals who have an interest in and commitment to public health. Since this is through HHS, not only does CDC participate, but candidates are also accepted into different operating divisions such as the National Institute of Health (NIH), IHS, Food and Drug Administration (FDA), and Centers for Medicare and Medicaid Services (CMS). Once those individuals are selected for placement across the department, they could be placed in most career tracts based on their educational

background and experience. The tracts include public health, administrative, IT, social sciences, scientific human resources, and law enforcement.

The placement within CDC is typically for 6 months for their home-based assignment, with an opportunity to complete a 120-day rotational opportunity outside of their immediate work area, as well as the addition of two optional rotations if these match the skill set and the needs of those individuals in terms of their training and career development. Along with the rotational opportunities, HHS also sponsors quarterly training that prepares interns to build their competencies for leadership and management skills. They travel to the DC area every quarter for this training, which focuses on leadership, written and oral communication skills, results, various competencies, et cetera. In addition to being a US Citizen, to be eligible to qualify at the GS-9 level, the individual must have a Masters, PhD, JD or higher level degree from an accredited college or university or a Bachelor's degree with 1 year of specialized experience related to the career track for which they are applying. They must provide a resume that describes the specialized experience related to career track and submit a narrative regarding accomplishments.

Currently, the ELP is being revamped. Because the program is general across HHS, guidance may soon change. Ms. Munir indicated that she would keep Ms. Cantrell updated on the requirements once the revamping process was completed. Historically, CDC has sponsored more emerging leaders than any HHS operating division. Of the 123 emerging leaders selected to work at CDC, nearly half (n=53) are in the public health track. Of the total number of emerging leaders, 80% are women and 68% are minorities. Sample ELP and PMF projects include the following:

- Contributed more than 2000 hours to H1N1 response activities
- Revised public health preparedness standard operating procedures and activities for airports, seaports, and land crossings within the Miami quarantine station's jurisdiction
- Planned and executed national meetings for both Emerging Infections Program (EIP) and Epidemiology and Laboratory Capacities (ELC) grantees
- Served as Country Officers for the CDC Global AIDS Program to support the President's Emergency Plan for AIDS Relief (PEPFAR)
- Facilitated communication between Congressional offices and CDC experts regarding pending public health legislation
- Conceptualized and developed weekly newsletter for the Division of Cancer Prevention and Control (DCPC)

To date in both programs there has been an 82% retention rate, with the majority of the people who start with the agency through both programs actually remaining to work at CDC. The following positions are examples of alumni in these programs who have risen through the ranks at CDC:

- Chief of Staff, Centers for Disease Control and Prevention
- Deputy Director, National Center on Birth Defects and Developmental Disabilities

- Associate Director for Program Operations, Division of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion
- Deputy Director, Office of Policy, Planning, and Evaluation, National Center for Injury Prevention and Control
- Deputy Branch Chief, Global Measles Program, Global Immunization Division, National Immunization Program
- Global Business Management Officer, Coordinating for Global Health
- Team Lead, Management Analysis and Services Office
- Lead Budget Analyst, Financial Management Office
- IT Project Manager, Office of the Chief Information Security Officer

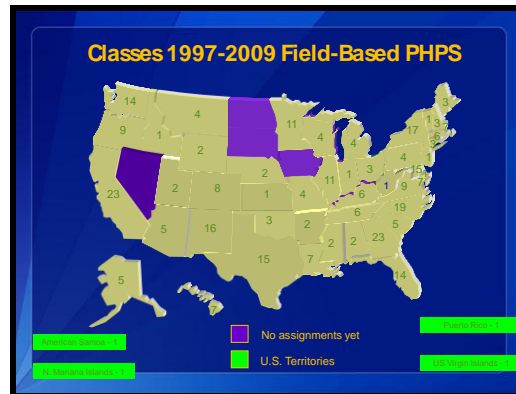
Public Health Prevention Service

Cindi Melanson, MPH, Branch Chief
Public Health Preventive Service Program Branch
Division of Leadership and Practice
Scientific Education and Professional Development Program Office
Centers for Disease Control and Prevention

Ms. Melanson presented information about two opportunities for which Division of Leadership and Practice would like to recruit candidates and host sites from the tribal community. The mission of the PHPS branch is to “contribute to the development of a highly trained public health workforce of PHPS fellows with public health experience and the management and leadership skills necessary to promote the health of populations at the global, national, state, and local levels.” PHPS fellowship eligibility requires US citizenship, at least 1 year of paid public health work experience, a Master’s Degree in Public Health or a management-related field from an accredited school or program with academic achievement in core study areas, strong interest in a career in public health program management. Fellows learn through a competency-based training program that includes case studies, classroom projects, and distance learning. This training supplements their hands-on work assignments at the community, state, national, and global levels. One of the key components is supervision and mentoring by CDC staff and in the field sites.

The 3-year program consists of two assignments in different program areas at CDC, such as immunization, injury control and prevention, chronic disease, infectious disease, et cetera. Because PHPS is a service and training program, during the first year, the fellows become acquainted with CDC programs and staff and participate in skill-enhancing training in basic public health sciences (in essence provide a service back to CDC). The second and third years, fellows are assigned to a single public health agency, such as a state or local health department, community-based organization, academic institution, IHS, or private sector partner. This experience enables fellows to utilize their academic training and the training received at CDC at a state or local level, while gaining more practical experience.

The host site eligibility process is similar to that for PHAP in host sites complete a proposal, describe the activities the fellow would be engaged in while in the field, and discuss how those activities relate to the competencies that this program has in place. In terms of host site distribution, approximately 25 fellows enter the program each year. This program began in 1997, so classes have gone to the field from 1997 through 2009. The following map depicts the location of the fellows:



Sample accomplishments by fellows in FY2010 included the following:

- Participated in H1N1 response activities across the United States
- Served on Stop the Transmission of Polio teams in Ghana and the Philippines
- Assisted with a measles outbreak investigation in New York
- Launched the 2010 Status of Health Report for DeKalb County, Georgia
- Established a funded Occupational Health Surveillance Program in Colorado
- Mapped resources for Haitians displaced by earthquake
- Co-authored a white paper on health and the environmental impact of mercury use in artisanal gold mining
- Co-authored an article on the health and the economic burden of cardiovascular disease in North Carolina

Like the ELP and PMF alumni, PPHS alumni have risen through the ranks to hold positions such as the following:

- Director, Southern Maine Regional Resource Center for Public Health Emergency Preparedness
- Program Coordinator, Healthy Teens Initiative, NYC DOHMH
- Program Manager, Border Infections Disease Surveillance Program
- Program Manager, NACCHO
- Program Manager, Epilepsy Foundation
- Community Health Initiatives Manager, Kaiser Permanente
- Manager, Global Business Coalition on HIV/AIDS, TB and Malaria
- Deputy Director, International Emerging Infections Program, CDC, China
- Team Lead, STOP Training Program, CDC
- Deputy Director, CDC Kenya
- Executive Director, Greater Prince William Community Health Center (MD)
- Director, Strategic Health Alliances, American Cancer Society, NY
- Public Health Advisors throughout CDC

Ms. Melanson indicated that as a graduate of the program herself, she could attest that it really does enhance academic knowledge needed in graduate school, and application of that knowledge while receiving mentoring and further training in public health management. Most people who have completed the program appreciate the diversity of the experience. She shared the following quotes from other program graduates:

- *“set me up for success in future endeavors; it gave me skills, professional development, credibility”*
- *“exposes fellows to different facets of government systems and [one can] find their own niche”*
- *“gave me opportunities to explore my interests, build on my existing skills and hone those skills that needed improvement”*
- *“connected me with health dept. leadership and gave me opportunities to build marketable skills and areas of expertise; I was able to build transferrable skills in writing, presenting, planning and subject matter expertise”*

As the program has grown, Ms. Melanson has continued to take on leadership positions at CDC and in health organizations across the US. She is also looking forward to potential partnerships from the tribal community. She welcomed engagement from TCAC members in terms of offering input on better ways to inform tribal communities about this opportunity so that they will have more applicants and host sites from Indian Country. She also left pamphlets on the information table.

Discussion Points

- Ms. Abramson noted that there are differences among tribes, and all native people have different cultures and traditions. They are not all the same. She expressed her hope that this would be kept in mind as programs were being developed. It would also be beneficial for students from more rural, woodland tribes to be assigned to positions in their native areas. They would like for their people to come home and remain home, if possible.
- Mr. Valdo asked whether there was a way to tease out the data to determine how many Native Americans and other ethnicities are being represented in these programs. Knowing this will help them market to other tribal professionals moving up through the ranks.
- In terms of placement, Ms. Melanson responded that they have struggled to recruit fellows. The program has a historically differently structure, and there is a mobility requirement. Perhaps this could be structured somewhat differently to make it more appealing to tribal communities. Regarding the number of Native American fellows, she did not have the exact numbers in front of her, but as she recalled there have been one or two fellows every 5 years who self-identify as being Native American. A number of tribal epidemiology centers have applied to serve as host sites, and there have been numerous placements with IHS. In addition, state and local health departments place fellows who are engaged in tribal work with populations in their areas. However, she did not believe they had placed anyone in a tribal government.
- Mr. Seneca added that Cecile Town is a Native American who is an epidemiologist who applied for the program and was assigned to the Albuquerque IHS. Melinda Frank was a PHPS fellow, and there are other Native American people who have applied for this. This is probably one of the more open programs for native people to enter and be successful in, and there is room for many more.
- Mr. Valdo reminded everyone about the discussion they had the previous day regarding CDC's internal knowledge and working relationship with tribal communities. Ford and Toyota groom people from within to take over positions. The loss of the two CDC tribal

liaisons last year created a major problem in terms of loss of institutional knowledge. Now a new Associate Deputy Director for Tribal Affairs must be groomed. The PHPS program seemed like a great way to bring somebody in at any level to equip CDC with competent, educated, and best qualified candidates. He would prefer Indian preference for this position, but would also like someone who has organizational knowledge of how CDC works, how the system works, et cetera. Having that balance and meeting that need is ultimately what TCAC is meant to advise on.

- Ms. Hughes emphasized that she was unaware of all of these programs, except the ELP because it is through HHS and she receives a lot of communications from HHS. She thought TCAC would be perfectly capable of helping CDC with input on these programs and dissemination of information about them.
- Mr. Seneca indicated that he, Craig Wilkins, and Chris Rosheim are part of the agency's recruiter cadre, a selected group of people from upper management who help to fulfill recruitment initiatives or mandates of the agency. Some initiatives they are working on include recruiting those with disabilities, those from Hispanic populations, and those from AI / AN populations into CDC positions. Bill Nichols, the Chief Operating Officer (COO) for CDC, is leading this initiative. They have been actively trying to entice native people to apply for several positions and at CDC. There are several challenges, one of which is getting native people to apply for CDC positions. Part of the problem is that applications have to go through the USA Jobs system. This is not the best way to target native people because there is not a check box for AI / AN. Applicants' qualifications pose another challenge. CDC targets Master's, PhD, and MD level candidates. It is sometimes difficult to find AI / AN candidates with these qualifications. There is significant under-representation of AI / AN compared to all other racial / ethnic groups in the sciences and engineering fields. He also sits on the board of the American Indian Science and Engineering Society (AISES), so he has been trying to reestablish a relationship between CDC and AISES so that they can work together to try to reinvigorate a program CDC once had to foster and grow a native public health workforce.
- Mr. Secatero asked whether they were going to hear from the Commissioned Corps. He mentioned to a Commissioned Corps Officer once that they are needed in Indian Country.
- Clarifying that while he was not speaking officially for the Commissioned Corps in response to this question, Mr. Alonso Core said that when he does speak in an official capacity about IHS and opportunities in Indian Country, he speak in terms of there being nothing he has ever done in his life that has been more fulfilling than the 5 years he worked in Indian country. He conveys that to everyone he speaks with. In fact, he says as a CDC representative, "Whatever you do in your career as a Commissioned Corps Officer, go to IHS and learn, because it is an extraordinary opportunity to work with extraordinary people in an extraordinary environment." He consistently tells other Commissioned Corps Officers that their career is not complete unless they have been there and had an opportunity to work shoulder-to-shoulder with American Indian people in their communities.

Reports from TCAC Members

Aberdeen

No report was presented on-site, and no report was submitted.

Alaska

Dr. Jay C. Butler, MD, Senior Director Community Health Services Tribal Consortium

Dr. Butler indicated that this was his first TCAC meeting. He was asked by the Alaska Native Health Board (ANHB) to fill the alternative position for Mr. Tim Gilbert. He did not know anything about a written report, but attempted to address some of the questions included in the template passed to him.

CDC has had some good visibility in tribal organizations in Alaska recently, particularly the previous week with the opening of the new CDC Arctic Investigations Program Laboratory at the Alaska Native Medical Center. A number of people were there from the Tribal Consortium where he works as Senior Director for Community Health Services, from the South Central Foundation, and from the Regional Health Corporation. There was a significant amount of media coverage, and it was a good opportunity to review some of CDC's work and successes in Alaska, particularly in infectious diseases and the viral hepatitis program.

In terms of issues, Dr. Butler reflected primarily on what he hears from the Tribal Consortium Board and from the villages throughout Alaska. The issues are largely the same that arise each time. Suicide is probably the highest priority. There has been a fair amount of media interest in suicide, and there has been progress in terms of talking about what has been a taboo topic in the past. Wearing his epidemiologist's hat, he grinds his teeth when the media talks about it being an epidemic of suicide because he believes it is worse than an epidemic. Suicide is a disaster that has gone on year after year after year, and it continues to be an important issue for Indian Country. It is the second leading cause of years of potential life lost among Alaska Natives. In the CDC *Health Disparities Report* published recently, one of the very first quotes from Dr. Frieden in the *New York Times* piece regarded how the high rates of suicide among AI / AN caught his eye, and he described that as heartbreaking.

Cancer is another issue that is frequently raised as a concern. Lung cancer is the leading cause of death among Alaska Natives. They have very much appreciated the support and technical assistance from CDC on tobacco programs, including support that comes through the State of Alaska to the Consortium and to the Regional Health Corporations throughout the state. They continue to have a large disparity in tobacco usage, although for the first time in the 2009 Behavioral Risk Factor Surveillance System (BRFSS), less than 40% of Alaska Native adults reported that they smoked cigarettes. Perhaps there has been some progress in tobacco. There is much more progress in addressing youth smoking. The rates of smoking among Alaska Native youth are about 3-fold lower than they were in 1995. They really like to highlight the successes in areas where Alaska Natives are healthier than in the past. The second leading cause of cancer death, and the most commonly diagnosed cancer, is colorectal cancer. Rates of colorectal cancer are about twice as high in Alaska Natives compared to non-natives living in Alaska. Through a grant, CDC has supported expansion of the colorectal cancer

screening program. There are a number of reasons why fecal occult blood screening does not work well in their population, including high rates of helicobacter infection that leads to frequent positives. Thus, everybody typically gets a colonoscopy anyway.

In terms of some of the public health activities being planned or implemented, unintentional injuries are a problem in Alaska. They are actually the leading cause of potential years of life lost in Alaska Natives. This is also a problem for non-natives. He noted that he took a bad fall the other day and was struggling with an old clavicle fracture. They received a performance improvement management cooperative agreement, and are very close to hiring a Performance Improvement Manager. They are very pleased with the progress in working with CDC on that to be better positioned to address the question of public health accreditation in the near future.

Regarding additional issues that CDC and TCAC should be aware of, he really appreciated the presentations throughout the morning. Professional development is major issue for Alaska. Only about one-third of his group are Alaska Native employees, which is wrong. He certainly hopes he leaves this job soon and gives it to an Alaska Native. What he heard that morning was encouraging in terms of opportunities for people who have achieved that level of training. They have some local programs that focus on reaching down into the high school level, but he wanted to make sure that CDC was aware that in Alaska, the message of opportunities for a career in health or public health must be communicated at the village level, and communication must begin in high school, or even middle school.

With everything going on with budgeting in Washington, DC, it will be very interesting to see what happens with the community transformation grants. Hopefully, CDC will be thinking about the tribal entities assuming those opportunities continue to be developed and funded.

Albuquerque

Lester Secatero, Chairman
Albuquerque Area Indian Health Board (AAIHB)
TóHajiilee, Navajo

Mr. Secatero reported that the State of New Mexico just got a new governor, Susana Martinez, who inherited budget debts of about \$500 million. She is making many cuts and laying people off. She appointed Dr. Catherine Torres to the state health department. Schools were cut 1%, but the good news is Medicaid got a 10% increase.

They have been having difficulty getting the Executive Director for the Albuquerque area to stay on. They have lost 2 or 3 Executive Directors in the past couple of years. He does not know the reason. He took it upon himself to appoint one of the board members who was with the state for 14 years and who has a lot of experience, Nancy Martine-Alonso. She has been the interim Executive Director since the last person left. They have a new Epidemiology Director, Mary Altenberg; a new Epidemiologist, Dr. Judith Espinoza; and a new part-time Epidemiologist, Irwin Phipps.

This year, epidemiology has completed its final report. Their start date was 2007 and he filed the report with IHS. He has 7 non-pueblos, 20 pueblos, and a 12-member executive council from 9 different service units. They are lucky in his area because they can get to a hospital within an hour. If anyone gets injured, they are flown out, and Navajo Nation is good enough because they let them use their EMS system.

We reach about 100,000 AI / AN people. He was telling NIHB that they even have Eskimos out there. He has met some of them. They are responsible for two Native American Research Centers for Health (NARCH) programs, a NARCH 3 and NARCH 5. NARCH 5 continue into the fifth year and NARCH 3 ended in September 2010. Also, AASTEC provides scholarships to MPH students. They have awarded a total of up to \$25,000 nationally in the past couple of years to different tribes.

AAIHB has an audiology program with 4 audiologists, and 4 technicians. One hardship is travelling to different areas in the State of New Mexico. They are wearing out the audiologist, who have to stay overnight in various places. They lose people because of that. Their reimbursement from IHS for audiology claims is slow. They have to pound on doors to get the money out of them. In December and January, the audiologists visited 33 sites and a total of 230 patients. They also have an HIV program that is going to hold an AIDS wellness conference in April. Mr. Secatero welcomed everyone to attend. He was talking to a Navajo coordinator there who he sure would like to have. The HIV / AIDS Prevention Program's Program Director is Ann Whyte. They have challenges with their IRB for people who want to conduct research. They used to go through Rockville and they have their own IRB in Albuquerque. However, for Navajo tribes, they have to go through the big Navajo. That means they have to go through two IRBs, which is rough.

Recently, New Mexico dentists were ranked 49th. They do not have enough dentists in New Mexico. In November or December, about 100 to 200 dentists got together and decided to hold a free clinic at the fairgrounds in Albuquerque. He did not know where they came from. About 2,000 to 3,000 people attending. They were camping in tents and sleeping bags, and the dentists spent 2 or 3 days pulling and fixing teeth. He has been advocating for many more dentists, and has been working with the American Dental Association and retired dentists to try to get more dentists in the area. About 69% of their dentists are in the metropolitan areas. The State of New Mexico has a waiting list of 6 months just to see a dentist.

They also have a colorectal project that is in its second year. Kevin English is really working hard for them there. They have access to 6 hospitals, and which is trauma. They have access to the University of New Mexico and can fly people in really quick. There is a VA facility in Albuquerque, which is about 40 minutes away. They are doing great outreach work after they were told that they were not getting services. The VA hospital caters to the needs of Indian people out there. They have sweat lodges and Pow-Wows near the grounds there, which is a big "shot in the arm" for veterans there.

Bemidji

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

Ms. Hughes reported that there are currently 35 tribes in the Bemidji area. They do not have an area health board, so she tries to work with the Wisconsin Health Directors Association. There is a health association in Michigan and one in Minnesota, but none of them work together. In Wisconsin, the health association is not very active, so Midwest Alliance of Sovereign Tribes (MAST) is now working to create a subcommittee under MAST of the health directors. This subcommittee will give her a new venue to work through for information dissemination. She utilizes the MAST listserv to forward information. She has her own listserv of health directors, but it is a challenge because there is so much turnover in people and positions that her listserv

is usually outdated. She believes she is reaching at least 75% of those she should be reaching. If not, those not on her list are likely to be receiving information from somewhere.

Ms. Hughes provides reports at regional meetings. She typically attends the Region 5 HHS meeting and provides a report there. When appropriate, she provide reports at the MAST meetings. MAST meets twice per year, typically in the spring and fall. That is usually the route she uses to try to keep people in her area informed of what is occurring with CDC.

With respect to public health issues, it is the cold and flu season, so those are the major issues currently. They had a fairly light October to December period, but are beginning to see the reoccurrence of colds and flu. They also have influenza vaccines left, so they are still encouraging people to get a flu shot. Oneida is in 5 school districts along with its own tribal school district. One of the school districts recently announced that they had an outbreak of whooping cough. This is being monitored very closely because it is so easily spread. They are taking the usual action, such as encouraging everyone to cover their mouths and wash their hands. She had not heard a recent report on transmission, but hoped that by the time she returned it would be under control.

Also of concern in terms of public health are budgets which, of course, are tight everywhere. She spoke to a couple of people in Michigan, who would find it very helpful to receive more funding through the state for their cardiovascular disease prevention programs. Apparently, the state is receiving funding, but that funding is not flowing to the tribes. They are having discussions with the state, but collaboration has not been the best in Michigan. They are hoping to see some improvement on this.

There is an on-going concern about data collection. Many areas have not allowed for the distinction of Native American with the other racial categories. For any place data are going to be collected, there should be a prerequisite for AI / AN to be recognized as a category. There probably also needs to be standardization of how those data are to be collected. Michigan is working with various organizations and consortiums to try to develop standards that will work.

In terms of health activities, throughout the month of October and again in May, Michigan holds women's health luncheons and teas. Wisconsin has family fun nights, which are focused on the entire family and the entire community. Minnesota has walk-a-thons and other events to promote the "Just Move It" campaign. In Michigan, several tribes participate in the American Cancer Society's "Walk for Life." For the past 4 years, all 12 of the tribes in Michigan have encouraged participation in that annual walk. This is a challenge promoted through the Inter-Tribal Council of Michigan (ITCM), and it is linked to the annual Michigan Indian Family Olympics. They encourage year-round training and fitness, and the challenges usually take place between May and July, with varied numbers of participation of course. The winning tribe is announced at the Michigan Family Olympics, which is hosted by the Saulte Ste. Marie Chippewa Indian Community. The Grand Traverse Band of Ottawa and Chippewa Indians are the initiators of the challenges to all tribes in Michigan. ITCM helps promote the challenge and is the neutral steps collector, because the challenges encourage individuals to walk a certain distance on an annual basis.

Oneida has a number of events, one of which is Winter Fest for which they promote snowshoeing, cross country skiing, and ice fishing. Information tables and booths are provided for heart-healthy lifestyles. There was recently collaboration with one of the local ice arenas who offered a free ice skating evening open to anyone. The diabetic team coordinates a lot of events throughout the year. For the March event, the theme is "Under the Sea Adventure"

family fun night. They will have activities, healthy eating ideas, games (potato sack races, bean bag toss, inflatable bouncers and play yards) to encourage young people to participate, and informational folders for parents to encourage healthy snacks and a healthy food environment for their children.

With respect to additional issues to think about in terms of CDC and TCAC, most issues related to funding and concerns about cutbacks, particularly the rumor about having to rollback to 2008 levels. Another area of concern regards Homeland Security. Oneida has received funding in the past for the Citizen Corps Program Pilot, Competitive Training Grants Program, Emergency Management Performance Grant, Homeland Security Grant Program and Tribal Homeland Security Grant Program. Funding is decreasing every year, and her staff just told her that they are going to be terminating some of the programs totally, such as the Citizen Corps Program. This has been very helpful in her area with outreach and training, preparedness education, and planning. They are hoping that funding continues because of its importance in support for EM-HS staffing, equipment, and training funds.

Ms. Hughes submitted the following official report:

TCAC Member: Kathy Hughes, Vice Chairwoman for Oneida Tribe of WI
Area or National Organization: Bemidji Area Representative
Timeframe: As of January 31, 2011

How have you been able to disseminate and share information about CDC to your Area Health Board, Area Tribal Consortia, and other tribes or tribal organizations?

Bemidji does not have an Area Health Board. However, MAST (Midwest Alliance of Sovereign Tribes) is in the process of developing an Area Health Board as a sub-committee under MAST. In the future this will be the organization utilized to filter all health related issues/concerns through.

I maintain a listserv of health directors in the Bemidji Area and forward on all pertinent information/inquiries to this group as they come across from the CDC.

When appropriate and necessary, I also provide reports, usually verbal, at the MAST meetings. They occur twice a year.

Reports can also be provided when I am in attendance at regional meetings coordinated through HHS or IHS.

What public health issues would you identify or what ones have been brought to your attention by other tribal leaders from your Area that you feel should be shared with the TCAC?

It's the cold and flu season, so all areas are experiencing outbreaks but nothing more than expected. Because January through March is when the season typically peaks, we are encouraging anyone who hasn't received the shot to come in and get one. While the numbers aren't high, they are increasing as expected.

In Oneida, we have recently had a concern over an outbreak in Whooping Cough and are encouraging common prevention measures (such as covering your mouth when coughing) to try to prevent a major outbreak from occurring.

Budgets are tight in all areas, so it is not unusual to ask consideration for funding increases. Michigan in particular would find it helpful if they could receive more funding through the State for Cardiovascular disease prevention.

There is ongoing concern surrounding data collection for the Native American population. Many areas have not allowed for the distinction of Native American with other racial categories. The collection of this type of data is much needed and as we encourage this to take place we also have to recognize the need for standardizing how that collection is occurring. Michigan is working with various organizations and consortiums with some success.

Please describe some public health activities being planned or implemented in your Area?

Michigan has Women's Health Luncheons/Teas in October and again in May, around Mother's Day. The Hannahville Indian Community along with other Tribes participate in the ACS Walk for Life. For the past 4 years all 12 of the federally recognized Tribes in Michigan have been encouraged to participate in an Annual Tribe to Tribe Walking Challenge.

The challenge is promoted through the ITCM and is linked to the Annual Michigan Indian Family Olympics. These ongoing challenges help to encourage year round training and fitness. The challenge usually takes place between May and July and levels of participation among the tribes vary from year to year. The winning tribe is announced at the Michigan Family Olympics which is hosted by the Saginaw Chippewa Indian Tribe. The Grand Traverse Band of Ottawa and Chippewa Indians are the initiator or the challenger who puts out the invitation to compete each year. The ITCM works to help promote the challenge and helps by being a neutral steps collector. Many tribes also host smaller local walking challenges which vary from year to year.

Oneida continues to promote the "Just Move It" campaign. We have events scheduled throughout the year to encourage non-competitive walk/run activities. One of those in "Winter Fest" where there will be snowshoeing, cross country skiing, ice fishing and information on Heart Healthy Lifestyles. We also advertised a "Free Ice Skating" event at one of the local rinks. Our Diabetic Team coordinates many events throughout the year also with the next one taking place in March. The "Under the Sea Adventure Family Fun Night" will include many games and activities to promote exercise activity and good eating. Some of the games: potato sack races, bean bag toss, inflatable bouncer, inflatable play yard.

What additional issues do you think that CDC and the TCAC should be aware of as they relate to American Indian/Alaska Native people and Communities? What additional information would you like from CDC?

There are many issues and most of them relate to funding, Concerns are with the cutbacks and the ongoing issue of accessibility to what remains available.

I am familiar with Homeland Security. Oneida has received funding from Citizen Corps Program Pilot, Competitive Training Grants Program, Emergency Management Performance Grant, Homeland Security Grant Program and Tribal Homeland Security Grant Program. Funds decrease every year which is a concern but now discussions are to terminate some of the programs such as the Citizen Corps Program. These programs are being used for outreach, training, preparedness education and planning in several areas. The need for funding continues

but perhaps just as important is the need for support for EM-HS staffing, equipment and training funds to remain ready for rapid response and recovery.

Billings

No report was presented on-site, and no report was submitted.

California

No report was presented on-site, and no report was submitted.

Nashville

Kimberly Cantrell read brief highlights from this report into the record

TCAC Member: Kitcki Carroll

Area or National Organization: United South and Eastern Tribes, Inc.

Timeframe: Recent Years

How have you been able to disseminate and share information about CDC to your Area Health Board, Area Tribal Consortia, and other tribes or tribal organizations?

USET, especially the staff of the Tribal Health Program Support Division, have disseminated and shared information that they obtained from the CDC in multiple tribal forums (e.g. Tribal site visits; USET Health Committee meetings; USET Executive Board; IHS meetings; national Tribal working groups like the Tribal Epidemiology Center Community Health Profile working group; IHS Nashville Area Diabetes Meetings). Normally our team references where it obtains its information used in its reports and presentations, including the CDC when appropriate.

The USET Tribal Epidemiology Center as part of developing Tribal specific population health reports and presentations (for population comparisons, to serve as surrogate measures when primary data is not available and to help explain disease processes), has utilized a wide variety of CDC data sources and websites. In particular: CDC Wonder system, Diabetes data, Maternal and Child Health data, Mortality and Natality data, Immunization Coverage data, Obesity data, Sexually Transmitted Infection data, Behavioral Risk Factor Surveillance System data, Youth Risk Behavior Surveillance System data, Injury data, National Health and Nutrition Examination Survey data, and Hospital Discharge data.

The USET Diabetes Center has worked with the CDC Native Diabetes Wellness Program to disseminate Diabetes Education in Tribal Schools (DETS) curriculum. A CDC official (Dawn Satterfield) spoke at the 2009 USET Tribal Diabetes Coordinators training. Another project of CDC Native Diabetes Wellness Program, "Talking Circles," was shared at the 2008 Diabetes Coordinator training by another CDC official (Lorelei DeCora). In addition, information on the CDC's diabetes related Eagle project books/DVD/ Big Books and other materials from the CDC's AI/AN National Diabetes Education Program are regularly shared by the USET team with all Nashville Area I/T/Us. This is an ongoing effort, but especially important when used as a part of The USET Diabetes Center's orientation program for new tribal diabetes staff.

The USET Dental Support Center disseminates CDC information both as part of developing its tribal specific reports and guidance as well as sharing new oral health developments with our tribes. In particular the CDC's Water Fluoridation Reporting System (which provides water

system fluoridation data) and the CDC's National Oral Health Surveillance System (which provides oral health indicators by state) are used both for population description and comparison work. Both of these databases have been helpful for comparing state data to oral health surveillance work that our Center and tribes have conducted locally. Another way that CDC information is utilized is by disseminating what is learned from the CDC liaison from the Division of Oral Health who has been assigned to the IHS. This CDC dental health liaison regularly participates on IHS Health Promotion and Disease Prevention conference calls and gives CDC updates. The regular sharing of information helps maintain a fluid partnership between IHS, CDC, the USET Dental Support Center, and the USET tribe dental health programs in addressing AI/AN oral health issues.

The USET-Vanderbilt University Native American Research Center for Health as part of defining the burden of diabetes disease for a research partner tribe, has utilized CDC diabetes comparison data (national and state) to show the enormity of the community's health disparity.

What public health issues would you identify or what ones have been brought to your attention by other tribal leaders from your Area that you feel should be shared with the TCAC?

Below is a list of some of our area's top concerns, based either on our Tribal Epidemiology Center's analyses which show that individual tribes or our area as a whole have substantially higher rates, or identified through discussions with representatives from the communities that we serve:

- Diabetes
- Prediabetes
- Obesity
- Alcohol/Drug Abuse
- Prescription Drug Abuse
- Hypertension/Pre-Hypertension
- Smoking
- Mental health
- Early childhood caries
- Access to dental services

Please describe some public health activities being planned or implemented in your Area?

On an ongoing basis the USET Tribal Epidemiology Center is conducting and supporting disease surveillance and using this data to assist our communities with their health improvement planning. Some of the population health report and presentations developed from this data and disseminated to our tribes include:

- Community Health Profiles
- Diabetes
- Obesity
- Hypertension
- Maternal and Child Health
- Sexually Transmitted Infections
- Mortality
- Methamphetamine and other Substance Abuse

- Immunizations
- Cancer
- Tobacco

The USET Tribal Health Program Support division has other ongoing public health activities, such as:

- Maternal and Child Health Distance Learning Program (partnership with Univ. of Kentucky/Univ. of Arizona) to establish mechanism to help educate Tribal community health professionals in public health.
- Assisting tribes with negotiating Tribal/State data sharing agreements for birth/death data.
- Partnering with the Council of State and Territorial Epidemiologist to host regional Tribal-State Health Official meetings (April 2010).
- Helping author a CDC Morbidity and Mortality Weekly Report article about the 2009 H1/N1 AI/AN death rate (four times higher than other races combined).
- Supporting IHS National Immunization Reporting System whereby tribal specific childhood immunization coverage surveillance data is maintained and quarterly reports distributed to Tribal health officials.
- Conducting tribal specific oral health surveys, and assisting IHS adopt our methodology for use in other IHS areas.

Many of the USET tribes are implementing their own public health activities; some examples:

- Tribes that are implementing programs such as local fitness programs, walking programs, and healthy meals-cooking demonstrations programs.
- Tribes that have been awarded CDC grant funds from the “Using Traditional Foods and Sustainable Ecological Approach for Health Promotion and Type 2 Diabetes Prevention” (Catawba Indian Nation).

What additional issues do you think that CDC and the TCAC should be aware of as they relate to American Indian/Alaska Native people and Communities? What additional information would you like from CDC?

- Revise the CDC National Center for Health Statistics “Model State Vital Statistics Act and Regulations” guidance document to include language designed to increase state government recognition of the public health authority of federally recognized AI/AN governments and their health agencies, and the need to share data with them as a regular public health practice.
- It would be helpful if the CDC could help us access AI/AN specific data – a lot of the data available on CDC websites are just for White-Black-Other.
- Start including AI/AN specific data in the CDC’s National Oral Health Surveillance System to make it easier for tribes to compare themselves with other populations.
- Each year provide an up-to-date CDC contact directory of individuals in departments dealing with the specific disease conditions and also the contact information for individuals that may be able to help us access CDC resources – i.e. departments like minority health.

We would like to work more closely with the CDC in the following areas:

- implement prevention strategies
- promoting healthy behaviors
- fostering safer and more healthful environments

USET request (similar as was previously requested at the August 2009 TCAC meeting) that the CDC initiate a long term, federally funded program that would develop and maintain a unified system for linking IHS/Tribal/Urban data (in a manner that is acceptable to our federally recognized Tribes) to:

- state and federally maintained National Vital Statistics Systems – especially death and birth records;
- state and federally maintained Notifiable Diseases Surveillance Systems;
- other critical disease and injury data surveillance systems; and
- to increase AI/AN sample sizes in current and future Department of Health and Human Services (HHS) health surveys and disease and injury surveillance systems to allow valid and reliable Tribal specific population estimates.

Background in support of last request above – synopsis of previous testimony

As the Country undertakes healthcare reform, assurance of adequate data for all segments of the United States (U.S.) society is needed for policy development and program implementation. Healthcare reform efforts require a health data infrastructure that provides accurate and comprehensive measures and defines key variables to monitor health status, health system performance, identify and fill persistent data gaps for racial, ethnic and other health disparity populations.

The need for improved data on the AI/AN subpopulation, whether defined by geography or some other characteristic, requires adaptive data collection standards, methods and analytical techniques. While several current survey mechanisms can develop estimates for the AI/AN subpopulation the sample sizes are not sufficient to adequately assess and report the health of the AI/AN people, especially the small populations of federally recognized Tribal groups that are spread across the U.S. Often times any attempts to develop population estimates about small AI/AN subpopulations based on these numbers are seriously flawed (e.g. BRFSS; NHANES; NHIS; etc...). The multiplicity of factors that contribute to health disparities requires enhanced availability of AI/AN data that is truly representative and a collection of data on a broad array of variables. Defining economically sustainable and new record linkage techniques that will not put individuals and/or specific Tribes at risk of harm, but do allow valid and reliable population health estimates concerning AI/AN communities no matter their size is clearly needed if AI/AN health disparities of the 21st century are to be adequately measured and addressed.

Under the Indian Health Care Improvement Act Reauthorization, Tribal Epidemiology Centers are to be established and maintained in each of the IHS Areas, and the CDC Director is to ensure CDC assets provide technical assistance and work closely with each center in strengthening AI/AN disease surveillance. Further, the US Secretary of Health and Human Services is to grant each epidemiology center access to use of the data, data sets, monitoring systems, delivery systems, and other protected health information in the possession of the Secretary. Because many Tribes and Tribal Epidemiology Centers do not have the necessary resources and know-how to maintain a steady and focused effort to gain linkable access to the multitude of health data systems, AI/AN communities are hindered in obtaining data and analyses that can help them solve their health disparity issues. Similarly, because many Tribes and Tribal Epidemiology Centers are not positioned within the national public health infrastructure that designs and coordinates national health surveys and data collection efforts to properly advocate for increased AI/AN sample sizes, surveys continue to be implemented that

do not have adequate AI/AN sample sizes for critical epidemiological analyses and health reports.

Thus, USET believes that with the CDC's technical expertise, its special partnerships with every U.S. state health department, its lead role in steering most if not all of the County's public health surveillance systems, that the CDC is ideally suited to lead an HHS wide initiative to better assist and empower the national network of Tribal Epidemiology Centers and the Tribal governments that they serve improve the coordination and enhancement of AI/AN data collection, linkage and analysis, and to assist the US Secretary of Health and Human Services in ensuring each Tribal Epidemiology Center has access to use of the data, data sets, monitoring systems, delivery systems, and other protected health information in the possession of the Secretary. USET call's upon the CDC Director, in partnership with the U.S. Secretary of Health and Human Services, to form a true and well supported alliance directly with Tribal Epidemiology Centers and their Tribal constituents, to develop a sustainable 21st century Health Information Technology enhanced AI/AN disease and injury surveillance system focused intently on better measuring and communicating AI/AN disparities.

USET requests the CDC's assistance in mobilizing a long term federally funded program to develop and maintain a unified system for linking IHS/Tribal/Urban data (in a manner that is acceptable to our federally recognized Tribes) to key sources of data and to modify sampling frames of existing and future national health surveys for the purpose enabling the Tribes and Tribal Epidemiology Centers to better monitor the health status of the AI/AN peoples.

Navajo

David Nez
Public Health Emergency Preparedness Coordinator
Navajo Nation

Philene Herrera, Program Manager
Navajo Division of Health

David Nez reported on what he does for the nation as a Public Health Emergency Preparedness and Response Coordinator, and his work with epidemiologists and other health officials from IHS and within the Nation.

The Strategic National Stockpile (SNS) within CDC is deployed with deliverables to states, but trickles down to the tribes that subcontract with states. As the Program Manager, he is required to develop an SNS to establish command and control over the entire operation. There has to be a mechanism to request SNS access through the state to CDC for any medical supplies needed in case of an emergency. Navajo Nation is one of the tribes that has been extended the responsibility to create a temporary warehouse, called a Receiving Storage Sites (RSS), where the state can help deliver medical supplies in case of a disaster in order to push it out to various locations in a very short timeframe. From those RSS sites, they distribute to the points of dispensing. This can be used for a number of delivery activities, but this exercise has been used lately primarily for H1N1 vaccine distribution. H1N1 vaccine was barely trickling in, and was originally made for priority recipients. Much of the funding he shifted was for vaccinators to contract for that, but it never really happened. Part of his role is to deliver training for Incident Command Systems (ICSs).

They try to maintain spending of funds using the Homeland Security Exercise Evaluation concept to be in compliance with healthcare guidelines. They are currently going through drills. For one of the first drills, they activated all of health organizations through one email to see how fast resources responded. There is a measurement skill involved. One of the requirements is to go back to CDC through the state. Some people cover some ground to get to these locations to be able to participate. From there, they go through a table-top exercise, and then go full scale. By August, they will be involved in a full scale exercise with the state to conduct the statewide hospital exercise using the SNS plan. In the State of Arizona, where they are funded for this program, they also have a committee called the Arizona Tribal Executive Committee. Luke Johnson from the Mojave Tribe is the chairperson and Mr. Nez sits on that committee as a Vice Chair representing 22 tribes from Arizona. They have a strategic plan regarding how they will implement certain functions and responsibilities to the state and CDC within the next 5 years.

In terms of challenges, CDC recognizes the state in its agreement for funding. For that reason, the state really does not recognize tribes across state lines. The state forces him to have three SNS plans, one for each state in which he has a population, which really fragments his resources. This makes tribes vulnerable and places tribes them at risk. He planned to discuss this with ASTHO as well. In his plan, he knows the tribe is probably about 250 to 300 population, but on a given year and a given season, he may have 400,000 to 500,000 population as his responsibility to medical supplies to wherever needed. His first resource on the ground is IHS for treatment, and he is mainly part of the logistics to support IHS. IHS does not have the logistic resources to push mass supplies to a disaster location, but his plan is to support that effort. They will rely on IHS for treatment and health care on the ground.

Last year, they received a little over \$400,000 for the H1N1 response. As mentioned, he shifted most of this for contracting or vaccinators, which really did not happen. However, once vaccines became available, everything was being processed through the state, and vendors were identified, the vendors started delivering directly to the receiving sites. Working with IHS, 5 service units were identified originally and that increased to 12 service units. From that point, distribution was opened up to anyone who could administer vaccinations. This is when they lost the ability to monitor where the vaccines were going. They also lost track of whether the priority groups were being vaccinated, and they never received reports back to their office on the funding sources. They received \$50,000 from CDC through the state to recollect this information and conduct a table-top exercise with all of the partners who participated in the H1N1 response to assess the data and review the operational procedures, because different guidance was coming in from different directions.

Navajo Nation's epidemiology center is about three years old. They have a couple of epidemiology staff and one administrative support person. Her key concern is data. Mr. Nez believes the epidemiology center's responsibility to the tribes is to provide tribal data. Basically, what she is saying is that in Navajo Nation, they really do not own any of the data about Navajo populations. Data are collected by IHS, counties, states, federal, and other researchers. The data technically do not belong to the local jurisdiction. She wants to open dialogue and forge agreements to be able to bring those data back where she will be able to use them for tribes, or open up her own data system. This is going to require a lot of funding for hardware, software, manpower, and so forth in order to use these data for tribal advantage in terms of garner funding and making determinations regarding where to direct funding sources to work on winnable battles.

Some reports they have received from the trauma center suggest that the number one cause of death is accidental injuries or accidents via auto, sports, falls, et cetera. Most of those are due to head injuries. Treatment for head injuries is expensive, with an average time for treatment in these trauma centers being somewhere in the three- to five-hour range from the time of report to temporary stability, to transport, to reach a facility to receive treatment. That is one of the projects on the list for Mr. Nez's health department. They have had some researchers evaluate this situation and offer some recommendations. Again, this takes a lot of funding.

Ms. Herrera indicated that she was with the Navajo Nation HIV, Health Education, and Teen Pregnancy Prevention Program. She added that the Navajo Epidemiology Center produced two reports, a cancer data report that covers a 9-year span and shows that the prevalent report of cancer was colorectal, and a report of a pregnancy risk assessment monitoring system on the New Mexico side of the reservation that had 586 participants. Most of the participants were between the ages of 20 and 34, and the report showed that pregnancy rate and improved maternal child health care had to do with entering the system early. Another report that Navajo Nation is ready to publish is the Youth Risk Behavior Survey (YRBS), which they have been conducting since 1993. Their latest report was 2008. There was a major delay between IHS turning the data over to the Navajo Nation so the Navajo Nation could work on it. The Navajo Nation said they would take care of it, so they got an epidemiologist and within about a 4-month time period were able to speed complete the report done. They hope to publish and distribute the report soon. That will assist a lot of schools with grants, policies, et cetera. There are many risks in the Navajo Nation and in Indian Country as a whole.

The HIV prevention program is also has revised a 14-year old HIV policy and code that was adapted by Navajo Nation Council in 1994. A workgroup worked with the national IHS HIV program on this project, and will send it to the tribal council for approval. They added a few enhancements, because over that 14-year timeframe, there have been many improvements in HIV treatment and care. The HIV prevention program is a recipient of HIV screening dollars from the same national office, so this year they hope to reach 1000 people through screening. Dr. Iralu from the Gallup Indian Medical Center is the infectious disease consultant for Navajo area HIS. He will be producing the HIV epidemiology report. Last year, they had 40 new cases of HIV. Ms. Herrera was recently informed by the Tribal Social Hygiene Program that we will have 41 new cases, so they have to work hard to bring those incidence rates down.

There are new elected officials in the executive branch, so they hope the new administration is tobacco-friendly so that they can have a tobacco-free policy, including in casinos. While casinos raise revenue, compared that to resulting chronic disease and overbearing health care costs, tobacco-free policies will cost less in the long-run. They must institute taxing, et cetera. They are addressing obesity through skateboarding for children to get them more active, putting on sports tournaments for youth, holding summer walks and runs, having monthly and seasonal observances to promote the heart health, obesity prevention, physical activity, et cetera. They will produce a cancer plan that is reflective of the epidemiology data they have been able to acquire and assess. In addition, they are looking toward public health accreditation.

Oklahoma

Kathy Hughes read this report into the record

TCAC Member: J.T. Petherick (Alternate), Cherokee Nation
Area or National Organization: Oklahoma City Area
Timeframe: June – December 2010

How have you been able to disseminate and share information about CDC to your Area Health Board, Area Tribal Consortia, and other tribes or tribal organizations?

Yes, the Oklahoma City Area Inter-Tribal Health Board (OCAITHB) and the Southern Plains Inter-Tribal Epidemiology Center (SPIEC) maintain active e-mail distribution lists, as well as hosting quarterly meetings and other events. CDC information is shared on a regular basis.

What public health issues would you identify or what ones have been brought to your attention by other tribal leaders from your Area that you feel should be shared with the TCAC?

Impact of health care reform activities and its effect on CDC activities, CDC activities in light of proposed funding cuts, ensuring funds provided to state and local governments reach Tribal populations.

Please describe some public health activities being planned or implemented in your Area?

Pandemic Flu training for Tribes, tobacco prevention and cessation, building healthier communities, health promotion/disease prevention, emergency management training, addressing long-term care needs in Tribal communities.

What additional issues do you think that CDC and the TCAC should be aware of it as they relate to American Indian/Alaska Native people and communities? What additional information would you like from CDC?

I think it would be important for the CDC to share its views regarding Public Health Accreditation and how it will potentially impact funding for Tribal Nations. Additionally, CDC and TCAC should discuss efforts to build public health capacity in Indian Country to ensure Tribal Nations wishing to become accredited have the tools to do so.

Phoenix**Candida Hunter
Councilwoman, Hualapi Tribe**

Ms. Hunter reported that one way Phoenix gets information out is through Inter-Tribal Council of Arizona (ITCA), which has a listserv and provides information to health boards, including the Nevada Indian Health Board. She also met some of the tribal leaders at the IHS 2013 budget formulation in January and was able to make contact with them to let them know that she is the Phoenix Area representative. At that meeting, the health priorities for the tribes that they came up with for HIS include contract health services, diabetes (including obesity and renal failure), behavioral health (including mental health and substance abuse disorders), cancer, dental services, maternal and child health (including adult / childhood obesity and women's health care issues), healthcare facility construction, cardiovascular health (including heart disease and hypertension), elder health and health promotion, disease prevention (including injury prevention), suicide prevention, and domestic violence prevention.

For public health activities, Arizona has the "First Things First" program that was passed by the voters and which focuses on providing health services for children 0 to 5 in Arizona to grow up

ready to succeed. Arizona chose to be their own regional council, so they are in charge of whatever health issues they want to address for their children ages 0 to 5. They have different activities depending upon what their priorities are in their region, and they provide education to their communities. For instances, Walapai has a maternal child health program, holds health fairs for youth, and provides education for prenatal up to 5 years old for parents as well as children. All communities have walks and runs, sobriety events, bird dancing (which is a physical activity that includes a lot of culture and tradition), et cetera.

In terms of information for CDC and TCAC, the previous day there was discussion about consultations. One issue is that there are many meetings and many tribal leaders sit on two or three committees. For example, that day 2013 IHS Budget Formulation meeting was also being convened and the next day would be the Consultation. Therefore, some people could not attend the TCAC meeting, and she was appointed. When thinking about setting up TCAC Consultations, she thought they should take care not to schedule them at the same time as national meetings.

With regard to capacity-building, CDC seems to be doing this by providing fellowship programs and internships. The problem seems to be that much of this is state-based rather than with tribes. Communication is lacking. One of the issues with some tribes in Arizona and Nevada is that they are extremely remote. They do not live a 3G network, so they do not have email capability and access all of the time. This is a major problem for tribes who continue to rely heavily on faxes and telephones. Some areas are like living in developing countries, which must be taken into consideration in terms of reaching out to tribes.

Northwest Portland Area Indian Health Board

Joe Finkbonner, Executive Director Northwest Portland Area Indian Health Board

As mentioned the previous day, NPAIHB is a recipient of the NPHII grant, which is one of their efforts toward improving the public health infrastructure. They have an elaborate network for disseminating information via their website and through distribution lists. They maintain a facsimile distribution list, but only a few of their delegates continue to have the desire to receive information via fax versus by electronic communication. The way their electronic communications are set up, information can be distributed in a variety of ways in order to target specific audiences in specific states. CDC can send something to them to distribute in Northwest Indian Country.

In terms of public health, this fall they conducted their 7th Annual Emergency Preparedness conference. Different about this conference was that they branched out beyond public health preparedness and asked their colleagues and partners in emergency preparedness to join them in a conference that included keynote speakers from the Federal Emergency Management Agency (FEMA); and Dr. Evan Adams from British Columbia, who is the Deputy Director for the Deputy Minister of Health in British Columbia, and who is also known as Thomas Builds-the-Fire in "Smoke Signals." He reported on British Columbia's process and outcomes for pandemic H1N1 influenza in British Columbia. Dr. Adams is also one of the co-chairs of the Northwest Public Indigenous Health Group, which will assess all of the coastal First Nations folks from Oregon, Washington, and British Columbia. They will seek to build partnerships and collaborations without regard to borders in order to assess issues on both sides of the US / Canada border.

Oral health is a major issue in most tribal communities, which is just starting to come to the surface. It is difficult to speak about this in any detail because the last oral health assessment IHS did was in 1999. Since that time, some of the dentist support centers rushed to conduct exams in over 8,000 Native American youth this summer. CDC was impressed with the extent and the volume of examinations that dental support centers accomplished. He saw a draft report, and the information is shocking. Not surprising was the number of carries currently in our young children's mouths. This must be a priority area for Indian Country.

Portland has historically fared pretty well in terms of data sharing agreements with all of its partners in the northwest; however, they seem to have reached an impasse with the area office of IHS. In fact, they are butting heads with IHS at this point. This is highly unusual because it is not even over information that is as sensitive as other information they have already shared. The point of contention involves a Medicaid project with the State of Oregon.

In other public health news, "Risky Business" is one of the trainings offered to tribes in the northwest. Three of these trainings are usually conducted annually. They spend a full day training on a variety of issues (e.g., injury prevention, cancer control, diabetes, et cetera) because all projects are attempting to reach the same target audiences. Unfortunately, they had to close their tobacco projects, but hope that the information they have gained will be transferring to some of their other epidemiology and HPV projects, so that the spirit of public health continues from the knowledge that was gathered from the tobacco projects.

Their cancer control project teamed up with their urban partners in Portland, the Native American Rehabilitation Association, which has a New Year's Eve Sobriety Pow-Wow every year. The cancer control project named a large number of pink shawls, and survivors of cancer were asked to come out during the New Year's Eve Sobriety Pow-Wow and they wrapped them in the shawl. This was a huge hit, and Mr. Finkbonner said he had a feeling that their "name would be mud" if they stop doing this, so it is probably going to be an annual event for them. It was such a nice gesture for everyone who attended, he thinks they will look forward to it next year. Hopefully, they will get their message out by honoring those who have survived cancer and letting them know that their struggle is noted.

Their NARCH program is planning a conference for the end of March to bring in past recipients to detail the projects they have worked on as a result of being NARCH recipients. It appears that a fair number of areas have some sort of NARCH grant or NARCH program, so this seems like a great link. If Native Americans are part of these training programs, for NARCH programs there should be a media design spot in the CDC epidemiology workforce development programs indicating that it would be a nice linkage to partner with one of the NARCH centers.

Portland submitted two formal reports, one include here and the longer one included as Appendix A:

CDC Talking Points 2011

Tobacco

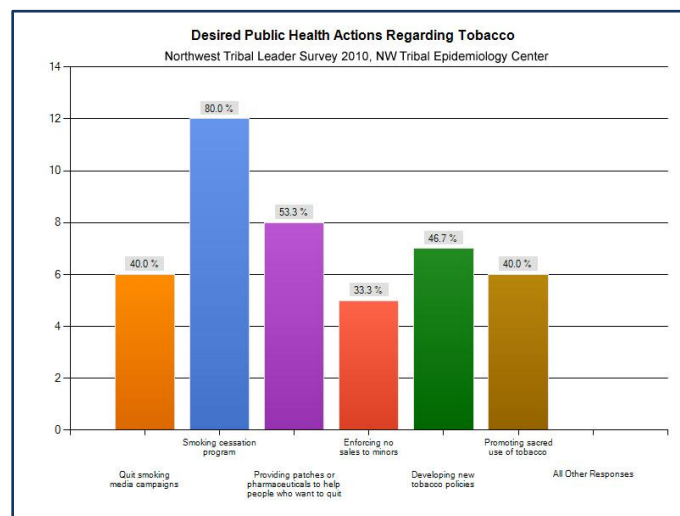
Commercial tobacco use is among the most preventable causes of disease and death within the American Indian/Alaska Native communities. In the Northwest, 37% of AI/AN youths and adults report current smoking, this results in turn in excessive second hand smoke exposure.

The Northwest Portland Area Indian Health Board, Northwest Tribal Epidemiology Center conducted a tribal BRFSS. Between 66 and 69% of all respondents reported smoking at least 100 cigarettes in their lifetime. Men were more likely than women to report smoking at this level. Respondents who reported smoking reported being unmarried, high school educated or less and have a household income below the poverty level.

Despite the current knowledge about the harms of commercial tobacco use and exposure to second hand smoke, there exists reluctance on the part of many communities to become smoke free. Tensions exist between job training and economic issues versus long-term health issues. These tensions will need to be discussed and grappled with by Tribes. Individual tribal community decision will have a high level of impact on activities related to smoking cessation. Tribal councils are responsible for a great deal of oversight including economic development, gaming, housing, and community health, with limited resources. Tobacco misuse is often overlooked by decision makers. To make tobacco a policy and health priority, it is important to emphasize the health benefits for generations to come. Successful programs must be based in the context of the cultural value system and be based on tribal priorities.

In a 2010 Survey conducted by the NW Tribal Epidemiology Center desired public health action priorities around tobacco use were assessed:

- Eighty percent of those surveyed were interested in AI/AN targeted smoking cessation programs.
- Fifty three percent were interested in being able to provide patches or pharmaceuticals to those wishing to quit smoking.
- Approximately 47% of health leaders were interested in developing new tobacco policies.
- An equal percentage of leaders (40%) felt that quit smoking media campaigns were needed for their Tribes and that the sacred use of tobacco should be promoted.



Teenage Pregnancy

Among those who answered a survey of tribes and urban Indian programs in 2010 performed by the American Indian Health Commission in Washington State, 75 percent thought that teen pregnancy was an important issue and 50 percent thought it was one of the three top risk

factors that could be changed to make the biggest difference in maternal and infant health outcomes for their tribe/clients.

In 2008, there were 137 babies born to AI mothers on Medicaid in Washington State who were 16 years old or younger at age of conception, about 7 percent of all AI pregnancies.¹ This percentage seems to be similar for AI living in urban and rural areas.² Age 16 at conception is considered a risk factor for low birth weight babies, and this occurs at a rate that is 70 percent higher than for the Medicaid population as a whole.³ It is an even greater risk factor for conception to occur under age 15, and this represents 3 percent of AI mothers on Medicaid, 70 percent greater than the total pregnant Medicaid population.⁴ While infant mortality rates have improved for the overall population in Washington State during the past 12 years in nearly every age group, the infant mortality rate has increased for those who are less than 15 years old by over 37 percent.⁵

While there are fewer health risks for pregnant women who are older than 16 years old, there may be social and economic consequences, including lower levels of education, employment, income over the course of their lifetimes. In 2008, the teen birth rate for all Washington State residents 15 to 19 years old was 31.8 per 1,000.⁶ A closer look shows that the overall teen birth rate is an average of extremely high rates for Hispanics (92.6) and fairly low rate for Whites (21.9).⁷ For all minorities, the teen birth rate was 54.5 per 1,000 and this is very similar to the birth rate for American Indians and Alaska Natives teens.⁸ In 2008, there were 239 births to AI/AN who were 15 to 19 years old in Washington State, which is a rate of 55.8 per 1,000.⁹ While the survey of tribal health programs conducted for this MIH Strategic Plan identified teen pregnancy as a priority, the meetings and focus groups with tribes to discuss issues and recommendations in the plan pointed to a number of areas where tribes are not making teen pregnancy a priority. At one tribe, teens reported that health and sex education classes had been discontinued years ago. At another tribe, teens said that they wanted condoms to be available in the school, but that idea was rejected by the Tribal Council. Teens said that they did not want to seek birth control or pregnancy tests at their tribal clinic because they were worried about confidentiality. Health care professionals said that annual exams for women were not recommended or provided until the woman was 23 years old.

¹ Laurie Cawthon, MD, MPH, Risk Factors for Low Birth Weight Among Washington Medicaid Women with Births in 2008, DSHS Research and Data Analysis, March 23, 2010.

² In the Seattle area, 6.3 percent of AI births were to teens during the period of 2001-2005 according to the Urban Indian Health Institute, Community Health Profile 2009, Seattle Indian Health Board, Seattle, Washington.

³ Laurie Cawthon, MD, MPH, Risk Factors for Low Birth Weight Among Washington Medicaid Women with Births in 2008, DSHS Research and Data Analysis, March 23, 2010.

⁴ *ibid*

⁵ State of Washington, First Steps Data Base, Infant Mortality Rates for Washington Births by Year of Birth, March 4, 2010.

⁶ Laurie Cawthon, E. Kohlenberg, D. Mancuso, B. Felver, H. Axelsson, Employment and Health among DSHS Clients, by Race and Ethnicity and Region. Presented to the Indian Policy Advisory Committee, January 14, 2010.

⁷ *Ibid*

⁸ *Ibid*

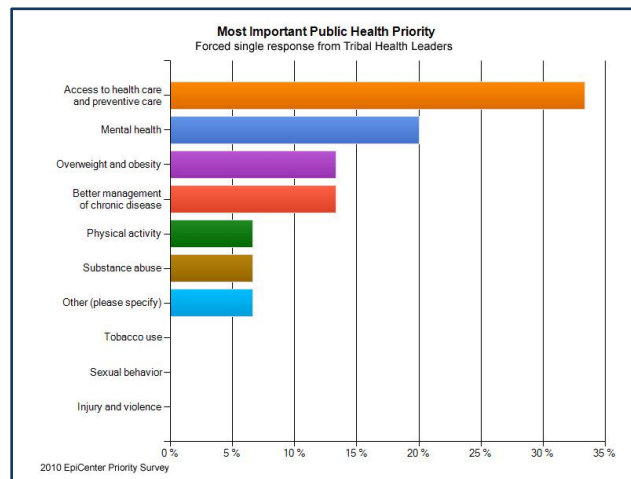
⁹ *Ibid*

Obesity

The Northwest Tribes have long promoted education to address nutrition and physical fitness. For the past several years, these topics have been among the top ten health promotion priorities for the NW Tribes, as determined by an annual surveys conducted the Northwest Portland Area Indian Health Board (NPAIHB), Northwest Tribal Epidemiology Center (EpiCenter). Similar interest in physical fitness and nutrition has also been expressed by Oregon tribal youth. In 2009, over 144 Oregon American Indian teens and young adults (ages 13 – 21 years) participated in a NPAIHB survey inquiring about their health priorities. The topics of greatest interest to AI/AN youth were physical fitness and exercise (58%), nutrition (49%), weight and body image (42%), and diabetes (31%) also ranked high.

At every stage of the lifespan, AI/ANs living in the Northwest are impacted disproportionately by high rates of overweight, obesity and associated chronic conditions. This is also true among AI/AN children and teens. In Oregon, results from the Oregon Health Teens survey indicate that fully one-third of AI/AN teens in 8th and 11th grade are overweight or at risk.

Of the solvable public health issues, overweight and obesity are the top priority to tribal leaders responding to a public health survey conducted by NPAIHB in 2010, however access to health care and preventive care, along with mental health issues outpace concern about these issues.



Tucson

No report was presented on-site, and no report was submitted.

Direct Service Tribes

No report was presented on-site, and no report was submitted.

National Congress of American Indians

Derek C. Valdo
Pueblo of Acoma
Southwest Area Regional Vice President
National Congress of American Indians

Mr. Valdo noted that NCAI disseminates and shares information about CDC through its HHS committee, and there is a health subcommittee that also gets information out for CDC. NCAI is

basically comprised of 7 major committees and about 30 subcommittees, with everything vetted through those committees.

With respect to public issues they would identify, during the last NCAI meeting in Albuquerque, 142 resolutions were submitted from Indian Country. He listed the 6 he thinks apply to CDC, which included addressing alcohol / drug / substance abuse; calling upon Indian Health Service for increased attention to Rocky Mountain Spotted Fever health emergencies in Indian Country; support for full funding for the Indian Health Care Improvement Act passed as part of PPACA 2010; support for full funding for the Special Diabetes Program; and taking a stand for healthy families and healthy futures by addressing fetal alcohol spectrum disorders (FASD) in tribal communities.

The primary public health activities planned by NCAI are hosting a national “Just Move It Campaign. Tribal leaders get out and run, take pictures, and try to take that program back to their communities. He and Ms. Hunter are running this year in an effort to support this cause.

In terms of the additional issues CDC should be aware of, from the national level, NCAI is the umbrella of Indian Country—the consortium of all tribes. They try to develop a national position that is supported by all of Indian Country regardless of population or land size. For 2011, NCAI is seeking increased appropriations for critical services, infrastructure, improved amendments to self governance programs, violence against women, ACT re-authorization, and protection of Indian Country from budget cuts or rescissions. About 95% of all federal funding to tribes is in the discretionary part of the budget. A large number of pilot programs are in the earmark language. In terms of the proposal to rollback to 2008 or 2006 funding levels from Mr. Valdo’s perspective is not feasible. They are trying to protect Indian Country from “taking any hits” because they have made tremendous gains in the last two years. Overall, their access funding for direct services and direct funding has increased across the board about 25% to 30%. If they must rollback to 2008 or 2006, that progress made over the last two years will be lost.

Also of importance is supporting trust responsibility, ensuring that federal consultation policies are in place, enforcing accountability, implementing the Indian Health Care Improvement Act included in PPACA, and implementing the Tribal Law and Order Act that basically delegated duties to SAMHSA, CDC, IHS law enforcement, and Department of the Interior to work together. All of this information is available on the NCAI website. Mr. Valdo encouraged everyone to visit the website and pull down some of the legislative priorities and additional documentation that is available.

Mr. Valdo submitted the following official report:

TCAC Member: Derek Valdo

Area or National Organization: National Congress of American Indians

Timeframe: 10/25/2010 to 02/02/2011

How have you been able to disseminate and share information about CDC to your Area Health Board, Area Tribal Consortia, and other tribes or tribal organizations?

NCAI disseminates and shares information about CDC through its Health and Human Services committee and the Health Sub-committee.

What public health issues would you identify or what ones have been brought to your attention by other tribal leaders from your Area that you feel should be shared with the TCAC?

Resolutions passed and supported at NCAI's annual meeting are available at the following link: [NCAI Resolutions](#)

CDC-specific resolutions include the following:

- ABQ-10-020 Addressing Alcohol/Drug/Substance Abuse
- ABQ-10-023 Calling upon Indian Health Service for increased attention to Rocky Mountain Spotted Fever health emergencies in Indian Country
- ABQ-10-040 Support for Full Funding for the Indian Health Care Improvement Act, Passed as part of the Affordable Health Care Act of 2010
- ABQ-10-045 Support for full funding for the Special Diabetes Program
- ABQ-10-101 Taking a Stand for Healthy Families and Healthy Futures by Addressing Fetal Alcohol Spectrum Disorders (FASD) in Tribal Communities

Please describe some public health activities being planned or implemented in your Area?

NCAI hosts Just Move It campaign at the national level.

What additional issues do you think that CDC and the TCAC should be aware of it as they relate to American Indian/Alaska Native people and communities? What additional information would you like from CDC?

National Legislative Priorities:

- Increase appropriations for Critical Services and Infrastructure
- Self-governance Program Amendments
- Violence Against Women Act (VAWA)
- Protection of Indian Country for budget cuts or recissions
- Trust Responsibility and Federal Consultation Policies
- Implementation of the IHCA & Affordable Care Act
- Implementation of the Tribal Law and Order Act

National Indian Health Board

Cathy Abramson
Saulte Ste. Marie Chippewa Indians
National Indian Health Board

Ms. Abramson indicated that she was recently elected as the NIHB Chair. Everything she does she is learning by trial and error. She is on the NIHB board and represents the Bemidji area. Bemidji does not have an area health board. In an effort to show support for the Bemidji area, she was elected. This is the second TCAC meeting she has attended. NIHB is regrouping and

will concentrate on strengthening its relationships with everyone they we work with. They have conducted a feasibility study of tribal participation in public health accreditation. They have recently released the “2010 National Tribal Public Health Profile” summarizing tribal public health performance activities and services and NIHB is currently conducting.

Ms. Abramson submitted the following formal report:

Good afternoon Honorable Tribal Leaders, Dr. Thomas Frieden, Dr. Judy Monroe and other Centers for Disease Control and Prevention (CDC) representatives. My name is Cathy Abramson, Chairwoman of the National Indian Health Board (NIHB). The National Indian Health Board represents the 564 Tribes and it is on their behalf that I present this testimony today. Thank you for the opportunity to present this testimony concerning the Centers for Disease Control (CDC), National Public Health Improvement Program (NPHIP) and the infrastructure investments in state, tribal, local, and territorial health departments.

The NIHB recognizes the efforts of CDC to strengthen and improve public health infrastructure and performance through various initiatives supported by what is now called the Office of State, Tribal, Local and Territorial Support (OSTLTS). Such initiatives include:

- Public health accreditation
- National Public Health Performance Standards Program
- Local and State Health Department Profiles produced by the National Association of City and County Health Officials (NACCHO) and the Association of State and Territorial Health Officials respectively (ASTHO)
- Health People 2020
- (And the recent) National Public Health Improvement Program which made funding available to state, Tribal, local and territorial health departments and organizations

A number of economic challenges and infrastructural issues have led to a decline in the implementation of the essential public health services across the United States. Essential services such as disease detection and monitoring, vital records, and health information technology are operating at minimal levels. Program capacity in chronic disease, injury, labs, and environmental health and other areas are at risk. Without a sustained commitment to infrastructure investments in essential public health services, the protections provided by the nation’s public health system will fail. We know that performance-based improvements have a strong likelihood to improve the volume and health impact of public health services, such improvements include improved efficiencies, cost savings, leadership development, and utilization of tools and strategies that improve quality.

While CDC has made a significant investment in creating standards for performance, increasing the capacity of organizations such as NACCHO, ASTHO, and the National Association of Local Boards of Health, among others, NIHB continues to be excluded as a national partner with CDC in performance improvement initiatives. Such exclusion has a direct impact on Tribes.

Nationally, CDC has invested a great deal to assess and build the capacity and performance of local and state public health systems; however, very little has been invested to build tribal public health systems. NIHB recognized this gap and continues to be at the forefront to ensure Tribes are included. For example:

- NIHB conducted a feasibility study of Tribal participation in Public Health Accreditation.

The study determined that Tribal public health accreditation is feasible and a summary of results were put into a Strategic Plan with short- and long-term strategies to include Tribes in accreditation. A number of these strategies are being successfully implemented, including the development of Tribal Standards and Measures. The Public Health Accreditation Board has partnered with NIHB to ensure the Tribal Standards and Measures are developed through a process of Tribal Consultation and that the resulting accreditation program is relevant, applicable and culturally appropriate for Tribal settings. The PHAB Tribal Standards and Measures are scheduled to be released just prior to the launch of the accreditation program.

- NIHB recently released the 2010 National Tribal Public Health Profile summarizing Tribal public health performance, activity and services.

As was mentioned previously, profiles exist for local and state health departments that cover the last decade and were conducted through funding from CDC. Given that NIHB does not currently receive funding from CDC to conduct public health systems research, NIHB was able to use funding from an alternate source to create a profile that is modeled after the local and state profiles and includes other indicators specific to Tribes. Due to NIHB's foresight and initiative, there will now be baseline data for a number of the Healthy People 2020 performance objectives that would have otherwise been unavailable.

- NIHB is currently conducting other public health systems research to harmonize the data collected in the Tribal profile with the local and state profiles and exploring Tribal readiness for accreditation.

The result of this project will be the first reports and articles to describe public health performance that includes ALL systems - local, state and TRIBAL. The significance of such work will contribute greatly to the understanding of our nation's public health system as a whole. The other area this project explores is Tribal readiness for accreditation that will inform the development of technical assistance services needed to improve Tribal public health capacity.

These are just a few examples of the contributions that NIHB has made to the larger national initiative to improve public health performance and capacity; however, all of this has been achieved through funding from other sources.

CDC's Office of State, Tribal, Local and Territorial Support includes Tribes in its mission and name only. NIHB holds a cooperative agreement with CDC and has been conducting work under this agreement. Despite our efforts to obtain funding to conduct this important work, to raise the level of support, technical assistance and quality improvement for Tribes, our requests remain unanswered. Meanwhile, the organizational partners working with local and state health departments continue to receive funding to elevate public health performance for the rest of the U.S. population.

More recently, CDC National Public Health Improvement Program funds have gone to an organization serving state health departments to provide technical assistance to 8 Tribal grantees. How can an organization that has little to no knowledge, experience, or understanding of Tribal public health systems provide culturally competent services and technical assistance to Tribes? The Tribes will be training their technical assistance providers about the complexities of Indian health. This is both unfair and unjust.

Since its establishment in 1972, the National Indian Health Board (NIHB) serves federally Recognized American Indian/Alaska Native tribal governments by advocating for the improvement of health care delivery to American Indian/Alaska Natives. The NIHB ensures that the Federal government upholds its treaty obligations to American Indian and Alaska Native populations in the provision and facilitation of quality health care to our people.

NIHB respectfully requests that Tribes be given the same level of funding, support and resources to build their public health performance and capacity as local and state governments. NIHB has demonstrated its leadership and capacity to provide the research, resources, technical assistance and training to Tribes in the area of public health performance and capacity. Funding for tribal public health performance and capacity needs to go directly to the Tribes and through the NIHB Cooperative Agreement, not a non-Tribal organization.

The Federal Government's provision of health services is critically important for Alaska Native and American Indian Tribes. This is so, not only because of the unique relationship that exists under the Constitution between the Federal Government and the Tribes, but because our tribal communities generally face far greater health risks than the general population. A strong relationship between the CDC and Indian Tribes is thus critical to achieving positive health outcomes across Indian Country.

Ladies and Gentlemen, Honorable Tribal Leaders, and representatives of the Centers for Disease Control and Prevention, thank you for the opportunity to present these comments today, and I look forward to working with the CDC TCAC and with larger CDC organization to incorporate these comments into the CDC's organization.

Tribal Self Governance Advisory Committee

No report was presented on-site, and no report was submitted.

CDC/ATSDR Program Update & Activities in Indian Country

National Center for Environmental Health / ATSDR Office of Tribal Affairs

**Annabelle Allison, Tribal Liaison / Lead Public Health Scientist
Office of Tribal Affairs, Office of Policy, Planning & Evaluation
National Center for Environmental Health / Agency for Toxic Substances and Disease Registry
Centers for Disease Control and Prevention**

Ms. Allison reported that she has spent the past 2.5 years working to gain visibility in Indian Country, assisting NCEH / ATSDR with tribal projects regarding environmental health issues, working heavily on a national initiative NCEH / ATSDR recently finished known as the National Conversation, establishing a National Tribal Environmental Health Think Tank, creating a training course titled "Working Effectively with Tribal Governments," working on an HHS Environmental Justice Interagency workgroup, and hosting a PHPS for 6 months.

When a tribe contacts NCEH / ATSDR with an issue, two mechanisms are typically utilized to help address the issue. There is a formal internal triage process within ATSDR used to determine how best to respond to a formal tribal request, either through general more informal technical assistance or through a more formal process of conducting a public health

assessment or health consultations and writing a report. She also has resources within NCEH, so some requests may go to them as well.

One of the largest efforts she has been involved in during her tenure with ATSDR has been the Navajo uranium assessment and mediation activities. In 2006, the Health Studies Branch initiated a study on the Navajo Nation related to water hauling practices. Approximately 30% of the Navajo Nation does not have access to piped water systems, so they must go to unregulated wells to haul water. In many cases, they are hauling water for their livestock and for themselves to be used for drinking and other purposes. The Health Study Branch was interested in assessing public health activities pertaining to water hauling. When the Environmental Protection Agency (EPA) Region 9 heard about this, they asked her group to include analyses for uranium, arsenic, and cadmium. Indirectly, ATSDR became involved in periodic progress update meetings with the Energy and Commerce Committee led by Representative Waxman in DC. This is commonly known as the Waxman 5-Agency, 5-Year plan. NCEH's Health Studies Branch conducted a water hauling study from 2006 to 2010.

Since the 1980s, Navajo Nation officials routinely went to Congress to give testimony about the impacts of uranium where they live due to the mining that occurred since the 1940s. Mining activities ended in the early 1980s, which left a considerable amount of contamination. In about 2007, Representative Waxman (D-CA) heard the Congressional testimony and created the 5-Agency, 5-Year plan. He compiled IHS, EPA, Department of Energy, Nuclear Regulatory Commission, and the Bureau of Indian Affairs plans to develop a tidier plan regarding how to assess and alleviate uranium contamination. When EPA Region 9 heard about CDC's health study on water hauling practices, Representative Waxman asked them to begin participating in their activities as well. Therefore, they periodically travel to DC to do present updates to Representative Waxman on the activities in which NCEH / ATSDR have been involved.

In 2009, NCEH / ATSDR learned that we were going to receive \$2 million to conduct an epidemiologic birth cohort study on the Navajo Nation. Since that time, they conducted some research on the Navajo Nation, met with a number of representatives from the various agencies, and invited several delegates from the neighboring academic institutions that work at Arizona University, University of New Mexico, and Utah State University to meet to convene to discuss the best way to conduct an epidemiology study on Navajo Nation. Based on this information and touring various sites, ATSDR developed a plan to conduct a birth cohort study. This study follows pregnant moms from the beginning of pregnancy to 2 years of age for the child. They anticipate that this will be 3-year study. The study was officially kicked off in fiscal year 2010. The University of New Mexico was selected to conduct the study, for which they will receive \$1 million. ATSDR set aside \$750,000 to divide equally between for Navajo IHS and Navajo Division of Health to engage in outreach and education in the communities about the birth cohort study, and to identify and recruit as many participants as possible through screening. The study is currently in the design stage. There have been several discussions about what the focus areas should be, and following a phased approach because Navajo Nation is such a large reservation and there is literally a lot of ground to cover. They anticipate recruiting 1300 to 1500 pregnant women for this study over three years.

Another activity that arose out of the water hauling study was that ATSDR provided training for Community Health Representatives (CHRs) in New Mexico in 2009 on how to convey the water hauling results to the household members who participated, and how to translate the information into the Navajo language. That was a very successful course. They are in the process of developing a DVD geared toward IHS clinicians about screening for individuals who suspect that they might have been exposed to uranium. This is anticipated to be completed by

summer 2011. NCEH / ATSDR have been engaged in various efforts with other tribes as well (Shoshone Bannock, Cheyenne River Sioux Tribe, et cetera).

The National Conversation was an 18-month effort on the part of NCEH / ATSDR to develop an action agenda of ways the public can be protected from chemical exposures. She felt strongly that they needed to work in this area with tribes, and they worked diligently to get inclusion to ensure that the perspective of the tribes was heard. For the National Conversation, 6 workgroups were created. NCEH / ATSDR managed to get one tribal representative on each of the 6 workgroups, as well as on the Leadership Council who oversaw the 6 workgroups.

Through this process, a number of challenges came to light. Through dialogue with and feedback from the tribal representatives who participated in the workgroups, it was pointed out that there is an assumption that IHS takes care of tribes in terms of public health services. This was substantiated by some of the emergency response efforts ATSDR engaged in during the past year related to the oil spill along the coast. There was an assumption that some of the tribes would be taken care of by HIS, so ATSDR had to deliver a lot of education about this. Another tribal challenge that stood out was the lack of knowledge about tribal recognition status; that is, what it means to be federally recognized, versus state recognized, versus non-recognized tribal groups. Significant education is still needed in that area.

The National Tribal Environmental Health (NTEH) Think Tank is an effort through which Ms. Allison plans to focus on the development of short- and long-term strategies to get to the heart of some of the priorities that need attention over the coming years. ATSDR has contracted with NIHB for logistical support, and plans to identify 12 tribal professionals from across the country to participate in this effort, along with sister agencies IHS and EPA. Three meetings are planned for 2011.

Realizing that there continues to be a lack of knowledge about federal recognition status and the idea that IHS is the primary service entity for tribes, Ms. Allison felt that it was important to conduct training with her colleagues within ATSDR. Thus, she worked over the summer with a team of tribal professionals to develop the "Working Effectively with Tribal Governments (WETG)" Training Course, which she hopes to offer in 2011. The course includes an overview of federal mandates which support the unique government-to-government relationship, and addresses the unique cultural values that shape AI / AN views of health and environment. The course intersperses lecture with exercises and CDC / ATSDR tribal activities, and she recently learned that she would be able to offer continuing education credits to ATSDR staff and medical doctors as well.

An HHS Environmental Justice Interagency Workgroup has been established, and three NCEH / ATSDR representatives participate on this workgroup. Ms. Allison's input to this workgroup is to ensure that tribes are invited and participate, and to reiterate that all federal agencies have a mandate to work with federally-recognized tribes. Currently, she is doing a lot of outreach at conferences, forums, meetings, et cetera to inform people about the services offered by NCEH / ATSDR. She hopes to continue to build partnerships and opportunities for collaboration with others as well.

Another of Ms. Allison's activities was to host a PHPS fellow, Mr. Juan Suazo, from April through September 2010. Mr. Suazo was instrumental in helping her to get some of the critical projects done that she had wanted to work on for a long time, including the rejuvenation of her Office of Tribal Affairs website. He also helped to compile the team and work with them on the training force curriculum. He was able to attend one of the tribal forums, and had exposure to

her colleagues within the Office of Policy, Planning & Evaluation (OPPE). Mr. Suazo is a young Hispanic man from New Mexico who seems to have a lot of knowledge and background interacting with tribes. The PHPS experience opened up ideas for him about how to continue to address issues that affect tribes.

Discussion Points

- Mr. Secatero wondered what else had been done in Fort Belknap.
- Ms. Allison reminded everyone that during the TCAC meeting last July, they were able to conduct a tour of the Zortman-Landusky Gold Mine that is currently being remediated. The tribe has been very concerned about contamination from the mining activities onto tribal reservation boundaries. They have a lot of water and soil quality data they can share from their collaboration with a local community college. ATSDR is in the process of acquiring that data and is hoping to conduct some analyses on it. The process has been stalled somewhat because of communications and issues pertaining to confidentiality.
- Ms. Hughes expressed her excitement about the activities in which NCEH / ATSDR are engaged. She offered TCAC's assistance with curriculum development.
- Ms. Allison said she would be happy to share the current draft agenda with TCAC members and would like to have their feedback. The beginning covers the history of the colonization, specifically with respect to how tribes were impacted in terms of diet and lifestyle. In addition to painting that picture, she also wants to discuss where tribes are today in terms of the issues they face, as well as the federal mandates that support tribes' unique relationships.

Office of State, Tribal Local, and Territorial Support

Craig Wilkins

Office of State, Tribal Local, and Territorial Support Centers for Disease Control and Prevention

Mr. Wilkins spent a few minutes to showcase one of the seasonal influenza videos, which is a public service announcement (PSA) featuring Wes Studi, a well-known actor from the *Last of the Mohicans*, *Geronimo*, *Avatar*, *American Legend*, and others. Jim Cosgrove, Division of Creative Services, who served as one of the co-producers for the PSA, played the video for the participants.

National Center for Chronic Disease and Health Promotion

Annie Fair, MPH, MSW, Public Health Advisor

Division of Cancer Prevention and Control

National Center for Chronic Disease and Health Promotion Centers for Disease Control and Prevention

Ms. Fair indicated that several programs are housed within DCPC, including: National Breast and Cervical Cancer Early Detection Program, National Comprehensive Cancer Control Program, National Colorectal Cancer Control Program, DCPC AI/AN Technical Assistance Cooperative Agreement, DCPC Urban Indian Cooperative Agreement, and DCPC AI / AN Special Projects (Tribal BRFSS Project; Breast Cancer in Young Women).

The National Breast and Cervical Cancer Early Detection Program is comprised of screening programs funded in all 50 states, DC, 4 US territories, and 12 American Indian / Alaska Native organizations. The program provides breast and cervical cancer screening and diagnosis to low-income, uninsured, and underinsured women. Services include clinical breast examination, mammograms, Pap tests, diagnostic testing for women with abnormal results, surgical consultation, and referrals to treatment. Approximately 5% of women screened through NBCCEDP are AI / AN women. Technical assistance to increase breast and cervical cancer screening is provided for tribes and states with large native populations. The 12 tribal programs include: Arctic Slope Native Association Limited, Cherokee Nation, Cheyenne River Sioux Tribe, Hopi Tribe, Kaw Nation, Native American Rehabilitation Association of the Northwest, Inc., Navajo Nation, Poarch Band of Creek Indians, South Puget Intertribal Planning Agency, Southcentral Foundation, Southeast Alaska Regional Health Consortium, and Yukon-Kuskokwim Health Corporation.

National Comprehensive Cancer Control Program is an integrated, coordinated approach across the cancer continuum. Currently, there are Tribal Cancer Plans in 7 tribes and tribal organizations. Some of the activities funded include: assessing cancer burden; addressing the needs of at-risk populations; creating cancer prevention priorities; and building infrastructure to increase AI / ANs' access to cancer screening and treatment. The next step is to implement these plans and foster collaboration with partners.

This year, the Branch Chief identified priority areas for comprehensive cancer control, which are to emphasize primary prevention; coordinate early detection and treatment activities; address public health needs of cancer survivors; use policy, systems, and environmental changes to guide sustainable cancer control; promote health equity as it relates to cancer control; and demonstrate outcomes through evaluation. NCCCP tribal programs include Alaska Native Tribal Health Consortium, Cherokee Nation, Fond du Lac Reservation, Great Plains Tribal Chairmen's Health Board (formerly Aberdeen), Northwest Portland Area Indian Health Board, South Puget Intertribal Planning Agency, and Tohono O'odham Nation.

The newest program in the division is the National Colorectal Cancer Program (NCCP), which was funded in 2009. This program funds 26 states and 4 tribal organizations. It takes a population-based approach to increase screening rates to at least 80% by 2014. The program is integrating with the public education campaign, Screen For Life, to increase awareness of the importance of screening. It was noted in 2005 that AI / AN had the second highest incidence rate for colorectal cancer, so routine screening can prevent cancer. NCCP tribal programs currently funded include Alaska Native Tribal Health Consortium, Arctic Slope Native Association, South Puget Intertribal Planning Agency, and Southcentral Foundation.

The DCPC cooperative agreement, "Collaborative Partnerships in Cancer Prevention and Control Program for AI/AN People," is a 5-year grant that is awarded to the Native American Cancer Research Corporation (NACR). The goal is to strengthen AI / AN inclusion in cancer screening and planning efforts throughout the nation. Because many tribes do not receive direct funding, they plan to convene 2 to 3 regional meetings per year so that tribes residing in these regions (e.g., Washington, Oregon, and Idaho; and South and North Dakota, Nebraska, Iowa, Montana, and Wyoming) can participate and learn about cancer prevention activities. The DCPC cooperative agreement, "WEAVING Resources for Urban Indian Women's Wellness," is a 3-year grant that was awarded to the Urban Indian Health Institute. The goal of the WEAVING Project is to help increase the number of urban AI / AN women receiving breast and

cervical cancer screening services. The focus is on developing program materials and toolkits that are accessible and sustainable.

The CCC Tribal BRFSS Project is a special project to collect tribal or tribal organization-specific BRFSS data through in-person surveys. This work will be done through the Tribal Epi Centers (TECs). They are in the first year of planning, and it is anticipated that 3 programs will be funded. Ultimately, they hope to fund all of the programs.

DCPC's breast cancer in young women AI / AN project, "Walking Together: Making a Path Toward Healing," is the result of new Congressional funding this past year to develop and implement a national educational campaign about breast cancer in young women. The AI / AN Project is a collaborative between IHS Phoenix Indian Medical Center and DCPC. Focus groups will identify barriers to care physically, psychologically, and spiritually. They want young women to share their stories. Recommendations will be developed to improve cancer care services for AI / AN young women.

With regard to resources, Ms. Fair left wellness magazines on the information table. One focused on breast cancer and one focused on colorectal cancer. These are nice booklets that were developed by Native American Cancer Research that are distributed to tribal organizations, which tribal organizations distribute at community events.

**David Espey MD, Epidemiologist
Division of Cancer Prevention and Control
National Center for Chronic Disease and Health Promotion
Centers for Disease Control and Prevention**

Dr. Espey reported on improving cancer surveillance and mortality data for American Indian and Alaska Native populations. Previous studies have demonstrated that race misclassification of American Indians consistently occurs in disease surveillance and vital statistics data. The magnitude of misclassification varies considerably, ranging from 3% to 50% of identified American Indian records in state cancer registries, and from 5% to more than 80% in infant mortality data. There have been few attempts to quantify misclassification in mortality data. Two recent studies in Montana and Washington state found that 9% and 15%, respectively, of American Indian deaths were incorrectly coded another race. Even a relatively small degree of misclassification in health data can impact planning of prevention and control programs and resource allocation.

The following table reflects what occurs cancer registry data are linked with IHS patient registration data:

Summary of Previous of AI/AN Linkages

Study	Incidence (# cases) before match	Incidence (# cases) after match	Change
Washington (1992-93)	153.5	267.5	74%
Minnesota (1988-93)	245.2	390.25	59%
California (1988-92)	89.6	211.0	135.5%
Puget Sound (1974-89)	(137)	(233)	70%

While the linkage does not completely solve the problem, it makes an enormous impact on the data. To improve the quality of cancer surveillance data for AI / AN, records have been linked from central cancer registries with IHS data. AI / AN cases misclassified as non-native are then identified, and “improved” data are used to report the cancer burden for AI / AN. Dr. Espey requested that anyone who was interested in receiving a summary of the linkages send him an email at dke0@cdc.gov (Annual Report to the Nation on the Status of Cancer, 1975-2004, Featuring Cancer in American Indians and Alaska Natives; and Cancer Supplement: An Update on Cancer in American Indians and Alaska Natives, 1999-2004).

Dr. Espey showed results by region, noting that this does not follow the IHS area scheme primarily because of data stability. Numbers in some of the IHS areas are not large enough to get stabilized data. He shared a table to show the tremendous impact that results from making these linkages in 2006. AI / AN and NHW incidence rates for gallbladder cancer for both sexes, by region, from 1999 through 2004 show one of the most remarkable increases reflected as a result of linkages. Gallstones are the most common risk factor for gallbladder cancer. Gallstones are hard, rock-like formations of cholesterol and other substances that form in the gallbladder and can cause chronic inflammation. At least 3 out of 4 people with gallbladder cancer have gallstones when they are diagnosed. Although gallstones are a very common condition, gallbladder cancer is quite rare, especially in the US. Most people with gallstones never develop gallbladder cancer.

Although liver cancer incidence is increasing in most race / ethnic populations in the US, it was elevated consistently in AI / AN men and women compared with non-Hispanic white men and women for the period 1999 through 2004. AI / AN experience higher morbidity and mortality from primary liver cancer than other US populations. During the years 2000 to 2004, primary liver cancer was the 9th leading cause of cancer mortality in US males and the 11th in US females. It was, however, 4th among AI / AN males and 6th among AI / AN females living in counties served by IHS. In addition, liver cancer mortality rates were 102% higher for AI / AN males and 150% higher for AI / AN females than for all races of males and females during this period. Alcohol abuse and viral hepatitis have a synergistic, positive association with liver cancer and are likely contributors. In 2002, the proportion of deaths attributable to chronic liver disease, a significant risk factor for liver cancer, was 4 times greater in AI / AN populations compared with US white populations.

CRC is higher in AI / AN in Alaska and the plains regions, although the reason for this is unknown. There has been speculation about smoking, which has been associated with an increased risk of developing or dying from colorectal cancer and of being diagnosed at an

earlier age. There has also been speculation about mounting evidence of an association between Type 2 diabetes and colorectal cancer. The regional patterns of lung cancer rates mirror the regional smoking prevalence, and native populations have the highest smoking prevalence of any race or ethnic group. Breast cancer incidence rates in AI / AN women were lower than for non-Hispanic white women overall. Although the rate for AI / AN women was similar to the rate for non-Hispanic white women in Alaska, it was nearly 3 times the rate of AI / AN women in the Southwest. Similar variations have been reported previously and maybe because of differences in reproductive or behavioral risk factors or variations in mammography rates. Cervical cancer is still somewhat higher in AI / AN women, especially in the Northern and Southern plains. Cervical cancer is a true public health success story that was a consequence of some concerted efforts. Unfortunately, they do not have data earlier than 1990 for native women, but for the nation, Black women still are higher than both native and non-native women, but it is almost the same in non-native women. This is because a lot of effort went into cervical cancer screening and follow-up after it was identified that there was an enormous disparity between native women and non-native women.

There are a lot of limitations with this linkage technique. IHS only covers 57% of the AI / AN population. This is known because one demonstration project to link a state cancer registry and a Bemidji area tribe for 1995 through 2004 diagnosis years showed that IHS identified 614 individuals who were not identified as AI / AN by the registry, while the Bemidji area tribe identified 242 individuals who were not identified as AI / AN by the registry or by linkage with IHS. The urban AI / AN population is more difficult to characterize. These cancer registry linkages have been incorporated into reporting in the US. The CDC-supported registries and the National Cancer Institute-supported registries link IHS data as part of their national reporting. They also use a regional scheme.

The next area to conquer is even more important, which is mortality data. It is known from a study that assessed how someone self-identified in the Census versus how they were identified at death when someone else was responsible for making that identification that 40% of natives who died self-identified as native but were not reported as native by someone else. This is usually done through the funeral home director. This is an enormous area for improvement for surveillance data, not only for cancer, but also for all deaths. A linkage was done between IHS data and the National Death Index (NDI), which is currently being cleaned. The NDI is a central index of death record information on file in the state vital statistics offices. NCHS and states established NDI as a resource to aid investigators with mortality ascertainment activities. These data are available to investigators solely for statistical purposes in medical and health research. The NDI contains a standard set of identifying information on each death (name, DOB, SSN, state of birth, et cetera). Linkages are done by NCHS and output includes underlying cause of death and contributing cause of death. The NDI linked with IHS records (~3.6 million) for deaths 1985 to 2008. Data will be available to participating agencies and collaborators, who will need to sign data use agreement. Data could be made available in SEERStat format.

Due to the remarkable and tragic burden of colorectal cancer in Alaska, a number of projects are planned to determine innovative ways to get screening to remote and difficult to screen populations. The colorectal cancer rate in Alaska is not only the highest in the US, but also Alaska Native women have the the highest in the world. The difficult of being able to use the stool blood test was mentioned earlier. A project is planned to determine whether a newer test might be applicable in Alaska natives despite the infection with H Pylori. This could vastly increase the ability to get screening out to remote populations.

Gloria B. Bryan, RN, PhD, Tobacco Program Consultant

**Office on Smoking and Health
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention**

Dr. Bryan offered an update on some of the Office on Smoking and Health's (OSH's) activities that they fund in Indian Country. She said she was very excited to hear during this meeting, her very first with TCAC, about the progress Alaska is making in terms of decreasing smoking rates. She was interested in the comments about the chronic diseases. She expressed her hope that tobacco interventions would be considered when thinking about how to reduce disease rates in particular areas, because it does play a significant role.

As the lead federal agency for comprehensive tobacco prevention and control, OSH develops, conducts, and supports strategic efforts to protect the public's health from the harmful effects of tobacco use. The goals are to prevent initiation, promote cessation, eliminate secondhand smoke exposure, and identify and eliminate tobacco-related disparities. Dr. Bryan clarified that when she talked about tobacco abuse, she was referring to abuse of commercial products, not ceremonial tobacco use.

A comprehensive tobacco control program is defined a coordinated effort to establish smoke-free policies and social norms, to promote and assist tobacco users to quit, and to prevent initiation of tobacco use. The CDC best practices document, 2007, addresses these components and includes infrastructure, surveillance, media campaigns in terms of communicating messages, cessation services, et cetera. This is a very broad and comprehensive document that includes a number of strategies [Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs—2007. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease and Prevention and Health Promotion, Office on Smoking and Health; October 2007]. Comprehensive tobacco control programs are based on sound research and evidence-based practices. Numerous other guidance documents have been published as well, including the following:

- The Surgeon General's report, "Reducing Tobacco Use (2000) and The Health Consequences of Involuntary Exposure to Tobacco Smoke (2006)"
- Task Force for Community Preventive Services' Guide to Community Preventive Services (2005)
- IOM's "Ending the Tobacco Problem: A Blueprint for the Nation (2007), the Public Health Service's Clinical Practice Guideline Treating Tobacco Use and Dependence (2000)"
- IARC "Handbooks of Cancer Prevention"
- WHO's Report on "The Global Tobacco Epidemic, 2009: Implementing smoke-free environments"

OSH currently funds 50 states and Washington DC, 8 territories, 8 Tribal Support Centers, and 6 national networks. The Tribal Support Centers are funded for 5 years, with the current cycle running from 2010 through 2015 under cooperative agreements. The expectations for the previous 5 years were very different from what is expected in the next 5 years. The awards are small, with each of the 8 Tribal Support Centers receiving between \$200,000 and \$250,000.

These centers are being asked to do a lot with very little funding, and OSH is going to try to get this increased. The Tribal Support Centers funded during this cycle include Black Hills Center for American Indian Health, Cherokee Nation, Great Plains Area Tribal Chairmen's Health Board, the Inter-Tribal Council of Michigan, Muskogee Creek Nation, Nez Perce Tribe, Southeastern Alaska Regional Health Consortium, and Tanana Chiefs Conference. All 8 of these centers have experience with policy interventions, some of them with tobacco policy interventions specifically. This is highly important for this funding cycle because policy interventions have been emphasized as the most effective way to get people to quit using commercial tobacco and to reduce exposure to secondhand smoke. They want to implement population-based intervention in order to reach as many people as possible. The purpose of the Tribal Support Centers is to reduce commercial tobacco abuse, eliminate exposure to secondhand smoke, promote commercial tobacco cessation, and prevent youth initiation.

Also in this cycle, the World Health Organization (WHO) policy package called MPOWER is being utilized. MPOWER stands for the following:

- Monitor:** Monitor tobacco use and prevention policies
- Protect:** Protect people from tobacco smoke
- Offer:** Offer help to quit tobacco use
- Warn:** Warn about the dangers of tobacco
- Enforce:** Enforce bans on tobacco advertising, promotion, and sponsorship
- Raise:** Raise taxes on tobacco

Some people refer to this as a model, although it is probably in the true sense a model. MPOWER includes interventions that have been proven to be effective. Beginning in 2009, MPOWER was introduced to most of OHS's partners. Last year, they introduced it to the Tribal Support Centers. Currently, everyone is expected to incorporate this package in OHS FOAs. This also aligns them with practices other countries are using, which makes them more a part of the global tobacco control community. These interventions are known to work in a number of countries and a number of cultural groups, so OHS has high hopes that they will see some different outcomes during this funding cycle. A few examples of the kind of activities that might fall under the MPOWER package include the following:

- Conduct the American Indian Adult Tobacco Survey (Monitor)
- Implement smoking bans (Protect)
- Promote QuitLine and other cessation services (Offer)
- Implement media campaign (Warn)
- Develop and enforce bans on commercial advertising, promotion and sponsorship (Enforce)
- Increase the price of commercial tobacco products (Raise)

OHS provides some funds to HIS (approximately \$75,000 per year) to conduct some specific. This memorandum of agreement has been in place for at least 10 years. A number of divisions and departments are part of that memorandum. OHS just has a small piece of it. IHS collaborates with the OSH-funded National Native Commercial Tobacco Use Prevention Network to conduct policy advocacy and implementation training at tribal level; and promote systems change in tribal health systems (e.g., Clinical Guidelines for Treating Tobacco Dependency). IHS established a Tobacco Control Task Force. A key activity for this group was to develop a strategic plan, which has already been completed and is updated periodically. The plan that is being finalized will go through 2013.

Another program OHS runs is the National Native Commercial Tobacco Abuse Prevention Network (NNCTAPN). This program is in year 3 of a 5-year cooperative agreement. NNCTAPN works with all of the 500+ federally recognized and state recognized American Indian and Alaska Native tribes in the US. These awards are approximately \$400,000 per year, which is still insufficient. The Inter-Tribal Council of Michigan is the managing partner / grantee. NNCTAPN grantees provide technical assistance to tribes through policy development. They also provide some technical assistance with regard to the American Indian Adult Tobacco Survey. They also deliver a significant amount of training, which is usually done regionally. They partnered with the Oklahoma Council on Education and Economic Development (CEED) to host training for tribal health administrators and staff in June 2010.

OHS staff members have spent the last 12 months trying to determine the best strategy for enhancing the work OSH is doing in Indian Country. They are not satisfied with the reach or resources provided to date. With that in mind, immediate next steps are to develop an internal action plan to guide program planning and resource development; expand networking and collaboration with other CDC divisions / centers and federal agencies; and strengthen communication mechanisms to share best practices and lessons learned.

Discussion Points

- Ms. Allison requested input about the form of cigarette, the E-cigarette.
- Mr. Collins responded that the E-cigarette is new to the market. Currently, less than 1% of all tobacco sales are of E-cigarettes. In the broad landscape of tobacco use, this is still not even a ripple in the water. The science is still evolving on this product. In the meantime, OSH continues to emphasize that commercial tobacco use is deadly. They prefer to focus more on that than on E-cigarettes per se at this time while the science is evolving.
- Mr. Valdo indicated that there is also a new K2, which is incense people are now smoking that is supposed to have the same effect as marijuana. He received a report in his community from the Santa Fe Indian School that students are buying this in hookah shops. Since it is said to have the same chemical make-up as marijuana, he was not clear why it was legal. Supposedly, it is 10 times as potent as marijuana, and is available for \$10. The students smoke it and it will kill them.
- Mr. Collins replied that there are a number of new products on the market. This is somewhat expected as a result of the new FDA legislation that went into effect in 2009, when tobacco companies knew that their ability to put new tobacco products on the market would be drastically hampered. While he was not personally aware of the product to which Mr. Valdo referred, OSH is not surprised to see many new products entering the marketplace. It is really important to take a policy approach in public health efforts. States regulate what products are sold in their communities.
- Mr. Secatero requested further information about the second goal of promoting smoking cessation in terms of what can be done to stop youth from smoking.
- Ms. Bryan responded that the first form of treatment would be the quit line, 1-800-QUITNOW, that can be called from anywhere in the US where it will be referred to a state number. This is telephone counseling that usually includes an intake interview to determine readiness to quit and exactly what the individual is expecting. Some states provide medications that will assist the person if needed (e.g., patches, nicotine gum, et cetera).

There is a cost associated with medication, so they are trying to make treatment affordable or free by working with insurance companies or Medicaid. Some states have online self-guided counseling. This is for those who have some motivation and really do not want to be involved with a counselor. Still, at any time during the use of the online services, they can access a counselor. Other states have group classes where they teach people about the harmful effects, offer them social support, and refer them to individual counseling if necessary.

- Mr. Collins added that through their partnership with HIS, the urban health facilities and the 368 facilities have implemented those guidelines as well. Using the electronic medical record, they are able to assess tobacco use for every person who enters a facility. For tobacco users, they can begin the process of advising them about the need to quit and make referrals for them.
- Ms. Abramson emphasized that a lot of smoking begins at a very early age, even in grade school. Children in school get in trouble because they have nicotine fits. Prevention must start early. Children can also take messages home to their family members who smoke. Her own children guilted their father into quitting by saying that they would get a new daddy if he died. She stressed that they must get prevention back on the table.
- Mr. Collins agreed. Everyone feels a responsibility to protect children. One thing that is necessary is a social norm change. It must become normal for there not to be commercial tobacco use. This is why it is imperative to address how the media portrays tobacco use. OSH is trying to help change the underlying social norms through its policy efforts. It is also important to develop and implement interventions in a way that is culturally appropriate for youth. How this is done in Atlanta for a group of inner city youth may be very different from how it is done for an American Indian community in Utah.

**Larry Alonso, FNP-BC, Commander, US Public Health Service
Native Diabetes Wellness Program, Division of Diabetes Translation
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention**

Commander Alonso emphasized what a privilege and honor it was to present on a project called "Using Traditional Foods and Sustainable Ecological Approaches for Health Promotion and Diabetes Prevention in the AI / AN Communities." This project comes out of the National Center for Chronic Health Disease Prevention and Health Promotion's Division of Diabetes Translation, specifically the Native Diabetes Wellness Program. This is a cooperative agreement that is in the middle of its 5th year. The project started in September 2008 and is due to run through September 2013. Originally, 11 partners were funded in 2008 and just before the certificate expired, an additional 6 were added for a total of 17 tribal communities being supporting with this funding. These funds support these communities in their efforts to restore traditional ways of securing and preparing local foods; integrating physical activities, social support, and policy change as a sustainability component; and sharing this knowledge through stories. Stories play an important role in American Indian culture. Stories are how wisdom is shared, how hope is shared and hopelessness is dispelled, how teaching occurs, how loneliness is banished, and how shame is made irrelevant. The following map depicts the location of the 17 funded tribal communities:



The project goals are to support sustainable, evaluable approaches that promote the use of traditional foods and physical activity in communities; encourage local policy changes to increase access to traditional foods and beverages; and engage community members to follow program progress, explore diabetes in context with history, emphasizing social support, and share stories that impart hope for preventing diabetes and its complications—specifically stories of healthy traditional ways of eating and being active.

Process and data collection is currently underway. When the FOA was published, they did not say, “You must do X.” The story of this project is one of tribal consultation. Dawn Satterfield and Lemyra DeBruyn listened to tribal elders, who told them to “look to the culture as a source of health.” The FOA was written with that in mind, and Commander Alonso is administering that project now. The initial 6-month reporting period reveals broad community support and engagement, speaking to a wide range of possible motivations (e.g., practicality, food safety, food sovereignty, traditional wisdom, and the importance of culture in restoring health). Food safety is one of Dr. Frieden’s winnable battles. Through these projects, they have seen a lot of engagement, with children and elders working alongside of one another.

Showing a Cherokee Nation picture, Commander Alonso explained that elders and youth participate in gathering wild edible foods. Once the children leave the bus, they strive to speak only in the Cherokee language. The food cannot effectively be considered outside of the culture, and the culture has a “health protective / disease preventive” aspect that seems to fade when held under a microscope. There is something about culture that imparts health or protects health.

Under this program, Cherokee Nation is implementing stickball leagues that are enjoying great popularity according to the Project Coordinator. Imagine when a budget is submitted that includes X number of handmade sticks, and PGO officers are scratching their heads. He also shared a photo from one of his site visit here to the Santee Sioux reservation in Niobrara, where he is seen playing in a river with the children. This is a part of the Young Braves program through which children are out playing, getting exercise, cutting rough-edged dogwood to create arrow shafts, learning how to hunt, and playing in the river. What is not seen are video games, unsupervised television, et cetera.

The Southeast Alaska Regional Health Care Consortium (SEARHC) has a compelling story to tell, which they have done using a digital storytelling format. SEARHC, among others, are validating the importance of storytelling as a healing and hope imparting aspect of this project.

SEARHC works with South East Alaska. This project, however, works specifically with two smaller communities. The two small communities that provide services that this project benefits are Kake and Wrangell. Wrangell has a population of about 2,000, and Kake has a population of about 500. This is important because these are the groups that may not have the ability to write FOA applications. Commander Alonso let the people tell the story, by playing the following video link: <http://digitalstoryexamples.blogspot.com/>.

The next story the Commander shared came from the Ramah Band of Navajo in New Mexico. Stories within stories are emerging, and it is quite remarkable to watch this happen. There is a story about composting that is worth telling, recognizing that the soil is inherently poor in the Ramah community, and there is a need to compost. When the Project Coordinator said that they needed compost, told people why, and shared his enthusiasm, suddenly people started bringing food scraps from all around the community. Before long, there was a community compost pile. They now they have 3 football fields of locally grown produce as a result. What began as the proposed 160 square feet in 10 planter boxes is now 3 acres (130,680 square feet), 5 planter boxes, and 2 greenhouses. The amazing thing is that the program is in the enviable position of its partners over-delivering. They stated in their application what they would do, but they are doing much more than promised because entire communities are involved. The significance of fresh, locally grown produce is being grasped by many communities across the nation. However, the significance in this project is very deep. With a history of dispossessed land and water, locally grown traditional foods represent a cultural healing opportunity.

Tohono O'odham Nation members are growing tepary beans, high protein, drought-resistant food grown in the desert southwest that is a major part of the Tohono O'odham Nation's culture. More practically, what many people do not understand is that the Tohono O'odham Nation reservation has one supermarket. It takes a long time for many people to get to that supermarket. If not growing food locally, it is difficult to obtain. Commander Alonso concluded his presentation by playing a Ramah Navajo video (file imbedded in the PowerPoint titled Randy's digital story.wmv).

Discussion Points

- Ms. Abramson liked this program because it brings the families together, and they can take pride in their traditions. They are gathering and are amongst the medicines. When she was young, her whole family used to go out to gather, picked berries, and fishing. They did not have soda. They always drank water, and they got exercise while out gathering and fishing. Picking berries is a lot of work for children. Their reward is to go swimming, which is more physical exercise. In their program, other traditional ways are being brought back like speaking the language. She thought somebody needed to give the diabetes program a raise, because their work is awesome. She thought these efforts could also be translated to cancer control and smoking cessation. Pieces of them were taken away slowly, but this program is helping them come back and is helping with their health. She hopes this program continues to expand so that it can go into more areas with more tribes. She is from the Sault Ste. Marie Tribe of Chippewa Indians, and they have a traditional foods program.
- With regarding to funding, Commander Alonso could not answer whether it would continue and / or expand. TCAC has recommendation power and strength, so he encourage them to speak out if they saw this program as valuable.
- Ms. Hunter wondered whether HHS had any plans to consider more gardening projects. There is funding through Office of Juvenile Justice and Delinquency Prevention (OJJDP),

which is largely focused on teaching youth about gardening. They have greenhouse in their juvenile detention center and in the community as part of the re-entry program. Many tribes say they are not growing anything. Grants like this are really helpful to tribes in preserving, restoring, and keeping culture and traditions alive. She wondered whether CDC had given any consideration to partnering with other agencies like Department of Justice (DOJ) to increase the potential for all tribes.

- Commander Alonso replied that there is a very interesting project the Nooksack Tribe is engaged in. They are going through their historical volumes to find descriptions of ancient gathering sites, and are using GPS coordinates and mapping that for posterity so they know where those places were. As the elders pass, so does the wisdom. They are keeping that and it is not posted anywhere. The Nooksack Tribe first asked what they used to eat, where they used to get it, where they could now get it, and whether they could produce the growing environments necessary to have traditional foods again. The same is true of the Salish Kootenai Tribe in Montana, which is trying to resuscitate the bitterroot.
- Dr. Butler agreed that it would be great if the philosophy and approach Commander Alonso described could be used more often, particularly by ATSDR and other groups that adhere strongly to the Precautionary Principle. They understand much better now, but not long ago, ATSDR was in one of the most remote parts of their state telling people not to eat the subsistence foods because they were not safe. However, this is so far out, there are no other options.

Supporting Efforts of Tribal Health Officials to Address Public Health Ethics

Drue Barrett, PhD
Lead, Public Health Ethics Unit
Office of Science Integrity
Office of the Associate Director for Science
Centers for Disease Control and Prevention

Dr. Barrett reported that CDC has created two primary committees that work on public health ethics activities. One is an extramural advisory committee, the Public Health Ethics Committee (PHEC), which is a FACA-chartered committee like TCAC. PHEC is a subcommittee of CDC's Advisory Committee to the Director (ACD). PHEC is comprised of about 12 members who are primarily ethicists from academic institutions. There is also an internal Ethics Subcommittee of the Advisory Committee to the Director, which is comprised of representatives from each of CDC's centers.

These two committees have been working together to develop infrastructure and address ethical issues that arise in the practice of public health. They have been engaged in a variety of activities, but have been focusing on some ethics guidance documents dealing with a variety of issues such as pandemic influenza, general ethical issues in emergency response, and allocation of ventilators during a severe pandemic. They are also developing training materials on public health ethics, including an online public health ethics course. In addition, they are developing case studies and organizing seminars for CDC staff to educate them about various public health ethics issues. They have also created a public health ethics consultation process at CDC. A consultation committee has been formed to serve as a resource to CDC programs if they encounter ethical issues in their programmatic activities. PHEC will be assessing ethical challenges that arise with regard to non-communicable disease interventions (e.g., taxing

foods). Many interventions raise very stern ethical issues, so PHEC will be delivering a presentation about this during the next Advisory Committee to the Director (ACD) meeting.

Efforts are also being made to be more supportive of state, tribal, local, and territorial health departments in dealing with public health ethics issues. The first step is to hear from these health departments about the challenges they are dealing with. To do so, they are hosting a series of webinars on public health ethics. These began with states and working closely with Regional Health Administrators in various regions. They are now ready to embark on webinars with local health departments, and want to reach out to tribal health officials. A webinar was scheduled with tribal officials on February 11th, and they worked with NIHB to identify participants for that webinar.

The purpose of the webinars is to describe CDC's public health ethics activities; provide examples of public health issues that commonly present ethics concerns; discuss key ethical challenges and how these challenges have been addressed by health departments; and discuss ways CDC can support health departments in their efforts to address public health ethics issues. They are trying to limit each specific webinar to about 20 people so that everyone can be engaged. She invited input from TCAC members about avenues in addition to NIHB outreach to let tribal health officials know about the webinars. They can schedule as many webinars as needed in order to reach as many people as possible.

Discussion Points

- Ms. Hughes noted that she receives many announcements about webinars, but did not recall seeing this one from NIHB. She suggested NCAI as an additional resource, given that they may have a broader listserv. TCAC member Derek Valdo is a great contact for NCAI. The TCAC itself is also an excellent resource, because the members represent regions across the country. Bemidji does not have an area health board, but all of the other areas do. TCAC members can all use their listservs to help disseminate the information to health boards and others who would probably be interested in this type of discussion.
- Mr. Seneca indicated that he is a member of the Native Research Network, which has a pretty extensive listserv that goes to all Indians, non-Indians, and Alaska Natives. It spans from New Zealand to Maine, and includes all people they are involved with or who are conducting indigenous health research. They are often working to address ethical issues in research, so they would be very interested in this. He requested that Dr. Barrett send the information to him so he could forward it to their listserv.
- Dr. Barrett shared her contact information in case anyone was interested in participating in a webinar, or wanted to provide further input about outreach or particular ethics issues. Her contact information is: dbarrett@cdc.gov. She also requested contact information for Mr. Valdo and Mr. Seneca, and indicated that she would go through Ms. Cantrell to forward the webinar notice to TCAC.

National Voluntary Accreditation for Public Health Departments

**Craig Thomas, PhD, Division Director
Division of Public Health Performance Improvement
Office for State, Tribal, Local, and Territorial Health
Centers for Disease Control and Prevention**

**Dean Seneca, MPH, Partner Services Branch
Office for State, Tribal, Local, and Territorial Support
Centers for Disease Control and Prevention**

Dr. Thomas explained that the National Voluntary Accreditation for Public Health Departments resides in the Division of Public Health Performance Improvement within OSTLTS. Accreditation is by no means a new effort. Accreditation readiness and the idea of incorporating accreditation into public health practice has been a fairly long-term goal. A great deal of work has been done at the local and state levels to increase momentum about this issue. National accreditation in other sectors, such as correctional facilities and education, have been very effective in ensuring that funds are provided to those institutions, and ensuring the quality of services that are provided. This is an important endeavor for public health. It is based on the 10 essential services, so much of what they had heard throughout the day would apply to the concept of national accreditation.

Most of the work that has been accomplished to date has been done through the Public Health Accreditation Board (PHAB). Systems do exist already in certain states, such as North Carolina, Michigan, and Ohio. Interestingly, one of the criticisms that has been encountered with accreditation regards whether it leads to better health outcomes. Those locations with systems in place are yielding some interesting results, especially with regard to H1N1. North Carolina has conducted some research in this area to compare local health departments that were accredited to those that were not in terms of their response times, coordination efforts, and so forth. Thus, there is some promise with respect to accreditation.

Dr. Frieden is very interested in accreditation being incorporate in programs across CDC. They are at a very important juncture because a national launch is scheduled for September 2011. Within that launch are state standards, measures, and documentation; local standards, measures, and documentation; and the concept of tribal standards, measures, and associated documented. There is about a 3-month window to make modifications to the accreditation documentation.

Mr. Seneca added that NIHB was funded through the Robert Wood Johnson (RJV) Foundation to develop a Tribal Advisory Workgroup. The charge at the time was to determine how accreditation would be undertaken in Indian Country. The workgroup began exploring accreditation, obtaining tribal feedback and input, and taking into consideration how standards and measures would apply to tribal communities. This workgroup yielded recommendations that support tribes being part of accreditation. Later, PHAB and NIHB created a “think tank” to further address this issue and determine how standards and measures could be applied to tribal communities. PHAB conducted beta testing for accreditation. In total, there were 30 beta testing sites comprised of 8 states, 9 local regions, and 3 tribes: The Navajo Nation Division of Health; Window Rock, Arizona; Cherokee Nation Health Services, Tahlequah, Oklahoma; and Keweenaw Bay Indian Community, Baraga, Michigan. The results of testing in these sites are being analyzed.

The Tribal Standards Workgroup closely reviewed the standards and measures for state and local health departments, and tribes had a significant amount of input into the overall standards that would be applied to state and local health departments. A package was developed that included tribal health department standards and measures, and NIHB did a broadcast on several listservs to put out a call for tribal input. The workgroup emphasized that they did not plan to alter the bar for standards and measures of accreditation specifically for tribes. They really need input on the cultural issues and specific examples of how public health is carried out

in Indian Country. Also being taken into consideration by the Tribal Standards Workgroup are incentives for participation because this is voluntary accreditation. This is critical. Incentives could be related to grants administration, technical assistance, et cetera. Everyone understands that the incentives for Indian Country will be very different for tribal versus state and local health departments.

Technical assistance and building readiness for accreditation are essential, must be concurrent with PHAB activities. It is important to work with partners to ensure that the potential applicants and health departments are engaged and aware of current efforts in preparation and technical assistance to seek accreditation. In 2010, NIHB released a public health profile. Some of the results speak to readiness for accreditation, and are a very good beginning. The results from the NIHB Advisory Board, PHAB “think tank” discussion, and tribal beta testing provide important input for development of tribal standards and measures, and support tribes being a part of this accreditation process. PHAB is working with the Tribal Standards Workgroup to review state and local standards and measures, and consider refinements that are needed to adapt and continue to test these in Indian Country.

It is important to note that a lot of this accreditation work is being built upon standards and performance improvement programs, such as CDC’s National Public Health Performance Standards Program that was the precursor to accreditation. Mr. Seneca was surprised to know that several tribes participated in the National Public Health Performance Standards Program. This is a beginning. The accreditation process definitely presents some challenges for tribes, but it also presents challenges for states. One of the things that he really likes about this process is that it is putting public health on the map in Indian Country versus just IHS providing basic clinical care.

Discussion Points

- Ms. Hughes expressed her excitement about the accreditation program, and has been hearing about it from the beginning. Regarding incentives, tribes would like to be accredited. However, they are probably most familiar with the Joint Commission. It is not clear to everyone why they need two types of accreditation. They have to demonstrate the added value of public health accreditation. What is done in Indian Country is driven primarily by what IHS requires them to do. She suggested deemphasizing that tribes will be asked to adhere to state and local standards. Her tribe does not have a public health code yet, but they would work on this. Anytime it is suggested that tribes do something according to state and local standards, it is simply not going to happen. CDC and IHS probably need to collaborate promote tribal accreditation. Most tribes are not capable of being able of going through two accreditation processes.
- Ms. Abramson requested clarity about whether tribes would be required to have two types of accreditation.
- Ms. Hughes replied that the way it was explained to her was Joint Commission accreditation is satisfactory for IHS. However, IHS is encouraging tribes to consider the public health accreditation process because it is possible that this will open up more opportunities. It would be beneficial to more clearly define what the advantages might be for tribes to seek voluntary public health accreditation.

- Dr. Thomas indicated that there is a major distinction between the Joint Commission and voluntary public health accreditation. Public health is focused on prevention and the Joint Commission is focused on treatment and care.
- Mr. Finkbonner clarified that tribes are not being but are being invited to participant, which is different. National partners are doing everything possible to be inclusive of the unique system of IHS in asking for comments. He encouraged specific tribes who may be considering seeking accreditation to look at the standards now and provide comments about why they do not accurately describe the assurances for the public health system a particular tribe provides or what is unique that they may need to capture in some other way.
- Ms. McKinnley was given the assignment by ITCA to review the document, which is huge. She learned more during this session than she did from the email that accompanied the document when it was delivered to her. She thinks more clarification is required about what exactly this accreditation means for tribal health departments. Her understanding was that this was a tribal accreditation process. However, when she began reading it, she saw “local” and “state” mentioned. She had to call a committee member, who clarified that it was a state and local document.
- Mr. Thomas clarified that this is a national standard, so they have discussed holding the standards the same for state, local, and tribal entities. However, the context needs to apply to each type of entity so that they can visualize themselves in the document. The more they can obtain input about how to tailor this document to make it more relevant, the better able they will be to promote the concept successfully.
- Mr. Seneca said he thought NIHB was going to call for input again, because they did not receive a great deal of input about those measures. There are items side-noted in the document that are specific for tribes.
- Mr. Thomas emphasized that the recommendation is to have a separate document for tribes that is tailored to Indian Country.
- Dr. Butler emphasized that it is critical to highlight incentives for participation. Nobody questions the Joint Commission. Their tribal facilities are competing for patients, who can go to other facilities. They want them to come to the native medical center. Commissioned officers have Tricare and can be treated on base, and their own employees can seek care elsewhere as well. Tribal facilities want to be accredited and be good at providing healthcare. He suggested streamlining the application and grants management processes as an incentive.
- Mr. Thomas replied that consideration is being given to this across the board. A number of national partners are funded to provide technical assistance for accreditation readiness, which in turn builds the capacity of the health organization. Simply by engaging in the accreditation effort, there is the incentive of organizations receiving the support needed to better enhance and build their capacity. That is a secondary but important incentive as well.
- Ms. Hughes asked whether they could forgo Joint Commission accreditation and seek public health accreditation instead.
- Mr. Thomas responded that IHS argues that both are important. It is still an interesting question.

Revision of TCAC Charter

Nakki Price, Policy Lead
Kimberly W. Cantrell, Tribal Liaison
Technical Assistance Branch
Office for State, Tribal, Local, and Territorial Support
Centers for Disease Control and Prevention

Dean Seneca, MPH
Partner Services Branch
Office for State, Tribal, Local, and Territorial Support
Centers for Disease Control and Prevention

Ms. Cantrell reminded everyone that work was done on the TCAC charter during the last TCAC meeting. During this session, the goal was to discuss the development of the new TCAC charter. The expiration of the existing charter offered them the opportunity to determine whether to redirect the focus of how the committee operates, and whether even the name TCAC is the right one.

Ms. Price explained that as it relates to the TCAC charter, her role would be to lead the members through the process and offer input if they would like. The purpose of this charter is to determine the roles for both CDC and for the group. She reviewed the charter very thoroughly and has some preliminary thoughts; however, they also wanted TCAC members to review the charter to offer feedback as well. One of the primary issues has to do with roles and responsibilities as well as products. There is a list of products included in the existing charter. In addition to the name of the committee, the data issue arose. TCAC is a great forum where ideas and perhaps a process for collecting comparable data could be devised.

She worked on Healthy People 2010 and 2020, for which her primary role was the public health infrastructure focus area. As part of her role, she convened a tribal sub-group for which she reached out to a cast of people. Approximately 50 to 60 people participated on these calls. One of the charges they were given was to offer advice about performance measures as it relates to healthy people for Indian Country; however, they have never been able to meet any of those expectations due to data. There may be data available, but it is not comparable given that we may have tribal epidemiology centers collecting data, urban health centers collecting data, regional health boards collecting data, et cetera that is not all necessarily the same. The data that they are each collecting is relevant to their goals and purposes; however, not all of the measures can be compared to one another to create some level of consciousness as it relates to public health problems and issues, or how interventions have worked.

She emphasized the importance of understanding that the charter will govern what the committee does, and should hold them accountable for whatever occurs. That is why this is very important to align it with the tribal consultation policy.

Discussion Points

- Mr. Seneca agreed that this was an opportunity to reframe the direction of this committee. He heard comments that some committee members did not feel that the agency was valuing and using the committee as well as it could. He also felt the TCAC name was misleading. As Ms. Hughes eloquently pointed out, this committee does not represent specific tribal

interests and does not hear tribal testimony. That is to be submitted directly to CDC. However, TCAC includes the word “consultation,” which is very confusing. A name change would help reinvigorate a new direction and would help support them working collaboratively together on projects. In refocusing this group, he thought they should try to work on some tangible projects with products that include outcomes and outputs. The data issue regarding a lack of data in Indian Country could be a viable project TCAC and the agency could work together that would be a win. Also, the agency probably could do more listening and TCAC members could do more talking from what he had been hearing.

- Ms. Hughes indicated that when she first came on the committee, she was always uncomfortable with “consultation” in the title of the committee name. As a tribal leader, she is not there for consultation purposes. That is reserved for the formal consultation session.
- Ms. Abramson expressed concern about the comments highlights over the NIHB support section within the charter. She believes TCAC needs the assistance of another organization that helps them gather information and collect data, so she took issue with the comment in the document recommending that NIHB be removed.
- Ms. Hughes thought that it would be best to compare the TCAC charter with HHS’s STAC charter to ensure that they align. Other committees are planning to do this. For example, the Health Research Advisory Council is reviewing its charter based on the STAC charter. The existing TCAC charter seemed to differ considerably from the HHS charter, and she thought that HHS should be their guiding point for drafting the revised TCAC charter.
- Mr. Valdo was under the impression that the highlighted edits in the existing charter were from Stacy Ecoffey in the HHS Office of Intergovernmental Affairs. He sits on the SAMHSA Tribal Advisory Committee as well, and they have the same mandate to make all of the advisory committee charters, using the HHS charter as the standard. There is a model that Secretary Sebelius wants to implement.
- Ms. Cantrell clarified that the edits were already in the document when she located it, and she did not know the history of the edits
- Ms. Hughes indicated that what was provided in the TCAC members’ binders was the TCAC charter with the revisions as it was presented during the TCAC meeting in Montana last year. CAPT Snestrud provided it, but she did not know who was working with her to redraft it.
- Mr. Seneca suggested having a clean charter without any edits to compare to the HHS STAC charter in order to develop a fresh revision.
- Mr. Valdo suggested putting the charter up on the large screen and going through it page-by-page. Then everybody could see what they were looking. It was frustrating him to bounce back and forth because they were getting nothing done. The same thing occurred in Montana.
- Ms. Abramson was on the HHS workgroup for the revision of their policy. Because she represents NIHB on the TCAC committee, she felt that she should speak up for NIHB. She understood about aligning the CDC documents to HHS documents, but her concern was making sure that the proper organizations were included in the CDC charter that can support and represent all tribes via TCAC.

- Ms. Hughes saw that the list of organizations had been removed. Other councils she is on are actually discussing expanding the list of national organizations to include the National Council of Urban Indian Health (NCUIH) and National Indian Council on Aging (NICOA), for example.
- Mr. Valdo did not perceive the highlight as deleting national organizations. He thought it was simply saying there would be three national organizations. All of these FACA-chartered committees require tribal leader representation (and an alternate) in terms of membership. He agreed with renaming the committee to remove the word “consultation” due to its implication. TCAC is a tribal advisory committee to CDC that exists to advise CDC on the 12 different areas. Others agreed.
- Ms. Hughes reiterated that there was a consensus to remove the word “consultation” from the TCAC name. Suggestions for a revised name included: CDC Tribal Advisory Committee and American Indian / Alaskan Native Advisory Board.
- Mr. Seneca suggested that the committee members “think outside of the box” instead of making edits to what already exist. They should go beyond that and work to define the group better.
- Ms. Price emphasized that the policy is the governing document and the charter establishes rules and responsibilities for people who are involved. They are two different things. The charter is just related to the group. There can be a policy without a charter. A charter just establishes a group, their purpose, their roles and responsibilities. Their relationship together is moot; however, she appreciated Mr. Valdo’s comments about SAMHSA and their policy. She also agreed with the idea to review a clean copy and take the opportunity to think about reestablishing roles and responsibilities. In her opinion, she was not sure that actually going through the charter and making decisions without considering other issues would be appropriate. Personally, as a policy person, she did not advise it because they had not had time to consider the charter and the ramifications that might occur once the charter was established. They would be holding themselves accountable for certain activities. CDC staff cannot speak on behalf of the agency as far as what they will and will not do, given that their activities are governed through legislative authority. There needs to be more targeted discussion about this wider than just going through the policy and making revisions at this point. She stressed that that was her advice as the policy subject matter expert.
- Ms. Hughes emphasized that they were there as advisory committee. They understand that CDC has their processes for determining what a final document is going to look like. She was hoping for a discussion amongst the council and CDC representatives for TCAC member’s suggestions about how they think the charter should appear. They have no control over how CDC staff presents the charter or to whom. They were suggesting at this point that the title of this advisory council be changed. They realized that this was not a decision they could make. It was simply a recommendation that they were asking be taken into consideration when rewriting this charter for the committee.
- Ms. Price said it was important to understand that CDC was not going to establish this charter to govern this group. As was mentioned, their intention is to work collaboratively and as part of this group. Their role is also to participate in decision-making using the consensus process. Regardless of the suggestions that are made, they cannot say that will

not consider them, because that is not how this is designed to work. When it goes through clearance, it will be a document that is created by everyone and not clearly based on CDC's impression. It is what the group wants as far as CDC and the group working together.

- Ms. Hughes stressed that she understood that. She has been working for a year and a half on rewriting the Health Research Advisory Council (HRAC) charter. They have had numerous discussions around the table about what the committee thought should be in the wording of the charter. HHS staff takes those suggestions back to OGC, which sends back any suggested changes they have. They are not demanding or ordering changes. They are simply suggesting them. Nevertheless, the committee knows that another entity is having input into whatever is developed as the final charter.
- Ms. Price said that when it came to the nitty gritty legalities, OGC will make sure that everyone can do what they say that want to do.
- Mr. Valdo pointed out that from a larger perspective, through an Executive Order President Obama has said that each agency has to develop a policy. There is no choice. Every agency is creating them. HHS is the parent that sits over CDC, so basically HHS is going to set some guidelines. There is a National Tribal Advisory Committee set forth by the Secretary and there is the charter, because there are some agencies like CDC, SAMHSA, CMS, et cetera that have committees and the orders that state what they are going to do. The goal is to try to create some alignment and consistency with all of those and HHS. There is always a hierarchy of control. His frustration is that this was raised during the two 2010 TCAC meetings, and now it is being raised again. If they did not get some focus regarding how to proceed, they would be going through this again in another 6 months.
- Dr. Duckworth clarified that during this session, one of the things they wanted to accomplish was to obtain feedback from TCAC members. She thought the suggestion to go through the document line-by-line was worthy, but it was not clear that they could get through the full document with the time they had remaining. She suggested following up with a teleconference if they ran out of time.

At this point, a clean TCAC charter document was placed on the screen. In addition, the STAC charter was brought up on the internet so that the two documents could be compared. The following sections of the CDC TCAC charter were reviewed, with comments captured under each topic where they were raised:

General Suggestions

- The TCAC name is misleading; considering removing the word "consultation" from the TCAC name
- Better align the TCAC charter with the HHS STAC charter
- Follow the same subheadings as the STAC charter.
- Include an evaluation component to determine whether TCAC and CDC are meeting their performance goals
- Include up to 5 "at large members"

- To close some of the gaps between TCAC and CDC, and to have a continuous TCAC presence, establish a TCAC Office within OSTLTS
- It was agreed that OSTLTS staff would make the recommended edits to the charter based on what they heard throughout the meeting and this session, and would email these to TCAC members for their review and comments

Purpose Statement

- Line 4: Replace the Executive Order 13175 reference. This establishes TCAC's authority and everything that guides why they are there and why it is necessary for the government-to-government relationship. Tribes are recognized as domestic sovereign nations, so having that referenced in the purpose statement is important.
- The purpose is to provide a complimentary venue for tribal leaders and CDC staff to work collaboratively to address public health issues. Concern was expressed about the exchange of information. If they want to work on a project together as a group, they have to show value to the committee and agency. Include concrete manageable products. Exchange of information is concerning.
- Measurable accomplishments can be included, but other advisory councils' primary purpose is to guide the policy of the agency or department.
- The generic wording of the STAC will give the advisory committee the broad base needed to do whatever they need to do with CDC, regardless of whether that is through individual projects or policy considerations. Components can be used from the STAC charter to align general concepts within the CDC charter. Many of the STAC charter statements are applicable to the CDC charter.
- The committee compositions will be similar to the STAC committee because CDC is asking for the 12 regions and national organizations to be represented.
- Consider whether to include 5 at-large positions for the CDC committee. SAMHSA included the at-large positions in their charter, making it more generic. This is the Secretary's attempt to have a national organization voice. The HRAC charter has been reviewed by OGC and will be finalized in May or June 2011. It does not include at-large members, but references 5 specific national organizations. While the committee could make recommendations about who should fill the at-large positions, there was some sentiment that Drs. Frieden and Monroe should determine what type of advice they need.
- Currently, there are 4 national organizations: NIHB, NCAI, Direct Services Tribes, and Tribal Self Governance. It was suggested that consideration be given to an organization that represents urban populations. It was noted that these advisory councils are established because of the government-to-government relationship between the federal government and tribes. Urban organizations are not part of that government. They all work with and need them, but they do not represent the government. Some support was expressed for flexibility in terms of not specifying organizations in order to allow other voices to be heard. To be consistent with the STAC charter, the ultimate agreement was include 5 at-large members.

- Change the language to read “majority vote” rather than “quorum,” given the difficulties TCAC has experienced having a quorum sometimes.

Given that the group ran out of time, Ms. Cantrell indicated that the input so far would give her ample information to rewrite the charter and distribute it to TCAC members for review and comment. Once the draft was completed and everyone had sufficient time to read and offer input on it, a conference call could be scheduled for more fruitful discussion.

Recap/Closing Prayer

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

In closing, Ms. Hughes reminded everyone to submit their final comments pertaining to the charter and consultation policy documents to Ms. Cantrell by February 14, 2011. She also reminded everyone that they also would be receiving the job description for the new position from Ms. Moore and should review and return their comments on that to Ms. Moore as soon as possible. There will also be an opportunity for another round of comments on the accreditation process.

Motion

Mr. Nez proposed that a new TCAC office be established within OSTLTS to address TCAC issues, recommendations, barriers, et cetera on a daily basis. However, it was clarified that the new Associate Director for Tribal Affairs position is to have a number of FTEs attached to it, and it is possible that together they will address the issues raised by Mr. Nez in terms of supporting the relationship between TCAC and OSTLTS. In addition, TCAC members requested the opportunity to review and make recommendations regarding the qualifications / roles for the new position / support staff. Therefore, Mr. Nez amended his motion. The amended motion was to establish a workgroup to define the scope of work for the new Associate Director for Tribal Affairs position and its FTEs, including its relationship / interaction with TCAC. The motion was seconded, and passed unanimously.

With no further comments, questions, or business posed, Mr. Secatero offered the closing prayer and the meeting was officially adjourned.

Attendant Roster

Tribal Consultation Advisory Committee (TCAC) Members

Joe Finkbonner, Portland (Northwest Portland Area Indian Health Board, Executive Director)
Kathy Hughes, Bemidji, TCAC Co-Chair (Oneida Business Committee)
Sherrilla McKinley, (Inter Tribal Council of Arizona, Inc.)
Brenda Neilson, Quileute Tribe (Northwest Portland Area Indian Health Board, Tribal Health Director)
David Nez, Navajo Nation (Public Health Emergency Coordinator, State of Arizona, New Mexico and Utah)
J.T. Petherick, Oklahoma (Cherokee Nation, Health Legislative Officer)
Alicia Reft, Alaska (Karluk Ira Tribal Council)
Lester Secatero, Albuquerque (Albuquerque Area Indian Health Board, Chairman)
Derek Valdo, NCAI (from Pueblo of Acoma, National Congress of American Indians)
Cathy Abramson, Sault Tribe of Chippewa Indians, NIHB
Candida Hunter, Hualapai, Councilwoman

Other Tribal Organizations / Tribal Health Boards / Tribal Health Professionals

Bridget Canniff, Northwest Portland Area Indian Health Board, Tribal Epidemiology Center Consortium, Project Director
Elaine Dado, Northwest Portland Area Indian Health Board
Annie Ferron, Tribal Liaison, Division of Cancer Prevention and Control, Phoenix Indian Health Service
Kyler Schneider, Oklahoma City Area Intertribal Health Board
Philene Herrera, Navajo Nation (Program Manager)

Centers for Disease Control and Prevention

Dan Baden, Director of Public Health Capacity Development
Kimberly Cantrell, Tribal Liaison
Judy Delaney, Liaison to OSTLTS
Melanie Duckworkth, Acting Senior Tribal Liaison
David Espey, Epidemiologist, Division of Cancer Control and Prevention
Rick Lancaster
Judy Lipshtiz, Policy Office, OSTLTS
Judy Monroe, OSTLTS Director
Harald Pietz, Acting Branch Chief, Technical Branch
Chris Rosheim, AI/NA/NH, Chairman of CDC HHS Minority Initiatives Committee
Kyler Schneider, E
Dean Seneca, Partnership and Support Branch
Sam Taveras
Georgia Moore, Associate Director for Policy OSTLTS
John Wilburn
Craig Wilkins, AI / AN Team
Rob Curlee, Deputy Director, Financial Management Office
Michael Franklin, Senior Public Health Analyst, Financial Management Office
Nakki Price, Policy Lead, Technical Assistance Branch
Annabelle Allison, Environmental Health Specialist, NCEH / ATSDR

Lynn Gibbs-Scharf, Branch Chief, Knowledge Management Branch
Julio Dient Taillepierre, Team Leader, Initiatives and Partnerships Unit
Larry Cohen, Lead Medical Epidemiologist, Scientific Education and Professional Development
Program Office
Detrice S. Munir, Deputy Management and Policy Fellowships Branch
Cindi Melanson, Branch Chief, Public Health Preventive Service Program Branch
Larry Alonso, Commander, US Public Health Service
Holly Billie, Senior Injury Prevention Specialist, National Center for Injury Prevention and
Control
Nell Brownstein, AREB/DHDSP/NCCDPHP/CDC
Wayne Giles, Acting Deputy Director, National Center for Chronic Disease Prevention and
Health Promotion
Myra Tucker, Tribal Liaison

Other Guests

Stephanie Henry Wallace, Cambridge Communications
Amy Johnson, Cambridge Communications